new statesman

AFRICA

Creating sustainable health systems

Special Supplement

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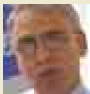
Introduction

This, the third in our series of six policy forums, focused on healthcare in Africa. The situation in many parts of Africa is dire. Money and good intentions are clearly not enough to fix the increasingly difficult task of ensuring even basic levels of health across much of the continent. HIV/AIDS is crippling not just the population at large but also, and in particular, healthcare workers. Too often, flourishing health systems have been destroyed by mismanagement and worse.

However, the experienced speakers, gathered by the *New Statesman* and Pfizer, recognised several good examples of what can be achieved. They also, and with unusual unanimity, argued for a more measured role for donors and others involved in providing development aid. Listening to those attending from Africa, it was clear that partnership, respect and flexibility should be watchwords.

Held in London on 1 July, just prior to the Live 8 concerts and the G8 meeting in Gleneagles, Scotland, everyone present understood the importance and timeliness of the meeting. Perhaps it was this understanding that helped keep the discussion upbeat, on track and practical.

Participants



Gerry Bloom
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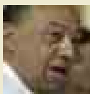
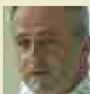
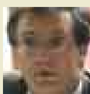


Paul Boateng
British high commissioner to South Africa



Andrew Bone
Head of executive affairs, De Beers Group



Richard Dowden (chair)
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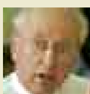
Links and project co-ordinator, Tropical Health Education Trust



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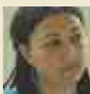
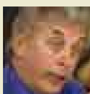


Mohga Kamal Smith
Health policy adviser, Oxfam



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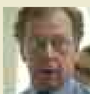

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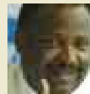

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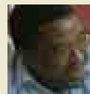

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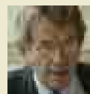

Keith McAdam
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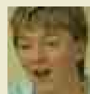
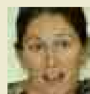


Linda McAvan
MEP and Labour member for Yorkshire and the Humber



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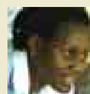

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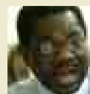

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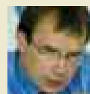
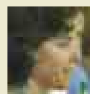
Chairman, Nigerians in Diaspora Organisation



Gareth Thomas
Parliamentary under-secretary of state, Department for International Development



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Africa:

Creating sustainable health systems

Richard Dowden Welcome to the University of London School of Hygiene and Tropical Medicine. The topic today is creating sustainable health systems in Africa.

Africa has only 1 per cent of the world's health workers, even though about 25 per cent of the world's people suffering from disease reside there. Among the poorest Africans, no one expects to get any treatment at all. They know that treatment must be paid for and they are as likely to turn to traditional healers as to western-style doctors.

African countries spend, in GDP terms, half of what rich countries spend at about 2.5 per cent of GDP. In real terms, this amounts to $13 per capita, compared to an average of $2,000 per capita. On top of this, the devastation likely to be caused by HIV/Aids is just beginning.

The Commission for Africa suggests $7bn over five years to rebuild health systems in Africa. This is on top of the $10bn a year to be spent on disease to try and turn things round. The bill for Aids in 2007, is going to be $18bn. That is a 50 per cent increase on 2005.

However, none of those figures will mean anything without commitment. In other words, it all comes down to politics.

Dr Patricia Mwebaze has come straight from Uganda. Tell us how things are in Kampala at the moment?

Patricia Mwebaze I work in Uganda at the Infectious Diseases Institute. This is an HIV treatment/care institute, initially started up for training doctors. We train our healthcare workers and doctors to work in communities. They are involved in medical care and in the treatment of people with HIV/Aids. We are also a research centre and we run clinical trials.

We have about 10,700 patients in our clinic. Three years ago, when I arrived, the fact we had no free medicines to give to patients meant many died. These days, patients come from all over the country because they believe the institute is a centre of excellence and we offer free treatment. On average, a physician sees more than 320 patients a day.

We get our drugs from a global fund and from a presidential emergency relief fund and things are getting better. But in the rural communities, things are gloomier because there are no facilities; even if they have trained personnel, there are no facilities. People may be given drugs but they are not able to have the rest of the treatment because the hospitals do not have the facilities.

Improvement is possible but there is still a long way to go.

Gareth Thomas Clearly it is a priority for the G8 to get more money for Aids treatment and healthcare in general. ▶

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▶ It has been great to see the cost of anti-retroviral drugs (ARVs) come down sharply over the past two years. Now it is about getting access to those ARVs. To do that successfully, we need to expand significantly the number of health workers trained to get ARVs to those who need them.

But we also need to encourage research into the other diseases. We need to encourage the pharmaceutical industries and research institutes to focus in on those problem diseases.

I touched on capacity. The other issue is the broader environment. We need to look at the stigma and discrimination that affects those with HIV/Aids, especially about the position of women in developing countries and the impact that our programmes have on them.

You touched on politics and governance. I was struck by the president of Botswana saying that the good news was there were more donors, more foundations and more NGOs. The bad news was that there were more donors, more foundations and more NGOs! Often the constraint is the capacity of the receiving country to handle the demands of the donors.

What is needed is improved co-ordination, so that all those donors and others are properly able to help these countries organise their health systems in the way that they need.

