When Does HIV Funding Strengthen Health Systems?
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WAFAA EL-SADR: Good morning and welcome to this session. Our session is entitled When Does HIV Funding Strengthen Health Systems? As all of you have been attending this meeting have been keenly aware of this topic and the great interest that this point in time in the history of the HIV epidemic and in the history of the response to the HIV epidemic.

Many believe that it is at a crossroads and at the moment in time when we are just on the verge of trying to achieve universal access of course there are lots of challenges in terms of some of the concerns about the funding for the scale up of treatment and prevention.

Some of the concerns regarding the effects of HIV on health systems and the effect of health systems on the success of HIV programs. All of these questions have generated a lot of interest in the topic of the interrelationship between HIV programming and health systems.

There are several sessions at this conference that are trying to address this topic and a variety of different ways by looking at presenting evidence from programs, evidence from cross-country analysis, case studies, looking at cost effectiveness work and many other perspectives.

At this session here, we are hoping to have a conversation as well as some presentations by the members of

this panel. We have structured this session to allow for a lot of room and a lot of time for engagement with you, the audience so that you have time to ask questions and to our panel members and hopefully the panel members will also have the opportunity to seek answers to some of their own questions from other panel members.

Without further ado, I am just going to tell you how we structured this session. There are going to be two very brief presentations and the instructions to our presenters have been to be very succinct and brief and just to provide some insights, some key insights. Then we have two discussions that will have the opportunity to reflect on those presentations from their own very different perspectives.

Then we will open it up for a conversation with the audience as well as moderated conversations across the panel members. Without further ado I am going to present, our first presenter who is our first presenter today is Professor Ruairi Brugha.

Professor Brugha is the head of the Department of Epidemiology and Public Health Medicine at the Royal College of Surgeons in Ireland. He has done extensive work in terms of looking at issues related to health system strengthening and the impact of HIV and on health systems.

He has been co-coordinating the GHIN Network. He will tell you more about that. He has been working again at trying

to understand the impact on global health initiatives on health systems. Welcome.

RUAIRI BRUGHA: Thanks Wafaa. Thanks to the conference for the invitation. The question here is when does HIV funding strengthen health systems. I will provide one case study to actually show how that has happened in one country and not in a very similar neighboring country, Malawi and Zambia.

Actually, the question which I am trying to ask here is how can HIV funding strengthen health systems. This is very much aimed at donors and their partners, but particularly at country decision makers and their partners. It is a simple message and I will start at the end with the message, which is that if countries can develop strategies for strengthening their health systems, then they will have a much stronger case for encouraging donors to channel their funds to these health system strengthening priorities.

The recommendations are firstly to countries and their partners that they need to develop coordinated overarching country level HSS, health system strengthening strategies and secondly to donors such as the Global Fund, PEPFAR and the bilaterales, be flexible and be willing to redirect your resources to country HSS strategies. Even if these are long-term ones such as basic health worker training which may not give you quick wins.

What is the evidence that this approach works. We see here just some figures to show the level of funding which came in to Malawi and to Zambia between 2004 and 2008. The key figure there is Malawi mainly got global initiative funding from the Global Fund, about 230 million where as Zambia also got a sizeable Global Fund grant, but got 570 million in PEPFAR over a four year period, about double the amount of money going into HIV per capita as was going into it in Malawi.

Our study, which the lesson is based on that, was a district and facility based study. Our teams in Malawi, Victor and John looked at nine districts and 52 facilities. In Zambia Joseph looked at three districts and 39 facilities.

Firstly, to acknowledge that there has been tremendous scale up in ART, particularly in Malawi and Zambia. I think it is always important when we talk about how is HIV funding strengthening health systems that we always acknowledge first is it achieving its primary objective. For those of us who were at the last session from Professor James Hakim, it is about saving lives. Those objectives are being achieved in Malawi and Zambia.

Now we turn to, well what has been happening to the health system there. We are looking just at staff numbers here. The relevant numbers here from Malawi are the ones in red.

Clinical staff numbers, doctors, nurses, clinical officers. What we see is a total increase of about 10-percent in clinical staff numbers across two years and two thirds of that was in urban facilities, mainly the central hospitals and urban clinics.

One third of it was at the district level, but not at the rural level. What we did see in Malawi was a very large increase in health surveillances assistance. Many of you would be aware of this, which is the former task shifting that Malawi has been doing.

Over half of the HSAs were being assigned to rural facilities. What do we see in Zambia? We saw a total flat lining of clinical staff numbers. No increase in doctors, nurses, clinical officers across the survey facilities. Just a slight increase in HIV counselors.

What does it tell us about country health system strengthening approaches? If we look at what the donors do. Many of you will be familiar with this. The Global Fund with funding from UK DFID and encouragement from Peter Picot did agree to reallocate Malawi's round one grant to enable Malawi to implement its emergency human resource program, doubling the training of new health workers.

We are not seeing the fruits of that until now in many cases. The Global Fund was willing to do this back in 2005, 2006 knowing that some of the benefits would not be seen until

now. Hiring new staff, mainly health surveillance assistance and salary supplements.

Zambia also had a national human resources for health strategic plan. Despite the greater amount of external funding coming in there, it lacked donor support for training, basic training of health workers and hiring of new health workers. Most of the money was going for workshops.

That is the first message that I want to give here which is that governments need to actually produce these strategic plans for strengthening their health systems. That is what will give them the leverage to be able to put pressure on the donors. We have this ready, now please fund it. Then donors will be under a lot of greater pressure to do it.

I look forward to hearing other examples from the audience here where other country's strategic plans have or have not been funded and is this a strategy that can work. The message is simple, but actually, the implementation is not so simple. It is political.

I would like to just acknowledge the Open Society Institute for the fieldwork in Zambia, the Alliance of Health Policy and Systems Research for the Malawi study, the country researchers and our network funders, Irish Aid and DANIDA.

WAFAA EL-SADR: Thank you very much. Thank you. [Applause] We will move on to our next speaker. Our next speaker is Dr. Mary Ann Lansang. Dr. Lansang is director of

the Knowledge Management Unit at the Global Fund. She has also been quite involved in doing health systems research covering a broad array of issues including vaccine research, tropical diseases, HIV, and many other aspects of health systems. Dr. Lansang.

MARY ANN LANSANG: Thank you Wafaa. Good morning everyone. I was asked to speak on what you would do if you received funding from the Global Fund for HIV and how it would actually affect the health systems.

In a preconference meeting here, we actually reviewed some work that showed that HIV funding could strengthen health systems. There is also work that showed that in some instances it can be a negative factor. Ruairi showed you some positive factors, but now we would like to share some tips that might help you strengthen the contributions of HIV funding to health systems and vice versa.

One very important thing is if you were to revive HIV funding what do you know about the national health sector strategy. Are you so involved in the HIV program that you don't know what is happening in the national health sector. What Ruairi mentioned, what is the national health strategy all about? How does the HIV program place in that national health strategy?

Have you looked at the other diseases, the major health burdens in the country that could also benefit from the HIV

funding that you are receiving? For example, in HIV what are the synergies with malaria and child health? What are the synergies with the maternal health? Those are questions that you need to bring forward.

Also, if there are joint funding mechanisms happening in your country like SWAPS, how do you make use, what is the synergy between your funding and the SWAP mechanism in your country? If there is an HIV aids pull mechanism, is it only for the global fund, the contribution or are you trying to pull this among other donor funds? As Ruairi pointed out, many countries, particularly in Africa do not just receive Global Fund funding, but all sorts of other donor funds.

Another is attention to the performance framework that you negotiate with the Global Fund. Sometimes we get indicators like number of trained health workers. At the end of the day, we also want to see what the health workers are being trained for. Is it for a short-term plan? Or as again Ruairi pointed out, is it really contributing to a strategy for the health workforce in the national health system? That would be very helpful for us.

In for example reviewing the phase two applications or for periodic reviews. It is not enough anymore to just say we trained 1,000 health workers.

