

**Global Health Working Session: Condition Critical:
The Health Care Infrastructure Chasm:
Extending Physical and Human Capacity
2006 Clinton Global Initiative Annual Meeting
September 20, 2006**

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[START RECORDING - PART 1]

FEMALE SPEAKER: Ladies and gentlemen, please be seated, and as a reminder as a courtesy to your fellow attendees, please turn off your cell phones and pagers for the duration of the program. Thank you. Ladies and gentleman, once again, please take your seats; we would like to begin the program. Thank you.

Ladies and gentleman, please welcome our producer for the Global Health Working Group, Daniel Stone from America Speaks.

[APPLAUSE]

DANIEL STONE: Thank you very much, and welcome to the start of the Global Health Working Group. We at America Speaks are delighted to be back with the Clinton Global Initiative again this year to again help produce the interactive portion of the Clinton Global Initiative. Now, CGI is a unique kind of conference in many ways. Certainly the people that come here make it unique. The panelists, the presenters, the speakers--all are part of the uniqueness. The emphasis on making personal commitment to the issues walking out of here also makes this a very unique event.

Another aspect of this event that participants last time said made it particularly unique was the emphasis on the interactive portion of the event that takes place in the

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working groups. So I want to spend just a couple of minutes sharing with you how this is going to work, because in most conferences we really rely on the people on the stage to stimulate us and educate us. But here in addition to relying on our panelists and moderators, we're relying on one another to share your expertise, your ideas, your experience to be a major part of what we take with us out of this experience. So I want to share with you how the sessions are designed. Each session is composed of two sub-sessions, each of which has a different focus, and each sub-session will last about an hour-and-a-half. All the sub-sessions will have a very similar format. The sub-sessions are divided into three segments. In the first segment, the moderator and the panelists will come to the stage, and they will share with us their views about the particular topic of that sub-session. Now as they talk, you may have some questions that you would like to pose to them, and if you do, I would ask you to take one of the little pieces of paper that's on your table, jot [your question] down, and hand it to the person who is sitting in front of the laptop. That person is what we call the facilitator, and I'll come back to them in a moment, but as you hand that to them, they'll enter that into the computer and will capture your questions.

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At the end of the first segment, we'll then turn to you, and I'll come back on the stage, and I'm going to pose to you a question that we would like you to discuss at your tables. You're going to have about half-an-hour for that discussion, during which time the facilitator at your table is going to lead you through the discussion. They'll help keep it focused. They will help make sure everybody stays engaged in the conversation. They will also be entering into the laptop some of the essential ideas that you come up with. As they enter those ideas, they are going to be sent back to what we call our theme team, which is in the back corner to your right. The theme team is a group of policy analysts who are very quick at turning around ideas, synthesizing them, so that at the end of the table group discussion, they will have been through all of your comments.

[In]the third part of the sub-session, we'll bring the moderator and the panelists back to the stage. At that time, they will first start out by addressing some of the questions that you had posed in the first part of the sub-session. Then Chris Jennings, the Working Group Chair, is going to come back to the stage and he is going to review with us the major themes that came up in your table group discussions--as well as a few, what they felt were unique, or

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creative, or particularly provocative ideas they want to share with you.

Then for the last part of the sub-session, we'll have the moderator and the panelists comment and respond to your ideas. That will close out that sub-session. Each sub-session will follow a similar format. So the real idea here is for you folks to stay engaged yourself, and really take advantage of the expertise of every single person at your table, making sure you get a chance to hear from everybody during each of these conversations. So I want to encourage you to have a great time with this. Be engaged, and hopefully this will stimulate your own thinking about what are the commitments you personally want to make by the time CGI is over.

So with that, I'm going to leave the stage and we'll bring on our moderator and panelists.

FEMALE SPEAKER: Please welcome our panelists, Paul Farmer, Julie Louise Gerberding, and Tedros Adhanom Ghebreyesus. [APPLAUSE] And our moderator, Sanjay Gupta. [APPLAUSE]

SANJAY GUPTA: Thank you very much. Can you hear me okay? Standing room only. There are so more seats over here if anybody wants to sit. I think there are some more seats available. I'm delighted to be here. I get a chance to talk

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about global health issues on CNN, but it is rare that I get an opportunity to actually meet with a group of people like yourselves, and our panelists actually talk not just about the problems, but about the solutions, as well. That's a lot of what we're going to be doing today.

I'd just like to take a moment to thank Chris Jennings, Chris Dow, and his team for putting this together. It's not easy to do. Lots of different issues that we're going to get through is due to them, so thank you, guys.

When you talk about solving global health problems, you talk about the human needs, you talk about money, you talk about bricks and mortar. Collectively these things are known as infrastructure, and some global health problems, no doubt are difficult and complex to address, but some are more simple, relatively speaking. They're affordable, and they're easy to replicate, but sometimes the lack of infrastructure stands in the way of success, and that's a lot about what we're going to be getting into today. That's a theme that's going to run throughout the discussion this afternoon. Someone once said that if the cure for AIDS came in the form of a clean glass of water, we still couldn't rid the world of AIDS. I think that speaks volumes about the lack of infrastructure in some places. We'll get at that as well.

Infrastructure again, is the human, physical, and

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institutional components of the health care system. It is the life blood of a health care delivery system as well, yet tens of million of people die every year because of infrastructure gaps, gaps in infrastructure specifically. A large component of that, as we will talk about, is the human element. What does that mean? Severe shortages of physicians, nurses, health care workers in many places around the world. Globally the shortage is about 4.3 million doctors, nurses, midwives, health care workers. Get this, Africa suffers the most, while they have about 25-percent of global disease burden, only 1.3-percent of the world's health care workers actually work there. I thought that was remarkable, and of course these conditions are made even worse by poor economic conditions and in some cases, the accusations of poaching of human resources, which we will talk about as well.

Bricks and mortar are equally important, something we're going to mention, and often times it's weaker in developing nations. How specifically? We will address. Health facilities are often concentrated in urban centers, leaving more than half the developing world unable to access their care. So a lot of times it's available in an urban center, maybe even not that far away, but still many people in rural villages can't access some of that life saving care.

