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**Kaiser/CSIS Forum with South African Minister of Health
Kaiser Family Foundation
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DR. MICHAEL SINCLAIR: – an honor and a pleasure to welcome Minister Motsoaledi to the Foundation this afternoon. We're also very honored to welcome our distinguished discussants, Ambassador Eric Goosby and our CSIS colleague, Jennifer Cook and grateful as always to CSIS for graciously cohosting the event with us today.

Minister, I must tell you standing here to welcome you makes me feel that we have come, in a sense, full circle because when Kaiser began working in South Africa now about 23 years ago, one of the very first, in fact the second program we helped establish together with Dr. Motsoaledi was in his hometown of Jane Furse in Sekhekuneland. I'm very proud to say the program is still going strong today.

We have enjoyed a very long and sound relationship with Dr. Motsoaledi since in his role as community physician and activist, as a leader of the progressive health movement that helped shape the post-apartheid health system, and as a political leader initially in the provincial government and more recently, in his role as National Health Minister.

Since his appointment as health minister in 2009, Dr. Motsoaledi has brought a veritable hurricane of new vigor to the public health sector in South Africa, most notably, resuscitating the primary health care fundamentals of the post-apartheid health system, putting in place a comprehensive

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national HIV/AIDS management strategy and directing and planning implementation of a national health insurance scheme.

As you can see from this audience, there's a lot of interest in South Africa's progress minister and I am very pleased now to invite you to speak [Applause].

HON. DR. AARON MOTSOALEDI: Thank you program director, Dr. Sinclair, Ambassador Goosby, and Jennifer Cook, ladies and gentlemen, good afternoon. I am going to try, in as short a space as possible, to present the health situation in South Africa especially in as far as HIV/AIDS is concerned. I'll just start by showing the situation only 21 years ago.

The most reliable statistics we get in South Africa about HIV and AIDS is from pregnant women in our antenatal clinics, is the most reliable because in our antenatal clinics, women have to test for HIV/AIDS but also because it happened over a 21-year period. Even before our first democratic elections in 1994, we're already doing these studies. So it just was done by 1990.

The prevalence among pregnant women in South Africa was at 0.7-percent but it just had started steadily growing until we are now at 29.3-percent meaning one out of every pregnant women presenting in our antenatal clinics is HIV-positive. It shows providence by providence. We've got nine provinces in South Africa.

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That's what you call states here and the biggest of them all is KwaZulu-Natal [inaudible] province and our number one province and it's in that order. It also shows that their highest prevalence is among pregnant women during childbearing age. That's where you find the peak of HIV, which is specifically problematic.

Because we did that study over a 21-year period, I just took four years over these 21 years, to show what has been happening in provinces in terms of prevalence. This is the prevalence of the Eastern Cape. This is the province [inaudible] state, which is regarded as the highest in HIV/AIDS. That is the province of Limpopo with my home ground where I met Dr. Michael Sinclair for the first time. The district I come from is there at the bottom right [inaudible] district, that's where we started working with Michael Sinclair.

The province of Limpopo is very rural but in terms of HIV/AIDS, it's not one of the worst. Together with Eastern Cape, which is also rural, I'll explain later because it actually showed us something in terms of the battle that we need to be considering. This is an Gauteng the commercial capital of South Africa, the Gauteng province.

As we can see there, the problems are mostly around the city of Johannesburg and [inaudible]. That's where the

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international airport is. This is the province of KwaZulu-Natal.

That's number one with HIV/AIDS. As you can see, the red area shows that in some districts, by the way, these maps are district by district, in some districts, the prevalence is as high as 46-percent as you can see, one of the districts there in 2006. So it's by far, our biggest public health crisis all over South Africa is in this. Fortunately, because of these maps, as you know, the KwaZulu-Natal is one of the most rural provinces where the king is still very highly respected.

After being shown this map, the king himself has taken special interest and he's leading the battle against HIV/AIDS more than many traditional leaders can ever do to an extent where he has even learned medical terms like where to find lymph nodes and all that and symptoms and science.

It was because of the gravity of the situation had when you are shown these maps that this is what's happening in our area. This is the province of Mpumalanga, which is number three, I mean number two in terms of prevalence in our country. This is a province of Northern Cape and the province of Northwest and the province of Western Cape. As you can see, Northern Cape and Western Cape have got a very slow prevalence.

These maps here correspond with the history of South Africa. The province of KwaZulu-Natal and Eastern Cape are

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provinces which carried the burden of apartheid because the 10 homeland [inaudible] governments were situated in this province. In my home province, there were three.

In Eastern Cape, there were two, which were all independent in [inaudible] and it was the biggest. The province of Western Cape and Northern Cape had never had the homeland inside them and it still shows in terms of development up to today. HIV/AIDS is following a similar pattern. So we're just emphasizing that by 2006 already, according to stats of South Africa mortality figures, six out of 10 South Africans will die well below the age of 50.

It's a very significant because of HIV very young people are dying and leaving the elderly behind. We are trying to demonstrate when did this happen in South Africa. We were not always a country like that but this happened strictly over a period of nine years or let me say eight to nine years.

As you can see there, these graphs are showing the pattern of death in terms of age from 1997. The lowest graph there, I think, is already if I'm not mistaken, shows that the peak of death was around 69 years, 77-79 years but over the years, it started shifting until by 2005, the top graph there shows that the peak of death is now occurring in our country around 30 years meaning it's very young people who are dying and that took place strictly over a period of eight years only.

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We are comparing ourselves with Brazil, which is in a much better situation as far as HIV/AIDS is concerned to show that the pattern of death among females between the age of 15 to 64 in Brazil in 2004, that is the blue graph. In South Africa in 1997, that is the stepped up graph. It shows that we're not very much different from Brazil even though we're trying to [inaudible].

By 2004 already, everything has changed. We had the peak of death both at 30 years and 65 years and these are young females. This stage of affairs was revealed but then unfortunately not followed up by a president of the Medical Research Council South Africa in 2001 who wrote in the journal.

