

ACCELERATING THE IMPACT OF HIV PROGRAMMING ON HEALTH SYSTEMS STRENGTHENING

Pre-Conference Meeting of Health Systems Experts, HIV Researchers and Implementers
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16.00 – 17.30 pm **Session 4: Research Methodology**

Susna De **Moderator**

Jos Perriens: [Coordinator Systems Strengthening for HIV, World Health Organization] on behalf of Dr. Badara Samb [Adviser to Assistant Director General, Team Leader, Global Health Initiatives, Health Systems and Services, World Health Organization].

Title: **What are the Gaps in Knowledge and Research Priorities regarding the Impact of HIV scale-up on Health Systems?**

Thank you. The first talk is some highlights from the talk that Dr. Badara Samb (WHO) submitted to me. He apologizes for not being here because of family reasons but I'm quite pleased that he could share his presentation with us. It's about interactions between health systems and global health initiatives and what we have learnt to inform research methodology. And this talk is structured with a bit of background – you have heard a lot of it already. I will dwell briefly on the findings of the Positive Synergies effort by [health system] building block and make a small comment on what it means for future research that is needed.

'Ad nauseam', you have heard about the building blocks for health systems from the World Health Organization. The only thing new in this [ppt slide](#) slide is the fact that here the building blocks are presented as hanging together. If you want to do something about one of them, you must expect effect on all of the others. And this is one of the findings also of Positive Synergies.

The methodological discussion focused very much on where the focus of attention should be, and one of the big arguments stated within the partnership was that it would be more productive to focus on the bridges between the different building blocks than on the technical content of each of

the building blocks separately. They have not made a methodological guidance, so I cannot expect [to speak] on that.

The sticking point in health systems development can be glanced from a number of reports: Universal Access to Global Plan to stop TB; on the World Malaria Report and I have put those sticking points in red or bold red on this [\[ppt slide\]](#) slide. It is the good [health] *financing*, its everywhere. It's the thing everybody dances around. Be it the technicality, maybe not of the commitment. And the other sticking point is the *human resources* shortage that cuts across health systems functionality, across the board and for all diseases. And the set of challenges are in purple. Well these things are worded differently. They have to do with government and the health sector - in coordination; leadership; management; partnership; alignment; accountability - all speak to the same problem. Now these problems are not global problems.

You see here [\[ppt slide\]](#) government expenditure per capita on health in low, lower-middle income and upper-middle income countries and if you see it's clear we should expect to find the majority of problems in low income countries that are unable to put on the table the \$25 per capita per year that governments are expected to spend on health to keep their population reasonably healthy¹.

And in geographical terms, this is showing you the millennium development goals for infant mortality [\[ppt slide\]](#). In geographical terms it is fairly easy to focus this discussion too. It's in sub-Saharan African and South East Asia. This is not only evident on child mortality but also in the lack of progress towards the target on maternal mortality [\[ppt slide\]](#). I don't have a slide on HIV but as you know the HIV problem is also clustered in sub-Saharan Africa.

The new findings of Positive Synergies are from 14 new studies and from a systematic review of the literature [\[ppt slide\]](#). About 250 [articles] were cited and they are aggregated along the lines of the health systems building blocks that I *did* show on the opening slide. Here I changed the order a little bit because I wanted to show the big sticking points first and this is the biggest one. In financing [\[ppt slide\]](#) we find that the association of Global Health Initiatives with overall increases in global resources for health is fairly strong and you might wish to read also the paper on the Development AID for Health² which shows how strong this association is.

There was no coalition between global health initiative resources and domestic health budgets or reallocation of resources meaning that there was no systematic evidence that recipient governments decreased their commitment to the health agenda or increased their commitment to the health agenda. So it was some positive, some negative and some neutral.

¹ http://www.internationalhealthpartnership.net/CMS_files/documents/taskforce_report_EN.pdf

² <http://www.who.int/hdp/publications/aid.pdf>

The global health initiative has contributed to some improvement in health, aid effectiveness and particularly in the area of predictable financing. I think they will also be credited especially in the Global Fund for supporting coordination and strategic alignment of efforts for HIV, TB and Malaria with national health policies because they put countries in the driver's seat. And then there is an indication that the specific funding may not be enough for alignment for country needs and country policies. This is a statement that comes in fact from one study in Cambodia, and the report also qualifies the statement that it cannot be generalized³.

The reality is that major donor institutions do in fact spend a lot on health systems strengthening. This is how government spends its money – 11% of its total spending was on health systems strengthening [ppt slide]. This is Global Fund - 35% of its spending went on health systems strengthening [ppt slide]. I don't have a slide for PEPFAR but it's also about 30%.

Now in the health workforce [ppt slide], the second sticking point, the findings were that there some positive effects and negative effects on the over-stretched workforce mainly in low income countries; and that measures to strengthen the health workforce are ongoing through the health systems strengthening windows and through specific commitments that are very well published by PEPFAR. The 140 000 new health care workers in its health focus countries by 2014; and it's an enormous challenge. The support by Global Health Initiatives for workforce development however has often been most visible in in-service training for disease specific services and in Task Shifting than in pre-service training or in the net expansion of the health workforce. Exceptions notwithstanding Malawi, Kenya and Ethiopia were highlighted in this meeting.

In government, in the early days there was a lack of alignment between the Global Health Initiatives and national policies; says the report. In recent times there is progress to be signaled. I have already mentioned the proactive course of action by The Global Fund in this regard but also PEPFAR that in the early days was heavily criticized for going it alone but will now conclude a partnership with prescribed countries in a full transparent and inclusive process. Global Health Initiatives were also credited for enhancing community participation in the way they were implemented and the way they organized their governance [ppt slide].

Health information systems were supported by Global Health Initiatives with the focus on the coverage and on the surveillance of specific diseases [ppt slide]. There was an impact in innovation and the generation and the use of information and communication technology, however, there was a failure in investing in more rational, robust, efficient and independent common data architectures in the countries and I think, and I will come back to that later, many disease specific programs would be jealous of the ability of, for example, HIV programs to

³ <http://www.who.int/hdp/publications/subhcambodia.pdf>

generate data almost on an annual basis. I don't know of too many health programs or health concerns programs that are able to report an annual basis on their progress. But sadly this massive investment in capacity for HIV and lately for tuberculosis and malaria has not spread over to global management and information systems yet.

In supply management [[ppt slide](#)], Global Health Initiatives were credited with improvements in availability and affordability for a number of commodities - mainly those that are relevant for their work. There was a growth in the volume of commodities but this was not met by improvements in the management of supplies and that it is very polite to say many disease specific programs managed their supplies in an old manner that does not really strive even to create complementarity or integration with national supply management systems. Now I'm not saying system and you haven't heard me saying systems - this could be private sector or public sector or a mix and nobody is arguing that everybody needs to be integrated into the national central store because that will not necessarily always speak to the best outcomes.

In service delivery [[ppt slide](#)], there was expanded access and uptake of targeted services and the attribution of the effect will not always be too clear to one or the other. Global Health Initiatives – there's mixed evidence of expanded access to and uptake of non targeted services with some positive and maybe some negative but I would say that the positive effects in spite of little documentation that exists, were better documented than the negative effects.