Mohga Kamal Smith There was a time after independence where some governments expanded primary healthcare to villages. In these countries, we saw a massive rise in immunisation and a massive drop in child mortality.

I think it is important to remember our history, that Africa is not all bad. There was a time when Zimbabwe had health workers in remote villages, as did Mozambique. Namibia had a fantastic programme that reached everywhere.

It was the structural adjustment policies of the World Bank and the IMF that put the nails into the coffins. And the donors allowed the Bank and the IMF to go on with these policies and force the governments to follow them. Now we do not have a health service to deal with our HIV problem.

Gerry Bloom I worked in Zimbabwe in the early 1980s. Promises of expanded access to healthcare were politically very popular.

In the post-colonial period there was no HIV/Aids, but many of the problems were similar. Governments promised and the people believed. Many health workers were trained and felt that dignity and a good career would be theirs.

I think the big challenge now is how do you reconstruct the social contract? How can health workers who have been so disillusioned start believing that the system will deliver?

Clearly, in the post-colonial period, the hopes and the promises were greater than governments could deliver. But much of what was being promised was done. I would say there was a lack of realism about what could be achieved and also about what people needed in order to work effectively over a career, rather than for a year or two. This lack brought its own problems.

Mohga Kamal Smith The World Bank came with purely economic policies. Take Zimbabwe where, overnight, the government had to introduce medical fees. The following morning the maternity ward was empty. It was not a time of evidence-based policies. They came to fix a problem without understanding what was happening on the ground.

Paul Boateng I do not think it is helpful to divide Africa between medium-income countries and low-income countries. The scale of a crisis in a country such as Swaziland, which now, apparently, can be described as medium-income, or even in a country such as South Africa, is huge. If we have to, it is better to divide between urban, where there may be the vestige of a health service infrastructure, and rural.

In the Limpopo province, the town clinic covers six villages. There is one health worker. When she is overwhelmed with work and the distress of dealing with her patients day after day, there is no one.

Patients in a critical condition have to wait for an ambulance to travel more than 70km to the clinic. The only means of communication are mobile phones used in emergencies to communicate with the doctor at the hospital.

The senior nurse has to use her own car to transport patients. There is no other transport. If the patient dies in the

car, she is then accountable because the insurance does not cover her.

What we need is a pan-African approach that shares good practice and skills. Health workers do not just move to Europe or to Dubai; they move from Ghana to South Africa. To build up pan-African institutions and pan-African responses is very important.

We have to rethink what we mean by health infrastructure. When I was a boy in Ghana, the health infrastructure was on the Gold Coast. There were primary care clinics and hospitals of varying degrees in the regions. But for real emergencies, you came to Acra for the equivalent of teaching hospitals.

That model is not suitable now, nor for the foreseeable future. But what we are starting to see is the beginning of partnerships between NGOs and the private sector.

The health worker may be the health-and-safety worker who spends the rest of their time being a mining technician or working in some other capacity in the company, and yet they are responsible for health education and the initial determination of the problem. Healthcare and drugs may be distributed, not in a government-funded clinic, but in a clinic that is provided between the trade union and a company, which may or may not involve an NGO.

Traditional healers can be part of the problem, but they can also be part of the solution. We have to see them in the context of the health infrastructure and work with them.

Leon Louw The fact is that almost all African countries have followed policies that produced poverty. We should be in Africa asking how African governments can stop causing poverty. Some countries do not become rich and others poor by chance. Aid, it seems to me, rewards governments that keep their people as poor as possible. In the traditional aid formula, the poorer you make people, the more you get rewarded for doing so.

Poverty is caused. It is not the natural state of things. Where is the manufacturing, trading and wealth generation that is the more natural state of affairs?

In countries where the state is what you call a "failed state", do we really think they are going to start to deliver effective healthcare?

The health markets in Africa are subjected to completely stifling micro-regulation and licensing restrictions. In my own country, South Africa, there is outright prohibition. If you now want to import medical equipment or pharmaceuticals or build a hospital, you have to get a permit to do so. You are simply not allowed to provide healthcare.

Countries get rich when they follow policies that make you rich. There is no reason why African countries cannot deliver prosperity and, therefore, health.

Reuben Olu Obaro When I look back to when I was a medical student about 25 years ago, and compare it to what I see happening today, one just cannot believe that this could happen. How did this happen?

The military decimated everything in the country. When the military came into power, students, lecturers and workers found it difficult to express themselves. Things gradually went downhill.

Then, just when you thought things were bad enough, the Aids epidemic came along. Now, the infrastructure is so bad, the poverty so grinding that one cannot understand the resilience of the human being. However, I feel that the black man in Africa has an interminable hope that tomorrow is going to be better and that he can go on. The IMF and the World Bank, have not done justice to Africa. The combination of the military and fiscal policies did a lot of harm.

> The black man in Africa has an interminable hope that tomorrow is going to be better

Andy Haines Prosperity has to be improved and we have to pay attention to the way that existing subsidies are often mobilised much more effectively by the top 20 per cent of the population than they are by the lowest 20 per cent.

It is important to improve the interventions that we have and to develop new ones. Recent work around child survival suggests that around two-thirds of the deaths could be prevented by just implementing existing interventions. The real problem is to how to scale up the delivery of these interventions. We need one million health workers perhaps for Africa and perhaps four million health workers on a global scale. Many of those will migrate, whatever policies are put in place. We will need to develop, as Paul was saying, cadres of community health workers, mid-level cadres, who could do many of the basic procedures.