He was not talking about HIV specifically, just said something is killing young women during childbearing age in South Africa, which is not in keeping with [inaudible] at least I still remember that quotation from the Medical Research Council but I think he wasn't taken seriously at that time because people maybe didn't understand what he was trying to say but this slide actually describes the situation that we are describing.

The results of this is quite devastating that visit as I did with the vice president of the country, Deputy President Kgalema Motlanthe who is the chairperson of South African National AIDS Council.

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In one of those red areas, red districts, we visited four families and in all of them, you find the grandmother with 10 children between the ages of three and 50. She will tell you that these children belong to my daughters. They're all gone and I'm remaining with them meaning grannies must now become mothers.

The slide shows that early on in life between the ages of three and four, there are more men who are HIV-positive than females but when sexual activity starts at 15 years, when teenagers start being 15 years of age, the girls shoot up as you can see from that slide tremendously. Many studies have shown that it's the females in South Africa who are carrying the burden of HIV/AIDS.

At those ages, you find out among the boys the prevalence is as low as four-percent, one-percent but among the girls, it goes as high as 28-percent and so the burden is carried by females as you can see. Later on in life, the situation changes. You have got more males now who are so early and later on is males but during sexual activity, more females.

So I like saying HIV/AIDS in my country, I don't know elsewhere, is a disease brought on by males but suffered by females. Unfortunately, because the slide also shows intergenerational sex, that is quite older people who are

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having sex with these young girls and infecting them. That's why there is that difference.

This sort of slide, I like showing it to end the debate in South Africa because from 2009, as I said, we started a huge battle against HIV/AIDS changing our approach, which was generally problematic.

Quite a number of people accused me of over exaggerating HIV/AIDS that we've got other diseases in South Africa like noncommunicable diseases and some people feel the Minister never talks about them. Every time he talks about HIV/AIDS, HIV/AIDS and TB. That brings an end to the debate. This study was commissioned by *The Lancet*, the British medical journal, *The Lancet* but the researchers were our own professors and researchers in South Africa.

It suitably shows that we have got the quadruple burden of disease and in the order in which it has HIV/AIDS and TB's number one. So that figure forms only 0.7-percent of the world population but do occur in 17-percent of HIV-positive people of the world unfortunately. Our HIV/AIDS is 23 times the global average. So by far, TB and HIV/AIDS is the biggest public health disaster that the country has ever faced.

So our second burden is maternal, newborn, and child health. In fact maternal mortality, newborn mortality, and child mortality have showed up in South Africa because HIV/AIDS has been shown to have increased maternal mortality in South

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Africa 10 times. In other words, in terms of, according to the National Confidential Committee of Maternal Mortality, 43-percent of maternal death in South Africa is caused by HIV as are 35-percent of child mortality. So it is a big problem.

The third one, of course, is noncommunicable diseases, which are on the rise like in any parts of the world, high blood pressure, diabetes, cardiac disease, etc. but in South Africa, there is a very clear pattern of relationship between noncommunicable diseases and HIV and AIDS. For instance, cervical cancer is on the rise.

In fact, in one of the biggest clinics in the country that is 10-percent of all the HIV people on treatment when they did pap smears positive women, they found that the rate of positive pap smears are at 50-percent so we are actually having a rise in cancer of the cervix, of the uterus because of HIV as are other cancers like Kaposi's sarcoma and many other cancers, which some of us just read in textbooks are coming back on the back of HIV/AIDS.

The last one, I'm sure I don't have to lecture you, everybody believes that's what characterized South Africa, the issue of violence and injury. When people have been discouraged from coming to the World Cup, they were quoting that as the biggest problem. To us, it's only, according to our research, the fourth biggest problem that the country's faced with meaning when we planned the health system, we

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planned it around HIV/AIDS and TB, maternal and child mortality, noncommunicable diseases, and lastly on the issues of violence injury.

TB, I'm a member of the Stop TB Partnership. That's why actually I'm here in Washington this week to attend a meeting of the Stop TB Partnership. They are the ones who produced this table. It's a 34-member international board, Stop TB Partnership established by the Global Fund immediately as Global Fund was established.

They established the Stop TB Partnership and there are the statistics that these are the 22 high-burden countries carrying 80-percent of the TB of the world. As you can see there in the, it's number one followed by China, Indonesia, Nigeria. South Africa is only number five but that's because of the huge populations of those countries above us if you do infection by population, we suddenly become number one. Our distant number two is Zimbabwe.

The last column is very problematic for us. It shows co-infection or what you call co-morbidity. How many people are sharing both TB and HIV/AIDS? As you can see in the very highly populated countries of India, China, Indonesia, and Nigeria, it's 5.3-percent, 1.9, three-percent, and 27.

In South Africa, it's only three-percent. For this reason, the co-infection of 73-percent has prompted us to regard TB and HIV as two sides of the same coin, same disease

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presenting in different ways so that when you see someone with HIV think immediately TB. When you see somebody with TB think HIV. We have taken a policy decision that we need to treat them as such under one roof and take them as the same thing.

The daily adjusted live years, what keeps people away from work, as we are trying to demonstrate that by far our problem is still HIV and AIDS and TB not injury and violence as people believe because they contribute very little percentages as you can see there. People are staying away from work mostly in our country because of a combination of HIV/AIDS and TB not because they are injured or not because there's violence. Those are contributing very little.

This just shows what I've just said that when women are pregnant, among the HIV-negative ones, the mortality rate will be 34 by 100,000 but among the HIV-positive ones, it jumped 328 by 100,000. Among those who died untested are 275. Both three figures showed the extent to which HIV because those who died untested is very obvious from that, there have been HIV-positive only that we never knew those details.

While our problems with Millennium development goals is that in terms of mortality, maternal mortality and in terms of infant mortality even though we have put up teams of very highly qualified people because we think the figure of maternal mortality is high but not as high as it was put there. We think in some way between three and 400 but because of the

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complexities of rural statistics and all that and the fact that men and women don't present in hospitals, etc., mistakes will have been made in terms of figures but they are being looked into but as for now, these are the figures we are using.

