Transcript

July 29, 2009 | www.mcc.gov

MCC and Global Health Initiatives: Paving The Road To Healthy Lives

MCC Hosts a Public Outreach Meeting

Speakers

Aaron Sherinian
Managing Director For Public Affairs,
Millennium Challenge Corporation

Rodney Bent
Acting CEO,
Millennium Challenge Corporation

Sally Shelton-Colby
Fmr. U.S. Ambassador to Grenada and Barbados

Shellie Bressler
Professional Staff Member,
Senate Foreign Relations Committee

Joseph Dwyer
Director, Leadership, Management And Sustainability Program,
Management Sciences For Health

Carol Hessler
Managing Director, Infrastructure, Environment, and Social Assessment,
Millennium Challenge Corporation

Transcript

SHERINIAN: Good morning, ladies and gentlemen. On behalf of the Millennium Challenge Corporation and the Global Health Council, it indeed is a pleasure to welcome you here today.

My name is Aaron Sherinian. I'm the managing director for public affairs at the Millennium Challenge Corporation. And as this crowd shows us, health truly is the talk of the town in Washington right now. An important aspect of that conversation is what we will go over today on global health.

I would like to again thank our partners at Global Health Council for helping to assemble their membership and those in the MCC stakeholder community who believe that global health has to be at the foundation of our discussions about fighting global poverty.

We today have assembled a remarkable group of people — hopefully, a provocative group of people — who are going to challenge a lot of the ideas and help maintain on the agenda what should be an important part of this conversation on health that's going on in Washington today.

I would like to do a couple of — remind folks on a couple of housekeeping matters, if you don't mind. Please silence those very busy phones. We know that your Blackberries are all-important and that people are going to be reaching you.

One caveat, if you are tweeting from this event — and we hope some of you are; please do — MCC is on Twitter and we are at MCCTWEETS, if you needed to reference our handle as you're registering your tweet from the event. And please do, as we will be doing as well.

We also wanted to remind folks that this event is being recorded and will be available on the web. So please don't say anything that you wouldn't want your mother to hear...

(LAUGHTER)

... but please do, as we move into the question-and-answer portion of the event today, identify yourselves and visit back at MCC.gov, where the transcript will be available, where you can share the proceedings with the colleagues that were not able to join you today. And hopefully we'll share some interesting things that will, again, challenge us and help us to move forward in this shared agenda.

It will now be my pleasure to introduce for some welcoming remarks someone who needs no introduction, because he has stood at this podium many times. And it would also be a missed opportunity if I do not mention that MCC's acting CEO, Rodney Bent, as most you know, is in his last week here at the Millennium Challenge Corporation.

So before introducing Rodney to offer some welcoming remarks to kick off this event, we would like to also publicly, as this will be most likely his last large-scale public event in this room here at our home, thank him for his 30 years of public service, for his

incredible contribution to issues that matter to all of us, and for helping to indeed improve the lives of those with whom the U.S. partners around the world.

So we'd like to say thank you and welcome to Rodney now.

(APPLAUSE)

BENT: Thank you. I haven't frankly expected that. This is the last time I think I'm going to be standing at this podium. So, you know, there's a certain sense of looking back, looking forward that comes over me.

We had a special farewell on Monday, and I didn't break at down at that, and I don't think I'll break down here, either.

(LAUGHTER)

But I am very impassioned about what the MCC has done and will continue to do. And I'm passionate about the issues of development that seems to me, whether it's health or education or good governance — we talk a lot about that.

These are issues that involve us all and will continue to involve us all for years and years and years to come. And I'm just happy I'm going to continue working on these kinds of issues. You — you remove one persona, but you take it with you in some ways. And I'm looking forward to that.

Before we go much further, I wanted to say welcome to Darius Mans. If you can stand up, Darius?

Darius is going to be the new acting CEO. He is — he is plan C. I was plan B.

(LAUGHTER)

Darius, here, has got just a wealth of experience in this. He spent twenty-five years at the World Bank. He has got — and I hope you won't mind if I embarrass you a little bit, but Darius has got gravitas and persona and experience that are just incredibly valuable to the MCC. And I would impress that upon him to make sure that he would stay.

And I'm delighted that he is in fact willing to do this, because he will bring, I think, terrific leadership to the MCC for — I don't know how long. I wish I could say it was only a month or two months. But in some measure, however long it is, I can assure you that the MCC is going to be in very solid hands and continue in doing the very good work it's been doing.

Well, let's talk about global health, which is really why we're all here. I actually am thrilled.

I wanted to welcome the Global Health Council for today's event. We at the MCC certainly understand the importance of health. It's like education. It's a bedrock of civil society and living everywhere. I can't think of an individual who doesn't think on a daily basis about their health, the health of their family, and the issues that health involves.

What we recognize here is that inextricable link between health and income and the whole variety of linkages. It's like that old song — you know, "The leg bone is connected to the foot bone." Everything is connected. If you don't have good health, then you're not able to work. If you can't work, any number of other consequences may come.

So, you know, we've always viewed health as being inextricably bound up with economic growth, with individual household income. So several of our programs deal with health.

I could go on at length. I won't. It seems to me you're really here to listen to the experts, and so I'm going to turn it over to the experts — including our very own Carol Hessler. I'm delighted that Carol will be able to talk about these kinds of things. And I look forward to seeing you all.

(APPLAUSE)

SHERINIAN: Thank you, Rodney. And it is now my pleasure to introduce our keynote speaker for today's events.

And while the ambassador is no stranger to this sector, and we know that she's no stranger to many of you who are her former and current colleagues and friends in the room, she provides an important voice. And we have with us today a voice that speaks out of experience, with passion and with candor, on the issues of economic development and of global health.

And it is truly a privilege to introduce to you Ambassador Sally Shelton-Colby. While I cannot do justice to her bio, I would like to take a few moments to tell you a little bit about that voice and the experience that helps form it.

The ambassador has held a number of important senior positions in the public, corporate and non-profit sectors as well as in international organizations that are important to so many of us here today. Many know her term as deputy secretary general of the Organization for Economic Cooperation and Development, or OECD, in Paris, where she focused heavily on the issues of international health in developing countries.

The ambassador served here in Washington and knows many of you from those days as assistant administrator for the Bureau for Global Programs at the USAID, where her management was of programs including HIV and AIDS, tuberculosis, malaria, maternal health and several other issue areas.

Her very distinguished public service career includes service as U.S. ambassador to Grenada, Barbados and several other eastern Caribbean nations, as deputy assistant secretary of state for Latin America, as legislative assistant for foreign policy for then-Senator, later Secretary of the Treasury Lloyd Bentsen.

There is more. I don't know how she had time to, but she has — was also able in this period to include an impressive private-sector portfolio, with time at Banker's Trust Company of New York City as vice president, where she was responsible for managing the bank's political risk portfolio, including other prestigious positions in the private sector.

The ambassador has served and continues to serve on a number of nonprofit boards of directors, including — and I sure cannot name all of them, but allow me to include a few that I know are particularly important to some of you: Helen Keller International, the National Endowment for Democracy, the National Democratic Institute, the Atlantic Council, the Pan-American Health and Education Foundation where she currently chairs the development committee, and the Institute for Governance and Sustainable Development.

As I know all of you know, the ambassador was one of the founders and the very first chairman of the Board of Directors of UNAIDS.