The evidence on the role of Global Health Initiatives in fostering equity and equality of access to non targeted health services is weak and they say is mixed. This is the [[ppt slide](#)] slide that I'm showing to you and I could also show you the slide of Jessica Price in Uganda [audio not clear], are not necessarily negative but I'm showing it for what it is worth. I'll come back to this because I take it that this is in terms of a story and when it comes to formulating a research agenda, we need to be aware of the value of stories.

Now the research considerations [[ppt slide](#)] that come from the Positive Synergies group, the only conclusion that Badara Samb gave me is that Global Health Initiatives and country health systems are dynamic and complex entities and to study interaction defies over simplistic, linear analysis and raises caution with respect to generalizations.

That implementation research should therefore reflect the complexity of health systems and include both quantitative and qualitative methods from a variety of disciplines such as health and poverty systems, engineering and economics and include the input of important stakeholders. That's not too much methodological guidance to go by but I think it is very important to read this if you can because when we discuss action in health, the reality is that 90% of the audiences that we are talking to are doctors or nurses or health professionals and what I see is an absolute absence of people from of other disciplines like economics or anthropology or sociology. Basically

we are talking to ourselves. It's a question or problem that was identified earlier this morning and building bridges to these other disciplines, I think is a matter of importance.

I'll click this again and then move to the presentation on the research priorities [ppt slide]. From the Positive Synergies, we have a fairly good idea of what we do know, which is not too much, and what we would like to know and we are not sure of. The Rockefeller Foundation sponsored a consultation [in Bellagio] organized by Columbia University [ICAP] in which a number of us participated including myself and the World Health Organization and one of the sentences in the report⁴ that you are having in your folders, regarding the relationship between HIV scale-up and Health Systems, is that it has generated numerous opinions but relatively little evidence [ppt slide].

To that I will add that instead of endless debate about comparative advantages of the vertical or horizontal approaches, whether Global Health Initiatives are a good or a bad thing, it could be more productive to focus on the best way to invest in responses HIV to broadly strengthen primary health care systems. The topics in this talk and this report include health workforce, health care financing, infrastructure, clinical services, monitoring and evaluation, strategic planning and policy development and health behaviors [ppt slide]. There is a limitation here, central components of the building blocks within the health services have not been covered; and the focus of the consultation was fairly much on health sector work and when we come to the discussion it is worth keeping that in mind.

Building blocks and sticking points together, financing and the health workforce would come on top in any discussion and the research question with regard with this [ppt slide] slide, in the supply of health workers that we see linked to HIV scale-up. Indeed what are the trends? We know that for example in Kenya, Malawi and Ethiopia we have positive trends but if you look at what happened in Zambia, it's not necessarily too evident that there is a positive trend. There was a story publicized which showed there was zero growth and some displacement of the health workforce to urban areas as part of investment by one of the Global Health Initiatives.

Then second, the impact of Task Shifting on health care systems. What is it really? Do we have positive outcomes and are these positive outcomes a reality across a number of concerns like TB, Malaria, like child health. How do we optimize Task Shifting to benefit a greater health agenda? The health agenda for the poor, for the elders and which the Global Health Initiatives have their focus and you will remember this slide by Wafaa this morning that shows burden of disease according to continent. And you will remember that HIV; TB; Malaria and maternal and child

⁴ <http://www.iasociety.org/Web/WebContent/File/ICAP%20Bellagio%20Report%20-%20Leveraging%20HIV%20Scale-up%20to%20Strengthen%20Health%20Systems%20in%20Africa.pdf>

health are basically too big on the [African] continent and it should therefore be legitimate to focus on those concerns first and that geographical area at least.

Then other practices and policies associated with retention of health workers working and this finding that HIV services help retain staff and then there are some positive examples but also many negative examples about internal brain drain to well funded NGOs. I think as much as this is a question, there is evidence about how a positive effect can be brought about. We have the case of Malawi, we have the case of Ethiopia -all were characterized by the inclusion of the human resource planning process and the policy formulation process that kept into account the national environment; the national planning process and the national priority setting; and that it did involve the stakeholders that would have to have a word on this - and I would think that this would be an area more of a qualitative assessment than a quantitative research. It's something you could not deal with than in a much more [audio not clear] I would think.

Then there is the acquisition of skills and competencies to deliver HIV services [which] help to deliver on other Millennium Development Goals. I would think maybe – certainly for TB there would be this trouble brought about [by] deliberate integration of TB and HIV programming but I'm not so sure that these same skills would also spill over to things like maternal mortality or Child Survival.

I added something here which was not discussed in a nutshell. In reality we do not really know how many fulltime health workers we need to deliver a comprehensive package of essential HIV services. There is a lot of attention for the dollar figures but reasonable quantification of what could be needed and what would be the target for development is to my knowledge based on assumptions that are not fully disclosed. A little bit more than four health workers per one thousands inhabitants, is that based on evidence? I don't know. It seems to be the math many people are using but my calculations of the needs of service delivery and the data that we did show suggested you will need more people to do it.

In health care financing [[ppt slide](#)], the second sticking point is - what are the costs associated with the delivery of comprehensive HIV services? We have the costs calculated by UNAIDS but the assumptions are to a significant extent extrapolated and even though they are quite reasonable, the evidence based on this important resource mobilization effort could be consolidate and even if you know what the cost is, the effectiveness of similar interventions is somewhat in tatters in particular on the prevention side.

This was an important topic in the HIV/AIDS Economic Reference Group coordinated by the UNAIDS Secretariat. For example would you know how much [dollars] you saved with a televised general population targeted television prevention campaign? I think this is something that is very difficult to quantify and could be served with more research. This is an extreme example but also targeted interventions for prevention are difficult to cost because of all kinds of denominator

problems. Because a lot of the research published in this area does say what people have been trying to do but do not state it in great detail what inputs were required to deliver the outcomes that they describe.

Benefits and costs of adding HIV services to other services have been poorly studied. Giving back on HIV, scaling up on the financing of other HIV services was identified as an important research topic paper by **Chris Marais and** colleagues and the results show that this impact on a global level is not negative and most of health continued to benefit from increased donor assistance in the last ten years but we would need to monitor this more closely and identify also a number of data gaps that will enable us to improve the monitoring of the financing situation.

And lastly – what are the optimum mechanisms for financing health services that require predictable long term support? This comes from the [Bellagio] consultation. I would submit that it's very important to study this to assess which optimization strategy for the financing but it should not deny the fact that what we really need is not to optimize rationing, but to go for a sufficient package to fund health services.

I think a global international solidarity mechanism to fund health and other priority social services should be a stronger concern for all of us especially because we are in a situation of economic crisis. And last week we heard about a lack of access in Ghana and in Uganda. The Global Fund came out with a cry of alarm that its funding is in limbo. And The World Bank and UNAIDS documented it in about a third of all countries where there was severely impacted treatment access; and about half of all countries and non-supported countries where severe impacts of HIV prevention are anticipated.

