Briefing on the Global Health Initiative

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MODERATOR: Good afternoon to everyone from the Africa Media Hub with the United States Department of State. I would like to welcome our participants who are calling from across the continent. Thank you so much for joining us. Today, we are joined by Lois Quam, who is the Executive Director of the Global Health Initiative and by U.S. Global AIDS Coordinator, Ambassador Eric Goosby who were both in Oslo, Norway, attending the June 1st global health conference hosted by the Norwegian government. We will begin today's call with remarks from our speakers and then we will open it up to your questions. And with that I will turn it over to Ms. Lois Quam.

MS. QUAM: Good afternoon. This is Lois Quam. I am the executive director of the Global Health Initiative for the United States. I am located at the State Department and, I am speaking to you from Oslo, Norway today. On Friday, Secretary of State Hillary Clinton gave the keynote address at a global health conference hosted by the Norwegian Ministry of Foreign Affairs. Norwegian Foreign Minister Jonas Gahr Stoere gave opening remarks at the conference. On the day of the conference, in the June 1st edition of *the Lancet*, the medical journal, there was a commentary on the conference published, that was co-authored by the State Department and the Ministry of Foreign Affairs in Norway. I would like to briefly highlight three parts of the Secretary's remarks and then turn it over to my colleague Eric Goosby, Ambassador Eric Goosby, with the Office of the AIDS Administrator.

First of all, the Secretary announced with the Norwegian Foreign Minister a joint effort around maternal health. About 800 women die each day around the world giving birth. This day, which should be a day of great joy, is for women, the most dangerous day in their life. The vast majority of women who die in labor and delivery die for reasons that are easily prevented. The Millennium Development Goal around maternal mortality has seen mixed success, with some countries seeing strong results, but in too many parts of

the world much, much work needs to be done. So Norway, the United States and other partners have joined together to focus on the 24 hours of labor and delivery, that most dangerous day in a woman's life, and are working closely at the district health level to strengthen healthcare systems to be able to ensure that mothers and their new babies can survive that day.

This initiative, which we call Saving Mothers, Giving Life, works with partner countries at a district level and brings together an array of U.S. government supported investments, the work for HIV and AIDS that PEPFAR is responsible for, and the longstanding work around maternal and child health from the U.S. Agency for International Development. A cornerstone of our work in Saving Mothers is the Global Public Private Partnership which includes Merck, the American College of Obstetrics and Gynecology, and the NGO of Every Mother Counts, where respective strengths and experience in resources can be brought to bear in order to reduce maternal mortality significantly.

Saving Mothers is working in partnership with the government of Uganda and the government of Zambia, working in four districts in each country in an on the ground approach to link health systems and strengthen health systems to improve the opportunity for mothers and their newborns to survive labor and delivery. Based on the learnings that will be found in these eight districts, the objective is to expand Saving Mothers to many more districts and many more countries into the future. So the Norwegian government announced their support for this work and the collaboration, and Secretary Clinton announced the U.S. government's support for this work at the conference on Friday in Oslo.

The second point I wanted to make about the Secretary's remarks is that she focused on the long-term commitment the United States has had to global health. As you know, the Centers for Disease Control, which is the American agency that provides international surveillance, detection and control of infectious disease, has operated for 65 years. The U.S. Agency for International Development, USAID, has operated global health programs for over 50 years. The important work that we have done around HIV and stemming the epidemic, which Ambassador Goosby will speak to, has been a longstanding and immense effort on behalf of the United States. And Secretary Clinton, in her remarks, highlighted the deep commitment the U.S. has to working with partner governments, working with civil society and faith-based organizations around the world to improve global health systems so that all the world's people can reach their full potential. She emphasized the importance of this work to the pursuit of healthy societies and emphasized the importance of finding new and more effective ways of working going forward.

The third comment that I would like to make about her speech is that she emphasized that in this next phase it is important that we work together in new and more effective ways. She spoke to the concept of country ownership and the importance of the United States working hand in hand with national governments, local governments, civil society in host and partner countries, faith-based organizations in host and partner countries, so that we didn’t simply bring outside resources in, but that we were able to work with

countries, following a country plan in ways that we were rooted and highly effective in the communities and in the nations where we work.