These potential health workers may not be in the formal sector. We need to strengthen African institutions that can embark on that course.

Richard Dowden Do you think that you cannot rebuild the old model; you must have something different?

Andy Haines We need to support the institutions that are outstanding. But there is a whole range of other fledgling institutions that many of us think are a priority to develop. ▶

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▶ We need research institutions, but we also need institutions that will reach out into the community.

Richard Dowden Susana. What do you think works in your Links programme?

Susana Edjang The needs are medical support, support for dialysis, HIV/Aids and support for chronic non-communicable diseases that kill people every day. Support is needed in terms of management. One of the hospitals run by us in Malawi is their only psychiatric hospital, for a population of 30 million.

We normally work with the private sector because they already have structures in place. Policies have to change at the national level. We have organised training of mental health and community nurses. I think you can differentiate between the private and public sectors in countries where the government cannot afford to help. I think this can be done through the policies that are sustainable over the long term.

David Mabey Gareth, is the British policy to support public institutions and governments or are you looking to public/private partnerships? Where do you see the balance?

Gareth Thomas There are some countries where you just could not support public institutions for a whole variety of reasons: corruption, import capacity or whatever. In those circumstances, one seeks to use UN agencies or to use NGOs to deliver basic care and services.

Governance is better where we do want to put money through new government systems precisely to build up the public institutions because they will, in the long term, ultimately be the only answer. NGOs can deliver basic services to some areas, but not all. I agree with Paul that we have to get behind African institutions.

We need to learn that the poor people themselves need to have a much greater say in the design of their health systems. We also have to build up public information systems. I do not think we have to accept that migration of health workers is inevitable. Through increased pay and better training, investment in the institutions, we can have the ambition of building up healthcare structures. In Malawi, we hope to increase nurses' and doctors' pay by 50 per cent over six years to double the number of nurses and a treble the number of doctors. That type of investment is essential.

Gerry Bloom I think we have to be careful about being too prescriptive in what we mean by public and private.

In China, there are public facilities, but basically people are

earning money from selling drugs. In Africa, it may not be legal, but it is how people survive and have done for 20 years. It is not helpful to say it is corrupt. We may need to build solutions based on what happens, rather than what we would like to happen.

A lot of village health workers were trained, but most have dropped out to earn a living in another way or are in the private sector selling drugs or work with traditional healers.

We cannot afford to train people again and disappoint them and point at them as the reason why there is no good health. We have to ask how they are going to make a living, not just for the next two years but the next 25 years. There is very little discussion that puts together what health workers expect for making that commitment.

Richard Dowden Keith, is the Infectious Diseases Institute funded entirely from the outside or is there a Uganda government contribution for that?

Keith McAdam The Infectious Diseases Institute was handed over to Makerere University on 1 July 2005, so it is a new institution owned by Makerere. It is a limited company under guarantee to the university, but managed independently of the sort of bureaucratic nightmare some institutions have had to develop to survive.

Things are changing very fast in Africa at the moment. Demand for care and how you manage that has become the prime question. If we were sitting in Uganda, every third person would wonder whether they had HIV. If they did not, probably their daughter, son or uncle does. In the context of HIV drugs being made available, there is a sudden

ray of hope shining on Africa.

The institution that I am lucky enough to be in is a very privileged one. It is a foundation formed by a group of nine academics from Uganda and five academics from North America, who went out for funding. Pfizer was the main donor, allowing the building of the new institute. The mandate that I was given was: "Please do not focus just on Uganda. There are 28 million people out there who you need to be thinking about too." So it is very focused on education and training. And we train trainers. So far, we have managed to train about 320 doctors from 15 different countries.

We have been able to assess how many people an individual trainee will train over the next five months. Much to our astonishment, it was 83 on average. There is a huge change going on and there are people out there in very small health centres who have been adequately trained to provide ARV drugs. The rural areas are the ones most lacking in access, but there is no model for urban care either.

HIV affects everything. There is a 30-50 per cent chance that any patient is HIV-infected. Healthcare workers, too, are being decimated. ARVs are very expensive. We require sustainability, which, at the moment, is not clear, unless G8 can really commit to it.

HIV affects everything. There is a 30-50 per cent chance that any patient is HIV-infected

And the point? There are people who were at death's door, but three months later are back being fathers and mothers. This is a huge social benefit. They are back earning. This is a disease of poverty.

The public-private partnership we are in has a lot of advantages, but how sustainable is it? Endowments might prove the answer. All the big institutions we get used to hearing about in the north use endowments as a way of sustaining themselves.

The only African institution with an endowment that I know of is in Namibia. It is an institution for lawyers. At the moment, we are very much dependent on donors and that dependency is helped by funding governments rather than by NGOs.

By funding the government system, you fund a sustainable system. We need to put into place structures and methods that keep fiscal accountability at the forefront. If we do not sustain governments, institutions crumble.

Richard Dowden In giving the ARVs, do you select whom they go to? Are you prioritising health workers first?

Keith McAdam We follow government policy, which is children, carers, health workers as the first priority, and mothers as they are usually carers.

