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Achieving the health MDGs by 2015: What needs to be done from a civil society perspective

Report from the third Joint Retreat attended by
civil society representatives to:

**UNAIDS Programme Coordinating Board
Global Fund to Fight AIDS, Tuberculosis and Malaria**

UNITAID

GAVI Alliance

International Health Partnership and related initiatives (IHP+)

Millennium Foundation

Roll Back Malaria

Stop TB Partnership

Partnership for Maternal, Newborn and Child Health

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Acronyms and Abbreviations

ART =	antiretroviral treatment
CSO =	civil society organization
CSS =	community systems strengthening
Global Fund =	Global Fund to Fight AIDS, Tuberculosis and Malaria
HCSS =	health and community systems strengthening
HLTF =	High Level Taskforce on Innovative International Financing for Health Systems
HSS =	health systems strengthening
ICSS =	International Civil Society Support
ITN =	insecticide-treated net
IHP+ =	International Health Partnership and related initiatives
MNCH =	maternal, newborn and child health
MDG =	Millennium Development Goal
MDR-TB =	multidrug-resistant tuberculosis
NGO =	non-governmental organization
ODA =	official development assistance
PCB =	Programme Coordination Board (of UNAIDS)
PLHA =	people living with HIV and AIDS
PMNCH =	Partnership for Maternal, Newborn and Child Health
RBM =	Roll Back Malaria
SWAps =	sector-wide approaches
TB =	tuberculosis
UA =	universal access to HIV/AIDS prevention, treatment, care and support
UNAIDS =	Joint United Nations Programme on HIV/AIDS
WHO =	World Health Organization

Note on text: All figures marked in \$ are US dollar amounts.

1. Meeting Goals and Objectives

The primary goal of the joint civil society representatives retreats is to develop a more strategic approach to working together as civil society, with the aim of better influencing and shaping policies so that they are relevant and responsive to the needs of affected communities. The third retreat, held 19-21 May 2010 in Noordwijkerhout, The Netherlands, follows two others in September 2008 and September 2009.

The May 2010 meeting focused particularly on the Millennium Development Goals (MDGs) and the global review process culminating in the United Nations High-level Plenary Meeting on the MDGs in New York in September 2010. The aim is to contribute to that process from a civil society perspective and influence its outcomes to ensure renewed commitment to achieving the targets in 2015.

More than 40 people attended all or part of the Noordwijkerhout meeting. The majority of participants had current or recent responsibilities as civil society representatives from leading health-focused networks and initiatives including the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund); the Joint UN Programme on HIV/AIDS (UNAIDS); the GAVI Alliance; UNITAID; the Millennium Foundation; Roll Back Malaria (RBM); the Stop TB Partnership; the Partnership for Maternal, Newborn and Child Health (PMNCH); and the International Health Partnership and related initiatives (IHP+). Also in attendance were guest experts and support staff. (Appendix 2 contains a list of all meeting participants as well as other current civil society representatives who were unable to attend.)

Because specific and general health issues are participants' primary focus areas, discussion centred on the three MDGs most directly associated with health—numbers 4, 5 and 6. Participants also recognized, however, that their work has significant and important links with efforts to achieve all the other MDGs.

The May 2010 meeting prioritized work towards a joint advocacy strategy, including:

- developing a joint civil society representatives position on progress so far toward achieving the health MDGs, identifying gaps, and considering what needs to be done to ensure that targets are met by 2015; and
- exploring opportunities of engaging with and contributing to the MDG Civil Society Hearings in June 2010 and the High-Level Summit in September¹.

The meeting consisted of two main parts: a series of presentations followed by group work. The presentations provided essential background information and observations, including the following:

- overviews of key elements of the MDG review process (discussed in Section 2.1 of this report);
- analyses from experts regarding progress, existing gaps, and recommended advocacy priorities from a civil society perspective (Section 2.1); and
- summaries of civil society delegations' ongoing activities and priorities toward achieving individual MDGs and all the goals more broadly (Section 2.4).

The subsequent group work led to the most important outcomes—specific recommendations by civil society representatives focusing on the following five core

¹ [Additional information about the September UN summit on the MDGs is available at www.un.org/en/mdg/summit2010/.](http://www.un.org/en/mdg/summit2010/)

areas: health systems strengthening, maternal and child health (MDGs 4 and 5), and HIV/AIDS, malaria, and TB (MDG 6). These recommendations, discussed in Section 3, will be shared with allies and constituencies at national, regional and global levels. They are intended to be a useful part of a coordinated, joint civil society advocacy effort aimed at improving and sustaining progress toward achieving the MDGs.

2. Progress Updates and Background Information

The first part of the Noordwijkerhout meeting consisted of more than 20 presentations that provided useful background information. Brief summaries are provided under three broad categories:

- **Section 2.1:** Updates and observations regarding progress toward achieving the MDGs and, more generally, improving access to vital health services in the developing world. This section includes perspectives and analyses from experts regarding “where we are” in terms of working toward and achieving the MDGs.
- **Section 2.2:** Overview of the ongoing Global Fund replenishment campaign efforts, an overarching priority for all meeting participants and most global health advocates.
- **Section 2.3:** Overview of the resource and financing needs for several leading global health issues, including those prioritized in MDGs 4, 5 and 6. Also discussed are issues related to domestic financing for health in Africa.
- **Section 2.4:** Updates and information-sharing from civil society delegations. The summaries discuss overall priorities—for both the delegations and the organizations they are representatives to as a whole—as well as priorities specifically related to one or more of the MDGs.

The summaries below are by no means comprehensive; in nearly all cases, they cover only a selected few issues, data points and priorities mentioned. Presentations, many of which are detailed and relatively lengthy, may be found online at www.icssupport.org.

2.1 Achieving the MDGs and improving access to health services: Progress and shortcomings

Section 2.1 summarizes presentations and observations regarding progress toward achieving the MDGs and, more generally, improving access to vital health services in the developing world. It discusses information from sources ranging from the United Nations Secretary-General’s Office to several global advocacy networks that focus on specific health issues (e.g., malaria control). One part, Section 2.1.2, includes overviews of access to critical services for those living with and affected by health issues mentioned specifically in the MDGs, such as HIV, TB, malaria and maternal and child health.

2.1.1 UN Secretary-General’s recent report on progress toward MDGs

A report released early 2010 by the UN Secretary-General’s Office contains an official, up-to-date overview of progress towards achieving the MDGs. The report, “Keeping the

promise: A forward-looking review to promote an agreed action agenda to achieve the Millennium Development Goals by 2015", is available on the UN's website².

As summarized by presenters at the Noordwijkerhout meeting, the report's overall conclusion is that progress has been uneven, and that without additional effort several MDGs are likely to be missed in many countries. Among the most significant shortcomings to date is that hunger is increasing and remains a major global challenge. An estimated 1 billion people, nearly one-sixth of the world's people, were hungry in 2009. That is the highest level ever. Also of note is the relative lack of progress in reducing maternal and child mortality, which means that many countries are unlikely to meet their targets for MDGs 4 and 5 by 2015. Poor performance in those areas was noted despite the fact that increased access to antiretroviral treatment (ART) has helped reduce deaths among women and children.

The report places most blame for the uneven progress squarely on the lack of resources and political will—i.e., the refusal to make the MDGs a high enough priority—in both recipient and donor countries. An influential trend has been a recent decline in levels of official development assistance (ODA) in the wake of the global financial crisis. ODA reached its highest level ever in 2008, but has since fallen. Less than half of countries in the Organization for Economic Cooperation and Development (OECD) have met the target of annually providing 0.15 percent to 0.20 percent of their gross domestic product for aid to the world's least developed countries. The consequences are especially dire for countries and people living in Africa, where the development needs are greatest. Wealthy countries have provided less than half of the development aid promised at the G8 Gleneagles summit in 2005, for example.

The Secretary-General's report includes several proposed recommendations for the "way forward" to accelerate progress towards the MDGs. Potentially useful and effective priorities include i) scaling up implementation of proven and innovative interventions in key domains; ii) ensuring sufficient, predictable, and well-coordinated financing for development, including from national budgets, ODA, philanthropy, debt relief and new financing instruments (e.g., new, dedicated taxes on financial transactions); and iii) expanding the global partnership to support the MDG agenda.

And finally, the report also reinforced the fact that the MDGs can and must also be viewed as interconnected. The following are among the numerous examples of such interconnectedness from various other sources:

- A report from Oxfam estimated that in 2006, perhaps 20 percent of the agricultural workforce in southern Africa was "claimed" to AIDS. Thus HIV (addressed directly in MDG 6) is a direct cause of food security challenges (addressed in MDG 1) because sickness and death associated with HIV reduce individuals' and families' ability to cultivate land and work.
- Reports from RBM and other sources note that the use of insecticide-treated nets (ITNs) can reduce malarial illness in pregnant women and young children by up to 50 percent. That impact underscores the direct link between malaria control (MDG 6) and MDGs 4 and 5 (maternal and child health).
- A recent GAVI Alliance assessment concluded that 5.4 million future deaths have been averted due to GAVI investments over the past decade. The majority are associated with increased uptake of hepatitis B vaccinations; a full 2 million or so, however, are more clearly related to immunizing infants and young children

² See www.un.org/ga/search/view_doc.asp?symbol=A/64/665.

against illnesses that often strike and kill the youngest and most vulnerable of society.

2.1.2 Other observations and data regarding access to vital health services

This sub-section summarizes key issues and developments regarding the following specific global health priority areas: HIV/AIDS, malaria and TB (MDG 6), maternal and child health (MDGs 4 and 5), and health systems strengthening (HSS). Observations regarding each of these five areas follow below:

HIV/AIDS³

The rapid scale-up of HIV/AIDS services is one of the biggest casualties of the global financial crisis. Many donors have not only stopped increasing their annual budget support for HIV/AIDS programming, but have implemented or announced actual cutbacks. As a result they have stepped back from their commitment to provide universal access (UA) to HIV prevention, treatment, care and support services to all in need by 2010. Few implementing countries, none of them high-burden, are expected to meet their targets set as part of the global UA drive. The impact is already stark: only about 40 percent of those in need of treatment around the world are currently receiving it, and that share is expected to fall sharply as countries implement new WHO HIV treatment guidelines.