As a part of her remarks, she spoke, therefore to, the importance of host countries or partner countries providing the resources to ensure that there is sufficient capacity in countries to meet the needs of their citizens. So this is a very important and groundbreaking part of her speech as she talked about the importance of real partnership between host countries and the United States in meeting global health goals. She spoke specifically on the necessity of partners, especially in countries where new revenues are coming on board from national resources and extractive industries, to use those resources to improve the welfare of their people and invest in health, and then for us to work together in coordinated ways. She talked about, at times, there can be so many people working in uncoordinated ways in global health that it can create a fragmented and less effective method. And she spoke in detail about the importance of donors coordinating with local governments, national governments, civil society, and faith-based originations, and then local government and national government stepping into the opportunity to develop greater capacity around planning, designing, fulfilling and, indeed, providing funding for healthcare systems.

So this brought together the longstanding contribution that the U.S. has made in global health and helps move it forward into a new era where we can be greatly affected. She called maternal mortality the canary in the coalmine and, by that, meaning the one way that we can see if healthcare systems are working is whether mothers can survive labor and delivery and that that is such a strong measure of whether a healthcare system is working and is functioning. So with that I would like to conclude my remarks and turn it over to my colleague Eric Goosby.

AMBASSADOR GOOSBY: Thanks Lois. I appreciate the description of how our effort with maternal and child mortality is exemplary of, really, a new challenge to the donor and participant country community around how we work together to maximize our ability to put a programmatic imprint on the ground that saves more lives. I think Secretary Clinton's main thrust in this was to challenge the donor community in the way it allows and partners with the partner country in deciding what the unmet needs are of the country, in prioritizing those unmet needs, and then allowing for that prioritization of unmet need to inform the allocation decisions from the collective donor pots.

I think that a strong partner country, as Secretary Clinton emphasized, is the critical ingredient to allowing for that orchestration of divergent funding lines coming from a donor participant as well as other foundations and private sector resources to come together to be additive as opposed to creating parallel systems of care. It is time for donors to say that we can do more, truly, if we plan and implement together. That donors will be willing to open their thinking and their prioritization processes to be more transparent and more collegial with partner country decisions around what is important, what should happen first, and what shouldn't. At the same time we need to acknowledge that our partner countries' capacity to play this convening and

orchestrating role is challenged, and that donors have an obligation to work with our partner countries to expand their capacity to manage, oversee, monitor and evaluate, and eventually finance these programs themselves.

I think that secretary Clinton further challenged the multilateral community to be more cognizant of how their role can directly help countries expand their capacity to manage, oversee, monitor and evaluate how we as donor communities need to look at the institutions and structures that support governments in deciding and understanding how to analyze data to establish concrete and defensible prioritization of unmet need decisions and how that should translate into those strategic and budget planning.

I think Secretary Clinton gave us a new call to reorganize ourselves, to define and increase our relevancy, to allowing and enhancing a country's ability to put program on ground, to keep it on ground, and sustain these programs so they can continue to deliver the services that the people are in need of. I think, finally, Secretary Clinton's challenge to our global community that if we put our resources on the table differently, if we allow for our partner countries to play the central role in convening and prioritizing the services needed for their own populations, if we look at and enhance the ability of the partner country to mobilize and garnish the resources from natural resources, that their country may afford to invest in their population for health and for education, that this indeed is as pathway to a more sustainable portfolio of services that these populations will need into the future.

MODERATOR: We will start our questions with our embassy in Kampala, Uganda, who is hosting journalists in the room.

QUESTION: Hi Lois, my name is Esther [Nakkazi]. I am a journalist with *The East African* newspaper. Now, in line of the issues you highlighted that Secretary Clinton said, we need to commit more resources, more funding for maternal health as a country, but in our current budget which is about to be raised by the government of Uganda, we do not see any commitment to increase funding for maternal health, let alone the healthcare sector hasn't received more increased funding. So I wonder if we are not just having the same rhetoric that here the donor states, the governments have to take more ownership, but governments do not actually do anything about it? And then, secondly, you said the countries that have resources, like Uganda has oil now, should be able to commit some of that money to maternal health. So is there any way that we are saying we can set priorities in accessing all resources for health, for maternal health, in particular? Thank you.