In *infrastructure and clinical services*: The topics would be - to assess the impact of infrastructure services enhancement financed by HIV scale up on non HIV services. It can be achieved by looking at challenges of utilization and quality of HIV and non HIV services; the effect on the management of other chronic diseases; and the impact of the referral systems. But equally important is to assess what elements in HIV programs enhance non HIV services delivery because I would submit that it is already possible to identify some of those elements and those should be taken into account right now in the design of new programs or in the readjustments.

Monitoring and Evaluation, Strategic Planning and Policy Development have only one slide in my talk because there are only three recommendations from the Bellagio Group Consultation in this area. One is - are the data systems developed for HIV related purposes being utilized for non HIV conditions? I dwelt on that already in my previous talk and the answer is NO. This is something that needs to be fixed. Has society become more engaged in monitoring and evaluation and influencing health priorities and programs? It's a question we do face that addresses those two aspects. I would think that monitoring and evaluation involvement if you want to study it would come with a meager harvest but [research on the impact of] influencing health priorities and

programs [would perhaps yield more]. I think that effective civil society is beyond denial and that should be recognized and supported. The impact of donor policies on national program management, implementation and health outcomes is one of the big sticking points in the discussion on Global Health Initiatives with fingers being pointed in all directions.

I would just finish by saying that the major Global Health Initiatives and the donor communities are increasingly aware and committed to solve the problems that one sided efforts are generating or have generated and that we are looking forward to a better future because of the realignment.

In the context of HIV scale-up, the two questions⁵ from this [\[ppt slide\]](#). You can discuss other things like for example how does funding for HIV alter community perceptions about stigma to improve service delivery but these two questions would consider to be the strategic two questions because it would be possible to identify how HIV inputs can be synergistic for the development of primary health care systems. That's why they are here.

And then the Bellagio Consultation missed of course a lot of things – access to commodities and technology was not on the agenda. And I would submit that access to [essential medicines] and intellectual property is an important topic. It's ongoing right now with experiments in UNITAID with the Patent Pool; with voluntary licensing experiments within the industry. This would require close monitoring and learning from experience and possible expansion if the results are conclusive. Improving supply management is an enormous area for operations research. How to go about getting drugs to people in the country is an enormous challenge.

We see less talk at a national level but we continue to hear alarming reports of stock outs at a facility level. And the amount of effort and attention given to this problem seems to be more like lip service than strong action. Then the introduction of new technologies and standardization would be an important topic. We have seen the successful uptake of rapid HIV serology [testing] but what about point of care CD4 technology? What about point of care Viral Load technologies that are on the way, and how to link that to the diagnosis of tuberculosis and Malaria? The optimization of service delivery – i.e. integration, quality improvement and documentation of health outcomes and a lot of things could be said about that. And then the relationship between service delivery, societal norms and standards - for example discrimination on health grounds and health seeking behavior was not covered.

⁵ Questions: To what degree have HIV related peer or community support organizations influenced experience with other diseases? Can peer support and multidisciplinary team approaches developed for HIV programs be adapted for the management of diabetes, hypertension, epilepsy, depression, and other chronic conditions?

But are data necessary? And I would think that data are necessary first of all to maintain the momentum brought about by investment in HIV/AIDS not necessarily to serve people living with HIV only, but to also improve the health of populations. And when we are planning research, we should realize that the good story today sells more action than data in a distant future. I would qualify the stories of Partners in Health in Haiti, of Jessica Price in Rwanda; and the anecdotes and documentation we have from Malawi and Ethiopia as good stories. We need more of those and we need to generate them quickly because the ton of data we will have from PEPFAR will be over and that is too late. And then another concern is that we must realize that bad news causes paralysis.

We should, not as researchers but as implementers, be deeply concerned about avoidance of negative outcomes and negative impacts. When we document, for example, that in our service setting ante-natal care is going down, we should resist the temptation to publish it today because it will make a headline but fix the problem and then publish the solutions once we have them even if that requires one year or two years of patience and combatant action. Then we also need data to rationalize and maximize the synergies between the response to HIV and systems development. I deeply believe that the response to AIDS can serve as a blueprint for universal primary health care because of innovations or the reinvention of the approaches that Wafaa presented this morning. Working on scope, commitment and a means to do for public health what is needed for public populations. We cannot afford (the global health community) to miss out on lessons of what we have learnt, including our ability to link to the activists and advocates who defend health causes, [which is I think] an essential element.

Thank you for your attention.

Susna De: Thank you Joss for that very rich presentation on the review of the evidence and suggestions for research priorities. The next speaker needs no introduction to all of you. Peter Berman is a lead health economist with The World Bank and I think you have the floor.

Peter Berman: [Lead Health Economist, Health, Nutrition and Population, The World Bank]

Title: **Applying a Health Systems Research Perspective to the Synergy Question**

Thank you very much. So before I get started I want to devote 30 seconds of my time to [*he sounds like he is asking the audience to stand up and stretch their bodies to freshen them up before the start of his talk*].

Thank you. The title of my presentation is 'Applying a Health Systems Research Perspective to the Synergy Question'. Actually something I came up with a little later in the day. My original title was to get an 'Overview of Health Systems Research Methods' and as you'll see I have some views about that question so I changed my title so that I wouldn't have to answer it, although I

might try and answer it anyway. And apply a little bit less ambitious objective to this presentation which is looking at how we have addressed this synergy question from what I call a health systems research perspectives, trying to tell what that is.

As I've got into this subject and looked at some of the literature, I basically discovered that over the last five years but mostly over the last two years, there have been at least six or seven major efforts to address this question of how Global Health Initiatives, categorical programs and these specific programs affect health systems.

The Positive Synergy Study we just heard about, some work in my Department in The World Bank on Integration and Categorical Programs, the paper that came out in Health Policy and Planning recently by Biesma Regien G. and others and apparently a paper by the Centre for Global Development, I haven't seen yet.

Robert Oelrichs (World Bank) has a volume of papers [coming out soon]. We have heard one of them today from David Peters on this question reviewing the literature, the work by Partnerships for Health Reform⁶ on the Systems Impact of the Global Fund and then there is a larger consultation that took place. This is a lot of activity, okay! This is probably somewhere between \$15m to \$20m worth of research and so we really do have to ask the question: "what have we learnt from all of this and what can we do to make use of this knowledge or what can we do better if we are not satisfied with what we know?"

I think a lot of the reports we've heard today suggest that the findings of these studies are not terribly robust and not terribly data rich. They maybe robust if they are very general or generic because they don't have to be that specific and I think another question we have to ask as researchers is, what really is our interest in this question? Is this a political question or is this a scientific question? If it's a political question, the attempt to do research on this question is only going to have limited value because I think really the decision and so on will be made in a different arena.

Research can help a bit but it's not nearly what's directly addressing the problem but I would like to take a more optimistic view. I think there is a political aspect to this question but let's take the more optimistic view that there is also a scientific aspect.

There is a real issue, a real concern about how the scale-up of categorical programs, Global Health Initiatives and so on can be made most useful for improving outcomes of the populations we are trying to serve. And I want you to notice that I have reframed the question as I said earlier this morning not to be about Global Health Initiatives effect on Health Systems. I'm going to get on

⁶ <http://www.healthsystems2020.org/>

that a little bit further. So without reiterating what has already been said numerous times, we do have fairly common accepted definition of health systems and I think that there are number of frameworks that have been proposed to help us understand what health systems are and how they function.