Ms. Shelton-Colby is currently a diplomat and a resident at American University and we understand that, in January of 2010, we will be getting a course on development with an emphasis on international public health. And I have a feeling you're going to have a few more subscribers after today.

We're thrilled to have this voice with us today, someone who can help kick up this conversation about an issue that is important to all. Please help me to introduce and welcome Ambassador Shelton-Colby.

SHELTON-COLBY: Thank you, Aaron. It's very nice to be here.

I am a little embarrassed to admit that this is my first visit to MCC. And I have admired your organization from the get-go. It's very nice to see some old friends in the audience. And it's nice to reconnect with Rodney Bent. We worked together a hundred years ago at Banker's Trust when development was at a very different stage from where it is now. That was about twenty...

BENT: Thereabouts.

(LAUGHTER)

SHELTON-COLBY: ... years ago, when the big issue with regard to developing countries was not development. It was the international banking crisis. And at stake were not only the survival of the bank we worked for, Banker's Trust, and a number of other banks around the world but also, I would go so far as to say, the very survival of a number of developing countries.

But that was then and this is now. When Aaron called me about making brief comments this morning, I protested, saying I was not a health expert. I worked in various capacities on health policy issues. But I'm not the health expert. And I felt I had little to provide with people like you who are all health experts.

But he twisted my arm and I decided that I would say yes, because I think there are — I would like to talk about health this morning in perhaps a broader perspective.

A couple of years ago there was a very interesting exchange of views between Laurie Garrett, who is at the Council on Foreign Relations, and Paul Farmer, whose name is probably well known to you for a variety of different reasons. And they had an exchange in Foreign Affairs magazine on health policy and health infrastructure.

And I saved those articles. I tore them out in my Foreign Affairs edition and saved them. And I went back and read them the other day, and they made as much of an impression on me the other day as they made a couple of years ago. So I'm going to draw extensively from their exchange. There was a good deal of agreement and there was some disagreement as well.

And one of the points that both of them made is that we are witnessing an extraordinary increase in funding levels. But obviously, at USAID, funding was significantly lower than what it is today for foreign assistance. There's been an extraordinary increase in both public as well as private giving, especially in the health area. It's unprecedented.

And it's particularly unprecedented when one realizes that the bulk of the funding is going to diseases of the poor. Because in the past, funding tended to go to those sectors that were basically rich-country sectors.

We're talking about billions of dollars and Euros and other currencies going from public, corporate, foundation and private giving. Now, as you probably know, the OECD, where I hung my hat for a few years, has something called the DAC, the Development Assistance Committee, which is the official entity that collects data and monitors the Development Assistance Committees for twenty-two member countries of the OECD.

That spending — and this is where most of my remarks are going to be focused on — that is the foreign assistance programs of the twenty-two biggest donors who are members of the DAC. That spending on development assistance, with health as the largest portion, has skyrocketed, at least until the recent economic downtown. And I think it's also important to point out that a number of developing countries are also increasing their spending on health. Sometimes significantly.

We don't have very good numbers, but in a number of African and Latin American countries, spending on health has increased dramatically. You might ask "What are the motivations for this?" I think they're diverse. I think some of them range from reasons of morality to reasons of foreign policy. In some cases, I think the increase in spending in health is going for — it's an investment in self-protection, since microbes know no borders.

The reasons are diverse, but the bottom line is that there has been a very significant increase in spending. And I'd like to talk about the challenges. It's easy for me to stand in front of this podium and talk about the problems and talk about the challenges as opposed to finding the solutions. But I will emphasize my — the challenges that I think the foreign assistance world is facing and leave it to you who are specialists to find the answers.

And I'll be very honest. And I may — some of you may not like what I'm going to say this morning. I think one of the problems that we and the development community face is that there tends to be funding going to high-profile diseases: AIDS, malaria, tuberculosis and other high-profile diseases, as opposed to the inadequate funding of broader health care systems — broader public health spending.

And you might say, "Well, that's better than not having this spending at all." And yes, I agree with that. But we need to make a stronger case for investing and strengthening of broader health care systems. And I'll talk more about this in a minute. I would say

also that those of us who care about health need to think more broadly about good governance and how we talk about health in a broader good governance system.

Good governance, health care systems, decent infrastructure to provide public health — these are all required and they're frequently missing. Laurie Garrett and Paul Farmer both argue that decades of neglect in many countries have rendered hospitals, clinics, labs, medical schools and health talent dangerously deficient.

Another challenge: We're all trying to manage for results. But the managing for results paradigm tends to favor specific aid targets that we can make numerical — the number of people receiving specific drugs, for example; the number of pregnant women with HIV; The number of bed nets. I think somehow we have got to figure out how to focus aid on broader measures, perhaps very difficult to quantify. But broader measures affect the broader public health.

Laurie Garrett specifically emphasizes in this article of two years ago that we need to worry about the broader scarcity of public health workers. That the world is short a staggering four million health care workers — that's in both developed as well as developing countries. And specifically, in developed countries like the U.S., eighteen populations are pulling health care workers away from developing countries.

It's estimated that one out of every five physicians in the United States is foreign trained. That's a staggering statistic. The American Medical Association estimates that by 2020, the U.S. could face a shortage of up to 800,000 nurses and 200,000 doctors. And the likely way we're going to close that gap is by tapping more doctors and nurses from developing countries.

I narrowly step on Rodney's toes a little bit, as a former staffer in the Hill, because I think one of the big problems that we face is the earmarking that comes out of the Congress. The earmarking for child survival. The earmarking is for a number of other health areas. And related to the earmarking problem, I think, is the tendancy on the part of the public to donate when there is a mass emotional response, such as the Asian tsunami.

We need consistent and sustained non-earmarked funding. Another problem — Rodney mentioned it — corruption. Laurie Garrett at the Council on Foreign Relations estimates that eighty percent of health funds in Guyana are diverted. Now, this is a slightly dated figure. But I think all of us who work in developing countries are concerned about the corruption issue. Hey, it's a problem in developed countries as well, not just in developing countries.

But having recently moved back to the United States from Mexico where I was working on corruption issues, I know how broad a scale it is. And I know less about corruption in the health sector, but I'm really impacted by some of the numbers that I'm seeing that Laurie Garrett and Paul Farmer and others have provided us.

I want to point to another area in my brief remaining moments that I think is often talked about. I think it's extremely important and I think a grossly inadequate amount of work is focused in this area, and that's donor coordination. I think it's almost boring to talk about.

Everybody says, "You know, it's right up there with motherhood and apple pie." Donor coordination. And God knows there's a lot of donor coordination that goes on. And on the ground we do precious little of it. We need to take donor coordination much, much, much more seriously.

And before I get totally away from my complaint about the amount of money that's going to specific diseases that the world cares about, I stumbled on an interesting figure. The World Health Organization gets more money for disease-specific programs than it does for its core budget. That's not an intelligent approach to international health care management.

The stove-piping issue. One of the big problems that I saw when I went into AID — and it was a goal that I set for myself to try to deal with this — was the stove-piping. Health people tend to focus on health issues. Agriculture people tend to focus on agriculture. Economic growth people tend to focus on economic growth. Democracy and governance people tend to focus on democracy and governance.