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Many clinics have less than basic laboratory facilities. This inhibits frequent testing, for example, that's needed for HIV patients. Impedes proper diagnosis of treatable tuberculosis and hinders effective disease surveillance as well. All of the components that are important for an equally effective health care delivery system. Simply getting drugs from manufacturers to people who need them the most has become very difficult in many parts of the world, but it's a fixable problem, and we're going to be talking about those solutions.

During the session, we're going to talk about not only why we have the infrastructure gaps, but how the best minds around can help overcome them, and that is in the spirit in which we lead this discussion. Like I said, we talk about these issues a lot. Today we get to talk about the solutions, and to accomplish that, we are joined by our panelists.

First of all, Dr. Julie Gerberding. Many of you may recognize her. She's the Director of the US Center for Disease Control and Prevention. Some of you may not know that CDC, besides operating in the United States, also operates in 45 countries around the world. She leads all that. It's not an easy job, I know. We'll talk to her about that. Dr. Paul Farmer is the founding Director of Partners

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in Health. He is also a practicing physician and professor at Harvard Medical School. He's had a book written about him called *The Man Who Had Saved the World, Mountains Behind Mountains*. That's a pretty cool book. Won the Pulitzer Prize. Dr. Tedros, he likes to go by Dr. Tedros, is the Minister of Health of Ethiopia. He is best known for his tireless work to modernize the provision of health care in Ethiopia. He's done some remarkable work and can be held up as a success story, which we need to talk about in order to have this discussion concretely. So please welcome our panel. [APPLAUSE]

Dr. Farmer, let me start with you. As was mentioned, we're going to be soliciting questions from all of you as well, so as the discussion goes on, if you have questions, give them to your facilitator. We'll try to get to as many of them as we can. You've done something a lot of people said couldn't be done. We just talked about the fact that while you may have great health care in urban centers, you may not have that in rural areas. How have you tried to address that problem? Has it worked?

PAUL FARMER, M.D., Ph.D.: I feel like I'm on Oprah. That would make me Oprah. [LAUGHTER] Never mind. I'll stop there, Sanjay. Doctors bantering.

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It's not a hypothetical problem, of course. As you said, it's the biggest problem that's facing us now. It's different than the problems that were facing us before. Things are, in some ways, better now. We have medications that we didn't have before. We have some funding that we didn't have before, but getting those interventions--I'll talk about AIDS for a second--getting it to rural areas remains really a serious, huge problem. I just came last night from Haiti, and it's a problem even there, which is so close to us. It's a big problem for the Clinton Foundation in Africa, but there are solutions, as you said.

One thing we don't have, we don't have the right infrastructure, the point of this discussion. A lot of that is human. There aren't doctors and nurses in Rwanda for example. After the genocide, there are probably only 500 physicians in a country of 8 million people, but what we do have are a lot of people who need something to do and want something to do in health care education and those are villagers. Most of them are peasant farmers. There is not enough land, so what we've done is train them to be, we call them a company of tourists, but I don't think it matters what you call them, they help deliver care on a daily basis to their neighbors. And lots of good things happen. One thing (and I'm sure we'll talk about this; I don't want to go on

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too long) is you don't want patients who have active tuberculosis, which is about half of the HIV patients who we see in many of the places we work, you don't want them in the health centers coughing on woman there for prenatal care, and kids there for vaccinations. So you're changing this into an ambulatory system that happens at home with neighbors, and I think lots of other good things happen too. I don't want to focus too much on Rwanda, but a lot of very terrible things happened there, 15 to 12 years ago, and to see neighbors helping each other is another way of delivering more effective care. Making sure that you address unemployment, making people able to adhere to complex regimens on a daily basis, and really starting a virtuous social cycle, whereby neighbors are helping each other. So I think that's one part of the infrastructure problem that we can address if we're willing to not pay people for their labor. To make sure that they also can feed their families if they are going to do this work. So that's how we did it.

SANJAY GUPTA: Paul, I'm going to ask you. I won't ask you to answer now. We're in a room of committers here, people who are going to make a commitment to this. What would you ask of them and of this initiative? Later on we'll get to that, okay?

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Dr. Tedros, I mentioned one of the statistics, and I found alarming, that's why I mentioned it in the opening remarks, that 25 percent of the global disease burden is in Africa, yet only 1.3 percent of health care workers. You've tried to help overcome that disparity in Ethiopia. How did you do it, and is it working? Grab your microphone there.

TEDROS ADHANOM GHEBREYESUS: I think I will focus on the . . . First we have identified four focus areas based on the major problems that our country faces. One is maternal health. Second is child health. HIV, AIDS with TB, and then malaria. So these were the focus areas. Then we have said to address this, the best approach would be primary health care because most of our problems linked with this are actually communicable diseases, and apart from whatever we have in relation to maternal health and child health. So we have said primary health care would be the best thing to focus. The next step was to really identify the workforce that can really help with our primary health care. We have identified the type of strategy we need to follow in order to satisfy the human resource needs. The strategy that we identified is flighting and retention strategy. When we said flighting and retention strategy this is meant specifically for the workforce that we're going to use for the primary health care. So basically these are low-level

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and mid-level health extension workers. We have set targets that can really be achieved as soon as possible to cover as many places as possible. When I say primary health care, it focuses mainly on rural areas, and to really train the health extension workers and the other categories, nurses, and health officers based on that category. I think the focus led us to really concentrate on the kind of health workers that we need to address our problems.

SANJAY GUPTA: So you're able to prioritize to some extent. What advice would you give to other Ministers of Health, specifically in Africa, to try and be able to recruit and retain health care workers to overcome this disparity? How do you get them to stay?