Robert Mallett I am going to speak up timidly for two institutions that have been maligned in these conversations: the World Bank and the IMF. We seem to forget that they came to try to solve the problem, just as debt relief is the new way of trying to solve it. They were trying to encourage a broken public sector to have more dynamic private enterprise. But governments did not institute an enabling environment to let the private sector flourish. I believe that the amount of money flowing into sub-Saharan Africa today is quite substantial, particularly for HIV/Aids.

What is missing is a co-ordinating mechanism for us to be able to target properly or hold states accountable. So, 15 years from now, people will say: "Those G8 people wound up debt relief, but they did not attach it to any outcomes."

Gareth Thomas With respect, I think there is one.

Robert Mallett It is all in very pretty language, using that word "governance".

Gareth Thomas There are also poverty-reduction strategies that countries have to draw up in order to set out how they are going to spend their resources, which governments can be held accountable to.

Paul Boateng We do need more resources, resources dispersed in a multilateral way. I say this specifically to you, Robert, in terms of the US on HIV/Aids. I think we need more effective donor co-ordination. You cannot separate HIV/Aids from what we are having to face in relation to the malaria crisis. One of the priorities for our presidency of the EU and at the G8 is to work with our partners to improve donor co-ordination.

I agree that we need support for governments and public institutions, but my experience has been that power concedes nothing without demand. This issue can be left to donors or to governments; civil society is key. Governments are deeply suspicious of civil society, just as they are with business. It is not just a question of getting government off the back of business, but also getting government off the back of civil society so it can make demands and organise.

Richard Dowden I read recently in the *New Statesman* of Oxfam being accused of being the government's poodle.

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Pfizer

▶ **Mogha Kamal Smith** When I came to this country, it was at the start of Margaret Thatcher's era. The then government cut expenditure on health and education. It is amazing now when people say, "Oh, there is a crisis in the UK. We do not have enough doctors and nurses", as if the government can wave a magic wand and a doctor appears. It takes years to train doctors, years to change the mentality of students wanting to become doctors, nurses or social workers rather than computer engineers or businessmen, whereby they can have a bigger car etc.

Michela Wrong In Kenya, the government stole $400m. The government made those decisions and they had the power to do so.

Mohga Kamal Smith The governments made decisions, but there was a lot of pressure on them to do some things but not others. Governments go to war and corrupt government officials put money into their pockets just as many other people do in this country and elsewhere. The reason for the World Bank's and the IMF's restructural policies was to try to deal with the countries' debts.

Paul Boateng We may or may not agree about the past, but it *is* the past. The IMF and the World Bank are not working in the same way as they were at the time of structural readjustment. They are now, potentially, our allies. We need to be better at listening to society, to elected representatives, to business and to the local indigenous NGO sector.

Mohga Kamal Smith Mozambique has 500 doctors. They want to recruit more doctors, but they cannot because the IMF has put a budget ceiling on Mozambique's expenditure. Zambia and Malawi cannot recruit because of IMF budget ceilings. The World Bank has changed a bit, but the IMF has not.

Michela Wrong One of the legacies of the past is a huge public scepticism towards health systems provided by the government. I spent time last year in Kenya, and a charity, in conjunction with the minister, was trying to introduce free health assistance. While the donors were not against signing up for the scheme, every Kenyan I spoke to was completely sceptical and thought it was going to be a disaster. Kenyans were anti the scheme because it would have required the middle classes to contribute a huge amount of their income to the central fund; historically these funds were systematically looted by the governments of the day. And we know the new government is up to similar scams. In the end, it fell at the last gate. This public feeling exists in many places in Africa.

David Mabey I support what Paul was saying. The wrong kind of aid can cause more harm than good. In Mozambique, we heard that there are 500 doctors, mostly in the capital, for 20 million people. So over 50 per cent of the population has no access to any form of healthcare. Yet large amounts of money are made available for ARV treatment programmes, where doctors are offered much higher salaries than normal.

> It is necessary to to encourage the free media as well as a civil society to flourish

So they go and work for these. The total benefit of this is 4,000 people on treatment. In the meantime, who is treating malaria, infant mortality, doing other interventions?

Gareth Thomas If you do not have good governance then, of course, there is going to be huge scepticism. So it is necessary to do the broader pieces of work around anti-corruption commissions, an effective judiciary and to encourage the free media as well as a civil society to flourish. It is necessary if we expect there to be a demand for better investment in healthcare.

If you do not have such a situation, then, I think, it is right for us to continue to focus on NGOs and UN agencies but that is not going to generate a sustainable health system.

Where governance is improving, risks have to be taken to put money through health systems. Too many donors commit money just for a year, so how can you expect African governments to take the risk of investing serious money and effort in health if they do not have the long-term certainty that donors will put in significant sums? Donors need to be thinking about five- and ten-year commitments.

The IMF and the World Bank are getting better and they need to be a force for good in investment in healthcare.

But nothing in life is simple and you have to strike a balance. African governments are right to challenge us to provide more aid, as they have done through the Commission for Africa. Similarly, on occasions, it is appropriate for us to challenge those governments themselves about how resources are being spent.

Richard Dowden When you do cut aid, do you try to send it via another route or just leave it in the bank here?

Gareth Thomas On occasion, we will withhold it for a short time. If it is short term – where the conflict will be resolved – we will wait before we commit further down the line. If it is a long-term conflict, we will look at other ways of assisting.

Leon Louw African countries are experiencing considerable growth for the first time ever. Countries in Africa respond in exactly the same way as countries anywhere in the world.