I'm obviously making a broad generalization and there are exceptions to my criticism of the stove-piping. But the stove- piping also takes place within specific technical areas, such as health. I can point to a number of examples. There will be an ARV distribution program for mothers and children, but no maternal and infant health capacity in a particular country.

So there's an urgent need to encourage greater technical collaboration between and among technical sectors. We need to get more collaboration in the health environment area, for example. In the health and economic growth area — in the health and education area — in health and water — health and nutrition — health and agriculture.

I just yesterday read a very interesting analysis by one of the leaders of CARE. I don't know if there's anyone from CARE here today — CARE is estimating that climate change may cut agriculture production in Africa by one-half by the year 2020. That's going to have tremendous impact on health.

I am going to conclude, because I'm using up my ten minutes. Another complaint or criticism I have is that the top three killers — and you all know this better than I, because you're out in the field — the top three killers in most developing countries are maternal mortality, pediatric respiratory disease, and pediatric intestinal disease. But those are not the three areas where most of health money is going.

And I also might mention the (inaudible). There's onchocerciasis, there's guinea worm, there's typhoid, there's diabetes, there's heart disease and there's still polio. What is needed, I would reassert, is investment in health infrastructure so that you can deal with a range of diseases from AIDS to maternal and child health to TB to oncho. And we should be able to use health monies more flexibly than we do on nutrition, on water, on sanitation.

And I'm going to take advantage of you as a captive audience for just one minute to talk for a minute about a health problem that I think is very serious, and it has grossly inadequate attention — and that's blindness.

In developing countries an adult goes blind every five seconds and a child goes blind once a minute. That means that between 500,000 and 700,000 children go blind every year. And 70 percent die within the first year of going blind. Now 90 percent of global blindness is in developing countries. And 80 percent of that is either preventable or curable — treatable.

And in addition, there's malnutrition, which is a subject for another conference. A child dies every 15 seconds from malnutrition — from diseases related to malnutrition, especially vitamin A. This vitamin A deficiency is a deficiency that is implicated in about one-half of child death in developing countries.

So these are issues that we really need to focus on and get more funding for. It's urgent. But most health money, as I was saying and as you know better than I, is going to AIDS, TB, malaria and to other projects, testing sites, hospices, orphanages, ARV disbursal stations, etc.

When Aaron introduced me, he mentioned that I was the first chair of — I was involved in the creation of UNAIDS and I was the first chair of UNAIDS, so my commitment to the fight against HIV/AIDS has been and is very, very strong. But we need to broaden out our approach to health care.

Back to health infrastructure. During the 1990s, Zimbabwe trained 1,200 doctors. How many are today left in country? Less than 300. In Zambia only fifty of the 600 doctors trained in the last forty years are still there. The International Labor Organization estimates that twenty to forty percent of Africa's health care workers are HIV-positive and are projecting a collapse of health systems in Africa. Much of this is due to immigration to developed countries or to work on foreign aid-financed projects in these countries. But there is a critical need for a stronger approach to the strengthening of health care systems.

And let me close with two remarks. Everyone here is well aware that the public support for foreign assistance is weak, to put it mildly. Back in the 1970s when I worked for Senator Lloyd Bentson — this is before the invention of the internet, so the e-mail didn't exist. Senator Bentson received about 1,000 letters a day. I worked with him for six years. How many letters do you think he got in six years, 1,000 letters a day, supporting foreign assistance?

AUDIENCE MEMBER: Four?

SHELTON-COLBY: One. One. And that was from the Dallas World Affairs Council. It wasn't even from a voting constituent.

I think Bob Gates is a saint to have put development as a foreign policy tool on the table. It is extremely unusual for the national security community to be an advocate of foreign assistance. And the fact that he has embraced development as an important tool in national security is extremely important, and the Obama administration seems to be continuing to embrace that concept of diplomacy, defense and development as an essential component of U.S. national security.

I hope very much that the increase in foreign assistance started in the Bush administration is sustained in the Obama administration. I worry about that, because of the budget deficits that we're facing, which the Financial Times yesterday is saying that we're going forward with a 12 percent budget deficit. That's impressive in my forty-some-odd years working on public policy in Washington.

So what do we do? I think it is up to people like you — all of you and me, to make a more compelling case than we have made to the non-development specialists. Everyone in this room, you're here because you care about development. But there are a lot of people out there who don't care about development, who don't understand what development is all about.

I've spent a lot of the time — I've spent a lot of the last fifteen, twenty years out in Peoria and St. Louis and places like this, talking about the importance of development to the U.S. national interests. And it's amazing the lack of knowledge about what we are accomplishing. And we're accomplishing a lot in the development field. But it's up to all of us to go out there and make the case, because if we don't, the funding for foreign assistance, whether it's going to AID or PEPFAR or MCC, the funding is not going to be there.

So it's our responsibility to get out there and make the case to the non-development field. It's not good enough to talk with your colleagues who are already convinced of the importance of development. We've got to get out to those who are not convinced — opinion shapers especially and make the case.

And lastly, I'd like to say I've been very impressed with MCC and its work, its approach to — its conditioning of aid; its insistance on good government — good governance. But there's an issue that I think is not talked about enough in the development community. And it's a criterion which I would like to suggest ought to be embraced by the development assistance community.

And the idea is not mine. Bob MacNamara worked on this issue for a very long time after he left the World Bank. And more recently, Oscar Arias, the Nobel Prize-winning current president of Costa Rica.

And he wrote just the other day, "Today Latin America is spending $50 billion just this year on the military."

That's double what it was just a few years ago. Now this is ridiculous — this is a direct quote. This is ridiculous. In a continent where 200 million people live on less than two dollars a day. Why can we not place military spending — I would also add that Colombia is the only country at war in Latin America, and yet Latin America is spending $50 billion this year, with 200 million people living on less than two dollars a day.

Why can we not put military spending up there as a criterion, along with a country's commitment to education and health care and good governance, as a criteria for countries in which we decide to work.

I need to close by thanking all of you for coming this morning. For spending a few minutes listening to a non-health expert expound on health issues. I think they are central to the foreign assistance agenda. And frankly, I would really like to see the rest of the OECD, the other members of the development assistance community at the OECD, embrace an MCC-type approach.

I have to be honest and admit that I was initially not someone who was certain that MCC was a good idea. I'll be very honest with you. I am now one of your biggest supporters. I thank you again for inviting me this morning.

SHERINIAN: Thank you, Madame Ambassador, for posing a number of questions that we'll have a chance to explore deeper and later on today during the second portion of the meeting. And I know I speak for everyone in thanking you for being so honest with us and for your passion about issues that matter to the world.

We're now going to move to the second portion of our program. And I think it will be a bit of a scene change.

We're lucky because Ambassador Shelton-Colby has agreed to help us moderate the second portion. So we're going to be able to pose some of those questions that she raised directly to her as well when we enter into Q and A.

But in the meantime, I'd like to ask our panelists to join us here at the table. And while they're doing so, I'm going to make a very brief introduction of each of them and turn the microphone over to them where they will give us a few minutes of opening remarks. And then we'll be able to have at them with some important questions.

We truly have an embarrassment of riches — or rather, in this case, an embarrassment of talent — I won't speak to their wealth. But truly an embarrassment of experience here on the panel today. And I will not be able to do them justice.

But allow me to introduce them, in the order which they will speak to you briefly.