Actually the main thing we want to demonstrate is that the maternal mortality has gotten worst after 1998 and that corresponds with the period at which HIV/AIDS reached the peak or started biting in the country that's mostly what I wanted to show. It also shows that here that when babies are born HIV-positive, they are 15 times more likely to die within the first six months. Put differently, HIV/AIDS increases the chance of dying the first six months by 1,500-percent. Now in South Africa because we have got 70,000 babies born annually HIV-positive that to us is very devastating.

In the continent of Africa, the figure is 400,000. There are 400,000 babies born HIV-positive in Sub Saharan Africa annually and 70,000 is in South Africa. ours, just comparing two provinces there, in terms of mortalities and taking action, this is where the province that is number two in HIV/AIDS, the province of Mpumalanga, it shows that in 1998 before HIV becomes worst, the lower graph, the purple, shows that death was quite very low in the age group zero to 11 months.

In the first 11 months of life death was not that low but that figure changed swiftly so that by 2006, you can see

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the peak there and it's at three months and this is the province of Western Cape, it was much worse than Mpumalanga, that purple graph at the bottom. There is a peak in 2003 at which time they started massive dual therapy and the death dropped to the lower graph, I think it is the red one in 2006 just showing that if action is taken, results are actually seen and they are swift.

I'm just trying to show that death doubled in South Africa in the period between 1997 and 2006 corresponding again with a graph, which shows the shifting of death patterns. If you go to our home office department and check the death rate, in 1997 it was indicating 317,000. I'm not talking HIV, overall death rate, in the country and by 2006, it swiftly changed to 612 million. There's a doubling of the death rate within that period of nine months. There won't be any other reason to give except the HIV and AIDS.

These are another very problematic statistics. South Africa paused termination of pregnancy in 1997 because we were worried about lots of backstreet abortions but unfortunately it had the effects of producing so many young people doing legal abortions and we think this is the problem that happened in Sub Saharan Africa, which even the United Nations population development picked up that Sub Saharan Africa, when we started the battle against HIV/AIDS because we believed prevention is

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very important using condoms, we unfortunately did drop contraceptive programs, family planning.

It no longer exists in many countries because if you introduce family planning, you will encourage young people not to use condoms. Unfortunately the effect is this, simply meaning that regardless of that consent, we've got to bring family planning back whether it is condoms or what. There has to be that because you can't have such young people, in other words, our conviction from this is that many young people in Sub Saharan Africa and South Africa specifically are using abortion as contraception, as family planning, which is not good at all.

This slide shows, actually it shows the issue I've just spoken about, the rate at which couples, specifically women, are protected against pregnancy using modern contraceptive methods including sterilization. As you can see, we are not doing very well. Our target is at the rate line and so we need to pick up contraceptive programs more than ever before.

We believe it was a mistake the fear that Sub Saharan Africa has that when you remove contraceptives, you push young women, young people to use condoms. It clearly it's not working. So contraceptives must also be used hand-in-glove with condoms.

This is primary health care utilization. Our target is up there. We are trying to indicate that our country has done

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something that I am not sure how many countries in the world that are battling with, running a curative health care system that is very expensive where primary health care is no longer utilized.

Forty-one-percent of rural clinics in South Africa were built after Nelson Mandela became president but the utilization has gone down. People are preferring to use hospitals most probably because primary health care and Mike will get a little bit surprised because one of his biggest involvements with us was on primary health care but it was soon dropped because people believed wrongly that when you get more sophisticated, you depend on a curative health care system because we have got money, technology, etc. It doesn't work. It doesn't work because diseases must be prevented not treated, doesn't work at all.

So we are showing this because and we're also showing that primary health care supervision rate is very low. We are doing so because I'm involved with a very, very difficult task of re-engineering the health care system in order for the health care system to be based on primary health care, on prevention, and promotion of health rather than treatment whether it's HIV/AIDS, TB, or any other diseases. Thank you [Applause].

DR. MICHAEL SINCLAIR: Minister, thank you. It's refreshing to have a frank fact-based presentation and as

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startling and as horrifying as the facts are, it at least gives us that empirical basis for a good discussion. I would like to ask Ambassador Goosby to make any additional comments please.

AMBASSADOR ERIC GOOSBY: Well I want to thank the Minister, colleague, and friend for his presentation for the candor in it. I also want to acknowledge the difficulty it is in reflecting such numbers and also expressing the impact that this has on medical delivery systems and the health professionals within them and the patient communities that use them.

It is extraordinary what South Africa has done under the Minister's leadership. President Zuma has pivoted the country into engaging in an honest and candid way about the burden of disease that they are confronted with and their attention and focus in responding to it.

Not a small lift, a huge lift that most people on antiretrovirals on the planet is in South Africa and the response to it is one of the most breathtaking things to see energized and for that effort to crescendo now into more specifics around the programmatic impact and the convergence with the primary care agenda that the Minister has put forward is truly the way forward. The United States is proud to participate in this effort.

I also want to highlight the fact that South Africa is moving their program and always have been the primary funder of

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their program for the treatment component and are moving aggressively to expand capacity at the provincial level and district levels for management, oversight and monitoring or evaluation, corrective reprogramming, retooling, refocusing of the effort to look at where the epidemic is indeed expanding, where the new seroconversions are and to align prevention programs to link and respond to that moving edge of HIV into the population.

This kind of geomapping and the alignment of programmatic emphasis on that moving, expanding edge is something that is very hard to move medical delivery systems to embrace it but South Africa again is taking the lead on that, moving toward a sustainable and progressively self-correcting system of care.

The final area that I think is commendable and strong in South Africa is their embracing of civil society, the acknowledgment that an emergency response as it moves into a sustained effort, needs to integrate and embed its programmatic footprint in the medical delivery systems that are in and of the public system as well as embracing the role, the critical role that civil society and faith-based delivery systems play in completing that delivery.

South Africa from really early on has used faith-based organizations in rural settings to cover that treatment need and has created, through the SANAC Council, the South African

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National AIDS Council, an entity that allows civil society to be at the planning table and at the table for the definition of the problem but most importantly to define the response and the Minister has been a leader in featuring the importance of that community dialogue and input and instead of being hesitant towards it, has embraced it and we are seeing now the benefit from that by looking at the programs getting stronger and being more responsive without it being a contentious dialogue.