Recently at the World Bank we hosted a meeting with GAVI and The Global Fund to review some of this material and the papers from that meeting are all available on the web⁷. So if you want to get into this a little bit further, you can read up on it further. But what certainly came out from that discussion is that there are a number of different health systems frameworks and that they can be thought of really, to some degree, as serving different purposes.

Some of them are primarily descriptive, some of them are intended to be more analytical or predictive i.e. some frameworks are intended to help us think about the various parts of the health system. To kind of lay them out and think about them as we might [with regards] what options we might be taking action on, in different areas. Others are really intended to answer questions: what would happen to health systems and outcomes if I do this? Or how do I decide what are the primary things I should focus on if I want to improve results in my health systems? These are the more analytic or deterministic and predictive models.

So it's helpful to see these different purposes and not try to fit one model to a purpose for which it was not suited. I think another conclusion from this meeting we had in Washington was that there is little appetite in the world for some kind of an endless debate about this framework or that framework or this set of labels or that set of labels on a different part of health systems. These frameworks have a lot in common and really there isn't too much to be gained from trying to have an attempt to synthesize into some universally accepted single framework. So just to look, of course we have seen the WHO Building Blocks Framework and that's one example of the kinds of frameworks widely used by the Global Health Initiatives and so on.

A second framework is the one that the World Bank has been using in its global program of training on health systems. The Flagship Program which has now been named the Flagship Program on Health Systems Strengthening⁸ and this is sometimes referred to as the Control Knobs Framework and its also uses the set of categories on the left side – you can see those Control Knobs – financing; payment, organization, regulation and behavior and then talks about intermediate performance measures and finally performance goals or outcomes; and there's a lot of similarities between these intermediate and final performance goals and even the categories of the control knobs are the same as the building blocks. So there is a lot in common amongst these

⁷ [Link to website for papers and materials]

⁸ <http://go.worldbank.org/D8UJMCA800>

frameworks but I want to take you a little bit further into some of the thinking we have done about the Control Knobs Frameworks because I do think that it highlights some of the distinction between descriptive and more analytical predictive frameworks and this diagram [ppt slide] is an attempt to place that thinking in a single chart.

Now when we talk about thinking health systems and health system performance, one of the key messages is that one should start with thinking about outcomes. And you can see in this chart that outcomes are really given a pride place at the top of this diagram. That is - health systems are a means to improving the outcomes the societies care about. Now we have described those outcomes in different ways - health status; financial protection; responsiveness; satisfaction and so on – but one of the principles we need to acknowledge is that societies have to decide for themselves the outcomes that they want to emphasize and the relative weight they give to those outcomes.

This is a social process and a social concern and you can see in this charter [ppt slide] [or chart?] factors like history; values; politics and culture are shown here because really this question of deciding what are the priority outcomes and how much weight to give to them is something that comes out of the [social] processes for those outcomes. Now this question is very fundamental to some of the things we have been talking about today. This is a group of people who have really devoted a great deal of their creativity and energy and lives to dealing with the HIV/AIDS problem. Clearly a major health problem in the countries that we are concerned about but there is a question in many people's minds: how much weight should be given to this problem relative to other problems? And this is a very legitimate question for health systems analysis.

So, starting with outcomes and with some process of trying to think through what are the important outcomes. This chart tells us that we should work backwards from outcomes through a causal analysis of the determinants of poor health system performance - health systems performance being defined as the outcomes that the health system produces.

So this working backwards to develop a kind of a causal framework or causal analysis of health systems performance is an analysis to what, I think David Peters showed us earlier today, that it is a kind of a logical course of a chain that typically we see one on the inwards process and output outcomes and so on and this involves healthcare and non healthcare factors. But it's through that development of that causal chain that one arrives back at these factors that we want to change to improve health systems performance. This is the definition we use for health systems control now. It's not just an area of health systems like service delivery or human resources but actually it's a strategy for changing health systems performance that might impact upon service delivery or human resources. So there is a bit of a difference in thinking about this. We are talking about how do you build up policy from strategy for change, which gets transferred into reform interventions, and then work back up the chain through the logical framework to impact on the outcomes?

We call this process ‘deciding what to do’. You see on the right side its diagnosis, and the process of taking reform action to improve health systems performance, therapy – nice medical analogy there. Often we are talking to physicians and even nurses sometimes. So this is a way of thinking about a kind of health systems approach to the question we are concerned about.

So what is health systems research because I was asked to think about health systems research approach to the problems we are talking about? Well I think the honest answer is that health systems research is not a very well developed concept. It’s a very new idea. I think one thing, we can conclude, is health system research should not be interpreted to mean all research on any aspect of the health system.

That would be too broad a definition for health systems research. *We would like to see health system research as focused on trying to predict or explain the causes of health systems performance.* The outcomes we are concerned about. That will be ultimate outcomes like health; financial protection as well as intermediate outcomes like access, quality and costs. So health systems research as a discipline such as it is and it’s a very new discipline really tries to answer questions like: what can we learn from differences of health systems across countries or across areas within a country that can help explain differences in their performance. Or to improve performance what health systems strengthening strategy should I use? What is likely to be their effect? So these are the kinds of analytical questions about the system itself.

Health Systems Research Methodology: Well I’d say, honestly I don’t think there is any such thing yet, that is some kind of new or explicit health systems methodology. Health systems thinking is really about how we ask questions; what questions we ask. Not a research methodology for health systems research. We already have a lot of useful research methodologies, and while health systems research might want to emphasize multidisciplinary approaches, a variety of research methods and so on, it is not as if we are creating a new methodology. I’m not sure there is really such a need for such a methodology. It’s really a way of thinking and asking questions.

So what are those elements of health systems thinking? We focus on outcomes. We start with the question: how does our action or change [for example] scaling up Global Health Initiatives affect outcomes? That would be a starting point for a health systems research approach to the kinds of questions we have been talking about. We developed an explicit analytical basis for linking the health system inputs, functions and strategies – call them building blocks, call them control knobs whatever you like - to outcomes. The causal framework I was talking about before.

We should take a multidisciplinary approach because many of the things we care about in health systems performance are affected by a wide range of factors not just financial incentives which economists focus on but politics and management skills and so on.

We believe that design is important – that is designing the strategy to improve health systems performance is critically important but implementation is also important and often too much emphasis is given to design and not enough to implementation in health systems research. And there is a wide range of research methods that are relevant for us. What we need to understand clearly is the rigor and validity; and be explicit about the rigor and validity when we use them.

So the synergy question – coming back to that. How the categorical programs like HIV/AIDS affect health systems performance? What can be done to assure more than official effects from these interventions? So there are some tough questions embedded in this type of question and I want to point out again that I'm not asking the question how they affect health systems. I'm asking the question; how they affect health systems performance. We don't care really about the health system, we care about the results of the health system but we might care whether HIV/AIDS programs affect other health system outcomes and if they do so through effects on the health system.

So to answer this question we have to be explicit. What are the outcomes of the health system that we care about? If we are saying does scaling up of HIV/AIDS improve or reduce access, quality or outcomes from maternal and child health services. We have to be explicit about that and that a lot of the research we have been looking at hasn't been very explicit about that. We should be asking counterfactual questions.

