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Sent: Saturday, June 2, 2012 5:31 PM
To: H
Subject: Fw: Remarks of Secretary of State Hillary Rodham Clinton At "A World in Transition: Charting a New Path in Global Health"

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Sent: Saturday, June 02, 2012 05:28 PM
To: Mills, Cheryl D; Quam, Lois E
Subject: Remarks of Secretary of State Hillary Rodham Clinton At "A World in Transition: Charting a New Path in Global Health"

Cheryl/Lois:
Wow! Very rarely does a speech bring me to tears, but this one did it. Talk about telling it like it is. This was a bases-loaded home run. Please tell the Secretary that I love her more than ever.....you guys too, of course.
Best regards,
Tony

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For Immediate Release
June 1, 2012
2012/873

U.S. DEPARTMENT OF STATE Office of the Spokesperson

REMARKS

Secretary of State Hillary Rodham Clinton

At "A World in Transition: Charting a New Path in Global Health"

June 1, 2012
Oslo, Norway

SECRETARY CLINTON: Well, that is quite a compliment. And whatever it takes to accept, I do. Your Majesty, Your Royal Highness, Mayor, my dear friend and colleague, your excellent foreign minister, also let me recognize Ingrid Schulerud, wife of the prime minister who, along with her husband, just hosted me and my delegation for a wonderful luncheon, and to everyone who has organized this extraordinary conference, which I think does come at a historical turning point.

It's no surprise that we would be meeting here in Norway, one of the most generous nations on earth when it comes not only to global health but so much more, and that we would have gathered here the panel and others who bring such broad and deep experience, and also have the opportunity to elevate an issue that is connected to so much else.

I often think about issues like maternal health from a personal perspective because I am privileged to have known what it meant to me to have had the great good fortune and gift of my daughter. And I think about what it would have been like that cold February day in 1980 if I didn't know that the facility was available. Or were it available, I didn't really know for sure if it would be open. And I couldn't count on a doctor or a midwife or a nurse being present. Or if they were, if something went wrong, that they would have the equipment and the expertise to handle whatever the emergency might be. But indeed, as we have just heard described by the minister from Sierra Leone, that is the experience of many millions of women every single day throughout the world.

So I greatly appreciated the invitation by the foreign minister to increase and accelerate our mutual efforts as to how together we, and hopefully bringing others with us, can do more to save the lives of mothers during labor and delivery. Now, maternal health has a value in and of itself, I think we would all agree with that, but it is deeply connected to a broader purpose. And our panelists have all very persuasively discussed that.

How do we achieve health systems that will help every country improve life for more of their people? And the key question comes down to, if you really want to know how strongly a country's health system is, look at the well-being of its mothers. Because when a woman in

labor experiences complications, it takes a strong system to keep her alive. It not only takes skilled doctors, midwives, and nurses, it takes reliable transportation, well-equipped clinics and hospitals that are open 24 hours a day. Where these elements are in place, more often than not women will survive childbirth. When they aren't, more often than not they die or suffer life- changing, traumatic injuries.

When China, Sri Lanka, and Malaysia upgraded and expanded their health systems, their maternal mortality rates dropped dramatically. When Zimbabwe's system began to crumble, its maternal mortality rates shot up dramatically. That is a powerful, inescapable correlation. And it is why improving maternal health is a priority for the United States.

Through our development agency USAID, we are supporting more skilled midwives and cell phone technology to spread health information. We're involved in the International Alliance for Reproductive, Maternal, and Newborn Health, a five-year effort to improve donor coordination. We are partnering with Norway and others to support innovative interventions that improve outcomes for pregnant women and newborns. And we are working to ensure access to family planning so that women can choose the spacing and size of their families. Reproductive health services can and do save women's lives, strengthen their overall health, and improve families' and communities' well-being.

And of course, women's health means more than just maternal health and therefore we must look to improve women's health more generally, because it is an unfortunate reality that women often face great health disparities. And

improving women's health has dividends for entire societies, from driving down child mortality rates to sparking economic growth. And Norway, as Jonas
just pointed out, has been a leader in not only doing that, but recognizing it.

And the comment he made at the end about the difference between Norway's GDP with oil and gas and with women's empowerment and involvement is very striking because a recent study that Norway has just completed demonstrated that Norway's GDP actually do more to the empowerment of women than the discovery of natural resources and their exploitation.