I think finally that the ability for the South African government to play the orchestrating role as the key planner in what and where the response should be tailored has been exemplary. South Africa, the government becomes the orchestrator of divergent funding lines from Global Fund, from PEPFAR, from their own country's resources, as well as other foundations and other bilateral programs to define one planning process that defines the unmet need. They prioritize that unmet need and then inform the allocation decisions that will best respond to these two epidemics.

Tuberculosis being the second epidemic that has converged in South Africa, they synergize with one another and again, challenge the medical delivery system to be responsive. The Minister spoke directly to that in some of his slides looking at that overlap but also looking at it as an opportunity to diagnose and treat both. South Africa really is the epicenter of the epidemic and it is really breathtaking to

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see the government engaged and crescendo in their response and orchestration of a meaningful and effective response. So I'll leave it at that.

DR. MICHAEL SINCLAIR: Thank you Mr. Ambassador. As you suggested, Minister, the burden of HIV on particularly the primary health care system, I think to a very large degree and particularly in provinces like KwaZulu-Natal and Eastern Cape, overwhelm the system and has created a lot of the push from primary health care towards a more tertiary option even poor people choosing to often case bypass their clinic and go to a doctor and pay out-of-pocket.

So as you're wrestling with this enormous issue of how to manage the HIV epidemic long-term, you're also wrestling with the need to strengthen the health system overall. So I think I would certainly encourage you in your responses later on to give us more information on that issue and perhaps Jennifer, you would like to make some comments in that regard.

JENNIFER COOK: Sure, just a couple of points. First of all, we're delighted, CSIS, to cohost this with the Kaiser Family Foundation and it's a real honor to meet you. I think you and the Zuma administration have really breathed this new energy and enthusiasm and sense of optimism into discussions we've had with public health workers in South Africa, I think into the partnership as well with the United States.

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Two things I wanted to touch on, first is the question of the big ambitious targets that you've set for yourselves and those are laudable. I think it's important to set the bar high but there's a lot of challenges that go along with that. I was a member of the Institute of Medicine Committee on the long-term impact of HIV/AIDS and how best to prepare for that.

I see Patrick Kelly from the IOM here and I think and I don't speak for the Institute of Medicine but I think South Africa's really one of the cases we had in our mind, I think as we thought long-term into the epidemic, the choices that we make today, how they affect what happens 10, 15 years down the line and what capacities you need today and what tradeoffs eventually will need to be made and it is a finite world no matter how many efficiencies or more resources you generate, there's still going to be tradeoffs.

South Africa, to me, was a prime example of that, one in the new health care restructuring, the effort really to push out to primary health care facilities integrated and comprehensive HIV, TB, and other health care to improve access. That requires big, big investments in infrastructure, in human resources, in data collection, and so forth.

I think the human resource component is one of the most daunting challenges to my mind for South Africa. I was last there in August with my colleague, Susan Brendidge, in the midst of the public sector strikes and health workers were not

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immune. Some joined in the strikes but I think some valiantly tried to get to work and couldn't make it. Now the government is in a tough spot on that.

It already has a major public sector wage burden, not just in health but overall but offers to increase wages by seven-percent were initially rebuffed. I don't think it was because health workers or public sector workers were greedy or overly ambitious. I think many in the government acknowledged they're struggling to get by on very little and they play this vital role.

So that's a tough question that South Africa will have to answer especially know as it has this big wage burden already and with this push out to primary facilities, it's going to have to, that burden or that workforce is going to expand even further. How do you sustain that over time?

The second big tradeoff and I know this gets a lot of discussion is really on the burden of HIV treatment and the cumulative cost of that going forward over 10, 15 years as you look at those graphs and the unfortunate but very real tradeoffs and decisions that are going to have to be made.

I think there's going to be public pressures to adhere to WHO protocols, for example, or we heard more and more of test and treat model, second line therapies, and so forth. Those costs, what gives in that? Who makes the decisions on

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these important tradeoffs? How does that get decided? Who gets impacted?

That's something that we have in our own country with our health care reform and right now with budget cuts in Congress, where do you cut to make a vision possible? So I'll stop there and come back perhaps later on the broader U.S. South African relationship.

DR. MICHAEL SINCLAIR: Maybe Minister you would like to give some response before we take questions from the floor.

HON. DR. AARON MOTSOLEDI: Yes well obviously I presented the problem. I didn't present the [Laughter] the solutions. Yes, let me start with HIV/AIDS. You are aware that on World AIDS Day 2009, the first of December 2009, the president of the country, President Jacob Zuma announced, made [inaudible] announcement which turned the situation on HIV/AIDS in South Africa.

The four treatment regimens targeting what I've been showing here, firstly, pregnant women that we need to treat them when their [inaudible] count is 350 or less in the co-infected people also and the fact that all the children when HIV-positive have really given a figure of 70,000.

We need to put them on treatment immediately and lastly to start prevention of mother-to-child transmission at 14 weeks rather than 28 weeks. That was broadly done and it welcome but you also announced prevention strategies starting with a

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massive HCT campaign where every citizen was encouraged to know their status, to test 15 million people, we've really to test and counsel 15 million people. Our target was by June this year.

We are already at nine million counseled and about 7.7 million who have been tested and about close to one million of them tested positive but we are moving in terms of knowing your status.

Now TB, last week it was World TB Day on the 24th of May. We made three announcements also on how to combat TB. The first one, we are beneficiaries of the gene expert technology, which is just new whereby we're able to diagnose TB within two hours rather than waiting for four weeks as we're doing before.

We found it a very, very revolutionary development in the fight against TB but the most important announcement we made on that day that how is it that if you have got such high [inaudible] technology within in your health centers, we are waiting for those people who will come, what about those who don't even know they should be coming?