TEDROS ADHANOM GHEBREYESUS: Yes, I think one thing based on the priorities if you identify the taskforce then what is important next is to really train as many as possible. For instance, to train 30,000 health extension workers. We need, for instance, 30,000 health extension workers by 2008. This is blanket coverage--200 extension workers per village-- and we have already trained and deployed 9,900. So one of the key elements we used to train as many as possible was to really focus on existing assets, exploiting the existing asset. That's not like business as usual. If we do it the business as usual way, we would have

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first built nursing schools. But instead we use technical and vocational training centers, the existing ones, to train our frontline health extension workers. So that was like a shortcut. We were able to train 9,900 actually in two years, and deployed them. So achieving the 30,000 will be possible in the next two years. Using your existing assets, we shouldn't go like the business as usual, building college and then starting them, keeping them, and so on. It takes time. So what do we have existing assets that we can produce more in a short time so we cover all our villages with the right category of health extension workers.

The other category for instance, if I use health officers, we use our existing hospitals--again, existing assets--to train thousands of health officers. We used to train, for instance, in rural [areas] 200 or 300 per year before. Now we have enrolled this year alone, 2,166, and this was possible because we used our universities and hospitals, existing hospitals, to train more, to take more, using the existing asset. My advice would be to look for existing assets in order to really train more, rather than go using the business as usual type. Then you can really increase your volume. You can increase your speed. Of course you should take care of your quality as well, to achieve any ambitious targets that you can set.

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SANJAY GUPTA: That's good advice, and I'll be asking the same question about what you would want the most out of this initiative and this group of committers.

Dr. Gerberding of the Centers for Disease Control:
What is the most unacceptable gulf between what is possible in health care and what is actually happening on the ground in your opinion?

JULIE LOUISE GERBERDING, M.D., M.P.H.: Well there is the gulf of what we don't know, but I think it's worse to know and not be able to deliver on that promise. So from where I sit, the most frustrating thing, domestically and internationally, is to actually have the knowledge to have proof of principle in a specific location, but not be able to actually scale up and out of that particular intervention, because of lack of capacity in infrastructure.

We have many challenges. At CDC we have defined three big ones. One of them is complacency, which is not a problem in this room, thankfully, but it is in some other areas of our country. The second is capacity . . . and the fact that we can go and do an imprint project. Maybe we can do a footprint project where we've left enough sustainability so that in that location it can grow and thrive independent of ongoing support. But the true blueprint projects, where you go, you learn something, and then other people can adopt

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that and build their own sustainable enterprise--those are few and far between, and very, very difficult to accomplish without the kind of investment and infrastructure that we've been talking about here.

For us, the real solution to that problem is connectivity, which [is] the challenge that brings friends like SARS to our doorstep in no time at all, but it's also an incredible opportunity to build the sort of networks that allow us to move knowledge, products, people, and enterprises much more quickly into the global setting. Let me just give you an example: we're in 45 countries, but obviously we're pretty small, and we can't possibly do very much, even with the scope of our budget and our resources. So by building an infrastructure capacity for others to come in and work on a regional basis, like we've done in Kenya, in Guatemala, in Bangkok, in areas of the world where CDC is making its own infrastructure investments in laboratories, and our top scientists, our disease investigators, training intensely the personnel in those countries, learning from those personnel, then we have a platform to innovate. Other people can come in and hit the ground running because our platform is there already in existence. They don't have to figure out how to get a computer in, or how to move people around, or how to get a motor pool together. We support the enabling capacity

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to facilitate the partnerships between the health ministries and the interested experts from other areas, and much more rapidly scale up and out the capacity to get things done. Building the connectivity between our health ministries and governments, or the WHO, building the connectivity between experts in academia and on-the-ground needs, building the connectivity between businesses who have enormous logistical capacity in these countries, and yet we're not leveraging that for the kinds of health infrastructure development that we're talking about. In some countries, CDC relies on international business persons to have situation awareness about emerging health threats, because people are monitoring the absentee rates, and they have such a strong stake in the health of their workforce.

I think from where we sit, building connectivity is the most important way to overcome the gap between what we know and what we could do if we had a delivery system, but it takes time and it takes the kind of human resource development, sort of the disruptive technology of health aids and people building health capacity from the ground up. We have a long way to go.

SANJAY GUPTA: Do you think that the United States as the richest nation in the world does enough?

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JULIE LOUISE GERBERDING, M.D., M.P.H: Well, I can tell you from where we're sitting that whatever anybody is doing, it's not enough. Clearly there [are] a lot of unmet needs and a whole lot of work that should and could be done. I do believe that we've learned something very important in the last few years, and I'm not here to advertise the US government as having a solution, but I do think that having an experience with PEPFAR taught us at least two things. One is that if you invest big, you get results. The second is that if you set goals and are transparent about what you're doing and expect people to perform to a certain level, you'll be surprised at what can be accomplished. I will admit when the PEPFAR concept first was raised, I was very skeptical. The numbers seemed too high. The process seemed too hard. I didn't think we had the infrastructure to be able to get anywhere, and I've actually visited one of the programs in Ethiopia, and they are so far ahead of our imagination because of the scale of investment, but also the fact that people are very capable of innovating and coming up with solutions if you just expect it to happen.

The lesson there learned [is] we can solve these problems through incremental programs. We have to be willing to be bold, to be big, and to really go in knowing that it's

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going to take a lot of resources, but if we do that right, in the long run, we'll come out ahead.

SANJAY GUPTA: Dr. Paul Farmer, you just mentioned that you got back from Haiti last night. You work at Harvard, and you work in Haiti. I wonder if you could just for a second take a step back and give people a sense who have never been to a place like Haiti, what it means to live in a place that has a health care structure the way it is right now. What does it mean for the average person in terms of what they can and cannot get? How they have to live their lives? Just what do you see down there?