Insist on trying to align the reporting systems of the donors. I know that the Global Fund is one of the major

problems in this and I am sure our minister here will say have something to say there. I think that there can be negotiations on the table. If you really want to strengthen aid and align health information system, be stronger in making a case for not just a vertical reporting system for HIV unless for a global fund project.

Try to take advantage of the opportunities that are happening now. The interest in strengthening human resources for health. We have a second global forum on health human resources next year. If you can show that your activities in HIV are really strengthening as has been shown in Malawi, in Ethiopia, in Rwanda. These are important mechanisms.

Interests in MG 4, 5, and 6 integration in this. Make maximum opportunity in this regard. National strategy applications. Yesterday I talked about the health systems funding platform. More and more we will be talking about platforms for delivering service. As you know in some other sessions here, we have been talking about single stream funding for round 11 moving forward. Those are opportunities.

Finally, I just would like to pose two questions for our panelists here. What synergies and benefits can be achieved by integration of HIV interventions with critical functions of the health systems? Second, what constraints and challenges should be managed when trying to achieve integration of HIV interventions with broader health systems functions?

I would just like to end by again stressing three key points. Promote longer-term approaches to capacity building for health systems. Ownership at the country level in terms of demonstrating that you are doing the planning. You are doing the planning for real integrated implementation.

Finally, very important, I should not forget this, that there are links between health systems strengthening and community systems strengthening. You should capitalize on that when you receive HIV funding so that service delivery is not just theoretical, but it reaches the people affected on the ground. Thank you.

WAFAA EL-SADR: Thank you. [Applause] Thank you very much Dr. Lansang.

At this point, I think we will move to our discussions. I will start first by introducing our first discussant who is Dr. Mphu Ramatlapeng. She is the Honorable Minister of Health and Social Welfare of Lesotho. She has been in that position since 2007.

She has extensive experience in a variety of different roles in Lesotho from actually being a physician right at the forefront of delivery of health services and now playing a key role in stewardship of the whole health system in Lesotho.

Lesotho has done some remarkable work. It has been able to really catalyze remarkable achievements in terms of the response to the HIV epidemic over the past just few years. I

think also important to point out is that one of the key achievements that has happened over the last few years under her stewardship has been the introduction of universal healthcare. Also an introduction of a stipend for community healthcare workers, which play a key role in the delivery of many of the very important services that were mentioned by Dr. Lansang previously.

Without further ado, I am going to ask the Honorable Minister to give us her prospective on some of these issues as she faces in trying. To integrate a lot of the inputs that are coming from within the country, within the experiences of the health systems in Lesotho as well as also some of the imperatives that are influencing or trying to influence some of the shaping of the policies within the country. Welcome.

MPHU KENEILOE RAMATLAPENG: Thank you very much and thank you for inviting me to be part of this panel to share my experiences in Lesotho.

Perhaps what I should say to the audience is that Lesotho has not attracted a lot of partners or donors. Therefore, it is easier for us to work with the few partners that we have. Also, there is a very strong political wheel in Lesotho. The government owns the programs.

I think it was easier for me to answer the question, when does HIV funding not strengthen health systems. I think the most obvious is when partners come into the country and

insist on setting up their own programs, parallel structures do not assist in strengthening health systems.

In fact, it causes a lot of problems when they close shop and go. The country struggles to absorb their experienced health workers who are trained in this parallel structure. That for us, we have seen that, it is a major problem. Therefore, in Lesotho you are not allowed to set up your own shop and give out medication or any program. That is simply not acceptable. Government has the sole responsibility. Everybody else is our partner who assists us.

Another issue is the funding. Until the advent of HIV and AIDS, I think this has really opened our eyes and shown us that really our health systems were very weak to start with. They have been very weak, we had this horrible epidemic, and we had to deal with the health systems.

If you will remember, I hear people that come from the countries of the North, you will remember that a majority of the countries would offer funding to countries, but would insist on that it is not meant for human resources. Irrespective whether it is human resources for health. Countries such as mine, we are always branded as a country that does not have capacity.

You would give millions and millions of dollars of Euros that had no one to move. Therefore, I really compliment

Global Fund on this one. I compliment Global Fund and the Irish government.

The Irish AIDS has been instrumental in showing the way that it is possible to fund human resources for health and Global Fund has done the same. This has built great capacity as we have seen in Malawi and in my own country too that has happened to some extent. Malawi because it went directly also to the medical school and has its own medical students.

Therefore, it is important to give equal funding for programs as well as for other health system strengthening part of the program such as human resources for health.

It is important that we have alignment of programs throughout whether you are funding a clinic that maybe is a privately owned clinic or a clinic that is run by government. For a start, we need to have the same programs starting with guidelines. If you think of the guidelines that in any country where you have different organizations. I am not afraid to mention them, because they are your friends.

If you have MSF, MSF will have its own guidelines. If you have Partners for Health, they will have their own and the government will have its own. The most important thing is that is the starting point. Have all of the guidelines.

The country must insist on having the same guidelines, working with the same partners you can reach a consensus and

adopt country guidelines. That for me has been one of the most important starting points for us.

I was talking to the Global Fund, you have round two, round five, round 6, round 7, now round 8 is already there, round 9 in the pipeline. What is important is alignment of all of these rounds. This talk has been going on now. I think it is about time we had them. Reporting mechanisms for all of these rounds is a nightmare. We have been able to do this by and large, [Applause].

If you have to report for PEPFAR, you report for Global Fund several rounds, and you have also the Irish aid and you have another partner. You need to have some form of alignment and simplify the reporting mechanisms. We already recognize by the way Global Fund is a great vehicle for delivery.

We recognize that and if you can do this for us, for countries that you save then you know very well the capacity in a whole. I am not even mentioning the medical. The reporting now you need counters, you need economists, you need all sorts of people. We have a challenge with that. If we can achieve alignment of the rounds, that would be great.

Indeed, another issue that I think the developing countries always come up with, countries always say they are giving $1 billion to country X, but half of that money is actually going back home. [Applause] If you want to build capacity in our countries, trust us. Build capacity of the

people who live in those countries. Empower them with education. Empower them to remain in their counties.

Listen to trained doctors for UK, for South Africa, for Canada, for the U.S. What we really would appreciate our nurses and doctors to be assisted to remain home. Global Fund is already doing part of this. It is doing a great job. You can do more. I think you have set a good example to other partners, other donors that this is achievable.

We appeal now to PEPFAR. PEPFAR money should remain in the countries that are meant to receive this aid. It should not be doing home. PEPFAR should trust us enough to have the programs within the mainstream health problems of the countries. If we can achieve this, I think we would have gone a long way. Thank you very much.

WAFAA EL-SADR: Thank you. [Applause] Great. Thank you very much for your insight and I think we will move on to our next discussant that is Professor Jean-Paul Moatti. He is currently Professor of Health Economics at the University of the Mediterranean in France. As many of you know, he has been quite involved in some of the economic analysis that relate to the HIV epidemic and the [Applause] response.

He is also an adviser to the global fund in terms of some of the issues that I just mentioned. He has published extensively on the health economics in particular and in

particular has economical issues related to HIV. Your comments are welcome.

JEAN-PAUL MOATTI: Thank you Wafaa. Thanks everybody for being here. My initial intention was to show you a number of slides that describe the results of evaluation of national art program in Cameroon, which has been carried out by our colleagues from the University of Yaoundé with support of the French Agency for AIDS Research.

It shows how decentralization of HIV care at a district level improved the cost effectiveness and the equity of access of the system. You can find that in some publications including things that have been published in AIDS in January of this year.

I would rather concentrate for the sake of a debate on more general messages. I fully agree with what Mary Ann and Ruairi already said on that. Our evidence from Cameroon just brings additional support to what you said.

Let me go to the three messages that I think the HIV community and the health systems community that sometimes in the past have fought between each other should not convey together.

The first message is that when donors talk about value for money, we should not discard that. We should say, yes. I am not saying that only because I am an economist. Yes, it is true; we can do better with the money we already have.