So we have decided to take the battle right into households and from the first of February one, we have put out teams to visit families. [Inaudible] we have got 407,000 people with TB. We think all those families must be visited and screened for TB. So from the 1st of February, we've already

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covered 18,000 families just in that period. These are teams of five where you put a professional nurse, a lay counselor, and three primary health care workers to visit families.

So that's, to us, we believe is the most important. The third one of course is through Global Fund, we're given money to put MDR hospitals and we unveiled them last week one per province. And now it's sort of a contradiction. When you unveil and celebrate that look I've done something that will help you put heavy MDR hospitals and utilizing them will increase if the house campaigns fail.

If the house campaigns become successful, [inaudible] and treated then you won't need MDR hospitals. So we're likely to close them as the house campaigns intensified.

Now lastly, the reengineering of primary health care must be in terms of what I've just mentioned and we've managed sort of, we've identified three streams of primary health care in the country, which we are busy planning to launch either this year or early next year.

The three streams are, we need five teams of very highly qualified people in each district in the country, a principal gynecologist, principal pediatrician, principal midwife, principal primary health care nurse, and principal family physician. If you put them in this group of five in each district to fight the mortalities then they're also helping prevention.

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The second is what base primary health care agent, which the method we are using we've seen it working very well in Brazil, in the primary health care approach in which we're taken there by Kaiser Foundation last year and we have updated. Lastly is a school health program where we think it's better to remove at least one nurse from each hospital and put them in schools, we're going to have a shortage of nurses in hospitals and have an overabundance of them in schools. There are 12 million school kids in South Africa.

We can do it for them to get HIV/AIDS and TB as it's likely to happen, put a nurse there and to stop what you saw there about contraceptives, reproductive health rights, immunization, HTC campaign, TB screening, all that must happen at school level. So that to the hospital only those who go is after you failed. That will tremendously reduce costs. If we come to Congress here and to Ambassador Goosby and to keep asking for money to put people on ARVs is obviously a losing battle. It is a losing battle.

So that's why primary health care, to us, is the key strategy because you detect the problems before they even happen. This is why there's been [inaudible] in our country as Mike says, people believe going to hospitals shows development. You are more developed. You've got money, you've got transport. You've got medical aid. You've got lots of doctors.

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That system doesn't work nor do I believe it will work in any part of the country. At the moment, we are engaged like U.S.A in health care reforms in terms of health care shortage. People are telling us it's completely unachievable. In the beginning, I didn't agree. I didn't understand them. Now I understand them, they are right. It's totally unachievable in the present method.

We wait for everybody to get sick and use the best possible technology to treat them. That is unachievable, I agree. Even if you are to give me a trillion dollars, I think it would still be unachievable but in a situation where you understand that disease can be prevented and you can promote health then anything is achievable and that's precisely the package we are putting forward to the country. Thank you.

DR. MICHAEL SINCLAIR: Thank you Minister. Alright, the floor is now open. When you ask questions, please raise your hand and if you would give your name and your organization, a microphone will find you. So if I can have an indication of questions and I think we'll take three or four together and then ask the panel to respond. So are there any questions? Yes sir?

CHRIS COLLINS: Good afternoon and thank you so much for being with us. My name's Chris Collins. Thank you so much Minister for being with us. My name's Chris Collins. I'm with AMFAR. I just want to underscore what others have said about

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your accomplishment on treatment delivery is amazing. it's inspiring. We want to learn from it. we want to celebrate it so thank you.

In that vein, you talked about the connection between HIV and maternal mortality, the need to make reforms, and increase demand around primary care, in this country we're engaged in the global health initiative and redefining some of what we do in global health.

I'm wondering what the lessons are from your experience in terms of using the HIV response as a foundation to build out to other health services. What are the lessons that might be useful for the global health initiative here in terms of how the AIDS response is a foundation for broader health delivery?

DR. MICHAEL SINCLAIR: Okay, other questions? Way in the back.

BENJAMIN: Hey, my name's Benjamin with the Center for Interfaith Action and Global Poverty. I was just wondering if you could comment on what you see as the potential promise in pre-exposure prophylaxis for HIV, which is currently under nine different medical concurrent trials and we've also seen the initial results, which show some promise but both for the Minister and for Ambassador Goosby how you see it potentially playing a role in HIV prevention down the road.

DR. MICHAEL SINCLAIR: Okay and there was somebody else to the right.

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SAUL EVAN: Yes, Saul Evan with the American Medical Association and former President on Medical Education for South African Blacks. I wonder if you could talk a little bit about how you're going to create the pipeline of training the health care professionals that are going to have to take care of the population that is now affected and where you see some of the economics of that playing out.

DR. MICHAEL SINCLAIR: Right. Training health care professionals and how is the cost of that going to play out and that feeds into the issue that was being raised by Jennifer earlier about expanding the workforce, the health care workforce, etc., etc. Perhaps Ambassador Goosby, you'd like to start with the prophylaxis question because that's probably a fairly concise answer and then Minister if you would answer.

AMBASSADOR ERIC GOOSBY: Sure. The use of pre-exposure proph is exciting to think and decide how that could indeed be integrated into a prevention effort that includes populations that are participating and highest risk.

Sex workers, men who have sex with men, injection drug users, individuals who are in a migratory pattern, truck drivers, miners who are in a transient mode for many months out of the year, all of these populations need to be targeted and looked at as individuals and as groups that could benefit from a strategy that included a pre-exposure proph matched with other prevention interventions that also target these same

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populations to keep them negative over time is something the PEPFAR program is looking at in a number of different settings including KwaZulu-Natal at this point so something we're looking at trying to understand how it best could impact and synergize with other prevention efforts.

HON. DR. AARON MOTSOALEDI: Well our prevention strategies as such I only mentioned one, the AZT know your status but we are actually using nine prevention strategies. One of them is this post-exposure prophylaxis. We've not yet rolled it over but we've had, in the way the Ambassador is describing but we've adopted just one of the prevention strategies.

The other one, which I forgot to mention, which was speaking to some of what you saw on the maps there is medical male circumcision. We found that curiously the areas that are red there [inaudible] do with areas in South Africa where there's no traditional circumcision. In South Africa we have got a lot of tribal groups and some of them do circumcision others don't.