Marty Makinen, who as many of you know, is Managing Director at Results for Development Institute. Marty has spent 23 years at Abt Associates, where he was vice president and fellow. And I know he is someone who worked closely with many of those who are here in the room today. Marty is a health economist with three decades of experience in technical assistance, teaching, and applied research related to health systems and policy in more than 40 countries in all regions in the world, with a particular focus on Sub-Saharan Africa.

Thanks, Marty, for being with us today.

And Carol Hessler is with us today. She is Managing Director for Infrastructure, Environment and Social Assessment for the Millennium Challenge Corporation. Her bio, along with others, is available for you to review with her considerable experience in development. But she's part of the MCC team with her experience on infrastructure, which she will address with us today.

Dr. Joseph Dwyer is Director of the Leadership, Management, and Sustainability Program at Management Sciences for Health, where he leads a world-wide team making improvements in leadership and management to improve client services. Dr. Dwyer has 28 years of experience developing, managing, implementing and advising international health programs.

We have with us today Shellie Bressler, who serves as Professional Staff Member focusing on global health matters and gender issues for the Republican staff of the Senate Foreign Relations Committee. She was the lead Senate Republican staffer for Tom Lantos and for Henry J. Hyde, and in United States Global Leadership against HIV/AIDS, Tuberculosis, and Malaria; and the Reauthorization Act of 2008.

We're very happy to have you with us today in what we know is a very busy season.

We also need to extend the regrets of Michele Sumilas, who many of you know and was scheduled to be with us today. She was unavoidably detained — and that is an excuse that holds water when we're dealing with the U.S. Congress and the schedule that they've got right now. So she sends her regrets and we hopefully will be able to have her with us at a future time.

So with that, we move it over to Marty and then the Ambassador will join us to moderate and throw out the first question and then talk to each of you. Thank you.

MAKINEN: Thanks for the nice introduction and good morning to everybody.

"Paving the Road to Healthy Lives" is a good title for this session, since there are a number of factors, as alluded to earlier, outside of the delivery of health services that help — and help in a major way to produce better health. These other factors in effect pave the way to health and to the effective delivering of health services themselves.

Those non-health service contributors to health rely on infrastructure to be effective. And this includes both physical infrastructure such as paved roads and what I'd called "soft infrastructure." And as you'll see as I go along here, I think that the soft infrastructure is a critical but weak point for health service delivery.

The principal non-health service factors that contribute to health include incomes and employment opportunities, education, especially girls' education, security, and water supply and sanitation. And before I go into the concepts of physical and soft infrastructure a bit more, let me comment on the MCC indicators for eligibility.

The MCC asked the Center for Global Development, CGD, a couple of years ago to organize a committee to help review its health related eligibility criteria. And I had an opportunity to serve on that committee — just one of many members. The two MCC indicators for eligibility related to health are true government spending on health and immunization coverage.

And the CGD committee, after careful study and deliberation that took months, agreed that these were the most appropriate indicators of governments investing in their people for the purposes of MCC.

So we did a lot of thinking and deliberation. We concluded that they had it right to begin with.

However, this conclusion was heavily influenced by the requirement from MCC — and a correct requirement, I think — that the indicators be readily available for the vast majority of countries and that they be collected by independent sources, so that they're not influenced by who's collecting them, or any conflict with MCC collecting them.

But that requirement emanated from consideration of a number of alternatives. So I'll come back to what I think would be a better indicator for investing in people than those two that are used by MCC. But unfortunately, it's one that's not collected regularly from any countries.

But now let's return to all of the major contributors to health and the concept of infrastructure.

A country that wishes to maximize the health of its people would embrace, as our keynote speaker mentioned, a combination of policies and make investments that would ensure economic growth, educational opportunities for all, especially girls, security, including the enforcement of laws and contracts, the element of good governance in many ways, and water supply and sanitation, in addition to spending on specific health services.

And then economic growth depends on adequate physical infrastructure including roads, bridges, energy supplies, etc. And also depends on — and here I'll introduce what I mean, but by examples of soft infrastructure: of markets, availability of technology, skilled workforce and information. Similarly, education, security and water supply and sanitation also rely on a mix of physical and soft infrastructure.

Education requires the physical infrastructure of school buildings, plus the soft infrastructure of appropriate curricula, etc. Security requires police, fire and emergency equipment, physical infrastructure and systems. Water supply and sanitation requires wells, purification systems, pipes and sewers, along with systems to monitor quality.

Requirements for effective provision of health services are similar. There's the need for physical infrastructure and as was cited earlier, there's been a decline in the quality of the physical infrastructure over recent years in low income countries in terms of hospitals, health centers, laboratories, X-ray equipment, microscopes, etc.

But health services provision also needs soft infrastructure, including supplies of health workers — an issue already raised — distribution systems for drugs and vaccines, continuing education of their health professionals, planning, research and management systems to make the services function. Consider this latter area, the soft infrastructure, where achievement often is suboptimal and disappointing in low income countries and gets relatively little attention.

Low income countries have taken what I would call an engineering approach to health services organization and soft infrastructure. They try to diagram it out and define who should do what. The results are elegant on paper, but disappointing in practice. The problem is that soft infrastructure isn't held together by bolts and seals, and relationships among actors aren't defined by the properties of materials, stresses and the laws of physics.

Instead, the health services systems are held together by relationships among the human beings who operate them and operate within them. Thus, the laws of human behavior are much more important than the laws of physics. What the people within the system are supposed to do is influenced by the incentives, disincentives, rewards, and penalties embodied in the system, whether by design or not.

Most low income country health systems — health services systems — embody many unintended incentives and disincentives and loopholes that human behaviors jump all over and jump through. The U.S. health system debate — or health reform debate — is taking up some of the soft infrastructure questions of the incentives embodied in, for instance, paying doctors a fee for every procedure they perform and every test they provide.

This moves our American doctors to over-prescribe procedures and tests in order to earn more money. This escalates the cost of the health system, without improving quality or outcomes. Some of the proposals for reform address this situation by suggesting paying for results, rather than paying fees for supplying the input.

The very different soft infrastructure of low income country systems results in similar consequences. Drugs of course are a critical input into curative care and thus they are highly valued by patients. Health workers in low income country government health systems almost always are civil servants who benefit from strong job protections.

Drugs are put in the hands of those health workers, who then have little to no risk of being disciplined, let alone being fired, if the drugs are lost. The lost drugs then find their way to cousins of the health workers, who sell them across the street from the government facilities where the free of charge drugs are in chronic short supply.

The doctors who graduate from government schools are guaranteed jobs in government service. And then some are deployed to underserved rural areas where health needs are great, but the supply of services is low. This is not very attractive compared to urban settings where there are schools for the doctors' children, many cultural and entertainment options, and possibilities to do private practice on the side.

Given civil service protection, many of those deployed to rural posts never show up for work, but yet collect their salaries and face no sanctions as a result. These systems weren't intentionally designed to provide these incentives or opportunities to misuse the system, but rather, no care has been taken to think about the soft infrastructure that leads to these unfortunate results.

Thus, I'd like to recommend that organizations like the MCC that make major contributions to support infrastructure development across all sectors be ready to support efforts to address not only physical infrastructure, but also soft infrastructure, especially in sectors like health.

So finally let me conclude by turning back attention to the indicators. And I'll give you a little kind of puzzle here for you to solve and I'll give you my answer and then you can see if you think I've solved it correctly.