Examples of Cameroon, the examples of Malawi show how in the delivery of HIV, malaria, and TB programs there have been significant improvements to do better with the resources we already have.

I fully agree with what my friend Ellen Tune said this morning at the plenary is that cost effectiveness approach should not be used to deny care, but we should also say that yes, we agree with using cost effectiveness approaches to improve care, to improve delivery of services. That is my first message.

The immediate message that we also have to carry and I say that with do respect to a great admiration to both Bill Gates and President Clinton. [Applause] We should clearly say that even if we do miracles; let's say we have 50-percent efficiency gains. Nobody has ever had that in all of the developed countries, any minister able to do that in France would have a statue on the Arc de Triomphe.

Even if we are able to do miracles, and I know that you people in the room, you are able to do miracles. You already proved it. Even if we do that, there is a crucial fact that everybody should remember. The most robust correlation in economics is between economy growth and expenditures.

What are the facts? The fact is that currently expenditures per capita in the rich counties are circa 3,500s. If you extrapolate that to 230 even with the most opportunistic

predictions, that leads us to around $6,000.00 per capita in rich for health. Currently in Sub-Saharan Africa, it is $35 U.S. per person.

Even if you do optimistic, predictions and linear extrapolations that mean that in 2030 it will not go beyond 100. With $100, even if you make it look like 150 with efficiency gains, you can't do miracles. You cannot do the MDGs. There is no other way to fight for additional resources. No other way, okay? So, yes, for efficiency gains, but that should not be seen as a pretext for retreating in funding, okay?

Second, I am an economist, so if you come to me and say we cannot do this in the economy crisis - due to economy crisis because our public deficit, our public debt in rich countries, doesn't allow us to do it, I can say fine, I've been trained in a good university. But if we do so, you have to tell it to the world. So let's be clear.

There are a number of scenarios that have been put front by the secretariat of the Global Fund. We have to be clear. It's only the "I" scenario, the doubling of resources, 20 billion for the next coming years. We are 10 billion ending in 2010. This scenario is the only scenario which gives us a little chance, a little chance to reach universal access.

All the other scenarios are retreat, okay? So, yes, we can face [applause] - we may have to say - our donors may have

to say that they want to retreat because of an economy crisis, but then they have to tell it explicitly, not to find pretext, okay?

And let me add about that. The other argument after that is okay, but even if you - we were able to give you in spite of a crisis it's doubling of the Global Fund and all programs to keep on scaling up, well, there's not enough demand; there's not enough absorptive capacity, okay?

But if, at the same time - we all know as economists that the creation of demand - we're not talking about the market here. We're not talking about perfect competition; we are thinking about complex negotiations at international and national levels, so, of course, you can manipulate demand.

So, of course, if you do everything to change anticipations of the Minister of Lesotho - if the Minister of Lesotho knows that whatever she demands she's not going to get it, of course demand is going to go down, and you have the proof that we don't need the doubling of resources. Following me? Okay.

So let's prove them wrong. Let's do a relationship in the direction that was already presented. Let's make the relationship between our AIDS programs and strengthening our systems in order to produce high quality demand grants and, frankly, doubling will not be enough to - because of what I

said about the macroeconomic economy context: no more than $100 in 2030, so let's prove it wrong.

And finally, and I will close about that. We also have to fight because I agree with President Clinton and the fact that due to the deficits, we're not going to be able to raise money like this. But let's face it, and let's use dirty words.

I know that tax on financial transactions sounds like a dirty word for many of our Anglo Saxon colleagues. I know that for years, because being a kind of leftist thing - although many [inaudible] economists from conservatives to progressives have been arguing for that long before the financial crisis as a way to prevent financial crisis and was not followed by the elite of the world.

Today we have people like the French Minister of Finance with the German Minister of Finance - God knows, she's not a leftist at all, okay, that are arguing in favor of a financial tax and we are unique together to start doing that. We showed in the campaign of Coalition Plus [misspelled?] for the so-called tax [inaudible], you heard about that maybe some of you, that simple 0.01-percent tax, not on all financial transactions, only on currency exchanges between banks will bring at minimum 40 billion.

Remember, for three years for the Global Fund we need 20 billion? This tax will generate a minimum of 40 billion per year. Okay, do the calculation. It's just a question of being

all together to start doing this kind of thing. I know it will be a miracle that we impose such a tax, but we've already done miracles. [Applause].

WAFAA EL-SADR: Thank you. I have a feeling if there was a contest to pick your favorite economist at this meeting maybe Jean-Paul would get the vote, right? [Laughter]. I do know that there are other economists in the room so maybe we'll have some different perspectives, who knows?

I guess for just to start the conversation - thank you all for your comments and presentations - it's interesting when we look at the title of the session, "When Does HIV Funding Strengthen Health Systems," and there is a divide out there, there's a divide between - somehow a divide that we're trying very hard to breach, and that's a divide between people who are passionate about HIV.

They're passionate about HIV because they realize it has an important impact on countries, communities, health systems and believe very strongly because of all the other issues around HIV: stigma, the social fabric of communities, they're passionate about doing something about HIV.

And on the other hand, there are, of course, other individuals that are passionate about health systems. And they're equally passionate about health systems. And there are a few people who bridge the divide who are passionate about both. So we're going to try here to try to see if there is a

way we can bridge that divide and, maybe, find a way to sync ahead. Rather than try to learn from the past and maybe derive lessons from the past, I think it's really much more fruitful to think ahead and think how can we work together to ask questions and derive answers for the future.

But my first question is one of the common critiques of the health systems researchers is the question of what are the outcomes? What are you trying to achieve by strengthening health systems? And that's a critique and a criticism that we have heard in many of the meetings here is can we derive outcomes that are - what are the meaningful outcomes?

Are some of the outcomes increasing just number of workers in facilities? Is that the appropriate outcome? It seems - or some others would say, it's just a process outcome. What are ultimately the outcomes of a strengthening - of an agenda of strengthening health systems?

And maybe I'll throw it back to the people on our panel on the platform here first to try to sort of think about what are some meaningful outcomes that I think we can all rally around. Do you want to start, Ruairi?

RUAIRI BRUGHA: So maybe I'll just start at the end with your question Wafaa, and have services delivered outputs which then lead to outcomes. And I think one of the good things about the evolution in the way the U.S. wants to work, which is much framed, perhaps, around the MDGs, is that we look

at women, we look at children, we look at men and we look at whether what we are doing is actually leading to better health.

I think we should frame what we are doing in HIV in the year when the MDGs are being reviewed to see how are we working collectively towards the health in HIV MDGs, and more widely than to education and poverty.

We saw some presentations yesterday which attempted to look and see how are non-HIV services are doing when HIV services are scaling up, and I think that's very early work. We need to understand when other services are benefiting particularly. When we are delivering ART and PNTCT and DCT and we see EPI, we see childhood vaccinations being delivered, we see family planning going up. We need to understand what is it, what are those positive synergies?

It's not enough to say - like we were saying through the WHO a year ago there are positive synergies. We actually need to understand down at the level of the district and the health facilities what is happening. And one thing which I think - if I can give a negative example and then a positive example in terms of where - how HIV funding is influencing health systems.

I'm hearing very little about districts. In fact, I've been hearing very little about districts for several years. I worked in Ghana in the '80's and the early '90's when there was this great strengthening of district health service initiative,

district health management teams, DMOs, funding was coming down - discretionary funding was coming down, sometimes through sector-wide approaches, often by through ministries. And people were being empowered at the level of the district to deliver the services as they saw that they were needed at the district level.

I'm not hearing very much about the district level now. I think the whole agenda is being far more dominated by what's happening at the global level. But there is a positive example and maybe to mention a funding - a funder that we've actually forgotten about and that's the World Bank Multi-Country AIDS Program, the MAP program.

We now, actually, with our Zambian colleagues from Frontiers are down at the community level below the district, and we're finding that, actually, there are a lot of CBOs, a lot of women-led organizations down at that level who have been empowered and who are delivering services.