PAUL FARMER, M.D., Ph.D.: Oprah style. Although Oprah can't do brain surgery, so you're okay. [LAUGHTER]

I'd like to say something good about Haiti too, about the work that's been done there. It's led by Haitians, but that's not typical of rural Haiti, certainly, because in the place that I left it would be embarrassing if after 25 years we didn't have something to show for it in terms of infrastructure. There is a modern hospital system linked to health care centers with a very strong community-based staff, so we've even done--and I think I've told you this before--we have done neurosurgery there, but that's the way the whole place should look. That's what the country needs. For people living in an area where there is not . . . and this is

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public infrastructure Sanjay. This is the public sector, just like what Dr. Tedros was talking about, that's been rebuilt. And it's been rebuilt with the kind of money that Julie is talking about also. That is with some AIDS money which we follow the rules, okay, but we leverage. Right, and we said can we use this new interest in AIDS to strengthen primary health care? Because a lot of people thought you couldn't do that. That's another bit of good news that would add to Julie's list, is that not only can people do it, and not only are they able to do it and it's hard, and it's doable, but you can also have lots of collateral benefits from this kind of intervention. Unfortunately, what life is like for most people in a rural village, in Haiti, or in Malawi, or in Rwanda, is there is no mosquito net when you're sick with malaria. You don't have access to care. Childbirth is . . . the most life threatening thing that a woman can face is having a child.

The scandal of all this, of course, as is the purpose of this meeting . . . all this has solutions. There is no question that the gap that Julie brought out is the one that is most frustrating. Not a knowledge gap, but our ability to bridge this. So that's what I think, the bottom billion in the world are facing these kinds of problems. They don't have access to health care and they don't have

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access to good prevention, meaning clean water, vaccines. Some vaccines they have, but many others don't. So the Harvard Haiti trajectory to me has been for 25 years this jarring three-hour trip between a place where there is a thicket of hospitals on every corner, and where the budget of hospitals . . . the one that I work in at Harvard is more than three or four times the entire budget of the nation of Haiti, eight or nine million people (one of Harvard's 20 teaching hospitals) and to a place where the big problem is food security and lack of access to care.

I would like to say one thing though, and that taking this model, including the one that Dr. Tedros talked about of having community health workers go visit patients everyday, since we're not on TB, my Harvard colleagues get very cross when I say what I'm about to say. One of the things we've done though is say how about we try and bring the Haiti standard of care up to Harvard, and do a better job of taking care of chronic illnesses like AIDS in Boston, by having community health workers there too. We have lessons we can learn from places like Ethiopia or Haiti if the resources are there to launch these programs.

SANJAY GUPTA: That's a great point, and so you've been able to actually translate some of those lessons because people living right around you in Boston may benefit from

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those as well. 25 years ago, how many years ago, you started in Haiti. Let me just ask you real quick, not to get too personal here, but why did you do it back then, what prompted you to get involved in Haiti? As I mentioned in my opening remarks, people were saying, you wouldn't be able to do what you've done down there.

PAUL FARMER, M.D., Ph.D.: At that age who knows why you're doing things. [LAUGHTER] I would add that the Director of Partners in Health, who is here in the room today, she was also there 25 years ago, but she doesn't like that said, because it makes her look too old. The reason for going there . . . I had met some Haitians as a kid growing up in Florida and had gotten interested in problems in our country, migrant farm worker access to care, for example. A lot of people in California, Texas, and eastern seaboard know about this problem. You know about this problem. So that's how I had gotten interested, but the drama of life and death, and knowing, again to quote Julie again, "Knowing that the tools that we have already at hand," and this is 25 years ago, could have prevented these deaths, taught me something that I'll never forget, and that is that even if we develop new tools, which we need to do. We need new vaccines. We don't have a vaccine for any of the big three--malaria, TB, HIV--but even if we have them, unless we develop an equity

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plan to make these available to people living in poverty, those who need them most, we're going to have a stock pile of new tools that we are not able to use effectively in really four places.

SANJAY GUPTA: Dr. Tedros in keeping along that same theme, in terms of things that you would like to have in Ethiopia, in this room here, again, a room of committers, people who are interested, very interested in what you have to say, what do you ask for? What do you want?

TEDROS ADHANOM GHEBREYESUS: I think as you many of you know, the maternal mortality in Ethiopia is really high. As I say, we are training health officers, thousands of health officers. By the way, this is as part of the strengthening of the health systems, and it's supported by the Carter Center by the way, and I would like to thank them for that. It's really something that can make a difference for our health system. Then from these 5,000 health extension workers we would like to train by 2010, who are going to graduate by then, we would like to train 700 of them, that's one person representing 100,000, means 70 million to train them on emergency surgery. So the current training of these health officers on public health for three years will be followed by up to one year of emergency surgery training. We don't have enough surgeons in our country, and

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we shouldn't wait until we get the proper surgeons, so we have opted to train these health officers, non-doctors on emergency surgery. We have already piloted and tested it. It works well, and my wish is if we can get funding for this training, training of these 700 health officers and nurses on emergency surgery, and they can do their own sections, because we are setting up a very strong community based intervention, but to save mothers, not only strong community based intervention, you need good facility based intervention as well. At least a cesarean section should be done at health center level, which is part of the comprehensive obstetric care. This could be like a complement to what the Carter Center is doing, to train those guys again, on emergency surgery, so they can do life saving interventions, training non-doctors on emergency surgery. Of course with that comes a [inaudible], means we may need to keep a minimum of 700 health centers. We're talking about [inaudible] for the operations of theatre. So if this is true, and this lies within the priorities of which I say, the maternal health, which is one of the top of the four priority areas. We would like to really make a difference, and if we can get support on this, it would be a huge support. I would like actually to suggest if any kind of support can focus on strengthening the health system like this one, that can really make a

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difference, because we have lots of funding for vertical programs like HIV/AIDS or malaria, but unless we increase the caring capacity of the health systems, our health system, which is already weak, may even collapse. So that's why we ask more support on health systems like logistics for instance. . . . The first one is a bit difficult. Maybe I can go for a second one: logistics system, which is a huge intervention also to really increase the provision of essential drugs in the country, a revolving drug fund.

SANJAY GUPTA: Maternal health, emergency surgery, the ability to do cesarean sections, the equipment needed to train doctors to be able to do these things and the infrastructure of course. Dr. Paul Farmer, same question. What keeps you up at night? What would you like to ask people to give if they could?