MS. QUAM: Thank you very much for your question from Kampala. I have been so pleased to be in Uganda with my colleagues at the American Embassy there on several recent occasions, and I would like to make two comments. The first is that we believe it is vital for the government to invest in the mothers of the country. It is vital for all

countries to invest in their mothers. And investing in mothers and ensuring that mothers can survive this dangerous day and make it to a day of joy is central to building a strong nation and is central to building a strong healthcare system that can serve the needs of all people. And it is important, and the Secretary emphasized this in her address, that as countries benefit from natural resources, that revenues from those resources are captured for the wellbeing of the people of the country, and that, specifically, that those resources find their way into healthcare and into this important work to save mothers and ensure that every woman can deliver safely in all parts of the country. We believe that very strongly, and we think that it is vital at this moment to ensure that countries, including Uganda, take a very strong role in not only designing, but in financing the healthcare services that are required to save mothers' lives.

QUESTION: Thank you. My name is Agatha [Ayebazibwe]. I work with *The Daily Monitor*. Lois talked about evaluation and monitoring of some of the projects here in Uganda. The American government continues to fund the healthcare system in Uganda, but sometimes the money is not put to use. So how are you as funders or donors going to ensure that this money is put to its intended use? Thank you.

MS. QUAM: Thank you Agatha. We have a very thorough and strong effort to ensure that the money that is allocated for global health is used for that purpose and used wisely. We will not tolerate the use of health money for any other purposes, and we have comprehensive programs underway to review that and when we find problems we address them quickly and thoroughly. Thank you

QUESTION: Hello, my name is Henry Lutaaya. I am currently with *Sunrise Newspaper*. I would like to get a bit more detail on the Savings Mothers program. What are some of the logistics, how much money are you investing in this, what other aspects are going to accompany this program? Thank you.

MS. QUAM: Thank you so much. When I was recently in Uganda, I was pleased to spend time in Fort Portal and in the districts in Uganda where we are proving the concept in Saving Mothers. We were very interested to work with colleagues in the local health districts and to visit a number of facilities, different levels of healthcare facilities, from the regional referral hospital, the Virika Hospital in that area, to local health clinics.

The focus of Saving Mothers is to make a difference in the three delays that can result in the loss of a mother's life. A delay in the decision to go from her home to a facility for delivery, a facility where a skilled birth attendant can meet her. The delays that can occur once she gets there in getting the help that she needs in making sure there is a skilled person there who can help her see if her labor and delivery is going to be safe or whether she needs to have more expert attention. And then the delay that can occur

when a mother's delivery runs into difficulties, to get to the specialist hospital where she can have a Cesarean section.

We had a very interesting visit where we were able to see those connection points first hand, and also as a part of that visit, many different facilities including the health clinic at the tea plantation in the region, to understand how all of these local capabilities can work together and where we can make a difference as a part of the PEPFAR program with all the important work that we are doing to treat and prevent HIV/AIDS and the longstanding work that we have been doing around maternal and child health.

So what Saving Mothers does is bring all those resources together into a stronger, tighter healthcare system that can allow women at the moment that their time has come to give birth to be able to step into that system and get cared for well. So we are focusing and pinpointing the existing resources that are involved, and then where we find gap in resources, we are looking to create different kinds of partnerships, whether that be with local companies or international companies, to be able to fill that gap. I look forward to my next visit to Fort Portal, in that region, to see how we are doing. We think we are going to learn a lot about what works. We think we are going to learn in cases about things we thought that may work that need to be adapted. And then our objective is to take all that we learn and be able to find ways to spread this work to other districts in Uganda and to other countries.

QUESTION: Thank you very much, my name is Ann Mugisha. I work with *The New Vision*. From your address, Secretary Clinton acknowledged that donors need to put in more funds that they are already putting in.

MS. QUAM: Secretary Clinton, in her address, talked about the importance for all countries to do more to invest in global health, and she called for all countries to do more to make the changes required so that every mother can deliver her new baby safely. She called on countries around the world, including Uganda, to put more resources into healthcare, for countries around the world like Uganda, including Uganda, to put the kind of resources and health systems in place so that every mother can survive labor and delivery and have that be a day of joy. When a mother bleeds to death, her nation bleeds, and all of these deaths are preventable. So the Secretary called on countries to invest in their healthcare systems and to take new resources coming in from natural resources or other extractive industries for that purpose. She also called in donors to do a more effective job of coordinating their resources so that their resources could bring greater value for money in terms of global health outcomes.