They're no longer getting funding, they're no longer getting funding from the donors that we pay attention to, but there has been some real strengthening there. And I think we need to pay a little less attention about what's happening at the global level and a little bit more going down and finding out what's happening at the district level and right down at the community level.

WAFAA EL-SADR: Thank you. Any other of our panel want to comment on the question or - okay. Briefly.

JEAN-PAUL MOATTI: Just very quickly. Just one example of things that you can do because Rwanda already did it. one of the main problems for access to care in Africa and also in southeast Asia is that contrary to what is in developed countries like mine, the majority of the funding comes from direct out-of-pocket payments from our source, so when you get sick you pay. And if you don't have enough money, you don't get enough care.

It has taken us in Europe, for example, some 150 years to go to a better and less regulative system in which we have universal family health interest. There is an initiative from the French and the German and governments and I allude to promote that. I know that some NGOs like Oxfam also did a lot of work in advocating for this type of solution.

The example of Rwanda is a typical example is a typical example of the use of health systems strengthening window of the Global Fund to improve not only access of HIV-infected persons to better coverage by community-based health interests, but also to use that to upscale others to all the poorest population.

And I'm wondering why Rwanda is an exception? Why not more countries in their strategy plans include some forms of - and a typical example of Ruairi just said. You cannot ask for

Global Fund to create an old universal entrance system in the country; you need to have a national plan for that. But once you have a national plan as Rwanda did, you can have some significant co-funding on the basis, and so, let's do this kind of thing.

WAFAA EL-SADR: Yes, thank you very much. While we're moving on to the next comment, I'd ask people from the audience, if you can start - if you have questions, we have several microphones and we'll get to you after the next comment.

MPHU KENEILOE RAMATLAPENG: Thank you very much. I think what we have done in Lesotho is we offer HIV/AIDS care at all primary healthcare centers. It's a mass-driven model so every center will not say - there is no HIV center in Lesotho. All primary healthcare centers are where you get your HIV - that's where you'll get your child vaccinated, that's where you'll deliver a baby, that's where you'll maternity and child health services. So, in fact, what we have done is [applause] we have linked it to the community health worker program.

We have, again, said to our partners, please do not bring in other CBOs and other people who have named them other things; we encourage you to go our way and we pay for it, we pay our community health workers a small stipend. And if you want to add to that, that is fine, but try and keep the same level as the government.

And this community of health workers have been trained. They go, they look for children, they look for children who have not been vaccinated, and encourage mothers to attend antenatal care.

So, basically, when we define, you know, the mother/baby package, it was also around the same model that we know the community health worker will check for the mother and [inaudible] package if the mother decides to deliver at home, whether the child has actually be given the proper treatment.

We are working very closely now with the World Bank to reward clinics or staff for work that they have done. It's a result of paying for the results. So if a particular clinic - in this particular case, it would be in a district - if they have done the job, I mean, they've met the targets that we have all set: the number of vaccinations, the number of deliveries at health service centers, then that particular facility and people who work there would be rewarded.

So I think we are getting there, we are not yet there, but, basically, we have not designed a different model from the one that the government already has.

WAFAA EL-SADR: Thank you very much. I think what I'm hearing is -

FEMALE SPEAKER: Waffa?

WAFAA EL-SADR: One second. You know, what I'm hearing is kind of the output of the - is the focus should be on the -

what are the outputs of the health systems in general in terms of the traditional issues of concern: coverage, quality, equity and so on.

In terms, as well, of what I heard from you is an interest in also trying to focus on some of the global outcomes of interest which are, obviously, focused on the NDGs in terms of child health, maternal health, HIV, malaria, TB and so on.

So it's a mix of, kind of outputs, but also with a bit of a push towards also coming up with some key outcomes that are of high priority for the countries and for the global community. A brief comment and then I need to go to the questions.

MARY ANN LANSANG: Okay. I just wanted to add to complement the discussion that one area that was not touched but which is quite important is procurement management systems. And you asked about health outcomes, there's an important intermediate outcome when we talk about procurement management systems and that stuck out.

And we'd really like to discourage vertical procurement management systems for the three diseases. If a country, for example, has three five rounds we still do not see an improvement in the procurement management system proposals for the other grants. So, some more work into an integrated procurement management system.

WAFAA EL-SADR: Thank you. I'll take the questions in the row from the people standing now - all of them and we'll try to answer them. Go ahead, please. If you can introduce yourself.

PAUL CRIST: Yes, my name is Paul Crist. I work with AIDS Healthcare Foundation and I am also an economist, but I'm sorry, Jean-Paul, you won't get any argument from me over your support for a financial transaction tax.

I just wanted to make a point that because there are many - there are not that many economists in global HIV and activists are usually - have a more limited understanding of economic principles and concepts.

I think that we need to talk more about some of the economic and the geo-political issues of HIV funding and health system development, and we need to do that now because the sooner that we move toward health system development - because health system development is slower to show benefits, but longer in effect, while HIV funding is basically aid that sort of expects a measurable impact next year.

So I think that we need more economists to sort of, you know, make the case so that activists can go out and demand that governments, especially in the United States, adopt the Robin Hood tax.

WAFAA EL-SADR: Thank you. Next?

REVEREND MASUPA: Thank you very much. My name is Reverend Masupa [misspelled?] from Zambia. I simply had to stand because Mr. Louie made a case study in Zambia on how HIV funding is strengthening health systems and, particularly, we are going to three districts. But really, I want to make it very categorical before the audience that the funding - the global funding system in Zambia comes in four contemporaries.

We have four principle recipients inclusive of the Ministry of Health and Churches Health Association, so, actually, it is not very, very true that maybe other principle recipients of the global funds are not putting these funds into strengthening the health system in Zambia.

I'll give you an example from the organization where I have an interest, and this is Churches Health Association. Right now, CHAs in Zambia is serving more than 80-percent rural health best systems using global funds. Now what challenges are we facing? We are facing challenges from the Global Fund because it is coming with strings attached.

If they tell you to use money on prevention, treatment, care and support, you cannot use that money on human resource capacity building. And I want to tell you, to say that we've done at least a community survey where we wanted the integrated approach services over family planning into VCT and PMTCT. The human resource - the nurses themselves are telling us, look, I

was not trained in family planning; I don't know anything to do with PMTCT, and so forth and so on.

So there is need for the Global Fund to start training human resource. Thank you.

WAFAA EL-SADR: Thank you. That's good. [Applause]. I think I'm going to take one more. There's another microphone - let me take microphone two, you've been standing for a long time. Go ahead.

LEEZEL HANIKA: Okay, thank you. My name is Leezel Hanika. I work for the South African Business Coalition on HIV and AIDS called SABCHA in South Africa, obviously. Our target market is very specific being in the business sector. And the issue around systems strengthening - and to get a better understanding, I actually looked at the WHO toolkit on health systems strengthening some time ago, and tried to look at how I could apply it to the business sector.

And I think that when we start talking about efficiency and optimization and improvement, we're not necessarily only talking about health, and the outcome is improvement in health. But the reality is that they're their own system. And you just mentioned procurement and supply, we're talking about MNE, we're talking finances, human resources, and often those resources are not limited to health services or health workers.

And so, it's quite difficult - I don't know if there's a toolkit around community system strengthening and what we

mean by that, but I would wager that it's still not going to be that helpful in terms of looking at the business sector. Why is this important in terms of scale? Out of the 48 million population in South Africa, 31 million is defined under the working age population. Out of that there is around 13 million people that actually have some form of employment.

Seven million are in the formal business sector. And then there's probably another two million that are informal employed or/and informal sector. And then there's another three million that are sitting in public service and community services, typically employees of some sort of agency and donor agencies.

So, I mean, this is a significant population that we're trying to target. And it's not always easy when we talk about the agenda of full system strengthening, and we talk about - and what those elements are and how we approach it. And if you approach it very narrowly from a donor fund perspective and you only limit it to health systems strengthening, you're actually excluding a lot of the elements that are actually vital when we start talking about sustainability, transfer, ownership.