It is not what the World Bank or the IMF does. It is what we do that makes us poor.

Linda McAvan Michela said the middle classes in Kenya cannot afford what is being proposed and they have no confidence. That is just a political process. Similarly, Bill Clinton's health package failed in the US because the political forces were not delivering it.

In relation to health, we are talking about poverty, wealth-generation, international trade policy and countries being affected by global policies; the problems are so huge that we seem unable to focus on what we could do.

If we are going to make a massive new resource commitment, can we guarantee that the new resources are tied down? We are moving away from project funding towards budgets to support governments.

Sustainability is crucial. We have the same issues in our own country. Odd pots of money for one or two years are not the answer. Structures are important in delivering care. Are people here aware of the strategy papers? Do you feed into them?

Gareth Thomas I think we are starting to see a number of governments in Africa wanting to be much more transparent about how their resources are used. One of the very interesting things about the Paris Club deal that has just been signed on Nigeria's debt is the president's commitment to allow not only international but also local organisations to monitor how those resources are used.

In order for the HIPC (Heavily Indebted Poor Countries] countries to qualify for debt relief, they have to prepare poverty reduction strategies. We need wider discussion about how poverty should be reduced.

Andy Haines To respond briefly to the issue about the private sector: in every country, there is a sort of inverse care law that the people who need healthcare the most have the least potential to buy it. It is very difficult to see how a for-profit sector can really deal with that.

So I think the vision has to be universal coverage. How you attain it is a matter for debate and probably will vary from country to country. However, strong government input and provision is the core of virtually every successful system that I am aware of around the world. In Africa, there is quite a lot of diversity. Countries such as Eritrea have made remarkable progress with few resources through tight government control and co-ordination of services.

I also wonder whether there are examples from other parts of the world. Ten or 15 years ago, people were writing off Bangladesh and saying it was a country where the health indices were very poor and were unlikely to improve. But there has been a dramatic turnaround. A lot of that has been driven by NGOs, strong, community-based NGOs. You cannot translate immediately from one continent to

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another, but it does demonstrate that where there are strong community-based mechanisms, strong NGOs, these can force through real change.

I also want to touch upon the strength and weaknesses of the disease-by-disease approach to health systems. There are strengths to that. One is that you get focus, and focus on a few interventions can make a difference. However, there are also serious weaknesses. We heard that people are being offered large salaries to work on ARV programmes. This disease-by-disease piecemeal approach will always give those kinds of distortions in the system and makes human resource development and retention very difficult.

Robert Mallett In Africa, most of the healthcare is provided by NGOs and by private people. A private network of healthcare may not be quite up to the standard of care at all times, but it is there. What we need are co-ordinating mechanisms and we need them specifically tied to public health outcomes.

I look at the language that is used in the G8 papers, which said, in effect, to get the debt deal, you have "to put in place policies for economic growth". Nobody disagrees with that. "Sustainable development and poverty reduction." Nobody disagrees with that. "Sound, accountable and transparent institutions and policies." Nobody disagrees with that. "Macroeconomic stability, the increased fiscal transparency essential to tackle corruption and boost private-sector development and attract investment, a credible legal framework; and the elimination of impediments to private investment, both domestic and foreign." That has probably been in every agreement we have ever had.

I would rather see specific attachment to public health outcomes so countries know what is needed, such as: "In five years, we want to make certain that 80 per cent of the population of girls has been educated."

The reason Keith is successful is because he had a group of people prepared to say: "OK, by this date you shall have treated this number of people and trained this number of physicians and, in turn, they will have trained this number."

That is what does not exist in most of these circumstances. We have no co-ordinating mechanisms and we have no real accountability by governments themselves.

Gareth Thomas I agree with part of what Robert has said about the need for specificity of outcomes, and much more tight language. We are beginning to say very clearly as donors, we need one Aids commission in a country that we all work behind, given the number of donors, and we need one monitoring and evaluation framework. That monitoring

and evaluation framework has to have clear outcomes that people can understand and should be used by all the donors, not just one or two.

Robert Mallett There has been one strategy for several years now and it has not happened.

Gareth Thomas Absolutely. For the past six months, the UK has been working the Americans and the French to get buy-in from the rest of the UN systems for those donors. In the end, it has to be a partnership between donors on the one hand and African governments on the other, and also the people of Africa helping to contribute to the outcomes they want.

Susana Edjang One nurse I know is a mother and also has responsibility for her nephews and nieces and the elders. I am talking at those levels. These people are working hard. They are trying to develop a community system or reach out to the health centres. They do not even have cars, so they cannot visit. They are willing, but they need help. Their circumstances are not as strong as those in the UK or in US.

Robert Mallett Absolutely. Paul started out by talking about the new solutions. He is right. Really, the new dynamic is the public/private partnership. At Pfizer, we recognise that what is lacking is a way to ensure people get appropriate training.

We have created, and are now trying to export that to other companies around the world, a means whereby we take our employees and send them to work, still on our payroll, in research centres in poor countries to train others. We think more companies ought to do that. It is like a private-sector

Peace Corps activity that seems to be working. It is nowhere near the level it ought to be, but if you have a good number of companies and academic institutions to do that, actually you begin to see you are making real progress.

Richard Dowden This seems like a good moment to move on from problems to solutions. We have all come across brilliant things in Africa on the ground, which do not get proper funding, do not get proper support, but they work brilliantly and are run by wonderfully talented people.