MODERATOR: Our next question comes from Dan Damon with BBC, calling from London.

QUESTION: I just would like to hear some specific stories, the individuals that you have met, the individual women, and how their lives have been more difficult and will be made much better by the Saving Mothers initiative. It is just the stories, really, that are so powerful. If you could tell me one or two of those.

MS. QUAM: Oh yes, I would really be happy to. I was in Uganda, and I was in the mountains that form the border with the Congo, and I was in a small village. It was the United States and the Norwegian government together. It was interesting, the Norwegians commented, the mountains looked a bit like Norway in some places and with the farms all the way up to the mountains. And we were in a small health clinic, and they talked about how so often women come quite late to the clinic to deliver. You know, many women have other small children, they are busy taking care of the crops, they think maybe they will give birth at home, they go into labor and run into trouble.

I heard a story about a woman there who came to that clinic to deliver twins, and she came quite late in labor, having walked a long way, and she was very tired. There was a traditional birth attendant who came with her and brought her to the clinic. There, there was a midwife who had some training and was able to deliver her first baby, and the baby was fine. But the second baby wouldn't come out. So they tried and they tried, and then they had to struggle to find someone who could drive her to another clinic. They finally found someone with a small motorcycle, and she drove for 20 kilometers on that motorcycle, on the back, to the Virika Hospital, which is a hospital that the Catholic Church has operated for many, many years in the Fort Portal region. And she got to the hospital, and she was in some state of distress. And she got there, and they were able to provide a Cesarean section and save her life and save the life of the baby.

But what the traditional birth attendant and the midwife who had helped her told me was that these situations right now happen almost by coincidence too often. If you happen to find someone, if you happen to get there in time, if it happens to work. We also heard stories of women who came from that same region, who when they got to Virika Hospital, died in the hallway on the way to the operating table because it had just taken them too long to get there. And we heard stories of women who couldn't afford to pay anyone to drive that motorcycle to get them to the hospital and went home to die feeling they had no other choice.

So the power of what we are trying to do is to work together to create a system, so that women who are in a farm on the hillside know that if they do walk to the clinic, that long road, in that tiring state of labor and delivery, that there will be someone there that can help them, and that if they need further help that they will have access to a motorcycle to help them, and they will be able to get to a facility where they will have surgery if they need it. So much is left to chance now and so one of the things that I wanted to—we went to a clinic, a new clinic called Midas Touch in Fort Portal that had just started doing Cesarean sections and had set up a really interesting arrangement with the help of my colleagues at USAID to offer transportation vouchers, so that people who had

motorcycles or cars could be paid to bring pregnant women who are in distress to that hospital for Cesarean sections. In six weeks, I think they had done about sixty Cesarean sections. And one of the interesting things that they said was that, over time, they wanted to do different kinds of surgeries too. They wanted to remove appendi[ces] from people who had appendicitis, or people who had other kinds of stomach problems could get surgery on an urgent basis at that kind of place. I thought that was so exciting to see because you could see that if you made the system work for mothers, you could also make it work for everybody else. I hope this gives you some color of the kind of work that we are trying to do.

QUESTION: Yeah, that is great, thank you very much. I was in Somaliland, and there were men going to the maternity hospital there because it was the best one in town. So thank you very much.

MS. QUAM: Yeah exactly, thank you.

AMBASSADOR GOOSBY: Lois, if I could also just amplify on your nice example. You know, in addition to the maternal, the ability to respond to the needs of the pregnant mother in that critical period just before, during, and just after labor, you have the convergence of a medical delivery system, as Lois described, interfacing with a transportation system that has to interface also with the kind of social mores of the woman and her family in presenting her to either a midwife or to a site with specific capabilities to respond in, as Lois identified, an escalating need that the woman can present at any time, that has a critical time period associated with it. So the cascade of all those potential services that may or may not be called into action for any given pregnancy gives you a sense of the extraordinary logistical orchestration that has to happen for it to all work.