And so, I just wanted to throw that back at you and say, you know, how can we look at system strengthening for improvements in health and start identifying some common elements that would actually be helpful across sectors? Ultimately, they are health systems within the business sector

from occupational health to primary healthcare that are being under utilized, and I'll conclude by saying that the entire aim is to be able to reduce the burden on the public health system so that we can provide access to those in greatest need through the public health system. Thank you.

WAFAA EL-SADR: Okay, thank you very much. Thank you. We'll talk about that, maybe, about the issue of the role of the private sector in particular. I would ask people to make their comments as brief as they can. Let's go to the back - very back microphone. Microphone four.

ECULU LEGON: Thank you. My name is Eculu Legon [misspelled?] from Napier, South Africa. I wanted to find out - anyone can answer this question - to find out if - why are donors not including the issues of social [inaudible] within the strengthening of health systems?

Because, for instance, the issues of port security are part of health because there's no point in focusing on health issues and [inaudible] addressing issues also on security because they are equally linked. Because for me, what is apparent in this conference is that issues of [inaudible], issues of [inaudible] are not talked, and yet, if you do not address those, we are not going to address the issues of health outcomes. Thank you.

WAFAA EL-SADR: Thank you. And that's, obviously, relevant to the equity issue. I'm just going to halt for a

second and see from our panel, if anybody wants to respond to the comments thus far. There was an issue raised about the issue of the business sector; one about social security and another one in terms of the human resource investment and the Zambia question. And another one was kind of about the language of economics. Go ahead.

RUAIRI BRUGHA: I think I would agree with the comments that came from the floor, and maybe more agree with them rather than try to answer them. I think what HIV has demonstrated is that the system, and that broader concept of the health system, or the health and HIV system, is much more complex than the system as maybe we conceived it at the time of ALMA-ATA and during the '70's and '80's.

I would certainly empathize with what the Reverend from Zambia said because in my own background, I spent 10 years delivering services in Africa as a missionary. And I think that one thing HIV has, maybe, helped us to do is to recognize that there is a much greater heterogeneity in terms of those who are available.

The capacity or the potential that needs to be developed into capacity to respond to HIV, whether you go right down to the community level or whether you go broader out to the missionary section, the NGO sector or the commercial sector in South Africa.

And I use South Africa as the example in my teaching of where the mining sector has responded. They were the first to introduce ARVs in many cases. Maybe just to leave it at that.

WAFAA EL-SADR: Okay. That's fine. Anyone else want to re-comment or -

MARY ANN LANSANG: Just a quick answer to agree that system strengthening includes much more than health; in fact, right now in the Global Fund, my boss - who I am replacing in this panel - has really proposed that we label this as systems strengthening and under that is health systems strengthening/community systems strengthening. And, perhaps, in the future, this interaction with the private sector will continue under that grouping.

WAFAA EL-SADR: The issue of social security.

MPHU KENEILOE RAMATLAPENG: I think the issue of social security is very important. Yes, indeed, this has not been included by most partners or donors, but we have seen where this - where we have had cash grants given to - especially to orphans or children who look after - who headed households. In Lesotho this has happened; it's just started, but we have seen really tremendous results. Children are remaining in school, and I think in other countries, too, so it is a very major important issue.

And I want to compliment the speaker for bringing this up because often we forget about the children who are left

behind by their parents. It is a very important issue and we need to be mindful of the fact that there are children out there who need assistance and who are orphans. Thank you.

WAFAA EL-SADR: Thank you.

JEAN-PAUL MOATTI: Just a short comment. Since we don't have a magic bullet to change fundamentally distribution of wealth between Vienna and, let's say, Lesotho or some other countries, we have to be smart. So, if you go - well, Global Fund has a mandate. It was created with a mandate. PEPFAR is a mandate and so on, so if you go to Global Fund by saying you should fund everything which is needed, again, we all don't even have $100 for health in sub Saharan Africa and we hardly have that in 2030.

They're going to say no, we cannot, you know, we cannot take care of everything. So what we have to do - what you have to do it to build national plans, national initiatives as Ruairi suggested and to play smart. And, for example, Rwanda played it very smart because they were able to articulate a national plan, including domestic resources, to go in the direction of social security with some Global Fund funding.

And it's the same for human resources. And I'm not sure, but even with your help, Mrs. Minister, we will be able to change the doctrine of the board of the Global Fund by saying, yes, we're going to now fund basic training for physicians and so on. So, yes, that's a constraint we have,

but let's find a way to articulate HIV, TB, malaria initiative that could be helpful in, you know, funding some part of a fundamental training that is needed for human resource credits.

WAFAA EL-SADR: Okay, thank you. Let's move on to the next comment. I'll go to two, yes. Go ahead.

STEPH TOPP: Thanks. My name's Steph Topp [misspelled?]. I work for the Center for Infectious Disease Research in Zambia. One of the reasons we're here is because there is so much HIV funding that the opportunities that have been identified and created by that funding for health systems strengthening are becoming increasingly apparent. But with huge amounts of money comes great temptation.

And I wanted to play devil's advocate just for a second and ask the panelists where the line should be drawn between ensuring what is clearly a necessary flexibility in the way HIV funds are used to strengthen our systems, particularly as we've heard today with regards to human resources and long term outcomes for our human resources, but where the line should be drawn between that and ensuring that the funds are actually used appropriately.

I come from a country which has recently struggled with this — I'm sure Mary is aware of this — the global fund has really been challenged for this in Zambia. So if you could maybe comment on that.

WAFAA EL-SADR: Thank you. Let's go to microphone 1.

FEMALE VOICE 2: I think that I just need to underscore and emphasize that in Zambia, we have four principal recipients. And yes, while the world seems to think that Zambia is in trouble, it's not with all the four principal recipients. We have two civil society with church and other in

Jews, and those are two principal recipient from government. And while we have had some challenges from one of the government principal recipient, the Churches Health Association of Zambia, which I am representing, is still going on. And money do get to the communities where it is needed.

Some congressmen have come and officials from the Global Fund and UNITAID all have proved that money is going to where it is needed.

So I also need to applaud Global Fund for a dual tracking system because I think seven years ago in Zambia we decided that money should not go into one coffer because if money had gone into one system, then they would be 100-percent in trouble. But as it is, money has continued coming to the other principal recipient, through the other principal recipient, including the church.

I also want to refer to the MAP program in Zambia by the World Bank. I think this is another lesson that we ought to learn. I think I'm addressing myself to the founders here and also you and agencies that to fund, and even World Bank,

that I think we need to have a transitional programs for these programs.

Because this MAP program, World Bank program in Zambia HIV and AIDS was for five years. And it has ended. Then what? So capacities were built at community level, but you can't sustain that because you didn't have a transition program. Thank you very much.

WAFAA EL-SADR: Thank you. We'll go way to the back.

JONATHAN MBUNA: My name is Jonathan Mbuna [misspelled?]. I'm coming from Malawi. I just want to ask you a question. How do we strike a balance between the increasing demand that is based on the health service, the system, versus the supply which is there?

If I can be a little bit illustrative, there are a lot of programs, a lot of funds, put into looking into, for instance, overall access, looking into issues of nutrition which my friend mentioned, looking into issues of social security. Whereas when you look at the system itself, the one which we use to the public health system, the resources there in terms of human resources are still inadequate. How do we strike that balance?

WAFAA EL-SADR: Thank you. Let's take — yes, go ahead, microphone two.

YOKA KAMELIANI: I'm Yoka Kameliani [misspelled?]. I work for Oxfam, and I'm one of those lucky people that you

said, Wafaa, who are passionate about HIV and passionate about health system and women's health. Oxfam has been working in both on the ground and at a global level for decades. So I'm in a lucky position.

And we really think that, one, we need to scale up the efforts for treating HIV and TB and malaria. Absolutely urgently. The way to sustain the impact we had so far and scale up that impact in the future, is to go through health system.