More specific details will be available at the conclusion of the ongoing UA review process. As specified by the UNGASS⁴ reporting framework, reviews must be nationally owned and led. The aim of the UA reviews is to provide an opportunity for stakeholders—including civil society—to take stock of steps towards national targets, identify current obstacles and decide together about what needs to be done now in order to achieve UA and, ultimately, MDG 6. The outputs will be captured in short aides-mémoire, which will then ideally be used to integrate gaps into new and revised national strategic plans on HIV and AIDS.

The UA review process will continue through 2011. In addition to seeking to participate and influence the process at the national level, the civil society sector could also have a potentially useful impact on rejuvenating the UA drive at global forums such as G20 and African Union meetings over the next 18 months. Several global campaigns have already been launched with similar goals in mind. For example, the International AIDS Society (IAS) is supporting a Universal Access Now campaign⁵ that, among other objectives, is focusing on i) ensuring that the 2010 Global Fund replenishment achieves maximum success, and ii) holding countries accountable to their development assistance commitments at G8 and G20 summits.

As part of their efforts, the IAS and other advocates are raising awareness of the growing body of evidence showing that HIV treatment has a preventive effect at all levels. By emphasizing the health impacts and cost-effectiveness of “treatment as prevention”, they hope to reverse recent trends away from supporting vertical HIV/AIDS programmes that underpinned the initial success in the UA drive.

³ Most of the information is based on presentations by representatives from UNAIDS and the International AIDS Society.

⁴ This acronym refers to the UN General Assembly Special Session on HIV/AIDS. The first UNGASS meeting was convened in 2001.

⁵ See www.iasociety.org/Default.aspx?pageId=401.

Malaria⁶

Two overall goals of the Global Malaria Action Plan—to achieve universal malaria control coverage by the end of 2010 and to eliminate malaria as a public health problem by 2015—will almost certainly not be met if the current funding and support climate persists. For example, although nearly 200 million insecticide-treated nets (ITNs) have been distributed and are in use, that represents less than two thirds of the estimated current need. Also, access to effective treatment lags in many parts of the world because of difficulties with procuring the most effective regimen (ACT, or artemisinin-combination therapies), the proliferation of fake drugs, and the persistent use of less effective and resistance-enhancing monotherapies. Malaria control advocates also acknowledge that treatment targets in some countries do not adequately reflect the real needs and limitations. For example, although 28 countries have reported that they might meet their ACT coverage targets, the achievement is of questionable value because the numbers and data refer only to the public sector. In many high-burden malaria countries, especially in Africa, most people (as high as 80 percent or more) get treatment through the private sector.

In addition to ITNs and effective treatment, the other two main pillars of malaria control are indoor residual spraying with insecticide and access to diagnostics. Scale-up of these interventions has also slowed in recent years.

Tuberculosis⁷

Led by the Stop TB Partnership, advocates are using the Global Plan to Stop TB 2006-2015 as a framework for activities and indicators at global and national levels. One major target in the plan includes detecting 84 percent of smear-positive cases by 2015 and successfully treating 87 percent of them. Recent data indicate that the second part of that goal has technically been met, but the overall impact of that achievement is limited due to two important caveats. For one, the overall target is set at the global level, and some regions (e.g., Africa, the Americas and Europe) are lagging significantly. Second, treatment success rates are based only on data regarding people who have actually initiated TB treatment. The success rates therefore cannot take into account gaps in case detection because TB cases that have not been detected are not treated. Such gaps remain a concern, with the most recent data indicating a global case detection rate of just 61 percent, a full 10 percentage points lower than the 71 percent target.

Efforts to reach targets set regarding two other high-priority areas—TB/HIV interventions and responding to multidrug-resistant TB (MDR-TB)—have also stalled. The accelerating growth of MDR-TB around the world represents a particularly difficult challenge. Currently, only about 7 percent of global cases of MDR-TB are detected, and just 3 percent of patients have access to treatment. The MDR-TB epidemic also directly influences treatment success rates and funding needs and expectations. Treating patients with drug-resistant strains is not only complicated and less successful on average, but costs up to 20 times more per person. Taken together, all of these serious obstacles are the main reason progress toward achieving the global TB targets are far behind in 27 high MDR-TB burden countries in particular.

MDGs 4 and 5

Estimates of progress toward achieving MDGs 4 and 5 (which address child and maternal health, respectively) are included in a report released in mid-June 2010 by Countdown to

⁶ Most of the information is based on presentations by representatives from Roll Back Malaria (RBM).

⁷ Most of the information is based on presentations by representatives from the KNCV Tuberculosis Foundation and the Stop TB Partnership.

2015⁸, an international initiative that advocates for and monitors coverage of effective interventions to reduce maternal and child mortality. The comprehensive report focuses on coverage levels in 68 “high mortality” countries monitored by the initiative.

The overall conclusion is that although some regions and countries are showing progress, others are failing to do so and even seem to be moving backwards. The majority of those nations are in South Asia and sub-Saharan Africa. The following are among the notable findings of the report:

- Uneven quality of care persists. For example, the percentage of individuals with access to various treatments and immunizations is nearly universal in some places, but virtually zero in Haiti.
- Nutrition indicators remain dire in several countries. Two thirds of the world’s stunted children live in just 10 of the countries surveyed.
- The report identifies a total of 57 “critical shortage countries”—i.e., those that do not have the minimum level of staff recommended to provide services required to reach coverage and mortality reduction targets. These countries lack access to skilled and motivated health workers at all levels, including doctors, wives and midwives. The report found a clear overlap among countries lagging behind reaching the MDGs and those with critical health worker shortages.

Representatives from the GAVI Alliance also stressed the relative lack of attention to health problems of specific relevance to maternal and child health. For example, 40 percent of all deaths of under-five-year olds in low-income diseases are attributable to pneumonia (22 percent) or diarrhoea (18 percent). Pneumococcal and rotaviral vaccines are available to help prevent most of these deaths, but overall immunization coverage in developing countries continues to lag. Coverage rates in those nations have climbed to 79 percent in the past 15 years, but that level remains far below the 95 percent rates across developed countries.

Health systems strengthening (HSS)

The HSS concept has received substantial attention and interest in recent years, but little consensus exists as to exactly what is meant by “health systems strengthening”. WHO’s six “building blocks” for HSS are often used to conceptualize it. The six are as follows: i) health workforce; ii) supply, distribution and maintenance systems; iii) management and organization; iv) leadership and governance; v) financing system; and vi) information and monitoring.

Several global initiatives and proposed mechanisms have been launched in recent years to help increase funding and support for HSS at country level. They include the International Health Partnership and related initiatives (IHP+); the Joint Assessment of National Strategies (JANS) process and tool, originally developed by an IHP+ working group; the Global Fund’s National Strategy Applications (NSAs); and the joint Health Systems Funding Platform, an initiative including the Global Fund, GAVI, the World Bank, and WHO.

These initiatives differ in regards to existing or proposed structures and specific indicators, outcomes and expectations vis-à-vis recipient countries. All, though, share the same broad objective: to streamline development assistance delivery and

⁸ The Countdown to 2015 report was embargoed at the time of the Noordwijkerhout meeting, in May 2010. Its findings were nonetheless presented, albeit with the request that they not be discussed with anyone outside of the meeting until after the report was formally released in June 2010. The report can now be found at www.countdown2015mnch.org/reports-publications/2010-report/2010-report-downloads.

implementation by coordinating donors and basing decisions on a clear, defined national health strategy. The ultimate goals are to better align development systems and processes to reduce transaction costs and waste; integrate services across a continuum of care; and increase efficiency at all levels, and among all stakeholders.

The different initiatives are at varying stages of development and implementation, although all are relatively new and with the exception of the IHP+ are currently only in pilot stages. It is therefore difficult to evaluate their impact and usefulness. Supporters are optimistic that such initiatives will help direct funding and other resources for HSS activities, including building the capacity and size of national health workforces. In their view, impacts of that sort will greatly improve countries' ability to achieve all health MDGs over time.

Studies in recent years highlight the extent of the current health worker shortage in much of the developing world and make it clear that it is the most pressing HSS-related priority. A WHO study from 2006 concluded that the global shortage had reached as high as 4.3 million workers, while a joint WHO-HLTF study from three years later estimated a shortage of about 3.5 million people (including 2.5 million professionals and 1 million community health workers). Comparisons between studies are difficult because they use different methodologies and cover different numbers of countries. However, the overall message from these two studies and another oft-cited one from the World Bank is that the shortages are critical in much of the developing world.

Governments and other stakeholders are seeking ways to address the problem. In March 2008, for example, a gathering of donor and implementing countries agreed on an agenda—the Kampala Declaration and Agenda for Action—that highlighted six key strategies to address the global health workforce crisis⁹. All depend on additional (and sustainable) funding, however, and for the most part extra targeted funding has not yet been made available or committed either externally or domestically.

2.1.3 Review process leading to September 2010 UN summit on MDGs

The most important upcoming MDG-related event for advocates and policymakers alike is the High-Level Plenary Meeting of the UN General Assembly, better known as the MDG summit, to be held 20-22 September 2010 in New York. The main objective of the meeting is to focus on accelerating progress towards the achievement of all the MDGs by 2015; through a comprehensive review process, participants will take into account the progress made with regard to the internationally agreed development goals. Discussions leading up to and during the summit will be based in part on the information and observations contained in the "Keeping the Promise" report released early 2010 by the Secretary-General's Office (and summarized in Section 2.1.1).

The September review will include six plenaries and six interactive roundtables, each of which will have at least 50 seats and be co-chaired by two heads of state of government. Of particular importance to participants at the May 2010 Noordwijkerhout gathering are

⁹ The six strategies are: i) building coherent national and global leadership; ii) scaling up education and training; iii) managing pressures of the international health workforce market and its impact on migration; iv) retaining an effective, responsive and equitably distributed health workforce; v) securing additional and more productive investment in the health workforce; and vi) ensuring capacity for an informed response based on evidence and joint learning. Additional information about the Kampala Declaration and Agenda for Action may be found at www.who.int/workforcealliance/forum/2_declaration_final.pdf.

roundtable 2 (on meeting the goals of health and education) and roundtable 5 (addressing the special needs of the most vulnerable). Summaries of all roundtables will be overseen directly by chairpersons.