Norway has been a leader in also pointing out the direct links between gender-based violence and health. So for our part, the United States is integrating services throughout our health programs so women and their families have access to the range of care they need. And we are linking our health programs to others that address the legal, social and cultural barriers that inhibit women's access to care, such as gender-based violence, lack of education, and the low social status of women and girls.

But you can't impose a health system, and you can't change some of these attitudes from the outside. We understand that. There has to be encouragement for it to grow from within, the kind of leadership that the minister is discussing about what is happening in Sierra Leone.

That is the principle of what we call country ownership. And I think it's important to stress the connection between maternal mortality, strong health systems, and country ownership. Because while the global health community has recognized that we have to rigorously think about what works and what doesn't work, and that we endorsed country ownership at the high-level forum in

Paris in 2005 and reaffirmed it in Accra and Busan, it is enshrined in numerous global health agreements.

But few of us have honestly forced ourselves to examine what country ownership means for the day-to-day work of saving lives. Now, for many people, that phrase is freighted with unstated meaning. Some worry that it means donors are supposed to keep money flowing indefinitely while recipients decide how to spend it. Others, particularly in partner countries, are concerned that country ownership means countries are on their own. (Laughter.) Still others fear that country-owned really means government-run, freezing out civil society groups or faith-based organizations that in some places operate as many as 70 percent of all health facilities.

And this is not just a matter of semantics, because if we are not clear about what country ownership means, we cannot know whether we are making progress toward achieving it. And we certainly can't identify what works and what doesn't. And what's more, we will achieve real gains in maternal health and global health more generally only with effective country
ownership. Now, one or two programs in isolation are not enough. It takes an integrated, country-owned approach. So let me share with you what our latest thinking about what that means is.

To us, country ownership in health is the end state where a nation's efforts are led, implemented, and eventually paid for by its government, communities, civil society and private sector. To get there, a country's political leaders must set priorities and develop national plans to accomplish them in concert with their citizens, which means including women as well as men in the planning process. And these plans must be effectively carried out primarily by the country's own institutions, and then these groups must be able to hold each other accountable as the women did in front of the parliament in Sierra Leone.

So while nations must ultimately be able to fund more of their own needs, country ownership is about far more than funding. It is principally about building capacity to set priorities, manage resources, develop plans, and carry them out. We are well aware that moving to full country ownership will take considerable time, patience, investment, and persistence. But I think there are grounds for optimism.

Economic growth is making it possible for many developing nations to meet more of their

people's own needs. In 2010, the GDPs of Mozambique, Botswana, and Ethiopia grew more than 8 percent. Nations across sub-Saharan Africa are seeing similar growth. And what we want to be sure of is that countries don't substitute donor funding for their own, because unfortunately, there are examples – Zimbabwe being one – where an existing health system that was providing basic services to many was allowed to deteriorate while the government chose to put funding elsewhere. We have seen ministries of health lose funding to ministries of defense or ministries of transportation. And so what had been possible only a decade before becomes very difficult going forward.

So what we are trying to do is to help put in place the essential pieces of strong health systems. That means we are helping to build clinics and labs, to train staff, improve supply chains, make blood supplies safer, set up record-keeping systems; in short, creating platforms upon which

partners can eventually launch their own efforts. Now, with this momentum, the question before us is not: Can we achieve country ownership? We think we are in a very good position to begin that process. Instead, we have to ask ourselves: "Are we achieving it? And if we are not, what must each of us do better?"

Well, some countries are. And earlier we heard about Sierra Leone. And I am very excited by what the minister has done to enlist 1,700-plus women as health monitors, responsible for checking up on their local clinics, reporting problems to the health ministry. That's a wonderful way for ownership to migrate down from the national level to the local level and then come back up as a reporting mechanism.

Or consider Botswana, where the government manages, operates, and pays for HIV treatment programs. With PEPFAR's support, it is also working with American universities to build a national medical school that will train the nation's next generation of healthcare workers. And perhaps we can then stop the brain drain, because so many countries train excellent doctors, midwives, and nurses who then leave that country. My birth was assisted by a nurse midwife from Ghana – the birth of my daughter, and I know how wonderful and skilled she was. Now she's back in Ghana, because she thinks she has opportunities to do her best work in her home country.

If you look at what India has achieved – and I appreciate the minister being here – six years ago, when the government launched its National AIDS Control Program, half the budget came from outside donors. Today, less than one fifth does, and the Indian Government covers the rest. But these are the exceptions, not yet the rule.