What would have happened to the performance of these health systems, measured in terms of outcomes, in the absence of the categorical programs? And sometimes we are looking at these links between categorical programs and health systems and comparing them to some ideal state of an idolized health system and of course we are not entirely satisfied because we are far from the ideal state but what would have happened in the absence of these interventions? When we don't have the most rigorous standards of evidence like randomized controlled trials what kinds of evidence should be accepted as good enough because this is the world we are living in?

So these are the kinds of questions I think we will be beneficial to ask more explicitly as we try to develop more research to address the synergy question. What most of the researchers have done so far is, I think is first, not measures the outcomes or performance for the health system as a whole or even explicitly selected priority outcomes or performance measures for the health system. And I think without that kind of explicit attempt to talk about outcomes, it's very hard to interpret the results of the work we see. When we see conclusions in the research like Global Health Initiatives are not well aligned with national priorities? Well, is that good or bad? It depends what you think about those national priorities, right?

Now if you think that anything that the Minister of Health says is a priority, should be the subject of alignment from all the external actors in the country, well then you think its bad but can you please be more explicit about that? And I think we have not been. Much of the research has also lacked

an explicit causal framework and systematic analysis of multiple steps in the causal chain. I think David Peter's framework he showed us earlier is a very good contribution to that - making it explicit can be a primary causal chain and secondary causal chain and there are links between the two of them. A lot of the questions that have been put up really are asking the question: does scaling up anti-retroviral treatment reduce human resources for other kinds of programs, for example? But let's be explicit. Let's lay out those causal chains and really ask how much evidence we need along those chains to draw stronger conclusions?

Much of the research is focused on inputs on lower level processes. That is simply the availability of inputs - drugs, supplies, human resources and so on. This is something but it's not much to take us down the road to answer the synergy question. And much of this research has often been used to weaken efforts for example asking actors in health programs, what do you think happened rather than representative measures of outputs or outcomes? So is it feasible to do rigorous health systems research on the synergy question. I think it is but it's hard. It will take time and it will have to be opportunistic.

That means we really need to be disciplined with the kinds of questions we are asking and why they are important and what we intend to do with the answers we might get. Are the questions political, ethical or operational?

Well I think they are more but there are certainly operational questions and I do think that also more rigorous research maybe useful. We should be doing more rigorous research but it's not a substitute for a more operational [research] focus on improving practice. We still need a sound causal framework but we don't need to wait years and spend huge amounts of money to come up with operationally useful answers to these questions if we put the thinking in advance to understand what are the questions and what are we going to do with the answers.

Thank you.

Susna De: Thank you, Peter, for that and for the emphasis on systems performance and the causal chain. Just moving quickly, I know we did start 15 minutes late. I don't know if we are allowed to go over time considering that we started 15 minutes late. I would like to introduce David Hotchkiss. He is a Professor at Tulane University and a Health Economist with USAID Health Systems 2020 Project.

David Hotchkiss: [Professor, Tulane University School of Public Health and Tropical Medicine]

Title: An Overview of Measuring Systems wide Effects of Disease Specific Funding and Implementation Programs.

Thank you. I want to thank also the conference organizers for inviting me. I think it's been a very useful day and its one of my first opportunities to have all these health systems people in the same room with the HIV/AIDS people and I think it's been extremely valuable and it's really yielded some useful discussion.

I was also assigned a very ambitious title in my presentation on Overview of Systems wide Effect Methodologies and that sort of scared the hell out of me and so I've decided to tone it down a little bit. The title of my presentation will be "Evaluating the System-Wide Effects of HIV Scale-Up: Methodological Gaps, Challenges and Recommendations". I think we have heard a lot, that Global Health Initiatives have been very positive. The facts are, whenever there does seem some wide agreement that further evidence is needed – more rigorous evidence is needed. That was the key message in the recent Lancet article⁹ that we don't have enough hard evidence of what positive or negative effects different health initiatives are having.

Usually in these meetings - research in this area has been capitalized on the serendipitous rather than the systematic but I think with the presentations we have seen today, with the recent Lancet article, with a lot of research that the Gender Network¹⁰ is doing, I think this is beginning to change. There is much more serious concentrated research in this area and it's a start but I think much more is needed to sort of illuminate this black box between inputs, as Peter Berman would say and health systems performance.

Just to give you a brief overview of my presentation. I'm going to talk a little bit about what type of evidence is needed. I think we know that. What are obstacles? What happened to obstacles through evaluation? What are some of the approaches available not only for monitoring but also evaluation - both are very important to increase the evidence base. And finally, where do we go from here?

In terms of what kind of evidence is needed well there is a number of different types. We need not focus only on evaluation but focus also on routine monitoring. Monitoring global goals and different aspects of Global Health Initiatives but also concentrate on country level health systems, program monitoring, focus on inputs, processes and outputs. Also we need a lot more special purpose evaluations of the impact of health systems strengthening initiatives. Not only of Global Health Initiatives but other kinds of controls, as Peter would say how that influences health systems performance. There is always a danger perhaps of putting too much emphasis on the

⁹ WHO Maximizing Positive Synergies Collaborative Group (2009) An Assessment of Interactions Between Global Health Initiatives and Country Health Systems. The Lancet (373) June 20

¹⁰ <http://www.gadnetwork.org.uk/>

monitoring and not enough on the evaluation and I think that can be a big danger. We need to also focus on the evaluation aspect.

Clearly all these aspects are overlapping and require more of an integrated approach at the country and global levels and such an integrated approach should serve the needs not only of Global Health Initiatives but more broadly of health systems decision makers; but also of people at a regional and also at district levels because ultimately in a decentralized context, those are folks who are making the decisions on how to refine systems in their areas. Given that there is such a great need for evidence, why is the evidence base so limited?

Well there are number of reasons why there is a growing demand for knowledge and what health systems strategies are effective - is not translated into a greater availability of evaluation research studies. I will mention just a few of the reasons. Evaluations require collective action and also commitment and typically systems researchers really do not receive the adequate financial support that is perhaps needed to really generate this evidence-base. This was really a key finding of a study that was done, I think two – three years ago, by the Alliance on Health Policies and Systems Research¹¹ and they found that less than 0, 2% of total health expenditure in developing countries is being spent on systems research.

So although we have seen a bit of a surge of funding in health systems evaluation, still there is probably not enough commitment there to really do enough to improve the evidence base. Also second to assessments of prospective to health systems strengthening, these assessments have not been typically built in from the beginning.

We heard some very useful, interesting rich analysis of Task Shifting and other kinds of innovations that have contributed to [HIV] scale-up, but unfortunately rigorous plans or evaluation plans that demonstrate the impact of those initiatives on quality of services or use of services on health outcomes, were not built in.

And so in many services there has been too little investment in tracking data; in many cases we don't have treatment or control groups to assess what would have happened to health systems had not these innovations, and had not this scale-up happened. I think what Peter Berman said is the key question to what we want to answer with health systems research.