UN personnel have not yet finalized the structure and invitation lists. However, representatives from the civil society sector will have the opportunity to be involved in all official and formal processes at the summit, including through participation on the roundtables.

More targeted and specific civil society advocacy opportunities were available at a series of pre-summit UN hearings in New York on 14-15 June 2010. Officially titled General Assembly Hearings with NGOs, Civil Society and the Private Sector, the gatherings provided representatives from the civil society sector the chance to raise issues of concern with officials and policymakers from UN member states. The official summary of the meeting will serve as an input into the inter-governmental negotiating process for the September MDG summit.

In the lead-up to the MDG summit in September, negotiations are already starting over the "outcome document". The Secretary-General's recent report on progress (discussed in Section 2.2.1) is being used as guidance for that document. Although the outcome document had not been finalized by the time the Noordwijkerhout meeting took place, it was clear that a main objective would be to convey a sense of urgency for scaling up actions to achieve the MDGs by 2015. It is also expected to focus on the need to highlight and ensure interconnectedness among all the MDGs¹⁰.

2.2 Overarching priority for all participants: Global Fund replenishment campaigning efforts

As noted in several places in Section 3, the ongoing Global Fund replenishment campaign efforts are an overarching priority among all participants. Most agree that it will be extremely difficult if not impossible to meet the health MDGs if donors are not willing to support the Global Fund adequately over the next three years. A poor or limited replenishment would also negatively affect efforts to achieve all other MDGs to varying extent, given the interconnectedness of the development objectives outlined throughout them.

Donors are expected to announce their Global Fund commitments for the years 2011 through 2013 at a meeting in October 2010. The campaign and associated advocacy will therefore be closely linked with activities related to the MDG review summit in New York a few weeks earlier (in September).

The Global Fund has described three resource scenarios as the replenishment campaign moves forward. They include the following:

¹⁰ The "zero draft" of the outcome document for the September 2010 MDG summit was presented by the co-facilitators, the ambassadors of Senegal and Denmark, on 7 June 2010 (after the Noordwijkerhout meeting). The text of the "zero draft", which UN Member States began reviewing shortly after it was presented, can be found at www.un-ngls.org/spip.php?page=amdq10&id_article=2476.

- Scenario 1 (a total of \$13 billion in replenishment support) would allow for the continuation of funding of existing programs. However, new programs could only be funded at a significantly lower level than in recent years.
- Scenario 2 (\$17 billion) would allow for the continuation of funding of existing programs. In addition, it would allow for funding of new proposals at a level that comes close to that of recent years.
- Scenario 3 (\$20 billion) would allow for the continuation of funding of existing programs. In addition, well-performing programs could be scaled up significantly, allowing for more rapid progress towards achievement of the health-related MDGs.

Based on the projections associated with each scenario, the Global Fund and advocates agree that \$20 billion is the minimum amount that donors should pledge. They are pessimistic because donors have signalled that they will provide far less; however, many also believe that effective advocacy regarding the MDGs over the next few months could help increase the odds in their favour.

Several advocates acknowledged that they will need to redouble their efforts even if their replenishment expectations are exceeded. Their reasoning is based on the fact that the following important advocacy priorities and developments are missing from all resource scenarios:

- the costs of diagnosis and treatment of MDR-TB;
- the cost of implementing the newly published WHO guidelines in malaria;
- the cost of implementing the new WHO treatment guidelines for ART, which implies 50 percent more people on treatment, and the use of improved (but more costly) first-line regimens and higher levels of second-line treatment; and
- the cost of keeping mothers alive so that they can look after their children and their families.

Maternal, newborn and child health (MNCH) advocates are concerned, for example, that failure to provide in excess of \$20 billion in the ongoing replenishment effort would limit the Global Fund's ability to adequately raise awareness about and support activities related to Decision Point Decision Point GF/B21/DP20 (Exploring Options for Optimizing Synergies with Maternal and Child Health). Through that decision the Board strongly encouraged countries and partners to explore ways to scale-up investments in maternal and child health in the context of the Global Fund's core mandate.

As the replenishment campaign intensifies, the Global Fund and its allies are trying to raise awareness about its important health impacts among policymakers, the media, and all other potentially influential stakeholders. According to data collected by the Global Fund, its programmes are responsible for saving an estimated 4,000 lives a day (e.g., by supporting HIV treatment access) and preventing thousands of new infections. Its malaria initiatives have helped several countries, including four high-endemic and five low-endemic African ones, achieve a 50 percent reduction in malaria cases in 2008 compared with 2000. The Global Fund itself also contributes directly to evidence-based arguments that disease-specific programming—in its case, investments to combat HIV, TB and malaria—contribute directly to progress regarding not only MDG 6 but also MDGs 4,5 and 8. More broadly, its programming contributes indirectly (yet also importantly) to efforts to achieve all other MDGs.

2.3 Financing and funding for health: Where we are, and what needs to be done

Section 2.3.1 summarizes the resource and financing needs for several leading global health issues, including those prioritized in MDGs 4, 5 and 6. Section 2.3.2 focuses on domestic financing for health in Africa.

2.3.1 International financing for health: Estimated needs and current gaps

No one disagrees that the amount provided or pledged for international financing for health is far less than what is needed. The size of the amount differs and fluctuates, however, because different institutions use different estimates and methodologies when compiling estimates and it is unclear where there is any overlap. With that caveat in mind, the following financing estimates and gaps were identified at the May 2010 meeting:

- **HIV/AIDS:** An investment of \$25 billion is needed for the global AIDS response in 2010 for low- and middle-income countries (132 nations total). That amount, which is based on country-defined targets to reach universal access to HIV prevention, treatment, care and support by 2010, is \$11.3 billion more than is available today.
- **TB:** An estimated \$44.3 billion will be needed for investment at country level over the next 10 years. Only about \$21.8 billion is currently estimated to be available, thereby creating a total funding gap of \$22.5 billion (or \$2.25 billion a year). (Note: Many observers agree that the total amount needed is actually much higher now because of the recent surge in MDR-TB.)
- **Malaria:** A total annual investment of about \$5 billion to \$6 billion is needed, an amount about four times higher than what is currently provided.
- **Family planning and maternal and newborn health:** To meet existing needs in developing countries, the total estimated global cost of investing in modern family planning and maternal and newborn health services would be about \$24.6 billion annually. Based on that number, the current financing gap stands at about \$12.8 billion.
- **Child health:** According to data from the 36 countries with the highest burden of undernutrition, an estimated \$11.8 billion more is needed annually to provide a minimal package of 13 proven nutrition interventions to all children in need. (Such interventions would include vitamins, deworming medicines, fortified foods, etc.)
- **HSS activities:** Based on WHO's six "building blocks" for health provision, as much as \$76 billion annually could be needed for HSS activities and interventions in 49 low-income countries. That amount would include training new healthcare workers and retention and rural placement, although it would not include retraining and some other services.

Taken together, these estimates indicate that the annual cost to provide high-quality, comprehensive services in these areas totals between \$138 billion and \$148 billion. The annual funding gap for such key health interventions stands at between \$77 billion and

\$87 billion. As high as these numbers are, most observers agree that they are far from complete because they cover only selected conditions and concerns. No estimates are readily available for important and serious health issues such as neglected tropical diseases and mental health problems, for example.

2.3.2 Domestic financing for health in Africa

The health needs and gaps are greatest in Africa, a situation that has long been clear. Sub-Saharan Africa, for example, accounts for about 24 percent of the global disease burden yet has a far smaller share of the world's overall population. Average life expectancy in that region is 38.7 years, compared to between 66.1 and 72 years for more developed countries.

Similar gaps are evident when comparing health spending. In 2004, for example, the world spent more than \$4.1 trillion on health; developing countries, however, spent only 12 percent of that amount (roughly \$480 billion), even though they accounted for 84 percent of the global population and over 90 percent of the global disease burden.

Many advocates, led by those in Africa, believe that one of the main problems is that national governments in Africa refuse or are reluctant to do better. In their view, national government spending on health is far too low both in terms of total amounts and per capita. They note, for example, that only 6 of 54 countries have ever met the 2001 Abuja Declaration commitments, in which African countries agreed to allocate at least 15 percent of their annual budgets to health. As many advocates note, African governments even allocate far less per capita than their counterparts in Europe and North America. As a result, in many African countries up to 80 percent or more of all health spending is out-of-pocket.

There are numerous reasons given for such weak and limited commitment. Some local observers and advocates argue that weak absorption and managerial capacity in national health ministries and other essential governmental entities are a main challenge. Other obstacles frequently cited are lack of political will, corruption, and distaste for continued reliance on external development support. Regardless of the reasons, a growing number of African advocates are impatient with their governments' poor performance regarding health and are seeking change. Some say, for example, that they are reluctant to continue seeking external support when their own governments are unwilling to provide a "fair share" for their own citizens.

2.4 Presentations from and about civil society delegations

This section provides brief summaries of presentations by civil society delegations from various global initiatives and networks at the Noordwijkerhout meeting. Most focus primarily on overall priorities—for both the delegations and the organizations they are representatives to as a whole—as well as priorities specifically related to one or more of the MDGs. The goal was to update fellow advocates and share information.

UNITAID

Highlights from the past year include the Board approving the establishment of a patent pool, a highly anticipated development that could increase development of and access to lower-priced medicines to treat HIV, TB, malaria and other conditions. The initiative is

now working to make the patent pool functional, which will include selling the idea to pharmaceutical companies and other potential partners and getting them to participate. Another important development was the launch of the MassiveGood campaign¹¹ in the United States in early 2010. That campaign, which provides air ticket customers the option to donate, is a form of voluntary solidarity contribution put in place by the Millennium Foundation to raise funds to help support UNITAID. Similar projects are currently being developed in other countries.