The indicator that I think best captures the total investment of a government in its people's health is one that requires a combination approach to investing across the board. Not just in health services, but in education, income growth, security, in water supply and sanitation and many other things as well.

It's one that requires a sustained commitment to investment to achieve good numbers in its measurements. It can't be pumped up in a short period of time — for instance, just to become eligible for MCC assistance. It also has an equity dimension to it, so that good numbers on it can't be achieved by serving only the upper part of the income distribution and masking failures to reach the bottom, with good achievement on average.

So the indicator that I favor is the rate of child stunting, or height for age. Think about it. And I thank you.

HESSLER: Good morning. Nice to see you all.

First I'd like to say that I am so excited to be asked to be associated with such an event with such an illustrious panel. Madame Ambassador, you were modest. You are a health expert compared to me. I am not a health expert at all.

But I'd like to talk to you a little bit about the stove-piping issue, because the person I've learned the most from in this organization in terms of the integration of what I do with what we are trying to do is Patricia Moser, who I'd like to introduce to you. Stand up, Patricia. She is our resident global health expert.

(APPLAUSE)

HESSLER: And we've been working a lot lately on issues of road safety — which is a key issue, and I really appreciate everything I've learned from Patricia Moser.

First let me go on little bit different track here and tell you why I love coming to work.

I certainly don't love federal bureaucracy. That's certainly not the reason I come to work in the morning. I come to work in the morning because for every rural and safe road that we do, incomes rise and people have access to markets, they have access to schools, they have access to health centers.

And you know, having lived in many countries in my life, you know, you really get an appreciation of the difference it makes just being able to get there. So that's why I come to work. For every water and sanitation project that we do, we decrease the risks of water-borne diseases — that are real problems in children. We lower the time to travel to find water, which as you all know marginally impacts women and children. Therefore, increasing time for school, for education, for rising incomes.

It's very exciting to me. It means a lot to the team. I keep worrying that with the new infrastructure money coming in from the U.S. government, all my engineers will quit, because they probably can make more money building roads in Montgomery County than in building roads in Africa.

But I think we have a really committed team at MCC. And the reason is, we understand and see the great integration.

So what are we doing at MCC? I mean, you've all heard we have $6.4 billion in commitments out there. Thirty-six percent of that goes to transport. And a large percentage of that transport is all about improving people's lives. It's about getting goods to market. It's about increasing access to schools, to health clinics, to markets. Eight percent is water and sanitation, and we're certainly trying to increase that. We also do direct health infrastructure in Lesotho, $122 million. In Mongolia, $17.5 million.

But let me talk a little bit about water and sanitation. Eight percent doesn't sound like a lot, but it translates to $530 million in funds and projects in Burkina Faso, Mozambique, El Salvador, Georgia.

For example, in El Salvador $24 million for potable water and sanitation system benefits 90,000 people in some of the poorest parts of the country. Thirty-six percent in transport equals 40,600 kilometers of roads under design now. Increasing electrification has huge impacts on vaccine storage. Think about how you store vaccines if you don't have any electricity.

So all of these things are very, very interrelated and really help motivate my team. Unfortunately they're all working too hard, so I don't see any of them here today.

But let me talk about one of our approaches to health that I'd like to talk about, because Patricia and I have been spending some considerable time on this.

What MCC does is we take a very integrated approach when we look at a problem of building a road. So it's not just an engineer out there saying, "Okay, here's my line of sight. Here's the curvature of the Earth. This is the most efficient way to build this road." Because efficiency is not enough.

What happens when you build a road in a very nice, straight efficient manner? You plow through towns. You separate people from the schools they have to get to, from the health clinics, from their markets. And actually, we're spending all this money on increasing and helping in maternal health issues only to have a situation where by 2014 a leading cause of death of children over five will be traffic deaths — the leading cause of death. So we're going to spend all this money on maternal health, and then we're going to throw these kids on the road to get run over by trucks, by bicycles, hit by motorcycles.

So when we look at a road and we build a road, we integrate the environmental health and safety people with the engineers. What makes sense? Where are the notorious — on a road rehab, where are the notorious what we call "black spots" — high traffic incidences? Where are the sensitive cultural issues? Where are the markets? Are the markets adjacent to the roads? How do kids get to school? How do they get to health clinics? How do they move around the village?

We've looked at internationally accepted design standards. And then during construction, we go and check. So we've had a couple of situations where we showed up — in one case, it is notorious — well, at least inside MCC – and we came in and the road was supposed to basically swing out to the right to avoid a village and there was supposed to be side trails into the village and market stalls. And then we came in and found that they were building the road straight through the middle of the village. Now, we stopped funding. I said, "Go back and fix it all." And they did.

We have a notorious picture — that Darius has seen — of a woman with her livestock trying to figure out how to get it to market. We went back and stopped funding, to fix that.

When we go onto a construction site and we don't see that there are appropriate environmental health and safety — we do environmental health and training and safety training on all of our construction sites, as a matter of course.

So this takes time; it takes effort. But then I think I'd like to get back to the issue of sustainability and the soft infrastructure. One of the other things that I'm very excited about that MCC does, because I've spent — I was in the private sector — I'm making amends now for all the coal fire power plants I built.

But the — one of the other interesting things is many of the times you're asked to do a development project, you go and it's, you know, 20 years ago someone else did it and now it's falling apart. One thing that we do by not stove-piping, by taking such an integrated approach is — in Lesotho, for example, yes, we're going to rehab health clinics. Yes, we're going to improve the hard

infrastructure. But — in talking to Patricia — are there enough nurses? Are they being trained? Can they actually get to these clinics?

It doesn't do us any good to build infrastructure that isn't sustainable over the long term. The roads — it doesn't do us any good to build a road if there is no ongoing system in the country for operations and maintenance. And I don't mean operations and maintenance just on the road we're building. I mean a system-wide approach to operations and maintenance. Because the one thing none of us want is to go back in 20 years and see that everything we've done has fallen apart because of lack of operations and maintenance.

This is another thing that I think MCC really needs to talk about more. We have stopped funding for countries not making their commitment to operations and maintenance. We have insisted that countries have the appropriate vehicle operating tax, the appropriate budgetary line items, the appropriate system for periodic and major maintenance. And we really do insist on that.

What we hope – obviously, we go away in five years, it could all fall apart. But by making a systematic and a systemic approach to operations and maintenance, putting it in the budget, training the right people, we're hoping that by virtue of it existing and operating, it will continue to exist and operate. And people will have expectations of what to expect from the systems that we build.

So I think we are taking a very integrated approach to how infrastructure works with other groups in the institution on environmental health and safety.

I think we are still an experiment. It's very early days, but I think we do have some incredible results to show.

I have outside of my office pictures from the field. You know engineers, we take pictures of everything. And some of them are quite uplifting — you know, a woman in El Salvador getting her first access to electricity ever. Whole markets being created on the side of the roads, with appropriate turn offs so people aren't injured on the road and children aren't playing on the road. And people are able to sell more goods and not worry so much about their children being killed in traffic accidents.

So I think that we are looking at the right combinations. It's hard work, but it's fascinating work. And you never are bored working at MCC. It's very exciting.

I think I'm going to have to go into some of the great quotes that Patricia gave me. So I'm going to — but you gave me some good quotes.