Third we keep tracking data but typically routine health information system data is of very poor quality and that has been a bigger area, instead of moving towards real evaluation research. A lot of studies in the area retrospectively look back on how service civilization changed over time and it's based on routine health information system data, but we really don't have a handle on whether

¹¹ <http://www.who.int/alliance-hpsr/en/>

that is good quality data or not good quality data and naturally that has prevented us from developing the evidence.

We heard earlier from Jos Perriens (WHO) that attribution is extremely challenging from a methodological perspective; both health systems were complex, and Global Health Initiatives are complex. I think there might be a mistake to try and attribute progress to anyone Global Health Initiative. And I think the recent evaluation of The Global Fund took that same perspective that given that the Global Health Initiatives were intertwined, it is difficult if not impossible to reattribute results to Global Fund or results to PEPFAR. So perhaps we should be looking at the assessments of evaluating the whole scale rather than individual funding sources.

Also there are some kinds of concerns among funders as well as people at country level, that there is a possibility of getting unfair results sometimes and also this limits the mobilization for health systems research. It also limits the capacity at the country level or that capacity is just too thin; and there is not enough capacity to do a substantial body of health systems research.

So what approaches are available for monitoring and evaluation? Well I'll repeat a little bit of what other people have been saying about conceptual frameworks. Conceptual frameworks are extremely useful because it helps us use the same language about what we mean about system-wide effects and it also helps us crystallize our research question so that these are clear and well defined. And as mentioned there are a number of frameworks. I'm going to put another framework to you and this is the framework of the International Health Partnerships *plus* again looking at inputs, processes, outputs, outcomes and impact.

One of the disadvantages of this framework and I think this is something David Peters' framework really addresses quite well, is that it really doesn't outline the possible positive effects and negative effects of Global Health Initiatives. So I think that is the first time I've heard of the framework but I think that seems like an extremely useful contribution. Frameworks also need perhaps to be more developed to look at the effects of specific types of interventions. For scale up is a myriad of many types of interventions and if we want to look at Task Shifting, if we want to look at pay for performance and if we want to look at retention strategies, clearly these frameworks may not be adequate and we need to have more tailored frameworks around specific types of strategies.

There are also a number of tools in tracking data. I'm going to look monitoring now and I'll talk about evaluation in a minute. A number of tools for tracking Global Health Initiatives and health systems, most of you know there are a number of major initiatives that are standardized and harmonized - health metrics globally including [...] group tracking MGDs; we have the Health Metrics Network; we also have the Institute of Health Metrics and Evaluation at the University of

Washington¹². So let me just mention a couple of other examples that my colleagues at the Health Systems 2020 Project helped to develop in recent years. One we thought about earlier today is National Health Accounts which I don't know if that is understood by everyone but that's just a tool for tracking sources and uses of funds and advocated by many now to be a key component of the health information system.

And comparison of any trends dealt over time can yield very useful insights into system-wide effects as it occurred earlier today from Charu Garg; the presentation from National Health Accounts comparing National HIV sub-accounts in two points in time I believe in four African countries and they came up with some very useful results in terms of how the scale up is associated with reduced out of pocket spending, there is also some conclusion about additionality. So that seems to be an important tracking tool that we need to invest in. There are also approaches available to assess health systems – note the example is the health systems assessment approach called “A How-To Manual”¹³ and here we have a huge manual. Indicators are organized by health systems building blocks and I think that idea is very useful to think about in terms what kind of indicators should be included into tracking of health systems.

Also in terms of evaluation, this has also been a huge topic of discussion in recent meetings in what are the best methods to use for evaluation. Well, I think it might be a mistake if we are too heavily reliant on randomized controlled trials due to the complexity of health systems and scale-up of interventions and also due to some of the other issues that I mentioned earlier. So that leaves us with some retrospective methods including the cross-country comparative analysis in the mixed methods analysis used by the Gender Network¹⁰ as well as by the Positive Synergies Group but also there are still some opportunities for some useful prospective research on various types of interventions.

Some examples of health insurance which is being supported by the Global Fund in Rwanda or human resources expansion and production also a useful area for some prospective studies. Retention would be another area as well. Also, I think the availability of methodologies seems to be very considerably quaffed by the control now on health systems interventions. For example we have extremely useful, well proven methods to assess different kinds of financing interventions such as pay for performance or health insurance but the other kinds of building blocks such as – as we heard about governance - the methodology is not quite as developed. Those are areas where perhaps we need to invest more to generate some useful findings on system-wide effects.

¹² <http://www.healthmetricsandevaluation.org/>

¹³ <http://www.healthsystems2020.org/content/resource/detail/528/>

So where do we go from here? We have a great opportunity to invest in systems research given the increased amount of interest in health systems. Many have called for a new science or health outcomes in health systems research but I sort of agree with some of the previous speakers that you don't necessarily need a wide variety of [new] methodologies we just need more commitment and funding emphasis on applying the methods that we already have to some of these key questions. And I think that might be the best way to proceed.

What is involved with pushing this forward? Well we need to advocate rigorously, as a key component of the health systems strengthening the agenda. We can't just take it for granted that health systems research will happen. We need to make sure that we build in rigor into the health systems strengthening agenda. Also in establishing health systems strengthening objectives, we need to establish systems to monitor and evaluate processes; we need to do a better job with the aligning systems. And with the implementation of country coordinating mechanisms, to give health systems decision makers at the local level and national level the data at the right points in time.

And [as previous speakers mentioned] focusing not just on continuing to develop frameworks, metrics and methods, but also on looking for opportunities for prospective research. I think a lot of these key bread and butter issues will go a long way to further the evidence base, to contribute towards strengthening synergies between health systems and global health initiatives.

Discussion:

Female Speaker: Thanks. I have to say that I'm just getting more and more irritated as this session goes on. And I want to – it's really focusing down on rigor. I'm so sick and tired of hearing rigor being synonymised with quantitative experimental randomized controlled trials.

My criminal lawyer brother and my crown prosecutor neighbor would be horrified to hear that randomized controlled trials were somehow the epitome of records. Can we just get over that - qualitative work can be absolutely rigorous and empirical. Absolutely - you want to avoid sloppy, lousy qualitative work; equally not to avoid sloppy lousy irrelevant qualitative work. Yes we can do with more randomized controlled trials (RCTs). I would love to see more pragmatic RCTs used as a matter of rolling out or scaling up so that you see, if you can work at scale, how do we measure things?

But if I want to know what Barack Obama thinks I need to talk to Barack Obama not a representative survey in some sense, though there may be on other things. If I want to know more, I might ask his wife or his kids about them. So can we get over this rigor equals quantitative nonsense? I think the part of me that wanted to be a surgeon is coming out. The part of me that wanted to be an anthropologist is also annoyed here.

So having said that I think there are couple of good things. Thanks for the really provocative presentation and Richard's comments there. On the list of possible approaches we heard on the last presentation and Peter's comments about how we don't need to invent new methods necessarily. Maybe we do in some cases but can we move beyond the sort of late 17th century approach to universal education and realized that it's not just industrial revolution era. Every child needs to learn this but rather we are beyond that. We are now in smoking cessation. No one will ever look at smoking cessation as the only intervention and if smoking cessation projects don't work then tobacco control is irrelevant. Can we not do that in HIV? Then the whole health system will be better and really look at things systematically. So I will shut up there.