Gerry Bloom Paul focused on civil society. I think he said people are making rational choices in Kenya. I think the big question is not what do we do in 20 years, but the framework for the next two or three years. How does one work with people to build success and build a social contract that works, so that then people can be more ambitious?

There is a real issue about process and about what are achievable goals and what will win more public support.

It is remarkable that we are talking about large amounts of money for HIV Aids. There is a whole lot of debate internationally on whether it should be used for prevention or whatever. There is much less work on getting local debates on moral issues. Should someone pay for ARVs to treat themselves? Should they sell them so their children get educated? These are incredibly moral and difficult issues. They are not for economists. As Paul said, we need local solutions.

We have to look at how drug companies should move beyond their area. There are big issues in Africa about counterfeit drugs. People mostly buy drugs either from peddlers or from the public sector or whatever. Large increases in the flows of drugs have not been matched by large investments in information on how and when to use them.

We need to empower people to know more about what choices they are making and for health workers to be much more engaged in the discussions about what happens with the money and also, of course, what their responsibilities are.

Paul Boateng My experience over the years has been, that where you use targets as a means of improving and enhancing public service delivery, that you have got to achieve ownership of those targets. Stakeholders have to be involved in developing targets if they are going to deliver. The targets must come from Africa or they are doomed.

The two words that I think have to be the basis of our approach must be "enablement" and "empowerment". Empowerment for the private sector to see that, yes, it does have a role to play in developing partnerships; empowerment for government. If you have states that do not have resources, then those states are not going to be able to create the context in which markets can deliver.

If you do not deal with issues around basic infrastructure such as road, rail and air, then Customs & Excise cannot really deal with inflows of materials and drugs. Only a state can do that, but then it has to leave the economic players free to play. Empowerment and enablement terms apply also to those issues of human capacity and human capital and capital itself. It is the expertise to tackle this that we have seen drain out of Africa.

We have got to find a way in which we build up Africa's capacity. We know from the UK experience that without partnership with the private sector, you cannot succeed.

> Africa has always relied on people coming from the north to sort out its problems

Keith McAdam Can I just add one thing? That is respect for the decisions that are made. If the decisions do not fit with what was expected by the donors, that is OK. You have to respect local wisdom, rather than impose decisions.

Mohga Kamal Smith A couple of weeks ago, I was in Geneva with the World Health Assembly and there were all the ministers for health from all over the world. They were bombarded with initiatives. These countries have a limited number of human beings to run around from Geneva to Washington to Kampala and to London and take on these initiatives. That is really important here.

I have had the experience of running a vertical vaccination programme in the 1970s and 1980s and also a mother and childcare programme. Both failed because they were not built on a health systems that can deliver on all levels.

My final point is about sending health workers to Africa. When I was in Geneva, the Africans there were saying it takes half of their time to train these workers about their country, the system, the people, the culture and then they go.

We must take into account what people all around are saying and listen. Africa has always relied on people coming from the north to sort out its problems and it is not good.

Andrew Bone I have lived in Africa for eight years and in several countries. I have managed a partnership between De Beers and the World Health Organisation, helping them in their eradication of polio. De Beers was one of the first companies that provided ARVs for all its employees.

What I saw from that was a model that created a multilateral approach. I believe the result of it was that

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▶ you created sustainability through ownership and the objective, whether it was intended or not in the first place, was creating at micro-community level in the bush (Angola was at war when we were there) a demand culture, so it came back to government.

Julia Moffett I think one of the most critical factors is the role of the media. It is one of the more proven solutions in terms of its interventions in health and other development priorities. It can play a role both in education awareness and in behaviour change, which is obviously so critical to sustain more effective health systems. I think anyone who works in health information and communications now has huge lessons to draw on in terms of creating culturally appropriate, locally developed, research-based content.

It is smart distribution. It is constantly being aware of the trends and changes in media consumption and information consumption. Radio, as Richard said, continues to dominate.

There are new and changing technologies, as we know. The combination of all that in terms of solutions or directives means that one of the exciting things about the media piece of this, that the Commission for Africa report touched on, is that there is a role for every sector. In the funder/donor community, this needs to be seen as much more of a fundamental aspect to all of the health and educational investments and good governance initiatives, too.

Transformation of state broadcasts needs to be moved up the priority ladder. I think there is a huge role for the private health sector in recognising that free and independent media is a fundamental part of the informed economies in the mature democracies that you want to function within. The private health sector is recognising, as Pfizer has, that you get a much bigger bang for your buck if communications are linked to all of your interventions.

Leon Louw It is important to remember that Africa now has some of the highest-growth countries in the world. It is perfectly capable of prospering. I want to see my continent look like your continent, and we can get there.

There are three elements to be considered. One is poverty. The second is health, in the sense of people living healthy lives with balanced diets, nutrition and safe water and not living in huts that are polluted with fires and so on.

Finally, the actual healthcare system. In all of that, we need discussions about PPPs [public-private partnerships], setting targets and the checks and balances necessary to ensure that those targets mean something and check how they are actually to be met.

Corruption occurs in Africa, Indonesia or Latin America

because those countries do not have the rule of law and the checks and balances that you take for granted in the developed world, where corruption is rare or difficult. The solution is the sorts of checks and balances that you have.