PAUL FARMER, M.D., Ph.D.: I think that what keeps me up at night is we need to be bolder about how broad these interventions are. The terminology that Dr. Tedros just used, he talked about . . . and we said we're well funded for AIDS and malaria. Again, these are what public health people call vertical programs. We have to be able to take those resources, which are new; he wouldn't have been able to say that three years ago. This funding is new. We have to be able to take that and render it horizontal. We have to

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make it available for primary health care, for modern obstetrics, for a broad range of interventions, and that I think we can do. But in order to do that, and to do it in the places that are the most difficult to reach, to go for the gold, the rural regions of Africa for example. Look at all the NGOs and interventions. They tend to be in urban areas. If we're going to go for the gold and really go to these poor places that are, and I don't want to name names of countries, but if you look at where the biggest foundations are investing, they're investing in middle income countries that are considered by Americans to be developing countries. There is a huge difference inside Africa or South America, or Asia between a country with a decent health care infrastructure and these really very poor countries.

That's where we should do it, and we have to link this improved implementation, in these centers of excellence or these networks of excellence to a veritable science of implementation. That's going to require training, some new research and some new tools. That is going to be . . . since we're in a room full of committers . . . it's going to be an expensive exercise in a sense (nothing compared to the kind of stuff that gets wasted destroying infrastructure), but it's something that we can do. We have strategies, but we need

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backing. We need some unconditional love, is what we need.

[APPLAUSE]

SANJAY GUPTA: Dr. Gerberding, as you survey the playing field of global health, the United States and 45 other countries, what do you wish you had?

JULIE LOUISE GERBERDING, M.D., M.P.H.: I think I would say the same thing that I just heard from my colleagues. We need a knowledge distribution system. We need to somehow be able to take the kinds of technology that made the world flat or the connectivity that made the world flat and use them in innovative ways in the areas that aren't flat yet. That may be people. That may be a cell phone in the hands of a health aide in the rural area who can reach back to the county and get information, or reach back to the tertiary care center and get a consult. We have such extraordinary innovation, but we aren't innovative about using it the poorest areas of the world, or the poorest countries. So if we could figure out how to redistribute our knowledge, and it is more than one direction, we learn as much as we contribute. I really think we could accelerate the solution to the problems, but fundamentally we're all saying the same thing. We know what to do, but we can't develop the systems to deliver on that in the places that need it the most.

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SANJAY GUPTA: Okay. Thank you very much to our panel. That ends this part of the discussion, the first 30 minutes. I'm going to invite Daniel Stone to come back up here for America Speaks to guide us through the rest of the afternoon.

DANIEL STONE: All right, thanks very much. So we've heard from our panelists and our moderator how essential it is to build and develop the health care infrastructure. Be that training. Be that logistic systems, delivery systems and so on, but the question is how to go about making this a higher priority so that this actually happens. The question that we would like you to focus on is what strategies could better ensure that the development of health care infrastructure becomes a priority for corporations, NGOs, policy makers and the public. Once you identify those strategies, what needs to happen to actually put those strategies into effect? You have 25 minutes for this conversation. Have a great conversation, and we'll be back up here.

[END RECORDING - PART 1]

[START RECORDING - PART 2]

FEMALE SPEAKER: Ladies and gentlemen, the discussion period is now over. Our moderator and panelists are now

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rejoining us.

SANJAY GUPTA: All right. We're back. They say doctors are always late. I wonder where they get that from? We had some great questions that have come in, and what we plan on doing now is These are some of your questions. We're going to try and address those to our panelists, and also we have Chris Jennings hard at work back there looking at some of the themes. He is going to be presenting those in a few minutes as well. We'll get to that. Let's get right into some of these questions though, and let me go straight to you, Dr. Tedros.

You often hear of the lack of absorptive capacity in developing countries as an excuse for missing key milestones in global health. Is that real, first of all? Is that your experience and what can donors and NGOs do to improve local capacity?

TEDROS ADHANOM GHEBREYESUS: I think the absorptive capacity, I can agree. I mean there is low capacity and partners should be involved in building capacity. For instance, one of the projects we have with Clinton Foundation is hospital management initiative. That builds the capacity of hospitals. And I would like to take this opportunity to actually thank the foundation. On the other hand, there is some misconception actually in terms of absorptive capacity. Many people think

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that we should do everything ourselves. For instance, there could be weaknesses in procurement. I don't think we need to do procurement ourselves. You can hire a procurement agent. I can give you one example. Recently, for instance, there was a memorandum of understanding [inaudible] between PEPFAR and Global Fund to create synergy, which is really excellent. We have asked our Global Fund partners if they can help us compress the fund, which is 2006 to 2008 fund in one goal, to ask it in 2006. We revised our targets, and they said why not. So we revised our targets and most of the things were like the problem we were stuck, was procurement. We outsourced that, so we are now doing everything that we were supposed to do actually until 2008 in 2006. And the targets we were supposed to [reach] in 2008, we are achieving them now.

The whole idea is one, you can build your capacity, but on the other hand, I think you don't need to build your capacity on the things that you can outsource to others. So you can really outsource many of the things, and you can even go fast. And we're trying to see in that respect, in really outsourcing in order to absorb more, and it's working well. Thank you.

SANJAY GUPTA: Great. Thank you. Dr. Paul Farmer, if we fail to build an effective infrastructure, this is another question. What are the threats not only in developing

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countries, but to the rest of the world as well? You started to get into this a little bit, but also any case examples, say avian flu?

PAUL FARMER, M.D., Ph.D.: Well, I think there are threats that we don't talk about a lot, and maybe this is not the forum, but obviously there are moral threats. That is the threat of not coming to the assistance of those in need. Not an insignificant thing for doctors to consider, of course. I know that's not what you had in mind, but as a fellow clinician I think we shouldn't give up that ground, that moral obligation to do something good, whether in public health or surgeons. We can hang on to that too.