Roll Back Malaria (RBM)

The main RBM priorities in 2010 are i) keeping malaria high on the agenda; ii) ensuring future funding; iii) making the money work for effective implementation; and iv) ensuring quality reporting on country progress. Advocacy efforts are focusing particularly on the 2010 Global Fund replenishment campaign, the success of which is considered especially crucial because the Global Fund provides about 57 percent of all international funding for malaria control and treatment. As part of its messaging in the run up to the September 2010 MDG review summit, RBM is also stressing the importance of promoting an integrated approach among MDGs 4, 5 and 6 to ultimately strengthen health systems. The RBM civil society delegation is also seeking to develop and exploit joint advocacy opportunities around the FIFA World Cup in South Africa in June and July (the United Against Malaria campaign); the July African Union summit; and a series of progress and impact reports on malaria control.

The Affordable Medicines Facility for Malaria (AMFm) initiative is another RBM campaign that the civil society delegation is prioritizing. Launched in April 2009, it seeks to reduce the price of effective malaria drugs and to drive older, ineffective drugs and monotherapies out of the market. It is focusing particularly on reducing prices in the private sector, where most people continue to get malaria medicines in the majority of high-burden countries.

Stop TB Partnership

A major ongoing priority of the partnership in general and its civil society delegation is the global MDR-TB epidemic. The partnership is also focusing on implementing new guidelines to treat TB/HIV co-infection, and ensuring that funding is available to put the guidelines into place. (The new global guidelines recommend that patients with active TB be tested for HIV and, if HIV-positive, be started on ART immediately.) As part of this effort, the partnership is prioritizing the global introduction of HIV testing as a standard TB diagnostic practice.

IHP+ and other global initiatives and mechanisms aimed at streamlining development assistance

As of May 2010, a total of 21 countries had signed up to the IHP+ initiative. One initiative-wide priority over the rest of the year will be to increase that overall number and, ideally, get one or both of two important potential donor countries (the United States and Japan) to become a formal signatory.

Key priority areas of the Northern civil society delegation include monitoring sub-grants to ensure that members of the sector are involved meaningfully; disseminating more information to country-level civil society organizations (CSOs) in advance of discussions related to the Joint Assessment of National Strategies (JANS) initiative; and monitoring the progress of the recently proposed joint Health Systems Funding Platform involving

¹¹ More information about the MassiveGood campaign is available at www.massivegood.org/en_US/.

the Global Fund, the GAVI Alliance, the World Bank, and WHO. Members of the civil society delegation are especially interested in evaluating the perceived and/or potential impact that the platform, which is currently being piloted in a handful of countries, might have on achieving the health MDGs and the extent of civil society engagement. The involvement of the World Bank is of particular concern given the bank's usual reluctance or refusal to interact closely with civil society when developing and implementing programmes at all levels.

The Southern civil society delegation, meanwhile, is also focusing on strengthening the capacity of Southern CSOs on the IHP+ and other HSS-related activities. Planned activities include creating a Southern communications hub and mapping health-focused CSOs in IHP+ countries.

UNAIDS PCB NGO Delegation

The most recent PCB report to the UNAIDS Board focused on stigma and discrimination, an issue that is also considered extremely important by the NGO delegation. Other priorities of the delegation include i) keeping universal access commitments (vis-à-vis HIV/AIDS) on the agenda as the focus within UNAIDS and elsewhere moves to the MDGs; and ii) increasing capacity to communicate with, collect data, monitor progress and expand reach to key affected populations whose invisibility leads to lack of access.

Global Fund Communities Delegation

The delegation's mission is to bring the voices and issues of people living with HIV/AIDS, TB and affected by malaria to the deliberations of the Global Fund Board and its committees, and through this ensure greater and sustained impact of the Global Fund at the community level. Its main current priority issue is the Global Fund replenishment, which it is seeking to influence by encouraging individuals and organizations in recipient countries to send letters and use other means to alert donors to the importance of the Fund's programming.

Global Fund Developing Countries NGO Delegation

Recent activities have included activities designed to increase participation from all regions and to improve communications among constituencies. Current and future priorities include seeking to ensure that Country Coordination Mechanisms (CCMs) function better (including the more meaningful involvement of civil society on CCMs); increasing the utilization of dual-track financing structures; and community systems strengthening (CSS). A notable area of concern is the belief that CSOs are most significantly (and thus negatively) impacted by the 10 percent across-the-board cut recently mandated by the Global Fund Board.

Global Fund Developed Countries NGO Delegation

The delegation shares several key priorities with other civil society-related delegations, including i) a successful Global Fund replenishment; ii) maintaining a demand-driving model (i.e., one in which all quality proposals approved by Global Fund's Technical Review Panel are funded); and iii) maintaining and strengthening civil society roles in all Global Fund processes.

The third priority is considered vital for two reasons. For one, the Global Fund is actively seeking to expand funding for activities associated with HSS and community systems strengthening (CSS); and second, the recent focus and attention on new development "streamlining" initiatives such as the IHP+ and Health Systems Funding Platform is already having a significant impact on Global Fund decision-making and programming. It

is essential that civil society delegations seek to maintain and expand meaningful civil society engagement as these developments roll out.

GAVI Alliance

Representatives from the GAVI Alliance stressed the important role played by civil society in their efforts to improve immunization and child survival. CSOs help the initiative's programmes reach places and regions where government infrastructure is sub-optimal, for example, and help strengthen health systems to deliver vaccines and other child health packages through activities such as monitoring.

Among the priorities of the GAVI civil society delegation are a second board seat for civil society; a change in rules to allow direct funding of CSOs (currently GAVI supports health ministries only); and, along with the alliance as a whole, additional donor pledges to cover current and expected funding shortfalls. In the meanwhile, the Board has signalled its interest in civil society objectives by agreeing to support the participation of two civil society representatives to important meetings leading up to the MDG review in September 2010. It also has agreed to support a half-time (i.e., six months salary for) a communications focal point for the civil society delegation.

Partnership for Maternal, Newborn and Child Health (PMNCH) (p. 17)

Unlike the Global Fund and GAVI Alliance, PMNCH does not provide funding. Instead, it serves as a collaborative entity comprising all stakeholders, from government to civil society, seeking to improve maternal, newborn and child health and achieve MDGs 4 and 5. Priority activities from 2009 through 2011 include developing a MNCH knowledge management system (i.e., more extensive website and information-sharing database); defining a core package of MNCH interventions; strengthening human resources for MNCH; strengthening an integrated approach to MNCH commodities; advocacy for increased funding and stronger policy commitments to MNCH; and tracking progress and commitment for MNCH.

MNCH advocates support the Global Fund and other initiatives that provide disease-specific funding and programming. Most agree, however, that although funding for HIV, TB, malaria and other diseases contributes to improved maternal, newborn and child health, they are not sufficient on their own. That is because many important MNCH issues and priorities cannot be, and thus are not, addressed under those specific funding programs. For example, Global Fund programmes do not provide funding or support for general family planning activities and projects, or for emergency obstetric care, which is essential for the reduction of maternal mortality.

3. Priority Action Steps and Recommendations

The presentations and discussions outlined in Section 2 laid the groundwork for the most important outcomes of the Noordwijkerhout meeting—specific priority action steps and recommendations by civil society representatives. These recommendations will be shared with allies and constituencies at national, regional and global levels. They are intended to be a useful part of a coordinated, joint civil society advocacy effort aimed at improving and sustaining progress toward achieving the MDGs.

The recommendations were developed by five separate working groups. They focus on the following priority health issues:

- health and community systems strengthening (Section 3.1)
- maternal and child health (MDGs 4 and 5) (Section 3.2)
- HIV/AIDS (Section 3.3)
- tuberculosis (Section 3.4)
- malaria (Section 3.5)

Only the final set of recommendations is presented below. Occasional overlap occurs because of the inherent linkages among all health MDGs, as noted in Section 2. Participants also acknowledged the shared messages that will drive all of their advocacy work prior to and after the MDG summit. Among the key messages are:

- integrated service delivery is critical—and requires investments in health systems;
- support should be provided for evidence-based interventions delivered through proven mechanisms; and
- we know what to do and what works—the demand and knowledge exist, but the resources are missing.

3.1 Recommendations regarding health and community systems strengthening

Overview

The achievement of the health-related MDGs is dependent on functional, efficient, equitable and well-resourced health and community systems. However, current health financing infrastructure impedes this as a result of:

- macroeconomic policies and donor conditionalities,
- lack of transparency and duplication of efforts,
- lack of political will, and
- lack of financial commitments from developing countries.

Overcoming these challenges is critical to achieving progress towards the health-related MDGs. One of the ways in which donors and developing country governments can demonstrate their commitment to overcoming these challenges is by increasing investment in health and community systems strengthening to ensure that the health-related MDGs can be addressed in a way that maximises their interconnectedness and their synergies. The recommendations in this section aim to achieve this.

Defining Community Systems Strengthening

Communities consist of people who are connected to each other in distinct and varied ways – ‘community’ has no single or fixed definition. Community members may live in the same area or they may instead be connected by shared experiences, challenges, living situations, culture, religion, identity or values. Communities are both diverse and dynamic, and one person may be part of more than one community.

Community systems are used by community actors to carry out activities and deliver services. Many are small-scale and/or informal. Others are more extensive - they may be networked between several organisations and involve various sub-systems. For example, a large care and support system may have distinct sub-systems for home-based care, nutritional support, providing counselling, advocacy, legal support, and for referrals access to services and follow-up.

Community systems strengthening (CSS) is an approach that promotes development of informed, supportive communities and community-based structures so that they can contribute to long-term sustainability of health and other interventions at community level, and to the development of an enabling and responsive environment in which these contributions can be effective.

1. The importance of, and critical role played by, community systems

Rationale:

Current policy debates and donor priorities at global and national levels recognise the importance of health systems strengthening, but fail to recognise the critical role that community systems play in ensuring the delivery of effective and responsive health systems.

Recommendations:

As a matter of urgency, donor agencies, the Health 8¹² and developing country governments must re-frame the debate on health systems strengthening so that it fully incorporates the role of communities and community systems strengthening. More specifically we would like to see bilateral, multilateral, Health 8 agencies and development partners:

- revisit WHO's framework of HSS "building blocks" and explicitly include the role of community systems strengthening as a key additional building block;
- ensure that commitments to health systems strengthening also include resources for community systems strengthening; and
- recognise the importance of community systems in supporting health system strengthening and as such start to programme for and support *health and community systems strengthening* (HCSS).