She gave me a quote from the World Bank: "Infrastructure not only contributes to economic growth, but is an important import to human development and a key ingredient to achieving the Millennium Development Goals. Health is not just the health sector. Health infrastructure needs to include water, sanitation, power, communications, security, access and section control and medical waste management."

And I think that MCC is taking a holistic approach. I would love it if we could take — have more time. As Darius knows, five years is just way too short, because there's so much we could be doing. But I think that's all I have to say today, is just that I'm very excited about our work and what we do.

I didn't even get a chance to talk about agriculture, where 25 percent of MCC money goes, to the agriculture and improving people's lives and saving time. Improve lives, higher income, saving time, access, should lead to economic growth for all and increased health and well-being for all.

So thank you very much for including a boring infrastructure person in a very interesting topic. Thank you.

(APPLAUSE)

DWYER: Thank you. Yes, I'm also very delighted to be here today. In fact, this is one of the best discussions I've been hearing on health systems, and it's partly because it's taking an overall comprehensive view of this and not just looking at just health providers or just even the health sector — but looking at all of these things.

I spent ten years living in Africa, traveling all over Africa working all throughout Sub-Saharan Africa, and then I worked for another ten years in addition to that, from the United States base, in relation to health systems and trying to improve health. And this discussion today reminds me of a comment when you think about health systems. It's a quote from Albert Einstein.

It goes something like, "No one can solve a problem from the same level of consciousness from which it was created."

And I think within health we are not going to solve the health crisis that we are in, in the many countries around the world, and especially Africa. We are really in a health crisis. We will not solve the health crisis only from within the consciousness of the health sector. We have to branch out. Or even in just the consciousness of certain segments of the health sector.

And I think the concept of infrastructure is really good. It's a very good term, because bringing in access and other things is important to all of this. My focus will just be on one thing. I'll say it in a few different ways. And basically it's what I think is also a part of the infrastructure in a way, partly because it doesn't come on the radar in other ways.

But a key missing link related to it is effective health systems.

There are many health systems frameworks. There's a whole group that's working now — multi-donor thing with World Bank and Global Fund, USAID and others, on health systems. And they've been reviewing — they kind of come with a common framework about health systems. And there's at least 15 different frameworks that are out there already. And many, many different systems of indicators. And they're trying to bring that together.

How can there be a common framework to really think about health systems? A couple of examples that WHO and many in the health sector would be familiar with. WHO has the six building blocks for health systems. There has been a lot of documents written for the G8s to advise a G8 on this.

And there — the WHO building blocks are very good. They describe the fundamental things that you need in place. But what's missing in all of this — the WHO document in fact is probably about 160 pages. And there's only one small paragraph in 160 pages that talks about the health manager.

And the question that comes to me with all my experience of living and working in Africa — MSH is an organization that's worked around the world. And what we're really trying to look at is when you come to health systems, who are the people that can actually make the health system work every day at every level and country-wide?

And there's the — health systems are critically important. But these health managers are often just not on the screen. WHO is working on now another thing about operationalized health since I think they will be addressing health managers much more.

In fact, WHO did a three-country study that was very good in Africa a few years ago. And they went out and they really tried to say "Who are the health managers?" And they had trouble even identifying health managers, because they're listed usually as the doctors or nurses, even though full time they're in health management and have been for years. Or maybe half of their time is in health management, half time is being a provider. But they're not really listed often times as a cadre of health managers.

And they often they find they have weak preparation on the health management part of their role — although they may have had good preparation in the medical clinic. And if there is any preparation, it's very ad hoc and very piecemeal. It's not a systematic set of giving them the comprehensive skills that they would actually need to really manage their health system.

GAVI did a very good health sector assessment. This was the whole health sector and not just the public sector in 2008. And there came a similar finding. They were focusing on people who were in health management positions. Out of that the ones who were doctors — 70 percent of the doctors who responded said that they didn't feel either "prepared at all" or "adequately prepared" for their role as a health manager. And 70 percent of the nurses who are in health management positions said the same thing.

And then of the hospital managers in the hospital, you know, secretaries and so on, they said they have had training, but it's the very traditional lecture training and hasn't been skills-based to really give them the kind of skills to lead a team to be results-focused, to interact with the community and so on.

We have also done a number of surveys from MSH and one of the — we found similar things, but one of the things we found from people all around the world, they basically said "We were well prepared to diagnose illness and to treat the ill and to heal the sick, but we haven't had hardly any preparation for these expectations now of being a health manager."

And oftentimes we got great quotes, which I don't have time to show today. But they are pointing to these traditions within months of getting out of medical school or out of nursing school, because they're posted in the rural areas and there's nobody else there to do the work.

So I also have been, for the last three years, leading a leadership round table with the health ministers and director generals and so on in health for the east central and southern Africa health community. And in the last session, that we just had in March of this

year, the health ministers themselves were really looking at the health system. And they're saying the health systems are broken. And these are the people who have major responsibility about the health system.

I've done a meeting earlier this year in February at WHO in Geneva. And WHO itself is essentially saying, in many countries, the health systems are broken. And so one of the things I think about when I look at that is that over the years there's been a lot of focus on the health provider — although they still need a lot of focus and they're very important. Now there's an increased focus on individual systems like the finance system, the health information system, human resource system. There's a lot of focus on human resource because of the health crisis.

The individual systems are really important, but we kind of think of them — they're like the engine. But what is the fuel that will really make the engine go? And what's missing is oftentimes just fuel. It's the health managers — trained, skilled, committed health managers to make the engine of the health sector go. Just like if you have a shiny bright engine and you don't have any fuel, it doesn't do it. It doesn't go anywhere.

If you have a very — even if you put in the right mechanical health systems or a good financial management system, a good information management system, and you don't have the people that have the commitment and the skill to actually run those, as soon as the outsiders go away who have installed the shiny bright system, they're not going to work.

So when I think of the broken health systems, sometimes I think of another quote that goes something like, "Human beings have an incredible ability to overcome challenges." Then if you think how many billions of human beings there are on Earth right now and all of the challenges we've overcome in the last — even just 10,000 years, much less going back before that — or the last maybe 300 years. Human beings really have an incredible ability to overcome challenges.

And then the quote goes on, "When we fail, it's often because we're trying to solve the wrong problem." And so that's what I think of sometimes, within the health systems, is that we need to fix the broken health systems; but we need to also be careful that we're not trying to solve the wrong problem by just focusing on a part of it.

And this meeting is a very good meeting because of that. And I have a four-page handout that kind of gets out this whole business in trying to support — it's the one that's out on the table — "Health System Strengthening". And it's just a four-page thing to try to help to bring out how critically important these health managers, health leaders, are. Even in things, like the Ambassador said, about governance.

There's all kinds of skills and abilities that they need in these roles now to lead the health sector that they're not getting in the traditional education — in medical school, in nursing school. We have a number of programs now in medical schools, nursing schools, to try to bring this in.

And we have nationwide programs in countries like Afghanistan and Kenya. And it's actually working. You can go in and health to build the health managers, the health leaders to do better governance, to take a stewardship role for the health care and to do it in a way that's over time and they get a comprehensive set of skills as opposed to just run off workshops.

Thank you.