Let me give another threat. I know it's on Julie's mind, and there are other people here, like Peter Small, who are experts in this. The problem of drug resistance. Now that may seem very arcane in this group, but if you think about 60 years ago, almost all . . . staff [inaudible], the stuff you hear about in the hospital that's on your skin. All susceptible, could be killed by penicillin. Now it's about 5 percent in this country. Bacteria, parasites, viruses--they acquire resistance to the agents we deploy to fight them, and the way that that will happen most quickly is if there is poor adherence or compliance, as we used to say, with the drug regimens. That's what happens with AIDS. You give people the

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drugs. You sell them. They can buy them one month. They can't buy them the next month. Of course they develop drug resistance disease. That gets transmitted. Now the threat I want to mention, and very briefly, is drug resistant tuberculosis. Just in May, we heard about at the CDC . . . We had a meeting with the CDC and heard about what is now being called XDRTB. Extensively, or extremely drug resistant tuberculosis. It's airborne. And in the case from South Africa, which is right near where we work in the Sutu, the case fatality rate is that the number of people who died within two months was 90 percent or more. Is that right, Julie? Yeah, and we've seen this before. And we're going to see it again. So if we can't think of ways to have collaboration, rich country, poor country collaboration--in the case of South Africa and the Sutu, that's rich country, poor country, South Africa being wealthy, the Sutu being poor--but if we can't organize this ambitious effort that we've been talking about, that's the sort of threat that I think we're going to also see. I don't want to single out certain countries. I've worked in several countries where there is XDRTB, and it's never contained by prison walls, homeless shelters, and hospitals. It spreads.

SANJAY GUPTA: Paul, let me just follow up for a second on that, specifically the first part of your answer. You talk

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about this moral obligation that maybe we have, and maybe that's more subjective. When you're sitting around talking to your friends and you're trying to get them to care about building health infrastructures in countries that some of them can't even find on a map, how do you get them to care about that sort of stuff?

PAUL FARMER, M.D., Ph.D.: Well I think that's it part of the obligation of those of us who work directly in the field, as they say. Doctors, nurses, people who are philanthropists who actually work in the field. It's our job to make this vivid and human to others. Sometimes we do that by saying, "Here, meet this person." Actually bringing them. Sometimes we say, "Here, look at this person's story. Look at this person's children." This morning I went to Montefiore to give pediatric grand rounds to a roomful of people, many of them young physicians. They've never been to Africa. They've never been to Haiti. They see the faces of these children, one hopes before and after, and it makes a difference. I'm giving a couple of things in addition to those things we are required to do, which is to have sound analyses of epidemic disease or problems of maternal mortality, have the numbers right. And one of the things we've been doing recently with the Clinton Foundation is to get a model [so] that people in business and philanthropy can understand how this works, but I

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think there is lots more that we can do just to say, hey, this is a fellow human being, and you owe it to that person to care about this.

Haranguing people is not a good idea, I've learned. Guilt is not bad though. Guilt is good. [LAUGHTER] But humanizing, showing people the face of this suffering, I think, is something we all shouldn't let go of. Just because we're scientists, university presidents, or teachers, we can also share what it means to be living in poverty and then face a devastating illness. I think we can do a better job. I shouldn't say that to you, because that's what you do for a lot of people in this country and globally, but I think the rest of us also need to learn how to do that better. Thank you.

SANJAY GUPTA: Dr. Gerberding, this next question is something that you think about a lot because I've heard you talk about that, but the question from the audience is this: How is it that soda companies and others can get their products to huts in the most rural villages across the world? Can these distribution systems be adapted, used in some way, to solve global health infrastructure gaps?

JULIE LOUISE GERBERDING, M.D., M.P.H.: I love the question of living in Atlanta where we have one of those important software distributors. It's a fascinating process, and as I understand it, this is a micro economy. In some

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communities, the person who is the soft beverage distributor is a very, very wealthy person. So there is a very strong market for those beverages, and it's a self-perpetuating and a self-evolving system because it creates trade, income, status, and opportunity. So having been up in the most northern part of Alaska, and in some of the remote parts of Africa, and always having a Coke, I think they've been highly successful. What can we learn from that? Well, one thing we can learn is that in order for a beverage company to be successful, they need clean water. You can't have Coke if you don't have clean water. So there is a very powerful principle there about the incentives for water supply . . . and how can we do more to take advantage of a collateral opportunity? The other is what can we co-market with the beverage? Can we put a bed net in the vending machine? Can we allow people to turn in so many soda tops and get a bed net or get something for their home? Or can we put clean water in the distribution system?

So it certainly creates opportunities, and, again, it's not that we don't know how to do it. It's that we can't take advantage of the knowledge distribution necessary to make it happen. That's why the people in this room are so powerful, because I'm sure there are a lot of people here who have thought about this and could probably come up with some really good ideas on how to leverage the systems that do exist.

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SANJAY GUPTA: Okay. Great. Well, we're honing down on this a little bit. I'd like to please welcome up Chris Jennings now. He's the Working Group chair. He's going to review some of the themes that you've all come up with. Thanks Chris.

CHRIS JENNINGS: Rat-a-tat-tat. We're moving here guys. Thank you. I have to say I was skeptical about this process, but it is incredibly impressive what you've produced. So it wasn't very hard to consolidate. We've collaborated and coordinated. Now we have three slides of common themes. By that I mean themes we have heard in table after table that seems to be highlighted consistently, and we want to go through those. Then after I go through those, there will be three quick PowerPoint slides, and then I'm going to go through the nuggets, which are really reflective of one individual concept that we didn't see replicated at all, but seemed to be actually very consistent of the application of the themes.

So why don't I start with the first slide? I love this technology. It's working. Sanjay, I'm going to give you the papers. Terminology matters. Except my technology doesn't work up here. Terminology matters. I think this is really a very important point, which is to say, infrastructure isn't capturing the concept in any way that means something to anyone. The specific line was it doesn't capture the human

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need. For example, it's about people; it's not about roads. It sort of sounds like roads and bridges, rather than people. Secondly, corporations need to begin to recognize and are recognizing their own interests to build infrastructure for their own labor force in the communities [in] which they live. Thirdly, when we're talking about infrastructure investment . . . We're not just talking when we're talking about spending big money on drugs or development of R&D or new products. Part of that investment needs to be about how we deliver those products once they are available and how to rapidly distribute them. Can we go to the second one please?