2. Accountability and transparency of donor aid and domestic financing for health

Rationale:

Given the multiple funding sources in the health sector and the complexity and lack of transparency inherent in some of these financing mechanisms, it is difficult to track how existing donor aid and domestic financing for health is being used. There is an urgent need therefore for donors and development partners to commit to ensuring greater transparency regarding where money for health is coming from, where it is going to, and what results it is delivering.

Recommendations:

We therefore urge donor agencies and development partners to:

- establish clear governance structures at local, national and global levels that enable civil society and parliamentarians to hold donors and developing country governments accountable for ensuring donor aid for health and domestic financing for health delivers the required results;
- ensure that civil society is fully integrated into the governance structures of all existing and future health financing mechanisms, including country health sector

¹² Health 8 (H8) is an informal group of eight health-related organisations—the Global Fund, the GAVI Alliance, UNAIDS, WHO, UNICEF, UNFPA, the World Bank, and the Bill and Melinda Gates Foundation—created in mid-2007 to stimulate a global sense of urgency for reaching the health-related MDGs.

teams, the proposed Health Systems Funding platform (being established by WHO, the World Bank, the Global Fund, and the GAVI Alliance), and health SWAPs (sector-wide approaches);

- urgently put in place mechanisms to meet the Accra Agenda for Action commitments on improving democratic ownership of official development assistance (ODA) and improving mutual accountability of donor aid; and
- as a matter of urgency, take steps to improve the absorption and managerial capacities of Ministries of Health in low- and middle-income countries.

3. The need for more robust and measurable indicators for HCSS

Rationale:

One of the challenges for civil society in holding donor agencies and development partners accountable for delivering effective aid to the health sector is a lack of clear indicators to measure the outcomes of investments in health and community systems strengthening, combined with a lack of indicators demonstrating how targeted interventions can support HCSS.

Recommendations:

As such, there is a need for multilateral and donor agencies, IHP+ signatories and development partners to work with civil society to develop a set of short but strategic indicators for HCSS that can demonstrate:

- what successful health and community systems strengthening looks like;
- the impact of targeted interventions and funding on HCSS;
- the impact of pooled funding and budget support on HCSS; and
- the impact of donor coordination mechanisms such as SWAPs and the IHP+ on HCSS.

In addition to developing a set of short but strategic indicators for HCSS we also recommend that donors and technical agencies work together with development partners, international and national NGOs and grassroots organisations to develop a harmonised monitoring and evaluation plan for HCSS, SWAPs, budget support and the IHP+.

4. Building an evidence base to highlight the impact of targeted disease interventions on all MDGs

Rationale:

The current scarcity of donor resources for health (caused by a failure to meet existing funding commitments), combined with growing challenges in responding to the health needs of people in developing countries (such as the emergence of drug-resistant forms of TB, the continuing growth of the AIDS pandemic and more recent challenges caused by the global economic crisis), is leading to a re-prioritisation of donor aid in the health sector, rather than commitments to increase aid for health to the scale that is needed to ensure all of the health-related MDGs can be met. One result is that donors are perceived to be shifting resources from targeted disease-specific interventions such as HIV, TB and malaria to other under-served health concerns such as maternal, newborn and child health and health systems strengthening. This shifting of priorities indicates that donors do not recognise the synergies between targeted interventions and HCSS.

Recommendation:

We believe that this shifting of resources will fail to ensure the achievement of the health-related MDGs. Therefore, we urge donors, developing countries and civil society

organisations to continue to build the evidence base and improve their communication with each other on how targeted interventions can support HCSS.

In particular, we urge multilateral and bilateral donors and developing country governments to work in closer collaboration with civil society (including NGOs, community-based organisations, faith-based organisations, and academic institutions) to identify the synergies between HCSS and targeted interventions that can make the greatest difference to ensuring the health-related MDGs can be met by the target date of 2015.

5. Investments for research into new tools and technologies

Rationale:

Existing treatments and diagnostic tools for many of the diseases that affect developing countries are inadequate or out-of-date. As such there is an urgent need for research into new interventions and new operations and systems to improve prevention and treatment of the key diseases affecting developing countries.

Recommendations:

To ensure an adequate level of investment into research into new tools and technologies, it is therefore important for donors and development partners to:

- recognise that the achievement of the health-related MDGs requires increased scientific research, including operations research, into new vaccines, drugs, diagnostics, commodities and systems, and appropriate formulations, such as paediatric formulations; and
- urgently prioritise greater investments into research that can enable the achievement of the health-related MDGs.

6. Reducing inequities in the MDG framework to increase civil society and community engagement

Rationale:

The current MDG framework has been criticised for its lack of ability to capture inequities in access to the services that are required to achieve the MDGs. This lack of recognition of inequities is also evident in the way in which the planning and implementation of health systems and services are conducted. A lack of recognition of inequities, combined with a lack of recognition of the role that communities and civil society play in supporting the delivery of and access to health services, thus translates into a lack of opportunities for civil society and communities, especially marginalised and vulnerable populations, to engage with and influence the planning and implementation of HCSS, especially when the World Bank is taking a lead in this area.

Recommendations:

We therefore recommend that, as a matter of urgency, donor agencies and development partners:

- ensure that all future work on HCSS puts communities at the centre of decision-making;
- ensure that civil society is fully involved in national strategic planning processes, including the IHP+-initiated JANS (Joint Assessment of National Strategies) process;
- integrate the principle of dual-track financing, which recognises the role of civil society in supporting HCSS, into all health financing mechanisms, including the

Joint Health Systems Funding Platform (GAVI, Global Fund and World Bank) currently in development; and ensure civil society is fully involved in the development, monitoring and evaluation of the Joint Health Systems Funding Platform.

3.2 Recommendations regarding Maternal and Child Health

1. Explore establishment of a global funding mechanism to achieve MDGs 4 & 5

Rationale:

MDG 5 (Improve Maternal Health) and MDG 4 (Reduce Child Mortality) are widely acknowledged as the MDGs that have made the least progress in the past 10 years. MDG 5, in particular, has been identified as the farthest “off track” by the UN Secretary General, including both target 5a (reduce maternal mortality) and target 5b (ensure universal access reproductive health). While funding for maternal and child health has grown over the past five years, overall levels are still considerably behind the needs estimated by WHO, PMNCH and others. And, funding for family planning has actually declined in real terms over the past 7-8 years. The lack of a global funding mechanism that explicitly includes MDGs 4 and 5 writ large within its mandate has contributed to the problem of inadequate funding for maternal and child health.

Recommendations:

- Donor governments and agencies, as well as developing country governments, need to make clear commitments to filling the funding gap for maternal and child health, including reproductive health/family planning, with sufficient focus on strengthening the capacity of the health system, and with appropriate links to other health issues, especially HIV/AIDS, TB and malaria.
- An existing global funding platform, such as the Global Fund to Fight AIDS, TB and Malaria and/or GAVI Alliance, should broaden its scope to address the full scope of MCH needs. Funding for such needs should be **additional** to funding for other health needs (see recommendation 3 below), not displacing funding for HIV/AIDS or other health priorities.

2. Ensure adequate focus on neglected elements of the MCH continuum

Rationale:

Within the maternal and child health (MCH) continuum, key elements are often either neglected or left out completely. These key elements include comprehensive reproductive health care, which in turn should include access to contraceptives; abortion-related care; management of sexually transmitted infections and reproductive organ cancers; and comprehensive sexuality education. Newborn health is also often neglected, despite the fact that newborn mortality accounts for a large (40-41%) and growing proportion of child mortality worldwide. Effective interventions for the reduction of maternal mortality, including the use of misoprostol for the prevention and management of postpartum hemorrhage, use of magnesium sulfate for the prevention and management of eclampsia, and medical as well as surgical abortion, are underfunded and often not available at the appropriate levels of the health system. Community-based provision of care for newborns is another neglected area, although evaluations have shown that such community-based care, especially early postnatal care, can significantly improve newborn survival. Finally, maternal and child health,

especially care during childbirth and treatment of childhood illnesses, requires an effective health system to be in place, including adequately staffed, supplied, and functional health facilities that are accessible and functional 24 hours/day, 7 days/week. As such, investments in health and community systems strengthening are essential.

Recommendations:

- Ensure that MCH funding, policies and programs take a comprehensive approach that adequately incorporates often-neglected aspects of maternal and child health, especially family planning, newborn care, and abortion-related care.
- Health systems strengthening approaches need to fully incorporate MCH needs and priorities, including (but not limited to) training adequate numbers of skilled birth attendants and provision of essential supplies and commodities for reproductive, maternal, and child health (including contraceptives). In addition, as noted below, health system strengthening strategies should include key MCH indicators for assessing their impact, to ensure that such strategies are adequately addressing key health priorities.

3. Promote integration across the health MDGs, and across health needs more widely

Rationale:

Functional health systems are critical to the effective and sustained reduction of maternal, newborn and child mortality – but are also essential for progress on other health challenges as well. As such, estimates of financing gaps for each of the key areas of health include at least some elements of health systems strengthening, such as training of health workers, improvement of supply systems, and expansion of health infrastructure. However, there is overlap in the financing gap estimates generated for each of these health areas individually; such overlap may result in overstating the actual health financing gap.

A more integrated approach to health is needed not only in the analysis of financing gaps, but also in the design of programmes and the provision of services on the ground. There is significant overlap in the core target populations for HIV/AIDS; MCH (including reproductive health); and TB and malaria. For example, women of reproductive age, with pregnant women being an important sub-group, constitute a major target audience for family planning and maternal health interventions; they are also a core target group for HIV/AIDS and malaria interventions. Providing services through a “one stop shop” approach, i.e. at a single, conveniently located health facility and on the same days/times, is much more effective for the users of such care. Studies are starting to indicate that integrated provision of services contributes to increased and sustained coverage of key interventions; these efforts need to be further evaluated and, as appropriate, scaled up.