In too many countries, if you take a snapshot of all the health efforts, you see donors – that's all of us – failing to coordinate our work, leaving some diseases underfunded, burying our partners in paperwork that I am convinced hardly anyone ever reads once it's filled out, paying too little attention to improving systems. You see partner countries committing too few of their own
resources and avoiding accountability for delivering results. And you see patients encountering a maze of obstacles that block them from the services they need. So therefore it is up to us – donor and country alike.

There is an old proverb that says: "When a man repeats a promise again and again, he means to fail you." At the turn of this century, we made a collective promise to cut the maternal mortality ratio by three quarters and achieve universal access to reproductive health services. And yes, we have repeated that promise again and again. And although we do not mean to fail, we risk failing all the same, if we don't change course.

So what do we need to do? Let me offer a few suggestions. Beginning with donors, governments, foundations, multilateral organizations – and I see a number of familiar faces. First, we do need to move from rhetoric to the reality of making it a priority to strengthen country-led health systems. That means meeting our commitments even in tough economic times. Part of this assistance should include an assessment of country systems, led by the countries themselves, with common international benchmarks so we can compare results across borders. And those are not only national borders but donor borders.

We need, for example, to follow closely the National Heath Accounts supported by USAID that give us an excellent view of the state of a health system's financing – not to point fingers or cast blame, but to identify gaps and then develop plans to fill them.

Second, we donors have to recognize that supporting country ownership in health requires hard choices. It is often easier to start a new program than to phase out an existing one, even when the existing one is not producing results. But if we are serious about helping our partners plan, implement, and ultimately pay for their own efforts, we have to be willing to make the tough calls.

Third, donors must embrace transparency, even when it brings bad news. For example, when Zambia uncovered corruption in its Global Fund program, some donors responded by punishing them for the corruption, rather than applauding them for uncovering it. Now, we should never turn a blind eye to corruption or throw good money after bad, but it is counterproductive to punish our partners when they root out problems like that. It sends exactly the wrong message: We want you to fight corruption, but if you find any, we might freeze your funding. Instead, we should say find the corruption so that we can help you fix the problems.

And fourth, donors need to solve the coordination curse. Donor coordination has been a theme at health and development conferences for so long, it is a cliché. But there's a reason it keeps coming up, and that's because it is critically important and notoriously hard to get right.

When President Obama took office, we recognized that the United States Government needed to do a much better job of coordinating with ourselves to start with, as well as our partners and other donors.

For years, health teams within the U.S. Government operated independently. HIV/AIDS teams under PEPFAR would work with a country to develop one plan; USAID, which was the implementing partner for HIV/AIDS, might very well develop another plan; in would come our malaria team, they would develop a third plan, so on and so on. It was enough to make anybody just dizzy.

So we are trying to integrate our programs. And under our Global Health Initiative, each of our country teams now assess how they fit within a comprehensive vision and program, based upon a health plan established by the country where we are operating. And we have worked with partners to develop these health plans in more than 40 countries.

For donors, tackling all these problems will be essential if we want to get more partners back on the path to helping build sustainable, country-owned systems. And this goes for the emerging economies that recently were recipients of assistance but now are net donors. These countries are playing an increasingly important role, and some have shared technical advice and lessons with their developing nation partners. We want to see that expand.

But at the same time, we look to all emerging powers to recognize that with this growing power comes growing responsibility, and they should consider working whenever possible through

existing multilateral channels and ensure that the ultimate aim of their efforts is to put more countries on the path to meeting their own needs, not to – figuratively and literally – pave the way for extracting countries' natural resources.

Now, partner countries have challenges to meet as well. First, I challenge our partner countries to invest more in the health of their own people. If you went to Abuja and agreed to put 15 percent of your national budget into health, we need you to deliver on that commitment. That should be a priority – not just for health ministers, but for all political leaders, starting with presidents and prime ministers to finance and defense ministers. Meeting this commitment will pay off many times over, making it possible to expand services to underserved areas and people, develop your workforce, and even expand economic growth.

And there's a special opportunity here for those nations that have recently discovered new sources of wealth in oil, gas, and other extractive industries. I urge you to follow the examples of two countries that are not often mentioned together in the same sentence: Norway and Botswana. Both discovered large stores of natural resources. Both

dedicated a portion of the income to health and education. And in both cases, their investments coming from their own ground, their own natural resources, are saving lives and lifting up communities. And both Norway and Botswana are very generous in being willing to offer advice and technical assistance about how to do this.