The second slide illustrates the value of outcomes of infrastructure investment in tangible ways. This was a theme that was stated over and over and over throughout the tables. People need to understand what the value is. Secondly, women. Women are the repository of information about what's happening and how best to deliver health care, both in terms of education and also direct delivery. Thirdly, individual communities want a sense of ownership, which is to say what Dr. Tedros was saying. Build up. Build up. Don't build down. They need to be part of the process, and that will make it a much more successful and sustainable infrastructure.

Third slide, please. Infrastructure development demands decades long commitment and biopartners. This came up

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a few times. Which is to say, don't be unrealistic. This is going to take some time to do it right, and it has to be a sustainable commitment by all partners to get it done right. Secondly, widening the application of 21st century IT and communications technology--this is the idea of applying technologies to the extent we can in meaningful ways. Thirdly, the private sector involvement has to extend beyond traditional orientation to the pharmaceutical world in terms of establishing an infrastructure that works.

Lastly, I want to just highlight the nuggets that we thought were particularly helpful in this discussion. I would call this more an application or extension of some of the themes. How do you make some of these themes work? What we picked up in your discussions [was] that we should create an alliance and dedicate funds for infrastructure, maybe be able to focus people on this issue and its meaningfulness in ways that capture the imagination . . . which I think runs very well to the second point, which is maybe a health corps that captures imaginations such as the Peace Corps and Teach for America ha[ve].

Then on a specific application of the technology point on the themes, people said use [inaudible] medicine to provide specialty care in underserved areas where possible, where there are energy sources and other creative ways to do this. Lastly,

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let's not say that there is an under capacity in all areas, particularly in training health care workers. In India, in Brazil and elsewhere [there] have been very significant trends in increasing supplies of providers and multi-talented caregivers. Don't always think this is about the West. The West has been sucking talent; some other people can actually apply it from country to country.

With that I'm going to close, turn it back and ask for some responses. . . other than to say that we captured as much as we can. We still have much more information in the back. I want to thank you all for contributing this. It was really an amazing process. Thank you. [APPLAUSE]

SANJAY GUPTA: We have just a few minutes now to go over some of these themes. Let's try and dissect these down a little bit. If we can get the second slide back up. I don't know if we can get that. The themes infrastructure starts with: Illustrate Values and Outcomes of Infrastructure. I thought that was interesting, and let me go to you, Paul Farmer. Illustrate the values and outcomes of infrastructure investment in tangible ways in order to educate funders. I wanted to set this down because I think this strikes the heart of what we've been talking about for the last hour or so. If you're making a pitch to your funders, if you're doing your

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pitch, which I know you need to do from time to time, Paul . .

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PAUL FARMER, M.D., Ph.D.: That's what I'm doing right now.

SANJAY GUPTA: That's what you're doing right now. What is the value? How do you illustrate the value of actually developing some of the infrastructure that we've been talking about?

PAUL FARMER, M.D., Ph.D.: As you pointed out and started this Sanjay, we're talking about infrastructure broadly, human personnel--it's a confusing term that someone must have noted--and also physical infrastructure. In the dramatic places in which dramatically poor. . . that are, what should I say, devastated by violence, no IT infrastructure . . . Actually there is someone here today who taught us a lot about the importance of solar power in trying to light up a rural clinic, but in these very dramatically poor places, I think one of the ways to show funders how important this is, is to say this is what it looks like now. This is what it could be like with a relatively limited investment. Then X months later say, you see, we told you so. You can do this. When you came to visit us in Rwanda and saw a hospital moulting out of the caterpillar form into--and this is a bad metaphor--anyway, being transformed into a beautiful hospital, I think it's

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dramatic. So . . . part of what we need to do, just like making the suffering, unnecessary suffering, vivid and compelling to people is to show that it can be done. As Dr. Tedros said, there are some myths out there about absorptive capacity too. There is the idea that you can't do this in the really poorest places . . . just not true. It's difficult, but it's not true. So I think it's a very pedestrian response, but to say that proof is in the pudding, come look yourself, and then again, trust us to continue this process.

I have also argued here that that infrastructure ought to be public infrastructure so that we can make sure that poor people have rights, because NGOs and faith-based organizations, charities and foundations, they don't offer poor people rights. Only governments offer rights. So someone living in Ethiopia can only go to a public facility and say, I'm here for my right to safe childbirth. You can't go to other places. So we need to build the infrastructure. Show it can be done. Staff it in a reasonable manner, and then show that this can be going on over time.

One last thing I'd like to mention about the brain drain, which was mentioned by Chris: It's true that the wealthy countries, what he called the West, are sucking resources out of Africa and many other places, but one of the reasons people leave is not because they want higher salaries.

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It's because they want decent working conditions. A Kenyan doctor once said, and this is a young man, "I didn't go to medical school to be a mortuary attendant." So unless we give them the tools that they need, whether they're Indian, generic medications, essential drugs, an operating room in that infrastructure, then the – it's horrible to say human infrastructure – then the personnel that we need are not going to stay. Once you do that, once you make a commitment, and this is a worthwhile investment, then they will stay. That's been our experience in both Haiti and Africa.

SANJAY GUPTA: You know it's been remarkable as well, you mentioned Rwanda, and I imagine there are a lot of anecdotes, Paul. I met a woman at your facility; a Partners Health facility outside of Kigali who came in very, very ill. She had to be carried in. She looked like she was going to die because she was HIV-positive and was just in the early stages of AIDS, and ended up with an abdominal infection. Well, she was treated. . . and within my week stay, by the time I left, she was actually discharged, happy and healthy and doing well. I was struck by those sorts of stories that actually show the infrastructure you say leading to someone, not only surviving, but able to carry on their way of life. I think those sort of stories speak volumes.

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At the bottom of that same slide, Dr. Tedros, it says individual communities want a sense of ownership over their own infrastructure. I think it's an important point. Once you get the infrastructure, the ball doesn't stop there. You have to keep moving it down the field and make sure the people who are actually boots on the ground are engaged in that infrastructure.

TEDROS ADHANOM GHEBREYESUS: May I say something on the previous one.

SANJAY GUPTA: Yes, please.