Recommendations:

- A comprehensive costing analysis should be carried out that clearly lays out the current and projected funding levels as well as funding gaps for all the key elements of health – HIV/AIDS, TB, malaria, MCH (including reproductive health and nutrition), as well as neglected tropical diseases and non-communicable

diseases. Such a costing analysis should identify the funding gap for each health issue individually, but also for health needs as a whole, recognizing the health systems strengthening components that underlie all health issues. In addition, the analysis should clearly specify which countries are included, what the time frame is, which interventions are included, and the projected coverage rates for the interventions included.

- Health systems strengthening approaches need to be assessed and evaluated not only in terms of their impact on health systems indicators such as number and distribution of health workers and availability of drugs and supplies, but also in terms of their impact on health outcome indicators. These health outcome indicators should cut across MDGs 4, 5 and 6.
- Health programmes need to look for and incorporate opportunities to strengthen integration and linkages, especially at the service delivery level, when such integrated services better meet the needs of women, young people, and children. In particular, integration of HIV/AIDS prevention, treatment and care with sexual and reproductive health services, maternity care, and child health care should be prioritized, especially in high-prevalence countries and populations. Such integration will not only better meet the needs of the target populations, it may also, in the medium and long term, improve the efficiency of the health system itself, by reducing duplication and promoting the most effective use of scarce human, financial and other resources.

3.3 Recommendations regarding HIV/AIDS

1. Universal access

Rationale:

In 2005, the High Level Meeting of the UN General Assembly Special Session on AIDS (UNGASS) called for the scaling up of HIV prevention, treatment, care and support with a view to coming as close as possible to universal access by 2010 for all those who need it. Thirty years into the HIV epidemic there is greater clarity about what works, including the importance of antiretroviral treatment (ART) for HIV prevention. Where there is political will and resources, it is possible to scale up the response.

However, there remains a significant shortfall in the global response and currently for every two people placed on ART another five people are infected. Historic concerns about the slow pace of scale-up are now being replaced by fears that current ART programs might collapse due to concerns about the sustainability of funding and cuts in contributions by major donors to HIV-related programming, including to the Global Fund to Fight AIDS, Tuberculosis and Malaria.

It is realized that success in the AIDS response underscores success in the broader development goals, and that success in the other MDGs is required to succeed in AIDS. Universal access to HIV prevention, treatment, care and support has a fundamental impact on other MDG areas such as poverty, environmental sustainability and maternal and child health. Considering other MDGs in isolation from the drive for universal access to HIV and AIDS prevention, treatment, care and support is short-sighted and ineffective.

Recommendations:

- Governments honor their existing political commitments to achieve universal access as enshrined in the 2001 and 2006 political declarations.
- When reviewing financial need to close the gap on HIV funding, governments should ensure sustainability of prevention, treatment care and support services, as part of an effort to build an effective response to the MDGs more broadly.
- By 2011, global targets for universal access and accountability mechanisms should be established with the full participation of all stakeholders, including civil society and key populations, and the new targets should ensure 100% global coverage of key interventions by 2015.
- Governments must recognize the important role AIDS responses have on improving health systems and gains in other health and broader MDGs, including improvements in maternal and child health, and the continued need to invest in integrated responses and strengthening health and community systems.
- Governments must recognize the impact that AIDS has on children, including the need to mobilize programs to ensure the elimination of pediatric HIV and AIDS and for a multisectoral community-based response to protect orphans and other vulnerable children.

2. Equity of access to services at country level

Rationale:

Globally, progress has been made towards the scale-up of treatment access; however, at country level there remain significant inequities to access of essential HIV prevention, treatment care and support services, particularly between and within developing countries. The promotion of gender equality and empowerment of women remain key challenges to addressing equity within the AIDS response at the national level. There is a need to speak about the role of stigma, discrimination and criminalization as they form ideological, cultural and legal barriers to the delivery of effective HIV response and to achieving the MDGs.

Inequities also exist between people living in urban and rural settings. Moreover, the quality of treatment delivery varies from the global North to global South, with patient-centred treatment choice often being replaced with protocol-driven treatments which are less accommodating of individual need.

Recommendation:

Planning and monitoring of universal access to HIV and AIDS prevention, treatment, care and support services should be mindful of issues of equity between men and women, developed and developing countries, as well as urban and rural populations within countries, in terms of models of care and considering the compounding impact of human rights issues. As such governments must:

- recognize and address the fact that discrimination, abuses against and criminalization of key population groups – particularly people living with HIV, people who use drugs; female, male and transgender sex workers; sexual minorities including men who have sex with men and transgender people – continue to fuel the epidemic and hinder efforts to achieve universal access;
- base programming and funding allocation on epidemiological data, evidence of what is most effective, and human rights;
- ensure that key populations are meaningfully involved in all aspects of the response to HIV;

- take urgent action in establishing and implementing laws, programs and policies for zero-tolerance of abuse and violence against women, girls, boys, and sexual minorities.
- Invest in removing all barriers – legal, economic, social and cultural – that sustain and enforce gender inequality, thereby contributing to the spread of HIV, which disproportionately affects women and girls;
- Help women and girls to gain independent control over their own sexuality, bodies and lives and take concrete measures to increase their access to and influence over the use of income, services and resources.

3. Links with other diseases

Rationale:

HIV does not exist in isolation as a disease and development challenge. There are close relationships with other diseases that share similar routes of transmission such as other sexually transmitted diseases and hepatitis contracted through the sharing of injecting equipment. In addition, the interconnectedness of HIV, TB, malaria and maternal and child health in many developing countries is already clearly demonstrated. Therefore, focusing on HIV alone could undermine the response to the wider health MDGs. At the same time, an awareness of the wider range of diseases faced by most-at-risk populations is also key to developing an integrated response to healthcare.

Recommendation:

Governments, donor agencies and implementing agencies work to encourage synergies within the health care system, building skills of healthcare professionals and developing existing or new guidelines to ensure the identification and treatment of co-infections and inter-related illnesses.

4. Human rights

Rationale:

Stigma and discrimination prevent people, especially those associated with a population that is marginalized, from accessing prevention, treatment care and support services. Stigma is especially prevalent at the health care interface. There is a need for more training and sensitization of staff to ensure the right skills set and attitudes to engage all populations affected by HIV, including with attention to age and gender.

Recommendation:

All those engaged in international development should be proactive in ensuring that those populations who experience the additional barriers to HIV services due to stigma, discrimination and criminalisation are enabled to take part in the design, review and delivery of HIV prevention, treatment, care and support. As such governments must:

- ensure a human rights approach in all HIV prevention, treatment, care and support programs and policies;
- repeal laws that criminalize same-sex relationships, the unintentional transmission of or exposure to HIV, use and possession of drugs (for personal use), and sex work;
- take action to ensure protection of the human right of all people to be free from stigma, discrimination and all types of violence, including gender-based violence, by both State and non-State actors;
- ensure the realization of full human rights of people of all ages, including people living with HIV, sex workers, transgender people, men who have sex with men, people who use drugs, migrants, prisoners and people with disabilities, by

facilitating and promoting their meaningful participation in the design, implementation, monitoring and evaluation of HIV prevention, treatment, care and support programming.

5. Combination prevention approach

Rationale:

Prevention success to date has resulted from a complex combination of strategies and several risk-reduction options with strong leadership and community engagement that is sustained over a long time. Given the continued rapid rate of new infections, it is clear that the HIV epidemic will only be halted if new infections can be stopped. This requires countries to 'know their epidemics', including data collection on populations most at risk of HIV infection and to respond with HIV prevention strategies that best match the profile of their country or regional epidemics. There is no single magic bullet to halting the spread of HIV. Therefore, a combination prevention approach is required. This approach is based on providing HIV prevention which would require behavioural change such as reducing concurrent relationships and using condoms, biomedical strategies such as circumcision and the prevention of mother-to-child transmission, treatment of HIV, other viruses and sexually transmitted infections and social justice and human rights.

Recommendation:

Countries need to use all available strategies and methods that are informed by evidence and grounded in human rights to ensure they prevent new HIV infections and halt the spread of the disease. In particular, countries should better understand their epidemics by improving the accuracy of indicators and data collection capacity, especially for populations most at risk of HIV, and tailor responses to their specific epidemics and contexts.

6. Food security

Rationale:

Access to adequate food and nutrition significantly mitigates the impacts of HIV and AIDS and is recognized as an integral part of the response in Article 28 of the 2006 Political Declaration. As infection rates continue to escalate around the world, particularly in developing countries with large rural populations and widespread small-scale agriculture, the inter-relatedness of food and nutritional security, HIV and environmental changes are becoming more apparent. HIV creates a potentially deadly cycle that removes the household's most productive earners, amplifies the impact of poverty, encourages migration, and can lead to increased malnutrition. In addition, many developing countries in the epicentre of the pandemic are reliant on small-scale agriculture. In Southern Africa, we have already seen the devastating impacts of drought and HIV. This is a clear indication of inter-relatedness of HIV, health, nutrition, poverty and environment-related MDGs.

Recommendation:

The relationship among HIV, environmental sustainability and food and nutritional security needs greater scrutiny in order to fulfil existing commitments to universal access and should be a key focus in a required cross-cutting response to MDG 6 and other MDGs.

3.4 Recommendations regarding tuberculosis

In order for the global community to properly address the continued and increasing threat of TB, governments, international organizations and civil society must come together on a common agenda to implement the following policy directions:

- adopt and ensure realization a global target for universal access and delivery of TB services,
- increase investment in new technologies,
- provide adequate financing, and
- address threats—including barriers to access.

Each of the four policy areas is discussed below, accompanied by specific recommendations.

1. Adopt and ensure realization a global target for universal access and delivery of TB services

Rationale:

Embracing universal access will be key to reaching populations most-at-risk and driving programs to go beyond earlier targets of 70% case detection/85% cure rates among infectious TB cases.