In addition to that, once you hit the medical facility, the ability to have the individual, the operating suite, all of the logistics around that, matched with an anesthetic capability and a clean blood capability, are all the types of additional service needs that could and will present itself in any given pregnancy. And to be ready for that in the first and the 300th pregnancy, not knowing which one will present all of those needs, becomes the task. And this is the reason, as Lois said, that maternal mortality is often the canary in the cage for looking at the integrity of a whole medical delivery system.

I guess, finally, I would say that the wisdom that Secretary Clinton put forward, and the challenge she put forward, is in the ability to see the convergence of all of these different systems having to come together to support the needs of any given woman at any given moment in time is a challenge that donors cannot typically fully embrace. The critical role that the partner country plays, the leadership in country, both the government and the public system and how that interfaces with faith-based organizations who often take up the majority of care in our rural areas, matched with the

ability for transportation and other services that may be present for things such as HIV/AIDS, which is where the PEPFAR program comes in, to have the kind of wisdom and vision to see that looking at the present medical delivery platforms that are out there and available, that partner countries in their orchestration role can weave together a system that does catch all of the needs of a woman in this critical period, becomes the real challenge. And what the Global Health Initiative in the United States has demonstrated for us, is that we indeed, if we look at the needs and services that are needed, we often can put our existing programs together differently to expand that service capability. And that is really what the Secretary challenged us to think hard about.

MODERATOR: Great thank you. Dan, your line is still open if you have a follow up question.

QUESTION: Yes, indeed, just to go further, the timetable on this program. It is obviously needed, and we have all seen that. It is just how can you implement it, what kind of response do you get from medical professionals, how will you get medical professionals to avoid the temptations of taking their skills abroad which happens to so many countries and they lose those who have the skills to save these mothers?

AMBASSADOR GOOSBY: Well you know, I will take a shot at that, Lois, if you don't mind, first and then please fill in. You know, that is a legitimate challenge that we have virtually in any country, including developed world settings. Your colleagues who develop the skill set that is more marketable in another setting, often are challenged to whether or not they will move to that new setting where they can increase the pay and lifestyle of their family, the same types of decisions that we all go through. I think what is different about many of, in most of the countries in which countries in which we work, is that there is not a baseline acceptable living wage that is indeed made available to nurses, doctors, and nurse anesthetists, and the overall health professional in the countries that we work in are generally not paid a living wage and are often leaving their country that they love and want to remain in because they cannot sustain and respond to the needs of their own family. I have seen that over and over and over again.

So I think, again, we need to challenge our colleagues and country, our partner country leadership, the governments, and the civil service systems in which they work, to acknowledge that there are some individuals that have an importance to society that should allow for an exception to be made for a minimum kind of living wage to be agreed upon and then enforced so these healthcare workers and the nurses, doctors et cetera, who work in these settings, are not motivated by just survival and sustaining and susceptible lifestyle as the motivator for them to move.

I think if you address that living wage issue, you would see a significant drop-off in the amount of movement. Because in my experience most of the doctors and nurses want

to stay in the country that is theirs, and that these are their people and they want to remain in front of them as they practice their profession. So I would just say that as a major flaw in our ability to retain confident and trained healthcare workers.

QUESTION: That's great. Thank you, Carrie.

MODERATOR: Thank you Dan. Next, we will take questions from our U.S. Embassy in Addis Ababa.

QUESTION: My name is Tadesse [Gebremariam], and I am from private media, *The Reporter*. My question is specifically about Ethiopia. How do you see, or can you comment about maternal mortality in Ethiopia and about our health extension programs, and, generally, about our health systems. How do you see this? Can you give us some comment about this? Thank you.

AMBASSADOR GOOSBY: I think that your medical health system in Ethiopia is really a profound transformation. Your minister, your government under Minister Tedros, has prioritized primary care, focused on maternal health and issues around medical transportation as a top priority for his country for really about five years now. That has been reflected in a profound expansion of the number of health professionals that are available in your health centers and has tried to push a primary care platform out to your district and village levels that have been really breathtaking to watch.

Our support, the U.S. government support of that effort has been high from day one. We have supported the hiring of thousands of healthcare workers and the repair and/or renovation of district and village level health centers that, again, are trying to put in place a primary care model that creates a one-stop shop for children and maternal as well as adult care needs, so an individual can access all medical care through each of these health center sites.