TEDROS ADHANOM GHEBREYESUS: The infrastructure is very important. For instance, as I said, in order to reduce maternal mortality, you need to have community-based interventions and facility-based interventions. Unless you do that, it has already assessed by the World [inaudible]. There was actually a study: unless you do the facility-based intervention, you cannot reduce maternal mortality. So that's why, and I think funders should be convinced of it. Okay. Community-based interventions and giving pills or other maternal health activities can help, but it cannot be complete. So whatever we promise to mothers really cannot happen with infrastructure. That's what we have seen.

The second issue is in regard to infrastructure or strengthening the health systems. We are getting a lot of

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support; by the way I would like to use this opportunity to thank all partners for this unprecedented support on HIV and malaria. We're very grateful for that, but unless we strengthen the health system, it will be really futile because if you consider the individual as loads of something to be carried by the health system, and if you consider the health system as a vehicle and try to really carry it, it can end up even crashing the health system. So there is a danger. And you cannot sustain anything actually, because there is not caring capacity, so unless we really strike a balance, whatever we are investing on malaria and HIV now, will just disappear like never has been done. So that is why we say, let's strike a balance to strength the health system.

The ownership issue, we have ambitious targets as I said earlier, and we are building hospital and health centers and communities are getting involved in building the infrastructures, in terms of whatever they can actually contribute toward the building hospitals, building health centers. They can bring [inaudible] from local areas. That, I think, ensures ownership. Also involving them from the very beginning. Listening to what they say.

I will tell you one focus group discussion we have done with mothers, for instance. We were telling them about contraceptive use. They told us about their choices, the type

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of contraception they need. They said, we need not pills, but we need, injectables, because husbands generally don't approve taking contraceptives. They also say it was extramarital affair and so on. So when they take pills on daily basis, they cannot hide it from their husband, so they ask for injectables. We told them, this is a family issue, you should discuss this openly and the husband should be involved and so on. They said, yeah; don't be silly, you cannot change their attitude overnight. You can help us, or educate them, but while we are doing that, we don't want more children, so give us the injectables, or the shots. We asked them, how do we do it? They said, when you come for your outreach vaccinations, you can give us the injectables at three months. So what I want to say is that they know the problems and they know the solutions as well. They're not ignorant, although they are from the rural, they know better than us.

The issue of sustainability or ownership is to just start from listening to them. Discussing with them. Ask them what they need and build starting from that. Then I think the ownership issue can be addressed. So based on that we are starting some programs that really are supported by them. So the ownership issue, if you really involve the community, listen to what they say, listen to what their priorities are. That can suffice it and I ask all our partners to also listen

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to our priorities. Thank you and we are committed to listen to all communities.

SANJAY GUPTA: Dr. Tedros, thank you very much and unfortunately we are running very short on time now. We tackled a difficult topic today. I think infrastructure is not an easy topic. Some people's eyes glaze over at the very mention of it, but it's an important topic to discuss if you're going to have an informed discussion about health care, the global health problems, the hard ones and the easy ones as well. You need to be able to be talking about infrastructure. You've heard about some of the commitments. You've heard some of the definitions, and we leave it to you now to hear some of the commitments that you're going to make as well. Before we get there though, we want to hear about some of the commitments that have already been made.

With that, I'm going to say goodbye. We're going to excuse our panel and thank you very, very much.

FEMALE SPEAKER: Ladies and gentleman, Donna Shalayla.

DONNA SHALAYLA: Thank you very much. Well, my eyes didn't glaze over. I get to introduce four commitments this afternoon, and let me start by inviting the President and CEO of US Doctors for Africa, Ted Alemayhu. Is Ted here? One of the big infrastructure issues is, of course, the mobility of quality medical care. And US Doctors for Africa is making an

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extraordinary commitment working in nine countries in Africa, and they will mobilize 200 mobile clinics with 2,000 medical volunteers to deliver high quality services, particularly treatment for AIDS and other infectious diseases. In addition, they know better than just to go and leave. They are going to strengthen over 100 standing clinics in those communities. The value of this commitment is \$75 million over five years. Let's congratulate Ted. [APPLAUSE]

A lot of people have had something to say about our multi-national drug companies. Pfizer gets it, and please welcome Joe Feczko of the Chief Medical Officer of Pfizer and Robert Mallet, the Senior Vice President for Corporate Affairs. [APPLAUSE] In much of the world drugs are delivered not just through a formal process, but through an informal process with lots of different people that community individuals buy their drugs from. And this proposal and this commitment [are] interesting for a multi-national company, because recognizing the informal system and building on effective collaborations with governments and NGOs, and communities in Africa, they intend to improve the delivery of drugs for malaria by strengthening that informal system. In Guyana, Kenya and Senegal, they will work initially in the informal system and build from there. This is a \$15 million commitment over five years. Please congratulate. [APPLAUSE]

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Thank you very much. Could I introduce Craig Nakagawa, the COO of VillageReach? Please welcome Craig. [APPLAUSE] VillageReach, of course, made their reputation in their work on immunization. They intend to build on that platform. One-hundred and seventy-one clinics where they've already approved the supply line for vaccines, and they are going to take that knowledge particularly in Mozambique for infrastructure improvements and they're going to expand that platform to maternal and child health, to family planning, to mental health, to school health, to nutrition to AIDS and leprosy, and TB, and target two provinces. They've done wonderful work in immunization. This expansion allows them to expand the infrastructure in Mozambique. The value is \$3.1 million over five years. Congratulations, Craig. Thank you, Craig.

Last but not least, let me welcome an old friend, Seth Berkley, the President and CEO of the International AIDS Vaccine Initiative. [APPLAUSE] Hi, Seth. Everybody knows the International AIDS Vaccine Initiative. Seth and his colleagues have chosen India, and India because they have some infrastructure strength, an industry that's pretty sophisticated and of course, world class scientists. And there they will strengthen the quality of testing and counseling to prepare for the introduction of vaccines. India, of course, chosen because it has all of those kinds of combinations. They

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have a global research and development capacity. A model for India and that preparation will help us introduce what we hope will be successful vaccines and create a model for the world. \$71.5 million commitment over three years. Please congratulate Seth Berkley. [APPLAUSE]

Please congratulate all four of the commitments. Thank you.

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