Recommendations:

In order to attain universal access we need to:

(a) Improve existing TB services and delivery, which would include:

- deepening the existing service delivery models to ensure empowerment of patients and integrate it with other services such as HIV and antenatal care;
- making TB services more patient friendly and creating enabling environments for access/treatment completion by, for example, using incentives and enablers to treatment success;
- empowering and engaging communities in outreach, support, and oversight;
- increasing active case finding (identify people at risk, groups at risk and screen even if they do not have complaints, as 'opposed' to passive case finding which is just checking for TB at respiratory symptomatics i.e. persons coughing for 2 weeks or longer);
- moving to universal drug susceptibility testing (DST) provisioning;
- moving beyond target setting that captures only people who test smear positive (i.e., have TB bacteria detectable in their sputum and are therefore infectious to others), when these people represent less than half of all TB cases; and
- integrating TB services into health programs as one of the important ways to ensure realization of universal access to quality TB services.

(b) Focus on vulnerable and at-risk populations, including the following:

- People living with HIV/AIDS (PLHA)
 - TB remains the leading killer of PLHA in low-income countries. One in four AIDS-related deaths is a result of TB infection.
 - HIV has acted as a catalyst in the resurgence of TB in sub-Saharan Africa.
 - Diagnostic and treatment challenges associated with TB-HIV co-infection must be addressed.

- Marginalized populations
 - Many marginalized populations are at an increased risk for developing active TB, including migrants, prisoners, indigenous populations, sex workers, trafficked populations and the poor.
 - People in these groups often live in cramped conditions with poor ventilation, which facilitates the spread of TB. As conflicts become more prolonged, refugee and IDP¹³ populations experience extended displacement in camps whose conditions assist the spread of disease.
 - In marginalized populations this becomes especially deadly when multi-drug resistant TB (MDR-TB) and extensively drug resistant TB (XDR-TB) are involved.
 - Prisoners, who also live in cramped conditions with poor ventilation, are at an increased risk of developing TB. For example MDR-TB has become endemic in Russian prisons.

- Women
 - Women should be offered TB screening and treatment services at all contact points within the healthcare delivery system/continuum, including during antenatal visits. This is important because women experience different risk factors, social and economic consequences and barriers to treatment than men. TB is the third leading cause of death for women worldwide, killing an estimated 500,000 women each year.

- Children
 - TB programs must put a specific emphasis on diagnosing and treating children, who account for 15-20% of all TB cases¹⁴.
 - New diagnostic methods and child-friendly drugs should be developed, and children should be included in well-designed drug trials.

2. Increase investment in new technologies

Rationale:

The tools we use to diagnose, treat and prevent TB are astonishingly out of date. The only vaccine, BCG, is almost 90 years old and is ineffective in preventing TB in adolescents and adults. Furthermore, it has been 45 years since a new anti-TB drug was introduced in the global market. Current TB diagnostics rely on 128-year-old technology. Therefore, the diagnostics, vaccines and drugs are inadequate to address the many inherent and emerging challenges of global TB control.

There is an urgent need for tools to diagnose and treat paediatric cases. Children are often excluded from TB drug trials from lack of incentives and difficulty measuring microbiological outcomes.

Recommendations:

Several promising new technologies are currently being developed. These efforts and activities should be supported as fully and thoroughly as possible. Among the new technologies is the use of biomarkers for TB diagnosis and monitoring response to therapy. This is important because case detection is difficult for sputum-smear negative

¹³ IDP refers to "internally displaced person".

¹⁴ *The Lancet's* May 2010 series on tuberculosis suggest that TB is likely to be "grossly under diagnosed and underreported" in countries where TB is endemic.

cases, childhood TB and reactivation of latent TB. Biomarkers can be helpful for providing diagnostic information and/or responses to therapy. Also:

- Qualified biomarkers are urgently needed to predict if an individual has been cured of TB, had reactivated TB, or is protected by vaccine. Line-probe assays are needed to diagnose and/or exclude MDR-TB in smear-positive patients;
- More use should be made of available liquid culture systems and rapid tests for antigen detection. The most effective TB diagnostic tool would be a rapid, point-of-care test that can be used by local healthcare workers. This test—in addition to the development of new vaccines and drugs—is necessary for scaling up TB control programs in resource-limited settings.

3. Provide adequate financing

Rationale:

Without sufficient financing, we will not be able to achieve the needed scale-up to universal access and delivery of TB services required to reach MDG targets.

Recommendations:

Global TB advocates, must support efforts to:

- revise estimates on the number of TB/MDR patients and TB-HIV patients in relation to new ARV protocols;
- fully fund the Global Fund;
- 2. expand bilateral programs—including full US appropriation, additional support for TB REACH¹⁵, the Japan International Cooperation Agency (JICA), and other bilateral opportunities);
- ensure robust national TB budgets (from local and external sources);
- support innovative financing mechanisms—including UNITAID, campaigns to establish a form of financial transaction tax (FTT) for health, and advance market commitments (AMCs); and
- better estimate stronger demand for financing.

4. Address threats—including barriers to access

Rationale:

Many threats remain which continue to obstruct the progression of TB control scale-up. Among the most important threats are the sustained HIV epidemic, the emergence of multidrug-resistant strains of TB, weak health systems capacity, poor infection control, stigma surrounding the disease, and barriers to access. We must address these threats in order to effectively implement WHO's Stop TB strategy and end the suffering of millions around the globe.

Recommendations:

- **Integrate TB/HIV services, which would include**
 - scaling up antiretroviral treatment (ART),
 - immediate initiation of ART for active TB cases,
 - coordinating the planning, financing and service delivery by national AIDS and TB treatment/control programs,

¹⁵ The main objective of the Stop TB Partnership's TB REACH initiative is to promote early and increased case detection of infectious TB cases and ensure their timely treatment, while maintaining high cure rates within DOTS programmes. The Canadian International Development Agency (CIDA) is supporting the initiative.

- offering TB and HIV diagnostic services as a basic standard of care (i.e., opt-out model), and
 - ensuring universal implementation of the Three I's (intensified case finding, infection control, and isoniazid prevention therapy) by National AIDS Commissions.
- **Actively prevent MDR-TB and aggressively scale up treatment, which would include**
 - strengthening DOTS¹⁶ programs to include treatment literacy/adherence counselling;
 - deepening the level of service provisioning including upgrading knowledge levels and infrastructure, especially labs;
 - expanding uptake of new diagnostics (and working to provide universal DST);
 - developing improved drug regimens with shorter treatment lengths;
 - promoting standards of treatment and care for MDR-TB;
 - supporting expansion of MDR-TB management, including lab capacity and trained health personnel; and
 - addressing supply chain bottlenecks for drugs and diagnostics.
 - **Improve health systems capacity, with objectives including building on TB programs, increasing synergies of TB-HIV programs, and strengthening the underlying systems. Activities and priorities to respond to these objectives include**
 - investing in a trained and well compensated healthcare workforce,
 - deepening the level and quality of TB service provisioning,
 - building up lab capacity,
 - building on TB supply chains, as well as addressing supply chain bottlenecks for drugs and diagnostics,
 - building on TB health information systems, and
 - increasing access to care by expanding service delivery models, especially at the community level.
 - **Address poor infection control, an important priority because**
 - poor infection control enables the spread of TB in clinical and other congregate settings, and
 - particular challenges exist around TB transmission among PLHA in healthcare settings.
 - **Fight stigma**, an important priority in general but especially for women because stigma tends to fall more heavily on them. TB is often used as grounds for divorce, dissociation from the family, and stripping of familial and property rights.
 - **Eliminate barriers to access, which would include**
 - eliminating user fees (individual level),
 - managing macroeconomic constraints (health system level), and
 - addressing SWAPs to ensure they include TB outcomes.

3.5 Recommendations regarding malaria

¹⁶ DOTS refers to "directly observed treatment, short course". It remains at the heart of WHO's Stop TB strategy.

Overview

The year 2010 marks a vital opportunity to reaffirm commitments to universal coverage of malaria interventions. In more than one-third of the 108 malaria-endemic countries, recorded cases and deaths due to malaria have fallen by 50 percent since 2000, results that show MDG targets can be achieved with high coverage of populations with mosquito nets, as well as improved access to effective diagnostics and treatment.

However, malaria still kills approximately 850,000 people a year, of whom 85 percent are African children, and is four times more likely to strike pregnant women than other adults. To achieve malaria control and eradication, comprehensive control measures are needed, and they should be supported by robust financial commitments and investments in cost-effective ways of preventing and curing this disease.

Malaria can be prevented and cured. We have evidence of what's working, so let's do it.

1. Strengthen civil society participation and community-based action: more community systems strengthening is needed to complement government services

Rationale:

The history of endemic diseases such as malaria clearly shows that without community involvement in the provision of health services, many people would not have access to basic health prevention and care. Community refers to specific group of people, often living in a defined geographical area, who share a common culture, values and norms. Thus, the contribution of community health workers is crucial to reach the health MDGs. The essential role that communities play in mobilizing people to access health services, providing health care to complement government services, and in particular the role they play in reaching marginalized or hard-to-reach communities, is not yet widely acknowledged. Malaria can kill in 24 hours; therefore, strengthening health and community system is a vital part of any malaria control programme.

Community participation¹⁷ is key to ensuring good governance and country ownership. But if community participation is to be effective, it must be developed as part of a clearly thought-out and coherent strategy. Community participation processes are more than just the use of an approach. What happens before and after is extremely important. It requires going beyond consultation to enable communities to become an integral part of the decision-making and implementation process. It reflects the need for strengthening the development of more active communities in their own right and to support advocacy at country and global level.

Recommendations for donor's agencies, government and development partners

- Greater recognition, support and investment of community-based responses and integrated **health and community systems strengthening**

¹⁷ According to WHO, 'community participation' can be defined as "a process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing and delivering services and in taking action to achieve change. WHO (1999). Community participation in local health and sustainable development: a working document on approaches and techniques. Copenhagen, Denmark.

- Ensure continued support at community level to protect gains already made in the fight against malaria. Communities must be at the centre of decision-making at all levels.

Communities play a central role in people's health and well being. Community health workers are a vital part of any national health systems, supporting government and the Ministry of Health in assuming overall responsibility for the development, implementation and monitoring of national health policies and strategies.