We found that those who are not practicing circumcision, the areas are red like the Zulu Nation. That's why the king has taken so much interest because they stopped the practice of circumcision 200 years ago when Shaka became king during the wars. The king has just cancelled that 200-

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year tradition that they must now circumcise but they do so medically no longer traditionally. So it's one of the methods.

So I'm just saying it's post-exposure prophylaxis, medical male circumcision, know your status provision of condoms, safe blood transfusion, which by the way, I don't know why we forgot to mention with the Ambassador here, we have achieved, through the help of PEPFAR, I can safely say getting HIV infection from blood transfusion in South Africa is close to zero because of the help from PEPFAR in putting at state facilities. So we do have some things to celebrate actually.

Now the issue of training, yes it is quite grave. Seeing that in South Africa, the training we are doing is not only for us. We are training for the neighboring countries, many countries within [inaudible] they don't have medical schools.

The medical schools are in South Africa. Namibia doesn't have, Lesotho doesn't have, Swaziland doesn't have and many others right up to [inaudible] all that, all those people have been treated in South Africa and yet unfortunately we've been producing 1,200 doctors per annum for the past 10 years regardless of that and the burden of disease. We have adjusted it to expand that. We are dreaming about increasing that three times. We don't know whether that is going to be possible but we are putting up that plan.

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The second area is about nurses. When you've got such a big burden of disease, you can't rely on doctors. You have to have very highly qualified nurses and treat in large numbers. In fact, by February last year, we only have 250 nurses who were licensed to initiate ARVs and we're only having 490 centers, which could initiate ARVs.

We've increased the centers to 2,000 because the number of nurses who have been trained has actually increased tremendously, 10 times and because if you are to expand that and use doctors only, you'll be able to achieve it. So for this reason, we are calling a huge big nursing conference next week.

Those who know and understand the history of South Africa, we brought the new South Africa through a process called cordessa [misspelled?]. We called that nursing conference a cordessa of nursing. that we need to have, to start the whole nursing profession afresh in terms of the number of people trained, the level of training, where did you get the training, etc. in order to be able to fight this burden of diseases. That will supplement the way doctors do it.

But lastly South Africa's adopted what you call midlevel workers, people who, it's a new profession, midlevel workers. We only produced 23 by now because it's only one university, people who are not doctors but they are not nurses either. They go for a four-year training and they can do some

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of the work, which is done by doctors or assist, but also can do some of the work, which nurses are not able to do and afford us a new level of worker that will help in terms of HR.

Jennifer, you've mentioned something about a strike, we have consulted many nurses even before this summit as a build-up. Nurses don't want to go on strike. The problem is that in South Africa we've got the trade unions all over and and in federations, new federations which will say if anybody goes on strike, all of us must go.

We're all workers and all that but nurses are trying to discourage that because they understand their role is essential workers and many of them definitely, they sure don't like it but the reason we are having this situation in South Africa is the wage gap between you know we are a very unequal society, the wage gap between the rich and the poor is too big in South Africa.

If we don't close that, this issue of having strikes will always happen because workers believe there is money elsewhere but it's being received by few people who are super rich and we're being left behind. So they just feel like striking all the time. If there can be a closure of this gap, doesn't exist in many countries I must tell you. Brazil used to be higher than us and I'm not sure but [inaudible] they are closing it.

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In South Africa, this gap is huge but obviously coming from the era of apartheid you can understand how we came about. The after effects is that we're having strikes all the time. The way people feel, there is money. All I have to do is to strike then I'll get it. Then you have to convince them that it's actually not like that. Thank you.

DR. MICHAEL SINCLAIR: Minister, the other question related to the extent to which your rollout of antiretrovirals might have some lessons for addressing, tackling some of the other health priorities in terms of health systems development and so on.

HON. DR. AARON MOTSOALEDI: Yes, yes obviously rolling out this HIV has taught us a lot of lessons in terms of training people. For instance, when you rollout, you need a lot of laboratory stuff. You have to do training. You need a lot of cost shifting. You've got to shift, as I've said, you are shifting over to nurses and you expand many more centers and you involve lay counselors.

You involve primary health care people. It brings a lot of lessons in terms of HR but also, Mike, you see my worry is I was not very happy on World AIDS Day when the president announced these measures because the media was more excited about treatment and that [inaudible] South Africa has turned the corner.

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At long last, there's treatment. I wanted them to get more excited about prevention and that's the [inaudible] to turn everybody's attention towards prevention, not to believe that once treatment has arrived, the problem is over because it can be. I mean imagine it's a newborn baby who goes on treatment today. If he's going to live for 60 years, it means for 60 years, he'll be taking tablets assuming that nothing will change. That's not a good life. It's not a win. So they issue of rolling out but also encouraging prevention is the best lesson that we think everybody else must learn.

DR. MICHAEL SINCLAIR: Okay, good questions.

AMBASSADOR ERIC GOOSBY: If I could just answer a little bit. Two things, our programs, PEPFAR programs, have seen the need to support the expansion of medical professions from the very beginning of PEPFAR and we are happy to say that in the last month, we've been able to start an initiative with the National Institute of Health that looks at the medical education needs in 11 different countries and 16 different medical schools in Sub Saharan Africa.

South Africa, as the Minister alluded to, is playing a partner role with a number of institutions and other areas in Sub Saharan Africa. The unique aspect of this initiative is that it targets the medical school, the African medical school to be the principal investigator and then they choose who they want to have as a colleague in curriculum development revamping

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the curriculum to make it more problem-oriented, more family practice kind of focused from an American perspective and to work with the faculty to teach them how to teach in an excellent fashion.

So it really is an initiative that's focusing on increasing the training capability of the medical schools. It adds a two to three-year residency for medicine pediatrics, OBGYN and surgery at the end of the medical school training as the medical student moves into their first years of in-hospital time for a three-year period and then also teaches them the methodologic skills and clinical research, how to read clinical research and make it part of their toolbox in understanding and caring for patients, so bringing that skill set into the medical school setting. We're also doing that in nursing schools. South Africa's medical schools, two of them, are some of the twining or collegial relationships that other medical schools have identified to partner with.