Second, partner countries must take on the flip side of donor coordination. While it's absolutely true we donors need to do a better job of working together, only one player has the authority to speak about a nation's needs and orchestrate all the different groups working in a county, namely the national government of that country. So we need you to help identify the needs that aren't being met and to convene the partners to determine who will fill which gaps. I applaud Rwanda and Ethiopia for their exemplary progress along these lines. Now, I know it is very difficult for many countries, but in the end only you have the power. No one else can do it for you.

Third, partner countries must begin bringing down the political barriers to improving health. That means making regulatory changes that allow faster approval of new drugs, procurement reform to ensure that drugs get to clinics on time, setting and delivering a living wage for health workers.

And it also does mean taking on corruption at every level. We've had the very sad experience of negotiating to provide antiretroviral drugs for HIV/AIDS in some countries, and it's very clear that the leadership of the country wants to make sure that they get their hand in the money for those drugs before it is delivered to the people who need it. And we have been very clear you have to take on corruption – local, regional, national – ensuring that drugs don't get diverted to the black market.

It means repealing laws that stop progress, like the unfortunate treatment of women in so many places, ending gender-based violence and discrimination, creating true health equality for women and men. In some countries, women and girls are considered inherently less valuable than men and boys and are treated that way by custom and law. In many countries, members of the LGBT community are considered very much outside the mainstream and are treated that way, often

therefore not being able to access health services that will benefit them and benefit the larger community. A system with built-in bias against any part of the population is not only unjust, but is unstable and unsustainable.

Now, my own country's views about this global health work is shaped by what we have learned. As I said earlier, we are very proud that PEPFAR helped create platforms that countries can use to tackle a wide range of health problems. But as many observers have pointed out, PEPFAR did not initially set out to strengthen country systems. Instead, it began by creating a parallel network of clinics that were separately managed and paid for.

That's a fair point. But let's remember that in 2003, when the world faced an epidemic unlike any we had seen, HIV/AIDS demanded an emergency response, and the United States had the resources to answer the call. And today, we've made phenomenal progress with more than 4 million people receiving lifesaving treatment, 600,000 babies having been born HIV-free, and just last year 40 million receiving HIV counseling and testing.

But we know now it is time to shift from that emergency response to a country-owned model built to last. Last year, when I spoke about the goal of an AIDS-free generation, I made it clear that it could only happen by embracing country ownership. And PEPFAR provides us the framework, because there are five-year plans we have made with nearly two dozen countries to identify their most critical needs, to make joint commitments to meet those needs, and outline steps for transitioning responsibility for their HIV/AIDS programs. Our partners are no longer just recipients. They are now managers of their own response to the epidemic. And what we're doing extends beyond HIV/AIDS. In Nepal, we have a USAID partnership to drive the expansion of family planning, maternal health, and children's health. Nepal is now on track to achieve Millennium Development Goal five, as are Bangladesh, Egypt, and other countries.

So I am very pleased that the United States will be a part of the Saving Mothers, Giving Life partnership, along with Merck for Mothers, Every Mother Counts, and the American College of Obstetricians and Gynecologists. We're not focusing on a single intervention, but on strengthening health systems. We are beginning with projects in parts of

Uganda and Zambia, learning what works and how we then can spread it. And I want to thank Norway for your extraordinary commitment, and I am pleased to announce the United States is committing $75 million to this partnership.

There are so many forums where matters of global health are discussed. I think every one of us have been to dozens, probably. But we have to do things differently. We have to be open about the obstacles that we confront. We have to be willing to admit what doesn't work. We have to be ready to applaud those who point out mistakes or corruption. That kind of dialogue can be difficult. There will be times when we don't see eye to eye. But it is fitting that we meet here in Oslo City Hall, where the world comes together each year to honor historic accomplishments that further the cause of peace, and think about the men and women who have stood here in this city hall being honored – the organizations like the International Red Cross or Doctors Without Borders.

Norway has long understood that the stability of any nation is tied up in the well-being of its people. And every life we save is a step toward that more peaceful, prosperous planet we seek. I think back to that day when I had my daughter and how fortunate I was. But surviving childbirth and growing up healthy should not be a matter of luck or where you live or how much money
you have. It should be a fact for every woman everywhere. And I think we can make this happen, and by doing so, bring the world closer to recognizing that working together we not only can save lives, we can help improve them, bring greater peace, prosperity to all.

Thank you very much. (Applause.)

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