(APPLAUSE)

BRESSLER: Hi. I'll be very brief because we are running short of time and I want to make sure that — looking at this crowd I know a couple of you probably have some questions. I am the most disappointed that Michele is not here, because we as the authorizers have gotten very good at blaming the appropriators for anything that goes wrong funding-wise — not our problem. You know, you need to talk to the folks who actually write the checks. We just recommend what the check's amount should be.

So it is a busy time up on the Hill. The Senate Foreign Relations Committee is sort of in a "hurry up and wait" mode. Senators Kerry, Lugar, Corker and Menendez, I think, introduced an authorization of foreign assistance bill yesterday, and we're all trying to digest exactly how that's going to relate in each of our sectors.

To be honest, it's not on a fast track right now. This is something that we will work on hopefully for the rest of the year, and have something able to go down to the floor of the Senate by the end of this calendar year. So we're all keeping our fingers crossed. But as mentioned, I was the lead Republican staffer on the Senate side for part of last year.

I have to admit, ten years ago before I came over to the Foreign Relations Committee, I was in Senator Lugar's personal office. And I had no idea what even PEPFAR stood for. Because that is the biggest problem we deal with. In the office there's one person who actually knows anything about foreign affairs, foreign assistance, foreign policy — literally one person. And that person may be one year out of school, and he said, "If I do foreign affairs, then I'll be able to go on cool international trips." And welcome to our world.

(LAUGHTER)

BRESSLER: So Peg Willingham spent a couple of hours with me explaining the AIDS program. Thank you, Peg. She's the one who taught me all of it.

But it's amazing how far we've come in such a short amount of time. And anyone who's done travel in Sub-Saharan Africa pre-2001 knows what that country was like. And then when it got closer to 2004, 2005, you could start to see the improvements.

And if you were to go to some of these countries now, I'm sure you would see where there was hopelessness is now a hope for the future. And we will start having to look beyond HIV as a killer, but as more a sustainability program, and how we can get countries to take a role in keeping this program going.

Because the biggest concern we had going forward is by putting all these people on ARVs and other health maintenance drugs, are we going to be responsible for ever? And that's a huge moral dilemma. We have four, five, six million people over the course of the U.S. involvement on long term life saving drugs. We can't walk away. And we need to have the countries step up.

And we can't rely on the Gates Foundation to do it all. We have to make sure that countries themselves take an active role in this program for the long term availability of a healthy workforce. One of the other main issues in there — we've not seen this as just a bill and funding for HIV, Aids, Malaria, Tuberculosis — but have the health care strengthening. Somebody's going to a clinic, make sure that they can get testing along with their child's vaccination.

And — how all this plays with general health infrastructure in the countries. Bringing in more doctors and nurses and care professionals that are in the country long-term; have them trained in their own country. Have the money to spend not only the diseases but the cultural issues of the area where they are going to be. So — sensitivities to a woman being seen by a male doctor.

I just recently got back from Afghanistan and I was appalled that there are women who will not see a male OB-GYN to deliver her baby. She would almost rather die, or her family would almost put her at risk, as opposed to having a male deliver her baby. And that is something in this country we could never ever understand and accept. But that's something that we have to be sensitive to when we are administering these types of programs.

And the last thing that we need to have a true focus on is disease prevention. This is the big emphasis of PEPFAR , whereas prevention — whether or not is educational programs, condoms, other biological — microbicides, things like that — bed nets for malaria, earlier intervention with tuberculosis and early testing, adherence to drug protocols, and that goes on with everything else.

AMC, Advance Market Committments, any type of — any funding to get vaccines out to the field, to get more research commitment for diseases that are less known or not as prevalent in the developed world. A good example is — they're in the process of launching a pneumococcal vaccine. My children had that same vaccine or a similar variation of it six years ago. We've had to wait a long, long time to get the same thing that is killing children in the third world of respiratory ailments; a vaccine that could really change remarkably the landscape in a lot of these communities.

But I'm going to leave it there so we'll have time for questions. And thanks everybody for coming.

(APPLAUSE)

SHELTON-COLBY: I just think that this is a wonderful presentation. I think they've been wonderful presentations. I'm going to ask the first question, then open it up to the audience, because we've got very, very few minutes. And perhaps we can take three or four questions before the panel starts to respond.

I think each of the panelists made a very important point, at least for me. Marty Makinen — one report that I think is extremely important and that is that when we think about health, we need to think holistically. For example, labor policy in a particular country can have a very broad impact on health.

Carol Hessler made a point that I think is so important and that is road safety. In a number of countries road safety is a very, very major health problem. Some countries it's the number one killer of women and children. Joe Dwyer spoke on the importance of taking the holistic approach, that health managers need to have better training.

And then Shellie Bressler, making a point that I think that is — two points I think are very important. The importance of setting a priority — keeping a priority on disease prevention and in that regard, specifically prevention of HIV. Where I sometimes feel that the focus has gotten a bit — so focused on ARVs and getting ARVs out there and sustaining them — that we have lapsed a little bit in terms of HIV prevention.

So my question is, how do we get these sort of extremely important, but not sexy issues onto the priority list or the priority structures of the other agencies?

Now, let's open it up. Some questions. Yes?

Q: Thank you very much. My background is in public health. There are a few points — because it's very short, we don't have more time. First of all, I want to thank MCC. In my native country, Burkina Faso — I left the country many years ago — but I hear from people that MCC's projects were the most significant U.S. intervention in the country, ever, so thank you.

Because usually the country — projects have come and go. It seems that the donors don't care about the — you know, this approach is here that you are speaking about. And come with disease specific interventions and don't seem really much to care about what people think. So, I mean, whatever you are doing, apparently it's making a difference in the field.

And that leads to my question to Carol Hessler. The disease-specific intervention you mentioned, I mean, education, the high percent of money spent on education. And it just comes across as, you know, there is nothing else that matters in the country. You can have an outbreak of meningitis or yellow fever or measles, but the education is the order of the day and — it's like the Iraq war — it's never ending. And yet it's not a priority for — I mean, for many professionals in the country.

The point I want to mention is health worker safety. I think some of the intervention mentioned the (inaudible). Sometimes people think it's just a matter of money, why people run away from my country. I'm obviously — you can guess from my accent I was not born here.

But some — I spent time there and worked in the rural area, whereby my hands swell in the heat and I'm working with blood and surgery practically every day with no gloves available. After three years, I just really decided, jeez, I mean, I'm only 30. I want to live more than 35. So that was an issue. That I don't know if there is anywhere in the MCC that it's being taken into account, health worker safety.

And the last thing I want to mention is this management...

SHELTON-COLBY: Very briefly...

Q: ... the management issue that I think Mr. Dwyer raised. There is no such thing as management training in most countries. And I wonder if it is being addressed by MCC. Because most doctors — we don't have the management training. And you are put in charge of things without having a clue how to put things in place. And you are the most educated, I guess, that's have to deal with the problems.

SHELTON-COLBY: Good. Good question. Thank you very much.

Yes? The gentleman here.

Q: Thank you very much. I'm Dr. Larry Casazza. I direct an organization called ACAM, African Communities Against Malaria. And I left my secure position on Capitol Hill to jump out and live in East Africa for the past two years including in Kenya.

My point is this. These presentations have been a litany of bad news, and I think a lot of good suggestions — but leaving out a major issue of good news. And that is in Africa, particularly in sub-Sahara Africa, the population demographics have been shifting hugely toward the younger — younger and educated people connected with IT. They're way ahead of most agencies in terms of advocacy, technical communications; and they're smart.