Female Speaker: I think I can cheer on now as well. Working for PEPFAR and having this public health evaluation program that was under PEPFAR, there was a call for human resources for health risk evaluations being done. I think those of us in the field were rather frustrated because some things that came forward weren't accepted at a global level because they didn't meet a certain research criteria at the global level; we felt that wasn't valid in the field level. And so you have to continually to fight the battle. And on top of that I did appreciate The World Bank in a meeting in Ethiopia and the human resources for health, where they took the policy makers and the government folks and went through a one on one on how you take the research and then interpret it for policy decisions. And when you look at the studies of before and after of the population where you can critically analyze that and I find people were refreshed.

How that skill we announced to them so they know when they get that document on the desk and they have to make a decision based on the data presented to them, that they can have the skill behind it and I would argue even in the case of public health evaluations under PEPFAR sometimes you wonder where that skill lies in global experts and if they truly are qualified.

I get to the methodology piece that people were commenting on. What is the proper methodology? Maybe just being a little loose on the definition will bring more opportunities there because we didn't see a lot of opportunities coming globally but I think each field country under PEPFAR has that opportunity for folks to present public health evaluations and human resources risk evaluations and the field has funding for things like that. So I encourage folks to think about that. Thanks.

Female Speaker: We are looking at the effects of HIV/ ART scale up overall on African health systems and the actual outcomes on maternal child health and the HIV prevalence in Burkina Faso, Tasmania and Uganda. I thought I would share with you some of the challenges we met and some of the methodologies we are using and also related to Christina's comment. When you say cohort studies with retrospective and prospective cohort studies with demographics available at those sites, about 100 000 population in each of the sites and you see a mixture of qualitative and cohort prospective studies.

We have seen data which has been collected on a regular basis through households interviews every three months but also a lot of qualitative studies interviewing people on access and equity of care, how they experience the quality of care with respect to human resources and also interviews with patients. Trying to relate policy and spending to actual quality of care, we find that even though we have this overall approach not looking separately at health initiatives but the overall scale up, it's really hard to attribute any sort of changes in terms of access, equity and outcomes to even ART scale-up as a whole.

Often times due to that there are so many interventions that is going on and so many separate small initiatives going on even in the districts where we are doing studies, so it is really hard to attribute any of the outcomes to these initiatives even when you look at them in a collapsed sense. So that's one of the comments I would like to make but also looking at the district level I think it's useful rather than looking at separate initiatives. You feel upset that - at district levels and also if you implement the interventions through the districts and let the local and the public and the government health clinics that are operating there to do the initiatives rather than having separate research initiatives, separate NGOs doing these initiatives - we've seen very little of the HIV earmarked funds trickle down to district level to help the people.

Mary Bassett: Speaking on health systems strengthening projects which I guess is why I came to be here today. But after I have made an observation, I think there is a question there having been outsider to these discussions till quite recently although I have lived for so many years in Zimbabwe. I think I should thank the panelists and thank Christina. I think in the course of the day there has been some tension back and forth on what the standard of research should be.

I heard the discussion by the Positive Synergy group and David Peters' summary that people chose through a lot of studies and you chose through 1,500 studies and found [about 16] Positive Synergies group – this referenced over [about 230] papers had 14 new studies and felt that some did okay, some didn't do okay, some were kind of neutral and we need more research. That was a principal conclusion. Just to the plus that the lack of hypothesis generation – I mean why did some do okay, why some didn't do okay and why were some neutral?

I would like to throw a hypothesis that strike me which I heard about in Rwanda which I think we all agree has a strong central government at the moment - perhaps an authoritarian government and they somehow got the global fund to pay for health insurance which is how we began the day's discussion.

On the other hand we had Zambia which I think I heard hasn't done so well – which Alan Whiteside mentioned at the beginning of the day that it's central government is pocketing the money. I think that's what he said. We just heard several discussions using the [WHO] building blocks framework and none of you mentioned governance. You all seem to have left it out of the discussion. So that's my observation and question something like that.

Male Speaker: Thanks. I have two questions – one for Jos and one for David Hotchkiss. You listed a whole set of research questions under various headings that emerged from that [Bellagio] consultation.

So under the health workforce research questions, there's a question which says '*what trends in supply of health workers maybe tied to HIV scale-up*' and something that's intrigued me today and in other forums and also in terms of this question – '*what impact has global funding had on the institutions which produce the health workers*' because if we are talking about scale-up of health workers like 140 000 – is the number that is being bandied around now – who is going to produce them?

I mean over the past 20 years [health workforce training] institutions in Africa; anyway, have mostly become much weaker because government funding has declined. So who is going to produce these? Are they going to be produced by people flying in from other countries and run short training courses because that's tended to be the business so far. So I think there is a very important question about the building of the training institutions themselves for sustained human resource production.

Today, it's very interesting in the Lancet paper and indeed in this course on health systems, WHO defines health systems as all organizations, people, actions whose primary intent is to promote, restore or maintain health - very broad definition. Then we come to the building blocks. The building blocks are concerned solely with the health services. I'm very pleased that on page 2,142 of that [Lancet] article, at least they put health service delivery on a different level from the other five building blocks. At least it makes a bit more sense that government's financing, health workforce, information systems, supply management - all contribute to health service delivery but what's missing here is all the other actions that the WHO definition itself says are necessary to promote, restore and improve health.

So this leads onto what Mary Bassett is asking in a way and I think Mary is talking not just about governance of the health systems. She is talking about governments. The context within which health systems perform or don't. We lived through a period in Zimbabwe when the context was completely different from now. A health system that worked, doesn't work anymore.

How come in Haiti NGOs have managed to take huge advantage of global health funding as opposed to many other countries? I will tell you why, it is because Partners in Health have been operating there for 20 years and they've got a very good relationship with Haiti health services and that probably is a very important contextual factor. We heard about Rwanda. Surely if we want to understand what enables health systems to become strengthened or disables them through this massive funding which is now available, surely we have to understand something about the context within which those health systems operate?

Otherwise we will get completely lost. We think it's just a technical question and I submit it isn't just a technical question. And of course here, the randomized controlled trials are not going to help us.

Male Speaker: Thanks. First I appreciate the very thought provoking presentations. I just got a question for the presenters about prevention. A lot of the discussions focused on the health systems outcomes related to care interventions and I'm wandering if you thought about HIV prevention in terms of HIV infection as a verdict and in this case I'm not thinking of PCMTTC but more community players. Community based programs, media interventions, condom distribution programs and if you thought about metrics and maybe even ways of evaluating those types of interventions.

Peter Berman: Responding to Questions

Okay, I think I can be very brief. On the question of research methods, I absolutely agree with you. I was very brave on what I even said when I put on that slide - I [feared I] would be misunderstood. What we need are appropriate research methods. We just need to understand what they are appropriate for and use them in the appropriate ways. So I stand corrected if that was misunderstood but that's what I believe.