I think that Ethiopia has also very much tried to move their supportive system, such as their blood supply system, which they have recently put into the Ministry of Health in Ethiopia, to ensure that the blood supply is checked for not only HIV and syphilis, but also for all the hepatitides that can be transmitted through the blood. So I think that, in many ways, Ethiopia is creating and/or has created a strong medical platform that will allow the rejuvenation that has also gone into the medical and nursing education system, which the United States has supported, to staff this significant expansion of service sites.

So I would say that the maternal and child health programs that we are speaking to here are part of that portfolio of services that Minister Tedros wishes to support and, in partnership with the Ministry of Health, the United States government will continue to

support a central capacity expansion in many of these centers. That is about all I would say.

MODERATOR: I think we have one more question in our Embassy in Kampala Uganda, your line is open.

QUESTION: I have got two questions actually. One is about the public private partnership that you talked about in the presentation you have here. And I want you to expand more on that. Yes, and the second question is that PEPFAR, which is ending actually next year, which focuses mostly on strengthening health delivery systems. In your opinion, in your view, how do you rate it? How has it achieved what it should have achieved, and do we see another PEPFAR coming onboard?

MS. QUAM: Could you repeat the first part of your second question? I couldn't quite hear you. Were you referring to PEPFAR?

QUESTION: PEPFAR II, which focuses on health systems deliveries, strengthening delivery, is ending next year. In your view, do you think that is has achieved what it what it set out to do? If not, do we see another PEPFAR coming on board?

MS. QUAM: I will answer on the private public partnerships as it relates to Saving Mothers, and then turn it over to you, Eric. In our work on Saving Mothers and maternal mortality, we have created public private partnership with a number of important organizations. The American College of Obstetrics and Genecology will be working with their colleagues in Uganda to do the kind of training and capacity building that is so important to make sure a skilled person can be with every mother who delivers. The company Merck has established Merck For Mothers which is an effort to bring to bear private sector resources for this important work. And we envision that this public private partnership will allow us to be more successful more quickly in reaching our goals. This builds on a strong record of public private partnerships that the U.S. government has had in global health for some time, and I was able to see a number of sites that USAID has operated for a long time during my recent trip to see Uganda. So we are focusing our efforts, focusing them strongly on Saving Mothers. Eric, over to you on the second question.

AMBASSADOR GOOSBY: Yes, thank you Lois. The PEPFAR reauthorization, its current authorization ends at the end of 2013, but we are in the process now of deciding on what our reauthorization effort will look like. You can rest assured that the Administration's commitment to continuing PEPFAR is complete, that the AIDS Free Generation that Secretary Clinton and President Obama spoke to at the end of last year

and have been referred to in public speeches by both, are our firm commitment to continuing to move toward our twelve million goal, that PEPFAR will cover twelve million people on treatment and that we are clear that we will achieve that and also all of our prevention and care outcomes.

We know that the reauthorization process will be difficult in this current climate to get anything passed and get the attention to our legislature in the United States, but we are committed to putting those issues forward. I think that, from a country perspective, PEPFAR is not going away. You do not need to worry about that. Our ability to move into a new phase of PEPFAR will really be characterized, as Secretary Clinton said in her Oslo speech, with a new partnership, with our partner counties, where we move forward together to respond to the needs of the populations in each of these countries. But not as a primary implementer, but as a supporter to the effort that is reflected by the priorities defined by the partner country leadership which includes civil society and faith-based organizations to develop a continuum of services that will continue to respond to the needs of HIV-infected populations for many years to come. So the United States sees this as a long-term commitment. We remain committed to it and will not change our priorities. What we will change is the way we work and partner with governments, private sector, faith-based organizations, and civil society in each country to create that vision of what the continuum of services should be. So, I will just leave it at that.

MODERATOR: Great thank you. And that concludes today's call. I would like to thank Lois Quam and Ambassador Eric Goosby for joining us, and thank all of our callers for participating in today's call. We really appreciate it. If you have any questions about today's call, you can contact the Africa Regional Media Hub at afmediahub@state.gov. Thank you so much.

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