We heard that the per capita expenditure figure in Africa is $13, whereas in the UK it is $2,000. We need to make sure that the limited resources are efficiently and effectively used. We need better systems because we are poorer. We need to achieve more health for less money. For that we need to mobilise the private sector, the informal sector and the public sector. All sectors need to work efficiently and effectively for the institutions of society. It includes the legal and political systems. We need to reward good behaviour. Governments are not corrupt if they have the proper institutions.

Andy Haines First is the crucial need for strengthening African institutions, not just in the health system but in institutions that will help capacity, by which I mean universities. In many countries, NGOs play an important role. Also increasing the capacity of governments to manage set priorities is necessary because many of them are weak and debilitated and their ability to do so has been lost. This needs to be driven from the south, but there is a role for the north.

Second, we know a lot about what to do in terms of interventions in the health sector. We know much less about how to do it. I would like to see more investment in research that will tell us how to overcome the barriers.

Third, I think there is a real challenge to the international architecture of aid co-ordination; whether the preoccupation of focusing on disease is the right way to go forward.

Fourth, we touched on migration. I think governments face an important challenge: 18,000 nurses from Zimbabwe have

gone to the north. It is a challenge that has to be faced by the NHS in the UK.

Fifth, we must look, as Julia said, at the media. I think that is a crucial missing factor. I think it is important for broader health education. Maybe it could be harnessed more specifically to capacity building.

Richard Dowden With regard to the migration issue, surely it is a matter of individual choice as to whether people want to come? Recruiting used to go on, yes. But a lack of opportunity in Africa, I think, is the message that we are getting now. I don't know whether you can turn the situation into a win/win situation so that individuals can come, we gain from their skills, and they are able to send money back. Then the African country is somehow compensated. I have discussed with Olu how you deal with people in this country who might like to return.

Reuben Olu Obaro When I came to this country originally, it never occurred to me that I would be staying for more than five years. My intention was to train as a radiologist and to go back home. In my home country, there is a huge gap in medical professionals because of migration. That gap needs to be filled as quickly as possible. We have to find a way of encouraging health professionals to stay in Africa. Of course, many people genuinely want to develop themselves intellectually and professionally.

The second aspect is economic. I appreciate the work that is being done on trying to wipe out debts, but a structure must be set up, including workshops in Nigeria, for example, where professionals can go when they leave the UK to train people in Africa. Many people would want to go home for three or six months, but have financial obligations in this country. We have our homes and families in this country. If we want to go to Africa, even if we take annual leave, we still have living costs to meet. Many people from Africa want to put something back into their society. We must create a structure that allows for training. Those professionals who are in this country must receive assistance to return to Africa, be it for three or six months. There must be a body in existence to assist them. That is the only way forward I can see.

Then there is the issue of health infrastructure. Perhaps the Pfizers and Glaxos could set up manufacturing industries in that part of the world. It would be cheaper to produce goods in Africa. Such industries would generate wealth.

Susana Edjang I agree with Olu that there must be a system to replace lost skills. I believe that links can do that. At the same time, people in Africa know what they want. When people decide to migrate, they face very different and difficult systems. Sometimes they come to the UK. If people do not find those circumstances sympathetic, they will move on to a place that is better; so the problem continues. The Commission for Africa should invest in human resources, in health workers, in managers for health workers, health institutions, education institutions; and that has to be co-ordinated.

Patricia Mwebaze As a health worker, I do not think the problem is really the fact that we do not have training. The problem is retention; how are we going to be retained as doctors or nurses or other allied health workers?

In our country, many times decisions are made without involving the health workers themselves. I think governments need to have senior people in these different areas and consult with them over what is happening. The government needs to find ways of actually motivating and retaining their health workers. And maybe we should not place too much emphasis on doctors and nurses alone. We can also involve community health workers.

I think patients are underestimated. Maybe they could be charged in a certain way so that they can pay, or they can bring a chicken or something, or have a trust run by the community itself. I am of the view that many of us health workers actually would want to stay in our country if things were better. I think governments should sit down with us and find out what they really must do in order to train us, retain us and sustain us as part of the health system.

> No funding can support disease-specific solutions. We have to have comprehensive healthcare

Keith McAdam I want to go back to disease-specific training funding. I must say the approach that Uganda is taking on disease-specific funding for Aids is very interesting. It is saying that no funding can support disease-specific solutions and it has to be comprehensive healthcare that is supported. It justifies that on the basis that HIV actually affects every part of the health system.

It is using an opportunistic approach to funding that is coming from elsewhere. If you say it loudly enough, even Aids-specific agencies will accept that. It is easy enough to argue the case that it will affect the entire health sector.

Another lesson I have learned from Uganda is that there is an annual national health assembly with representatives from all parts of every country. In the morning, there are

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questions from the communities around the country. In the afternoon, the government answers questions in batches.

It is quite impressive in terms of building up consensus about the requirements of that community.

I want to endorse your plea for communication support and press media, not only for training and for continuing medical training, but also in the context of data and records. Even in a city such as Kampala, people are shopping in four or five different clinics for the ARV drugs for their families. There are lots of interesting solutions through a focus on media. Local solutions are important ones. In Kwa-Zula Natal, songs and stories are used a great deal in plays and acting to get the message over.