And I'm sure the minister would agree with me that when we talk about health system – health system, not general system – a health system, it's like the chair you're sitting on with four legs.

You have to invest in infrastructure, in health workers and medicine as a caveat for whole product issue, and health information system. These poor areas have been neglected for decades thanks to global policies. And now we're trying to fix these bad policies that happen over the years, again from Geneva. It doesn't work.

As the minister rightly said, it works from the country. As a health worker myself, if I am in my clinic, you upgrade my clinic, you gave me $50 or whatever every month, and you say, here is what I want you to do, offer vaccination, HIV treatment and prevention, the whole health outcomes that I'm

supposed to do as health workers, and based on that I will get my $50.

WAFAA EL-SADR: Okay.

YOKA KAMELIANI: That's how it would work. And Jean-Paul, just one thing. I'm not a health economist, as you know I'm not an economist as you know, but it doesn't take much to understand that it's false economy to say cutting now or flattening now is saving money. It isn't. Five years down the line we will have to pay more.

Not only that more people will be ill with HIV, TB and malaria, but also the cost of treatment is going to be double and triple and more than that because we will create resistance to infection, HIV, TB, malaria, pneumonia, diarrhea, will all have resistance and we have to spend now and we have to increase the spending now.

WAFAA EL-SADR: Okay. Thank you very much. I think, I appreciate the comments. I think maybe we will take a short pause before our next comments. And some were questions, but some were really comments. Anyone from the panelists want to respond to some of the comments?

JEAN-PAUL MOATTI: Well, of course Mogi [misspelled?] I agree with you as often. What I was saying is that it would be a short-term thing to stop scaling up. That's why I was arguing for at least doubling of the Global Fund. And, yes, we've done some work that I hope will be published soon, maybe

with the help of the Open Society Institute by the way, showing that at mid-term, which is ten years from now, fifteen years from now, the good economic investment, the good macro-economy choice, is to keep on scaling up, taking into account of the whole thing.

I have sometimes the impression when I am in Geneva, and I include myself in the criticism, that we are in Moscow 1940's planning for the world. That's not the way to do things. We know that.

And so, I think that there is a kind of speed. It is the beginerant characteristic of a bureaucracy — and I have no value judgment, I'm part of this bureaucracy — to create norms. Okay? But norms mean less flexibility.

So if you take the run that was successful, because there was some ambiguity of what was of system strengthening when they add background, if you just go too much into defining what is health system strengthening, what is not health system strengthening, and that it becomes a kind of way to evaluate the grants of a global fund, we're going to lose.

So, we have to speed up. That's why we need national plans. We need initiatives to show how we can integrate Global Fund, PEPFAR funds, into a broader healthcare reform. And that can only come from the country. And there's a race there.

We have to be quick, because if you're not quick enough, there will bureaucrats, including myself, including

myself, somewhere in Geneva or Paris or Washington that will tell you what is good and what is wrong.

WAFAA EL-SADR: Thank you. Now, any other comments from the panel? No? I mean it's interesting, there was one comment that I thought was quite interesting in terms of where does one draw the line which I thought was kind of interesting, of these programs or these funding sources that have been, they have a mandate, and yet we're kind of working on the edges of trying to demonstrate the flexibility and stretch the edges.

And I think everyone has done that to a large extent, certainly within the countries themselves because they care about the people and so on. But I think it is an interesting issue of where the line should be drawn and how much flexibility, as Jean-Paul was mentioning, how much flexibility should there be in these definitions.

It is interesting that, in terms of my impression, is that from the, whatever the evidence is, and the evidence has been, I have to say, not quite rigorously done or studied, the preponderance of evidence does not show that the investments, these vertical programs, these initiatives has had a negative, a dramatic negative effect.

We don't see an increase in childhood mortality. We see a decrease in childhood mortality across the board. There hasn't been an increase in maternal mortality. There has been

a decrease in maternal mortality. There's been kind of more of an infrastructure, an increase in infrastructure.

There's a trend towards increased survival so I have a feeling that we are, in a way, reassured that there hasn't been major negative impacts and it would be interesting to see, hopefully with sort of the pendulum swinging towards health system strengthening, we will continue to see that broad positive impact. But I think we should be cautious to sort of see what happens over time as well.

Yes?

RUAIRI BRUGHA: Wafaa, I would be concerned about a lack of long-termism. I mean the case of Zambia has come up here, and we've been working with our Zambian colleagues for several years now [applause].

And it's not just our own work, but it was another paper came out in *Human Resources for Health* about a month, six weeks ago, that projected that at the best Zambia could hope for, is that in ten year's time, it will have 20-percent of the health workers that it needs. Where it currently needs 10-percent.

So, yes, I think there has been a tendency for disease focused programs to draw the line and say, can we show results according to our own main objectives, and that is very understandable.

But there is a limited pool of health workers in Zambia, in Malawi, across Sub-Saharan Africa. We weren't able to demonstrate that there was a movement of health workers from the public sector to the NGO sector. It was definitely reported to us, and many others who have done studies report that that's what is happening.

I do think we need to take a broader, maybe global perspective on this key component. I mean of the six components that WHO has identified, I'd like to draw attention firstly to the health workers.

And the Global Code and Health Worker Migration which was passed at the World Health Assembly in May because, in Malawi, we can call for funding for health worker training and basic training, and it's a long-term investment.

And the U.S. may agree that it's going to double and triple the basic training of health workers in Africa, but if it doesn't mend its ways, and if my country, Ireland, doesn't mend its ways in terms of recruitment of health workers from overseas, we are just pouring water into a bucket knowing that there is a very big hole at the bottom of it.

I think I'll come back at the end with my second point which is the other building blocks that I would like to talk about which is the one of health information systems and some of the issues that the minister brought up about parallelism, but I'll come back to that at the end.

WAFAA EL-SADR: Okay, great. Thank you. [Interposing]

MARY ANN LANSANG: Just a quick comment with regard to the comment of Jean-Paul and to reinforce that when we talk about health systems, we really need to put in context in relation to the proposals and to the programs that we develop.

Sometimes the TRP, the Technical Review Panel, has noticed that people give proposals that are quite formulate with regard to the building blocks and say we need this, we need that, but do not argue the context, do not argue the strategy and do not argue what it does in the long-term, so.

WAFAA EL-SADR: Thank you. Let's go to this microphone one please.

DONALD SHEPARD: Thank you. My name is Donald Shepard at Brandeis University. I have a question for Jean-Paul Moatti. I'm also a health economist. I strongly endorse your comments. In particular your suggestion about using economics to find ways of doing things better. I have had the privilege of working in Rwanda with Dr. Angelique Rwiyereka and others and our work supports your findings that investments in AIDS has improved health systems generally with vaccinations and curative visits.

And my question is, are there other examples that you could mention, or other panelists, where economic analysis has found ways that the health system can do a better job than might have been obvious without such analysis?

WAFAA EL-SADR: Thank you. Let's go way in the back.

DEENA ROSA: My name's Deena Rosa [misspelled?] and I'm from AIDS Healthcare Foundation in Zambia and, first of all, I appreciate the diversity on the panel because I think it gives a representation from a whole bunch of different angles.

One of the issues that comes up that was partially raised was fiduciary responsibility and oversight by the funders because if, money, corruption is occurring in governments and money is disappearing, what do the funders have responsibility in correcting that and proving that there is enough money to around, really, if it's spent where it's supposed to be spent. [Applause]

WAFAA EL-SADR: Okay.

DEENA ROSA: And then secondly, with the programmalic oversight as well. Because I know, in Zambia, there is quite a bit of money that's coming in for various things but doesn't get to those various things. So, it seems as well that in our trying to help, not all help is helpful if there isn't people minding the store.

WAFAA EL-SADR: Thank you. Microphone number three. And thank you. Yes?

MARY ODUKA: My name is Mary Oduka [misspelled?]. I'm from Uganda. My question goes to the whole panel, and I consider that health system strengthening goes beyond the

health sector and we've been discussing mainly around the health sector.