I think the comments about governance and the context are also very valid. One of the dilemmas I think we have is that we are often doing research at the level of a specific country or part of the country and I think probably one of the hardest things about doing health systems research in low income countries is that often the intervention that was designed is not really implemented or not implemented as it was supposed to be. So you end up not being able to study the thing you actually set up to study. You study something else that occurred because of local context or weak governance or whatever and that's a very frustrating conclusion to draw.

So I think that this is the problem that we have - is that I think we often encounter a situation where we set out to answer certain questions but the reality on the ground is not the reality that suits the question we set out to answer and then the alternative, of course, is to study that reality in a more controlled environment which doesn't answer the question either because you really want to know what happens in the real world.

I think the case we heard before from Malawi was extremely interesting in that regard. The proposal to collect data on the actual human resource requirements, costs and so on to deliver services at a scale of national level, you know that's a unique opportunity to really answer some of the questions that people raised.

Male Speaker: Regarding the research question, if I said randomized controlled trials were never useful kind of evidence I might have misspoken but I would argue that randomized trails are really

not appropriate for many kinds of interventions and I know from my experience with implementing health systems research myself and reading the literature that there's a number of interventions where there are some pretty good rigorous research without doing randomized controlled trials. I'm thinking about the contracting health literature, I'm thinking about the health insurance literature conditional cash transfers, etc. Those are the examples where very solid research has been done without doing randomized controlled trails.

In response to David's question, I'm not sure whether I have got a great response but I think it's in the list of things that Peter mentioned that we are asking questions for political reasons or is it for scientific reasons. In order to answer the kinds of questions David was posing I'm not even sure that quantitative evidence is the best kind, perhaps we should rely more on careful case studies using qualitative methods. I think those kinds of methods might answer those kinds of questions in a more appropriate way.

Regarding the issue of prevention, I can't say I thought about it carefully but I do think that this whole idea about Task Shifting and community workers are conventional strategies as well and there have been some research done and a lecture on that and I think we need to build on that to see what type of prevention strategies do produce good solid evidence on health systems strengthening.

Jos Perriens: Responding to Questions

Thank you. On the two points – I would like to briefly talk on this question of HIV or the Global Health Initiative on the ability of institutions to produce healthcare workers. This is a question that could be repeated many times over if equally legitimately asked what is the impact of HIV on the global health initiative education sector or the ability of subsistence agriculture to sustain the livelihood of populations or the ability of the entire society on human capital.

Now this specific question is not on the list because having an answer to that question will not generate the action that is needed to solve it. We know that healthcare worker education institutions in Africa can graduate about 5,100 people. That's about as many people as my small country, Belgium generates on a yearly basis in its medical schools. The solution needs be found to overcome that gap whether there's HIV or no HIV around otherwise that the entire population cannot be served and I would therefore say this is a priority question.

Second the role of governments and leadership. If I had the keynote address in this consultation, I would have elaborated on it. I did not specifically address it when it comes to financing because even though I had a slide on it. The slide did show how some governments increased HIV spending when ODA for HIV increased, some government didn't do that or even increased their own HIV spending. I didn't show the slide because the explanation eluded me. I think the explanation is that government are constrained in their ability to spend money as they wish

because of formal or informal budget gaps but I could be wrong. I think this would be a very interesting topic for operational research. With that I would like to leave you. Thank you.

Time Closing Presentation:

Alan Whiteside: [Title]

Title:

Alan Whiteside is speaking very faint as he seems not to be using the microphone or standing far from it. It's difficult to make up what he is saying but there is a lot of excitement and laughter in the room as he begins his talk. The same jubilation is shown when he finishes his talk. Unfortunately, despite several attempts, it's difficult to transcribe what he is saying. [For Alan Whiteside's closing presentation, please refer to the power point slides on the website]

Jacqueline Bataringaya:

Thank you, Alan. We have come to the end of the day and at this point I wish to apologize on behalf of Craig McClure, the Executive Director of the International Aids Society who was here this afternoon and was meant to make the closing remarks and thank you all but he wasn't able to stay as he had an urgent engagement at 18:15 and had to leave. So it is left to me to close and I think it's a great privilege to stand here and do this.

So I wish to thank you all for coming and to recognize that we did receive funding from The Rockefeller Foundation and we wish to extend out gratitude to the Foundation but also to the World Bank for the funding for the reception we had last night. But especially to you all because as we all know this was not a funded meeting [for travel and accommodation]. So that means that it has in some way been a partnership of all the various agencies that have invested in their staff in the countries, from the universities to come here and spend the day with us.

And so we hope that as we move forward we can also remember that this is a partnership and that we are going to all of us share both successes but also perhaps where we haven't done too well. And in terms of moving forward, again we will be sharing when it comes to ensuring that what comes out of this meeting can be put to some good use. I just want to highlight a few things that I think were mentioned today that typically are not always highlighted in the discussions of this nature especially coming from the HIV background and maybe with one foot, a tiny one, on the health systems side. Alan has just emphasized that we haven't even begun to touch on the massive scale up of HIV that's needed. We've only just begun.

I think somebody mentioned that we are getting to the limits of what this current scale-up can achieve with the way things are running. If we want to get to the next level of scale-up, that's where you have to come up to the health systems question. But we also have demand for massive scale up for the other issues, the MDG targets and deadlines are upon us so we can't ignore that anymore and so for that we are looking at how do HIV programs support that effort? Today we have recognized that for massive scale up of HIV programs to continue, massive effort strengthening of health systems is needed, and therefore we need massive resources to do this.

A couple of questions were asked and more towards the end. First - what's the role of context? Many times health systems strengthening people say - context specific, context specific but we didn't hear enough of that today and when we've discussed methodologies, I think one thing we didn't really address was what went wrong with all the studies that we said were not rigorous enough? And I think Christina didn't mention this, we are tired of these kinds of methodologies being perhaps given more credence than others. And next time it will be good for us to really look back and say these studies – this is what we could have done differently.

Having said that I think we did achieve a lot, being reminded that its not enough to strengthen our systems if we are not looking at our outcomes. It's not enough to talk about this issue if you are not making sure that at the primary care level, the services are available; and thinking beyond that to the social determinants and ensuring equity and remembering that it's all about human rights which the HIV community has successfully brought on to the table.

So I would finish my comments by reminding us again that at the end of it, as many of us want to always call to the attention, its also about how we strengthen the human health workforce – and unless we start to increase the numbers, unless we start to address the vacancies that were pointed out, but unless we go beyond the traditional way of looking at it and look at perhaps the politics and some of the dynamics and the governance of it. We may not be able to continue to make progress.

So the next steps, we will write a report from this meeting and it will be available in the website on the webpage but we will send it to you all. All the slides and presentations – with the permission of the presenters we will also be putting it on the website in the next couple of days. This meeting has been recorded as it is the practice of meetings around the International Aids Conference so that those who are not here can listen to our discussions and we will transcribe and also put it on the web. And then finally we will produce a report and we may come back to some of you just to clarify a little bit what exactly you meant during the discussions and what the questions were just so that our colleagues who are not here can also really understand and hear directly from you.

Thank you very much for coming and especially to the South African colleagues that have come in numbers and given this meeting a lot of importance. So we hope to see you again next time.



Thank you.

END OF SESSION FOUR

END OF THE PRE-CONFERENCE MEETING