Finally, the place of micro-finance to deal with poverty in clinical situations does seem a way forward. People may be poor, but they have a chance for training, even within the clinical setting. However, they lack the small amount of money needed to invest in their particular skill. An example is a bead project in Kampala, where HIV-positive women are using magazines sent to them. They pick a colourful page and roll it into a bead. You can fit a whole batch of beads in an envelope and send them to the US for $10 a string. That money all comes back to these women, who are now building their own clinics and building their own houses.

Richard Dowden The last thing I want to do is to go round everybody and say, if, next Thursday, you walked into the room and you have the eight old men sitting around, what would you say to them in 30 seconds? Michela?

> Just as UK university students have to repay their loans, African doctors should do their time

Michela Wrong I will be devil's advocate about retaining people in Africa. Maybe we should be thinking about obligation. Maybe the government should be funding tutorials and fees for African universities, and just as in the UK university students have to pay back their loans, so African doctors should have to do their time.

If people were to apply for a British visa and the British government has formed an agreement where there is no way that you, as a practising doctor, could leave the country until you had done your three years in a rural hospital or something like that, there would be the possibility that every time you want to renew your stay, you also have a little tax that you send back home to pay for someone else.

Reuben Olu Obaro But this particular problem that we are talking about needs something much more than that. We are talking about money being given to Africa, and what Africa needs is to structure a method where that money can be efficiently used.

Michela Wrong Yes, but this is self-perpetuating. You say how frustrating it is to work in an African hospital. It will always be frustrating if the best and the brightest leave.

Reuben Olu Obaro But it is not self-perpetuating if the hospitals have the equipment they need. We would need to develop a robust way of saying: "This hospital is lacking these facilities." Companies here sell equipment to Africa and refuse to maintain it – that needs to change. Having equipped these hospitals, we need to put people in there to train people to use the equipment.

Michela Wrong But there is also a question of aspirational motivation because, when I meet young Africans, it seems that they look to jobs in the west to prove that they have succeeded.

Reuben Olu Obaro There was a time when Nigeria had a training programme and, as part of that, people came out to the west and became an expert for one year, then went home so they had the combination of both African training and western training. However, the economy collapsed. That was taken out of the equation. We have to fill up that gap as quickly as possible.

Robert Mallett This is an example of where African countries ought to be creating "pull" mechanisms, to pull talent back home. We have to create the institutions that make these workers want to be there, so that being in a Nigerian institution is as great and important as being at Cambridge, Oxford or Harvard. That is what the responsibility is.

One of the big issues we have not talked about is that there is not a safe place to discuss the roles and the competencies of all of the private sector, or the different roles of civil society, governments and their responsibilities.

Instead, aided and abetted by the media often, we have this confrontational approach, that drug companies put profits before patients and they should make their drugs available.

I would love the opportunity to sit down and talk, to say: "OK, if you want to talk about making drugs accessible, here are some ideas we have. Here is what we ought to be doing. Let us see if we can play with those and see what kind of agreement and commonality of interest we can have."

What I sense much more strongly is that everyone here is for the public financing of healthcare systems. I have not heard much of an alternative, except from Leon.

Richard Dowden Can we just go round the room very quickly?

Mohga Kamal Smith My message is that we must not forget that we want these people to have some money to get out of poverty.

Richard Dowden So, drop the agricultural subsidies. Andrew?

Andrew Bone Well, on the one hand, they need to create a demand culture that will pull these things through. On the other, we should expect all sectors to create frameworks for co-operation and collaboration. One way to achieve both these aims is to use our approach, which is highlighted in our contribution to the Business Action for Africa project. This builds on the Commission for Africa and supports local businesses. This approach works right across society. It is also helping to sustain a robust free media that can address all of these problems.

Keith McAdam Imaginative public-private partnerships can work. They demand respect for local institutions and that respect is needed by all donors.

Andy Haines Support African institutions to develop and retain the human resources for health systems.

Michela Wrong Drop the subsidies so that Africans can finally help themselves.

Leon Louw My message to the G8 men in suits, in their smoke-free rooms, is that they should ensure that whatever they provide in the way of healthcare infrastructure in Africa comes along with the institutions that enable the healthcare to survive. Make sure that it is sustainable.

Julia Moffett They have to recognise that investment in media development and information and communication systems not only strengthens but protects your investment.

Robert Mallett I would ask them to make sure that the poverty-reduction strategy had specific, well-defined, visible public health and educational conditions attached, with timetables and a built-in process to ensure that we are achieving those objectives.

Susana Edjang We are dealing with global problems. I think we all have to work together.

Reuben Olu Obaro I want to see a robust programme that will enable professionals to go back to work in their countries on a long-term and short-term basis. Second, we need to help hospitals lure back health professionals with proper facilities. Third, the G8 must encourage multinationals to set up some outlets in Africa, first to manufacture drugs and second to help with the maintenance of equipment.

David Mabey I will try to persuade the G8 presidents that it is not charity, but it is in the world's self-interest. We simply cannot afford for things to be as bad as they are or as good as they are in other countries.

Gerry Bloom Commitments need to be long term and any solutions will take a long time so they should foster realistic expectations and realistic local solutions. They should involve health workers but other players too, both in discussing what is required of plans and obligations. We need much more than standard health education.

Richard Dowden Let me thank everybody very much for coming. I have learnt a fantastic amount today. I give you our host.

Spencer Neal Thank all of you for being here and for having made some fantastic contributions. Thanks to Richard for chairing a lively meeting.

Thank you.

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