In terms of the GHI question that Chris asked, there are many lessons that we learned from our work outside of the United States that have informed and given us insights into strategies that may be more effective. The idea of using existing medical platforms on which we add other services to expand the service capability of that medical platform be it HIV/AIDS, be it maternal and child health that just makes sense and we believe we'll be able to extend the service portfolio of

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programs that were already engaged with significantly to enhance the services that the individuals who are using these service sites can benefit from.

DR. MICHAEL SINCLAIR: Okay great. Alright we're going to start with some questions and starting in the back there, way in the back and then we'll work our way forward. Can we get a mic in the back there please?

BENJAMIN MOTAMBI: Thank you honorable Minister. I'm Benjamin Motambi also from South Africa. I want to commend you for turning this thing around in the way that you and the new leadership have done and restoring our promise to our people towards primary health care. My question is with regard to the big goal that we have for knowing your status. Out of 15 million citizens, reaching 15 million is still a little far from where we should be and certainly may not be realistic or necessarily desirable to reach all 15 million.

So the question really might be one of prioritization and in a country where the epidemic is so generalized, what do you see as the way forward in terms of who we should reach first with this program? Who are the people we should prioritize? Thank you.

DR. MICHAEL SINCLAIR: Right thank you. Just a little bit further forward. Yes, Janet?

JANET FLEISHMAN: Thank you very much all of you on the panel and especially the Minister. My name is Janet Fleishman.

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I've done a lot of work with CSIS on gender and issues of HIV and global health. I wonder if you could speak for a minute about the integration of family planning and HIV.

You spoke so eloquently about the situation of women and girls of reproductive age in South Africa and clearly they have reproductive health needs and HIV issues that are often linked and each can be a platform for helping to address the other. I wonder if you could speak for a minute about your plans or your strategy to look at the integration not only of TB and HIV but family planning and HIV. Thank you.

DR. MICHAEL SINCLAIR: Alright, I think there was a question just in front of you, ma'am?

NENE FOFANA: Hi. I'm Nene Fofana with Population Services International, PSI. I want to thank you for this opportunity to be here and respond to questions. My question is about public/private approach. You are talking about this very interesting public health program that you're trying to bring up to scale and I wanted to know how your government is or how you'll be working with the private sector to make that happen. Thank you.

DR. MICHAEL SINCLAIR: Alright so Minister, quite a menu there. Would you like to start and then we'll ask Jennifer to chime in.

HON. DR. AARON MOTSOALEDI: Yes, yes. Well the issue of putting a target of 15 million South Africans by June

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obviously was not a goal in itself, which after reaching then closed up. We just targeted to have a period of heightened activity, so that in other words, to bring awareness. Obviously I like people to test even thereafter.

Many of them to test more than once, in other words, we just initiated it for South Africa to start learning that you have to test for HIV every year. In some sectors, that has been achieved. For instance, Ungulu Cove [misspelled?], which is one of the biggest mining companies, when I visited them two weeks ago, I found out every year, the workers have tested and because they [inaudible] successful, they reach a 94-percent testing rate among the workers. It's an annual thing.

So we were trying to establish that annual thing by saying we targeting 15 million people. Obviously at the end if it's all 15 million who have tested I would be very happy. So the media was asking us that no this figure is not going to be correct. Some people are going to repeat, I said yes I'm encouraging actually. I'm testing at every available opportunity.

When I show people that they need to test, in my own department, when I test the workers, I tested at their lunch when the president tested, I did so. We want to take the [inaudible] to parliament. I'm insisting that all members of parliament must test publicly, I'm going to test again, so

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every available opportunity so that people must get used to these.

So they think of 15 was just to have a target really. I mean they think of 15 million and who are the people who are targeted specifically? We want to take the campaign into schools. We've already started at universities and answer many questions at the same time. When it comes to PPPs, for instance, the people who are doing the testing in our universities are the private sector or pharmaceutical industry.

They came together and say Minister, we want to help you. Let's take the university students and launch this campaign in universities. So it's another public/private partnership that is going on.

We need to test people in the farms. We need to do so in industry and we've already done that. We've already started, for instance, with escort our escort South African Electricity Commission, our power supply because I've been able to show them that one of the red areas there is where most of the power stations are and they got scared, then we started the program to go to the power stations with them.

It was initiated by the deputy president of the country personally and so are doing it with them and [Inaudible] is one of our biggest construction companies joined in wherever they've got a construction site with lots of workers, we go

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with them there, we test and the fund is showing again that it's another PPP.

The integration of family planning and HIV is one of the most important deliverables that must come. So in our school health programs, that's basically what we are targeting that if you've got a school health nurse, they are there exactly for that, for contraceptive health right, integrating HIV/AIDS treatment, and family planning but this morning, I met the International Partnership for Microbicides, if they get successful, this will be a revolution. This Microbicide ring to protect against HIV where they are also trying to put this ring with microbicide and contraceptives that will be a revolution.

The problem in Sub Saharan Africa of dumping contraceptives because they are scared that if you don't use condoms only, young people might believe that I am not going to for pregnant because I'm on contraceptives but not use condoms and not being exposed to HIV.

If you got a microbicide ring, which has got both contraception and ARVs in the gel, that's a revolution we want to see to integrate the facilities very well but we are disintegrating them as in this school health program. Our main motivation of having school health programs is to do exactly that apart from the other things.

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Now the public/private partnership I've already mentioned, last week I met the [inaudible] no less than 15 companies who came and said Minister, we want to participate in this health programs. Where do we start? I gave them to, that I'm giving you HIV/AIDS and HR, the HR we're speaking about here.

How many people can you sponsor to become doctors, nurses, pharmacists, physical therapists? I said go back and work that and come back and meet me only on these two, then we'll start talking. So that's going to be a huge PPP, public/private partnership because I said we might not be sharing lots of things in common but we are sharing are the human resources. When you train doctors, some of them go to work for private companies. So if there are more, there'll be enough for both the state and them and I said they must try and fund such programs.