Obviously — I've been back here for just a couple of weeks and I've been going to lots of meetings like this. Some of the quotes are unbelievable. One last week on health policy was that "poor people are not stupid." Definitely. Any of us could not survive in their environments if we were just under — living under the same conditions.

My point is this. There are resources. There are documented evidence from (inaudible) survival projects over two decades of these programs that go on. But they never get the recognition of what has been learned there. You talk about health systems and you stop at the health minister. You're leaving out the most critical element. It's like talking about the agricultural sector and not mentioning farmers. In the health sector it's households and communities. And we've got to really begin to tie those groups in, in terms of describing what that system should be looking like.

Thank you so much.

SHELTON-COLBY: Good. Thank you very much. Very helpful point.

Yes? The gentleman here and then there's one last question in the back, and then we'll get back to the panel.

Q: Thank you. I'd like to ask Ms. Hessler a question about infrastructure. In the United States in the first half of the last century, particularly after the second world war, we saw a huge expansion in infrastructure: subways, airports, roads and the interstate highway system. But then we've had problems, like the bridge collapse we've seen in the State of Minnesota.

And just a month ago, with the subway system here in Washington D.C. With all our money — with all our ability to foresee the importance of maintenance — if we had done such a shoddy job here with the bridges, and have a list of potential failures all over the country, we couldn't really expect these countries to do a much better job than we are here.

SHELTON-COLBY: Last question in the very back and may I ask you to keep it very, very brief. And then I'll ask each panelist to respond. And I'm sorry, 45 seconds each.

(LAUGHTER)

SHELTON-COLBY: I'm the time policeman this morning.

Q: Thank you and good morning. My name is Young Lee (ph) and I'm a student at Northwestern Med School.

And my question is — I see two main approaches to global health. There's the top down, large scale approach that you guys take. And then on the other side, there's the community based grassroots approaches that say a small organization like mine takes.

And these work side by side, often not in coordination. And the grassroots approach is we take of immediate needs in communities. It fills the gaps that a lot of these top down approaches don't take care of. But at the same time, we lack the breadth and the resources. And we can't address problems on the systemic level.

So my question is how do you see these two approaches work more in coordination in the future?

SHELTON-COLBY: Very good question. Thank you very much.

Marty, do you want to start answering and then Carol and then — 45 seconds.

MAKINEN: OK. Let's see. Health systems are on the agenda of development agencies, but I think they risk missing the boat to a certain extent with them. As my colleague from MSH mentioned there's an effort to look at framework. So I think the kinds of things that I was talking about, about incentives, disincentives, rewards, sanctions, are missing from that discussion — are given too short treatment. That there's a lot of emphasis on strict building blocks but it's still an engineering approach.

I agree with Mr. Dwyer that management skills are missing, and with our commenter as well. Those are important, but they'll be relatively ineffective if we don't address all of the — those other things that I think are missing.

Definitely lots of stuff should come from the bottom up from the communities, from the households, from community organizations. And we need to marry it all together. So...

SHELTON-COLBY: That's it. Carol?

HESSLER: Great. OK. Forty-five seconds.

(LAUGHTER)

The gentleman from the University of Wisconsin: We don't expect — I mean, but we have to try. We have to try on setting up systems for operations and maintenance. And we also have to bring lessons learned from the mistakes that we've made and that we've seen around the world.

And finally to that point, we have to be careful of "gold-plating." There's no point in over-engineering a project. You have to have the appropriate engineering for where you're working. And that can be a difficult discussion. I know it looks good, but it doesn't make sense.

As for how to you make these issues sexy and get on the priority list — I'm really thrilled there's an organization — of course, now I can't remember it, but it's a make roads safe initiative. And they've been quite smart. They've been getting Michael Schumacher, who I've never heard of, but it turns out a lot of people have — he's a racecar driver. And Michelle Yeoh?

(LAUGHTER)

HESSLER: You know, from "Crouching Tigers, Hidden" – whatever? Very good movie. And Michael Palin – remember, from "Monty Python and the Flying Circus?"

Michael Palin is a big international traveler and they've been — they have been trying to make this sexy. They have incredible video outreach, conference outreach. These three people are really working very hard to make that issue sexy. So they've been quite smart in terms of granting people like Michael Schumacher, like Michael Palin, who have traveled all over the world. And who a lot of people know.

And they've hit different groups, because some people — I've never heard of Michael Schumacher, but I've certainly heard of Mr. Palin. They've done a great job. It's a hard issue, to make these things sexy, but I think, you know, once again, you don't get anywhere if you don't try.

DWYER: Thank you. I'll just draw from two issues. One of — a question from the gentleman from Ghana related to our funding of leadership and management for health managers.

And I'm not too familiar with the MCC, in terms of what they're doing, although I think they're probably better than some of those other donors. But from USAID, there are definitely parts of USAID that are very much recognizing this now, and starting to find creative ways to go about it. Not just one-off workshops, but ways to systematically do this — in USAID missions, but also from the central part of USAID.

And also the Global Fund has now finally been really wanting people to apply for strengthening health systems and bringing in this kind of training, because sometimes the old programs weren't working very well. I think the results focus that people are starting to take now really brings management and leadership to the floor which is important.

To make this issue sexy — I was at a meeting they held at Global Health Council earlier —where they do a lot of trips up to the Hill. They have said it's very difficult to get the Congress people to understand why leadership and management and health systems is important. And to try to sell it to them, whereas they want to fund something specifically, for this person who is dying at that moment in time.

So it's a big challenge that we all have.

BRESSLER: And I guess I can sort of play on that. It's a huge challenge. And I'm not going to say anything reactionary. In Burkina Faso, Liberia, Zimbabwe, with the cholera. You know, the more information that comes out, the quicker that the groups like UNICEF and groups like that will bring it to our attention.

Supplemental appropriations often are the best funding source, because you're not going to make friends anywhere to say "Well, let's just take $500,000 from this PEPFAR initiative in our country to deal with the water supply." And then there's some justification to do it. But it's not to be used as a substitution for development assistance. And that was something we were fighting along the line during the reauthorization — that it's not a slush fund.

Getting girls in school is an important goal in every developing country. Educated women are the key to a lot of these countries' graduation. But that means educated women will have a less likelihood to find themselves HIV positive — and therefore we should use PEPFAR money for school books — it's just a hard sell.

So that's what we have to do. But it's more the awareness, and having folks on the ground giving indications. We're having a lot of problems. After the way — we see emerging a different breed of mosquitoes that are not responding to our insecticides, or whatever. So that's something that — I meet with people almost every week on things like this. And it's important that this information come back to us so we can have an educated understanding of what's happening on the ground.

SHELTON-COLBY: My thanks to the panelists for having highlighted some issues that are not as perhaps visible or prioritized as they need to be. And my thanks especially to Shellie Bressler for bringing a Hill perspective to this.

I think we all have the challenges of more creatively framing our arguments not only to the our communities, but also to the non-development world outside, which ultimately will be a major determinate of our funding levels.

And thank you all again for coming this morning. My thanks to Aaron for organizing this.

(APPLAUSE)

SHERINIAN: Ladies and gentlemen, as you exit, please find materials from each of our panelists available outside the room. Thank you.

END