I'll give you the example of Uganda where you find recruitment is under the ministry of public service, recruitment of health workers, training of health workers is under the ministry of education, and the delivery of the services under the ministry of health.

And yet we, particularly, the bilaterals — I work for a bilateral agency — but many of us bilaterals come in and we fund vertically and we fund with various sectors. So there isn't much integration, even within the countries and within the various ministries. And particularly and possibly the minister from Lesotho would be able to help us in this.

When we're talking of developing a national plan, it has to be a national integrated plan, working with all the various sectors that are able to help strengthen the health system. So could you please comment on that.

WAFAA EL-SADR: Thank you. Yes, go ahead microphone one.

BERT HOUTZ: Bert Houtz. I lead the BD PEPFAR lab strengthening program which is a public private partnership, and we're doing great work in Uganda and Mozambique in both teaching laboratory quality management, this is through selected corporate volunteers. Also, in helping to facilitate

strategic planning meetings which has gone quite well in Mozambique.

And so, our focus is country ownership, and I want to invite listeners to consider partnering with corporations. There is a lot that can be contributed in terms of improving efficiencies. Not just technical training but process mapping, research sharing. Thank you.

WAFAA EL-SADR: Thank you. And last comment in this section of the –

NANCY PIELEMEIER: Good afternoon. I'm Nancy Pielemeier from ABT Associates, and I'm honestly quite disturbed that we have such little evidence, even after the last decade, of increasing funding. And I know we were involved in early attempts through the sector-wide, looking at the sector-wide effects of the fund and other funding mechanisms and that was absorbed, I believe, into the JINN Network [misspelled?].

And I'm wondering why there hasn't been more investment looking, over time, at the effects of these investments and whether the global fund, and there's no one on the panel from PEPFAR, but I think that's an important question for PEPFAR as well, as to whether there is going to be real, serious attention to funding research that can look across time because the data presented today really are old and ignored a lot of things that have happened in the last three years for example,

that we've been involved with in Zambia. And I'm sure that's the case with Malawi as well.

The question is basically, we are just talking really based on opinion at this point, and we really need to have a concerted research effort that is continuous in order to be able to have an informed discussion.

WAFAA EL-SADR: Thank you. I think, let's go some of the comments. And do you want to comment on the issue of the –

MPHU KENEILOE RAMATLAPENG: Thank you very much about the involvement of other sectors, other ministries, in the overall planning of the government. The minister of health certainly does not, it is part of the overall government and it has its own clearly strategic plan but which is part of the government plan.

And the implementation plan also is agreed by all sectors, and you would find that your proposal would really have a lot of difficulty going through, whether it is PEPFAR, whether it is Global Fund, if it did not align itself with your national strategic plan and implementation plan.

And overall, now the way I have seen Global Fund functions, they function not in unison, they find out what you are doing with other partners and they compliment the work of other partners. I know when we are talking of child grants, we worked with the EU, UNICEF and Global Fund complimented the

work that was already been done in the country. And there are many, many examples I know from different countries.

So if you do not have a national plan, I don't even think you cannot even start your application. So majority of the countries in Africa I know have some plan, some strategic plan and implementation plan and there are many partners that are working with different governments. I know my former employer which is Tandem Foundation worked extensively with different countries to develop these plans and they are country owned.

So we work with the minister of public service. Yes, they know what we want. They know how we want to get there. Minister of education is a partner, too, that works very, very closely with us. So I want to concur, you already have the answer, but yes we are working with these entities and we are achieving the results. Thank you.

WAFAA EL-SADR: Any comments from other —

RUAIRI BRUGHA: We may be at wrapping up time, so I'll get in —

WAFAA EL-SADR: Ten minutes.

RUAIRI BRUGHA: Oh, not quite. And I think Mary, you're much better able to actually discuss the issue of mainstreaming across the sectors and across the ministries than I would be. And you and Irish Aid are very much pushing that agenda. I think if one tries to understand why that's been

difficult, I do wonder sometimes, in retrospect, whether the effect of the Global Fund in its early years caused a lot of confusion with regard to the mandates of the National AIDS Councils and Commissions versus the role of the CCM.

But I think from what we saw in Zambia, it's been quite disappointing in terms of other ministries willing to actually take on HIV control activities. Nancy, you're in a far better position to talk about the challenges and lessons learned in the area of national AIDS spending and national health accounts and I'd defer to Jean-Paul here because I think there were some good presentations last week about the importance of good enough data and not waiting until data are out of date if it's a matter of informing decision-makers.

But I do think some of the lessons that we have presented here do have a lasting value, and I think again and again we're hearing the same question around can countries come up with coherent national strategic plans for service delivery, but also national strategic plans for strengthening their health systems.

I think there is an issue of them getting the donors to buy into these, and there are problems around attribution. And I think where parallelism which the minister brought up at the beginning, where it has been most pervasive hasn't been around the issue of the willingness of donors to buy into national plans, they've all been saying that.

Even the Global Fund was saying it to us back in 2004. Where donors are least willing to sacrifice their parallel systems is in their information systems, and I think that's the other building block, in terms of the experience we have seen, Zambia has been running eight different health information systems in parallel. About five of them specifically in the area of HIV. And this has been government bodies, not only PEPFAR and Global Fund coming in.

And I think what we need is some rationalization and some integration and sacrificing the idea – if I look and see what went wrong with Global Fund five year evaluation, I was on the outside and one of my theories was that, and I know Burnich Farklander [misspelled?] said this at the time to us, everybody wants to throw in their information needs. And in the end, information systems are not serving the decision-makers at the country level.

So let's make it simpler. Let's focus on the collection of data at the district level, at the health facility level, at the district management team level. And let's get them to analyze the data. Because we've found, and frankly we spent two years trying to clean and analyze data from health systems, health facilities in Zambia, and the data were so flawed because nobody really cares what's happening down at the district level.

WAFAA EL-SADR: Thank you very much. And I think your comments are really quite meaningful. I do believe that, I think that the other issue is that people in general, there hasn't been as much emphasis on using the data and using the data to inform the programs sort of that circle, that cycle.

And there's nothing that, at least I believe, that makes as much of a difference in the quality of data — the only thing that really makes people produce quality data is when the data helps them, is when they can use the data to inform how they take care of a patient or it informs how they shape a program or how to improve a program or how to respond to new needs.

We've done the upstream part of collecting the data and sending it upstream, but I think there hasn't been as much emphasis as to, kind of, how are people using the data on day to day at all the different levels and that's an area that's not easy. And I think that needs capacity building and work for the future.

Other comments? I know that there was one comment on, I think that one of the comments was about fiduciary responsibilities and I don't know whether Jean-Paul or maybe Mary Ann can comment on that issue.

MARY ANN LANSANG: Well, yes. From the perspective of the Global Fund, fiduciary responsibilities really a nature

issue. We are accountable to the donors who provide funds to the Global Fund and the PRs.

As you know, we have a very active office of the inspector general. And in fact, Refact's [misspelled?] absence today in this panel is because he is accompanying the office of the inspector general in some of the inspections.

But it shouldn't just be at hindsight. Right now, within the house, within the secretariat, there is a very strong move now to improve the country team approach to make sure that the team that's helping and negotiating with countries is better equipped in terms of not just the fiduciary responsibility, but also facilitating the target towards programmatic effectiveness.

So it's going to be a helping team but at the same time to make sure that this comes across, the fiduciary responsibility.

I also want to add that this is part of the building blocks that we are talking about. Good governance and stewardship is really something that the countries themselves need to address internally.

WAFAA EL-SADR: It's interesting too. I always think that the fiduciary responsibility is not just to the funders but really is to the people who are the beneficiaries of the services. So it is about ultimately trying to do what's good and use the funds appropriately for the people who need them.

We're almost done but I want to take the last three comments and hopefully they're very brief and then I'll allow people here on the stage to give 30 seconds, their last few words. And I know 30 seconds will be a challenge for Jean-Paul, but — [laughter]. Okay?