- Recognize and support the crucial complementary role played by communities in promoting access to health care by delivering 'non-medical' actions: health prevention and awareness raising, health promotion, social mobilization and counselling.
- Ensure that country ownership goes beyond government ownership for a meaningful involvement of communities and invest in advocacy at country and global level.

2. Sustainable, predictable funding and good governance: Political will is key

Rationale:

Current investment in malaria control is saving lives and providing far-reaching benefits for countries. But additional sustainable and predictable funding needs to be available to carry the success forward and to strengthen community involvement

In some locations, due to extensive malaria control efforts, an entire cohort of children lack immunity from malaria because they have been protected from exposure through the use of long-lasting insecticide treated bed nets (LLINs) and indoor residual spraying (IRS). They remain susceptible to a more severe infection until malaria transmission is greatly reduced and eliminated.

Support for new drugs and insecticides development is also essential to minimizing future risk and costs, and to reverse resistance. Sixty years ago, quinine was an effective anti-malarial. The disease has subsequently evolved, and quinine is no longer effective in many endemic parts of the world. And with a first-generation vaccine on the horizon, it is time for donors and endemic countries to begin preparing for likely introduction.

Without sustained and predictable funding, the significant contribution of malaria control toward the achievement of the health MDGs could be reversed.

Recommendations for donor's agencies, government and development partners:

- Harmonize indicators to allow for data-driven, efficient, and cost-effective malaria programmes integrated into national strategy plan to achieve the health MDGs.
- Use of national plan and country system to increase aid effectiveness
- Measure the impacts of existing aid instruments such as budget support, and adopt an evidence-based approach
- improve governance at local, national and international Invest in research on new and improved tools—to continue progress and sustain the achievements made to date (in prevention, treatment and control)—as well as on operational research to better understand what drives uptake and help promote higher use of interventions. Such investments would also allow for data-driven, efficient, and cost-effective malaria programmes on the ground to be better integrated into national strategy plans to achieve the health MDGs.

- Increase sustainable financial resources for health and ensure full funding for the Global Fund. Donor governments must meet their 2010 ODA commitments, African governments must meet their Abuja target of allocating at least 15 percent of domestic budgets to health, and of removing taxes, tariffs and non-tariff barriers on malarial commodities to ensure greater access to malaria prevention and treatment.

3. Holistic approach for the MDGs with disease-specific control programmes

Rationale:

Because the MDGs are interdependent and interrelated, we must work on correlations and links among them. Achieving MDGs 4 and 5 will not happen if there is no targeted support for AIDS, malaria and tuberculosis. In the same way, expanded services to promote maternal and child health contribute to the achievement of the universal coverage targets for malaria and HIV/AIDS and MDG 6.

For example, clean water is vital for good health and safe medical care, and such programmes also contribute directly to MDG 4 (reduce child mortality), MDG 5 (improve maternal health), and MDG 6 (reduce malaria, HIV...). Furthermore, malaria preventing keeps children healthy and able to go to school, and reduces the time women spend fetching water; therefore, such programmes contribute significantly to MDG 2 (primary education) and MDG 3 (gender equality). Similar points can be made regarding other programmes such as the promotion of blood donation, long-term food security, and programmes to reduce poverty and discrimination. A holistic approach is key if we want to reach the MDGs.

Recommendation for donor's agencies, government and development partners:

Promote a holistic approach among MDGs 4, 5 and 6 with disease-specific control programmes to ultimately strengthen health and communities systems

4. Partnership

Rationale:

Getting rid of the burden of malaria is such a huge task that it is only by working together that the greatest strides will be made towards reaching the MDG target by 2015. Strong inclusive, effective, global and local partnerships improve our collective action towards truly moving forward together to reduce child and maternal mortality. Reaching the MDG targets will only be possible through a significant scale-up in programme implementation (effective prevention and treatment coverage) that no one can achieve alone.

Recommendation for donor's agencies, government and development partners:

Ensure strong inclusive, effective, global and local partnerships to improve our collective action towards the MDGs.

Appendix 1. Testing and Feedback on the Delegation Self-Assessment Matrix (DSAM)

At a previous meeting in September 2009, civil society representatives agreed to commission an independent report on issues related to accountability. The consultants completed their report, "Developing an Accountability Framework for Civil Society Representatives Working on Global Health Issues", in early 2010.

The report was distributed in advance to participants at the May 2010 meeting in Noordwijkerhout. At the conclusion of that meeting, respondents were asked to test the main tool proposed to improve and enhance accountability among civil society representatives, the Delegation Self-Assessment Matrix (DSAM). The feedback will be used to further develop the DSAM over the next few months, a process that will include at least one additional workshop (at the July 2010 International AIDS Conference) with civil society stakeholders.

Most respondents agreed that the DSAM is a potentially useful tool. Some thought that in general it is a bit too "soft" because it does not provide indicators for users to measure themselves against clearly and specifically. In their view, the matrix's linkages and categories should be more explicit in terms of definitions and evaluation techniques.

Others, however, thought the current open-ended structure and language were appropriate. They oppose a more prescriptive approach based on the belief that a "strong" and "rigid" set of key performance indicators (KPIs) would alienate many potential users. A less explicit approach is more "comforting" because it takes into account the fact that cultural and context differences mean that people have different ways of perceiving KPIs and evaluations in general. Participants who oppose more specificity in the DSAM also argued that it should be considered a broad tool that individual delegations and representatives adapt for their own unique circumstances and needs.

The full accountability framework report including the DSAM will be made available online at www.icssupport.org.

Appendix 2. List of Civil Society Representatives 2010

This appendix lists all of the current civil society representatives to UNAIDS PCB, the Global Fund, UNITAID, the GAVI Alliance, IHP+, the Millennium Foundation, Roll Back Malaria, the Stop TB Partnership, and the Partnership for Maternal, Newborn and Child Health.

All of the representatives were invited to participate in the meeting in Noordwijkerhout held 19-21 May 2010. The country listed refers not to nationality or citizenship, but to where the individual is based. People whose names are followed by 'NA' were not available to attend the meeting.

Name	Country	Position
UNAIDS PCB delegation		
Lydia Mungherera	Uganda	Delegate Africa
Felicita Hikuam	Namibia	Alternate Delegate Africa
Vince Crisostomo NA	Thailand	Delegate Asia and the Pacific
Rathi Ramanathan NA	Malaysia	Alternate Delegate Asia and Pacific
Ian McKnight NA	Jamaica	Delegate Latin America and Caribbean
Amira Herdoiza	Ecuador	Alternate Delegate Latin America and Caribbean
Rhon Reynolds	Netherlands	Delegate Europe
Matthew Southwell	UK	Alternate Delegate Europe
Evan Collins	Canada	Delegate North America
Maria Antoinetta Alcalde	USA	Alternate Delegate North America
Sara Simon	Belgium	Communications Facility
Natalie Siniora	Netherlands	Communications Facility
Global Fund Communities delegation		
Carol Nyirenda NA	Zambia	Board member
Rolake Odetoynbo	Nigeria	Alternate Board member
Rachel Ong NA	Singapore	Communications Focal Point
Global Fund Developing Country NGO delegation		
Karlo Boras	Serbia	Board member
Bobby John	India	Alternate Board member
Cheick Tidiane Tall	Senegal	Communications Focal Point
Global Fund Developed Country NGO delegation		
Joanne Carter	USA	Board member
Mohga Kamal-Yanni NA	UK	Alternate Board member
Jacqueline Wittebrood	Netherlands	Communications Focal Point
UNITAID Communities delegation		
Esther Tallah	Cameroon	Board member
Nelson Otwoma NA	Kenya	Alternate Board member
UNITAID NGO delegation		
Mohga Kamal-Yanni NA	UK	Board member
Kim Nichols NA	USA	Alternate Board member
Jessica Hamer	UK	Liaison Officer UNITAID Delegations
Millennium Foundation NGO delegation		
Khalil Elouardighi NA	France	Board member
Mohga Kamal-Yanni NA	UK	Alternate Board member

Millennium Foundation Communities delegation		
Carol Nyirenda NA	Zambia	Board member
Esther Tallah	Cameroon	Alternate Board member
Jessica Hamer	UK	Liaison Officer MF Delegations
GAVI delegation		
Faruque Ahmed NA	Bangladesh	Board member
Alan Hinman NA	USA	Alternate Board member
IHP+ delegation		
Lola Dare NA	Nigeria	Southern Representative
Mayowa Joel	Nigeria	Alternate Southern Representative
Sue Perez	USA	Northern Representative
Elaine Ireland	UK	Alternate Northern Representative
Roll Back Malaria delegation		
Halima Mwenesi NA	USA	Northern Board member
Rima Shretta NA	USA	Alternate Northern Board member
Akudo Anyanwu Ikemba NA	Nigeria	Southern Board member
Esther Tallah	Cameroon	Alternate Southern Board member
Aude Galli	Belgium	Replacing Northern Representative
Louis da Gama	UK	Replacing Southern Representative
Stop TB Communities delegation		
Carol Nyirenda NA	Zambia	Communities representative
Blessi Kumar	India	Communities representative
Stop TB NGO delegation		
Peter Gondrie	Netherlands	NGO representative
Nils Billo NA	USA	Northern NGO representative
Sandeep Ahuja NA	India	Alternate representative
Partnership for Maternal, Newborn and Child Health		
Ann Starrs	USA	NGO representative and Co-Chair
Presenters/Civil Society Officers		
Kate Thomson	Switzerland	UNAIDS
Michael O'Connor	Switzerland	Global Fund
Geoff Adlide	Switzerland	GAVI
Billie-Jean Nieuwenhuys	Switzerland	International AIDS Society
Kirsi Viisainen	Switzerland	Global Fund
Alan Brotherton	Switzerland	International AIDS Society
Richard Burzynski	Switzerland	UNAIDS
Prudence Smith	Switzerland	Roll Back Malaria
Giorgio Cometto	Switzerland	Countdown 2015/GHWA
Support team		
Jeff Hoover	USA	Rapporteur
Peter van Rooijen	Netherlands	Facilitator
Barbara van Wijngaarden	Netherlands	Administrative support

Note: Some delegates are involved in multiple delegations and are therefore listed multiple times.