Yes, microphone three?

SERGIO TORRES: Hi, I'm Sergio Torres. I'm here from the London School of Economics and I have a question for Mary. You mentioned that you guys discourage sort of vertical procurement management systems. And I've done a bit of work on Botswana, and it seems like one of the strengths of the program there in terms of achieving high coverage is that it was a vertical procurement system. And I'm wondering if you know, under what conditions these vertical or horizontal programs are successful in your experience.

WAFAA EL-SADR: Yes, at the microphone four please.

NICOLE KANNELL: My name is Nicole Kannell (misspelled? 01:28:01] and I live and work in Togo, West Africa. First, I just want to thank the panelists today for addressing things in a very honest way and realistic. Also, I just wanted to make a comment and then ask for any feedback.

I appreciate that we're talking about multi-level approaches, and I do feel like that the global level has gotten a lot of attention. I work on a community level, even in very rural situations. I guess what I'm thinking is perhaps we rely

so heavily on western models of doing research and getting results, and I feel like sometimes that breaks down on a community level and perhaps that's why it's such a hard thing to do to bridge the gap between the global and the international level and the funding down to a person in a village.

So I was just wondering about what you guys think of maybe stepping outside of some western models and thinking a little bit more divergently about how we look for research and the results.

WAFAA EL-SADR: Okay. Thank you. Brief comment on four.

JOHN CUTLER: Yes, very briefly. I'm John Cutler from the Health Metrics Network based at WHO in Geneva. First of all, thank you very much to the panelists and to the participants. I think this has been a very interesting follow on to the pre-conference meeting that you chaired on Friday and Saturday.

Just very quickly, the HMN framework actually provides a reasonable approach that countries can use that actually strike many harmonious notes together with the comments that you've made concerning the use of information using a more modern, businesslike approach to information gathering, but focusing not so much on the gathering side because we've been doing that for so many years, but especially the use.

Getting the information to the hands of the people who need to either make policy or plan, make management decision, whether it's at the national level, the district or provincial level, most especially at the on-the-ground level so that we can actually have informed decision-making. We can help to use that information to create economies to save costs and most especially to get the goods and services to people in need.

So we work very closely with the global fund and global fund partners as well as implementer, UN AIDS as well, and many other organizations. Thank you.

WAFAA EL-SADR: Thank you very much. Hopefully we'll start summing up and we'll start from — everybody will have 30 seconds. So, we'll start with Dr. Lansang.

MARY ANN LANSANG: I just wanted to answer, a quick answer with regard to the vertical versus horizontal procurement. It's an interesting question. We have not looked into it, but there are 19 country case studies going on and we'll certainly ask those who are looking through this to check that question.

Last thoughts really is to go back to the very important element of country-led systems, and we have a shining example here with our minister who has given so very thoughtful lessons that we should actually replicate.

The other is, economists are very important in the game and, I wish we had more of you, Jean-Paul, because when you

talk investments, when you talk economics, it also brings home the message.

RUAIRI BRUGHA: And just two points. I'm a key correspondent this year which is sort of an [inaudible] at this in terms of what I'm doing at the AIDS conference and one of the things I was writing about yesterday is this false dichotomy which has appeared this week around ARVs versus health systems

And this to me is the first health systems AIDS conference I've been at. Probably because it's the first time that we've actually got some evidence to present and some lessons, and we need more of that.

I think it would be a terrible shame if we end this week with a zero sum game where somehow it is seen as a competition between putting the funding to ARVs and putting it to health systems.

And maybe I would just put a call, which I already did at another session yesterday morning, to, and it's not aimed at the U.S., it's aimed at the donors working collectively with the governments, to commit to making sure that the commodities, the products – we've got the ARVs, they work, they can have a preventive function where now we're getting a microbicide and we need health systems to deliver them.

We need health workers to deliver them. We need to invest in those systems. They are not an alternative and they

can be synergistic. And I hope by the end of this conference the message that goes out is that, yes, we will invest in both.

Maybe just a second point. And really it's an answer to one of the last questions there. I think, inevitably, a lot of what has been happening over the last ten years has been talked down because of the necessity of responding to HIV and because the way we were doing things wasn't adequate and there weren't enough people involved. I would hope, as we move forward in 2011, there will be a lot more bottom up working.

And I think concerns have been expressed about money maybe going astray. I would farm more trust district health management teams and district AIDS task forces and district AIDS coordinators and even community health workers and community based organizations with the money. Yes, maybe little bits will go astray. I'd like to see more money that would go down there and let's have a bottom up strengthening approach as we move forward. [Applause]

MPHU KENEILOE RAMATLAPENG: Thank you. HIV funding belongs to the entire health system. I think it's stratology to talk about one or the other. Health systems will be strengthened because HIV is in every aspect of the health system.

Regardless of where the money enters, whether it is in the maternal and child health sector, whether it is in the AFT or drugs or procurement, it will strengthen the health systems

if utilized appropriately. So my view is, it's not one or the other, it's both. [Applause]

JEAN-PAUL MOATTI: About the contribution of the economists, my recommendation would be first, do not harm. 1981 by my co-initiative cost-recovery policy introduced based on two flawed econometric bad studies. Twenty years of fighting, 200 other studies to counteract that. Okay?

So, yes, pay for preferment is very important. It can work in some circumstances, but there are some circumstances in which it may not work. So one size fits all doesn't work. We have to evaluate the conditions for making these things go better.

Secondly, in terms of evidence, I don't fully agree with the colleague from AFT. We have quite evidence that, after all, all this investment has rather had a positive impact on health global funding, on health system strengthening. Not enough, I fully agree. But, quite a lot by comparison to other things that we keep on doing in development assistance, okay? But I fully agree with you that we need more evidence and that we need to bring mechanism.

For example, I think that as long as the Global Fund doesn't create a kind of two mechanism for operational research, a lot of lessons we could learn from comparing between countries is not going to work. If you want to do a multi-country project in the framework of a global fund, no way

today because you have to deal with too many CCMs. So, think about it.

WAFAA EL-SADR: Great. Thank you very much. [Applause] And before I thank our panelists and thank the audience, just a few thoughts.

I think this is the first International AIDS Conference where we've had this special track that's focused on health systems, economics, as well as on operations research and I was very fortunate to co-chair the track. And it's been very heartening actually to come to the meeting and, even in the planning of this meeting, and to see the interest by diversity of stakeholders and actually submitting abstracts to the meeting and also to see the interest by all of you attending these sessions here at the meeting.

It demonstrates a coming together across the divide, I believe, when we can all come into one room and talk to each other and disagree with each other, but also sort of gain, garner some insights from the conversations and learn each other's language which is very, very, very important.

So I do believe we have successfully taken that first step is bridging the divide, but we have a long way to go and I think we have a common agenda that we need to work on collectively over the next many, many years.

There are lots of challenges ahead of us. There are the challenges of the immediate needs. The immediate needs

today as well as the long-term needs and how does one balance those is not easy. How does one balance those in terms of a funder, in terms of policymakers, in terms of an implementer is not easy.

And I think it's having that vision to be able to do what needs to be done today but think about what's going to be needed for the future is probably the biggest challenge to all of us.

I want to end by reminding us all, and I know everybody knows this, is that HIV is really or taught us that bottom-up is the way things should happen. It's the voice of the community, after all, that generated this global response and it should continue to be that way.

And it is country ownership, not just country ownership, it's people ownership I call it, of the future and the programs that I think is what's going to be durable and sustainable for many, many years in the future and will achieve all of our global goals.

So with this, I'd like to thank you all for coming here and, of course, thank our presenters, our discussions and all the questions, the people who asked the questions. I think that, again, this is the beginning of a conversation or a continuation of a conversation. There are lots of other sessions at this meeting, some of them today and some tomorrow

that will deal with some of these very difficult but very exciting questions.

Thank you very much.

[END RECORDING]

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.