DR. MICHAEL SINCLAIR: Jennifer, would you like to comment on this human resource public/private issue?

JENNIFER COOK: Yes and you know, and one question I did want to ask is the intersection between the private health sector and the public health sector. There are some models of kind of co-location within health facilities of private and public that was one. I guess I kind of rather step back because it strikes me through the conversations, whether on training and the new kinds of models that you were mentioning

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that follow very much along the Fogarty research partnerships with South Africa.

I mean for all the challenges that South Africa has, it has some amazing and very unique capacities and really in playing a catalytic role in the region and in Africa more broadly. The lessons that you took from Brazil probably a lot of African countries can turn to South Africa on the TB/HIV intersection not just in your programming but also in the basic research that's being done in South Africa and Cayruth and Caprisa and so forth.

In the integration and the primary health care push of family planning, TB, and HIV, in terms of the new model of a U.S. engagement with South Africa, I think that's focusing less on the provision of ARTs and more on these catalytic issues of training, human resource development, and so forth.

I really see South Africa in that way on so many of these things, on circumcisions, so many of the things that you mentioned on these prevention technologies, on measures of incidence so much that in a way that South Africa's grappling with the broader world can learn from. I tend to think that U.S. engagement with South Africa will be moving in future. South Africa is, after all, a brick now, or bricksa [misspelled?], whatever you want to call it, towards that catalytic kind of role.

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So in that, I wonder in all of these things that you're trying out, your outreach and the rest of Africa and in the region, how you see yourself playing that broader role on all of these things that you're trying out within South Africa.

DR. MICHAEL SINCLAIR: So how much are you sharing with the rest of the continent?

HON. DR. AARON MOTSOALEDI: Well the first thing is that you must understand that South Africa is two countries in one. We have got the Western Country and the developing country, third world country in one country. Take for instance this issue of medical care, there are lots of high-tech medical procedures, which can be done in the rest of the sub-continent.

They are all done in South African because we have got a very strong, highly developed private health care sector but that works as hand-in-glove with that, you've got the huge burden of HIV/AIDS, high maternal mortality, high infant mortality. It doesn't make sense to be so highly developed on one side but have such high mortalities. That's why we want to produce primary health care as an intersection between the two but our level of engagement with the continent is that we're doing that almost every week, must approve somebody coming from neighboring countries to do some form of procedure or other. So that's the first level.

The second level I've told you in training, we're training lots of people within the subcontinent but the third

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one because South Africa is an economic giant in the region, there is a feeling for instance in the mines, the people who are working in the mines are mostly not South Africans. They come from Lesotho, Botswana, Swaziland and so there's a lot of migration and they got worried about this issue of TB.

The reason that we've got that high burden apart from HIV it is from the mines. Remember that South Africa had gotten migrant labor system where husbands were forced to leave their wives and come and work in the mines in [inaudible].

So it also accounted for the problem we're having. So what we are planning now through this Stop TB Partnership is to call all Ministers of Health in Southern Africa, all the Ministers of Minerals and Labor and Ministers dealing with migration to come and draw a common strategy for the whole region not only for South Africa.

We will drive it but it will be for the whole region so that in South Africa, if we've got this plan for TB, it must all be for the whole region, if we've got this protocol for HIV, so whether a worker is in the mine in South Africa or in Lesotho they must be on common treatment and that's what we're doing to influence the regions in South Africa of course, driving that type of strategy because they see us as a problem but also as a solution at the same time. Thank you.

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DR. MICHAEL SINCLAIR: Alright so let's go to Chris sitting up front here now. Jack can you get a mic? Oh here we go.

SAMUEL EODISIAN: My name is Samuel Eodisian [misspelled?] U.S. Department of Health. One of the cornerstones of the global health initiative is moving towards country ownership. Conceptually it looks like a great idea but there are many challenges.

I remember President Zuma when he was president in waiting visited the U.S. with Dr. Zwelan Kesay [misspelled?] and went and met with counterparts from the Ministry of Health and OGAC, one of the issues that President Zuma actually very eloquently pushed forward was that this concept was good but it has to be well planned, couldn't be precipitous. It has to have a transition and he said actually a long transition. so from the point of view of South Africa, what have you learned about the transition and what ideally do you see as a good transition towards country ownership for a program like HIV/AIDS?

DR. MICHAEL SINCLAIR: Alright, good. Other questions right behind you there.

PATTY WEBSTER: Hi, my name is Patty Webster. I'm with the Institute for Health Care Improvement and I'm honored to be here and thank you all very much for sharing your insights. I know that one of the points, major points, of your plan

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honorable Motsoaledi was quality improvement methodologies and I'd love to hear more plans to further spread this.

I think there's been phenomenal examples across South Africa of how quality improvement has been used from the bottom up to really impact on your health systems, to improve the systems given the resource constraints that we have and that goes back to the question of the HR constraints.

I'd love to hear further plans on spreading these methodologies to retain patients in care now as we have a system that we need to chronically manage these patients because there's been some fantastic examples already in South Africa and coupled with that, my question is what plans to involve the community and patients as one of the most underutilized resources that we have to help improve those systems and get their perspectives on that. Thank you.

DR. MICHAEL SINCLAIR: Thank you very much. Right behind you here.

AMANDA LITTLE: Thank you. Amanda Little, Georgetown University, Minister, Ambassador, doctors. I would like to return to the question of training and look at the flipside of it. As someone who's been involved with medical and nursing education for a long time, it's not just the training or the education, it's the retention of the worker after they have been well educated.

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As you're having a fresh look particularly at nursing even next week, will this be on the agenda so that South Africa doesn't just put a lot of resources into training many in the various types of health care workers but they can also retain them and also look at how they can be good maybe regional neighbors so they're not attracted to the other countries surrounding South Africa that many workers often want to come after they've received training in their own countries. Thank you.

DR MICHAEL SINCLAIR: Alright, thank you. Minister, do you want to kickoff on ownership issues?

HON. DR. AARON MOTSOALEDI: Yes, I think we've already started in South Africa. While we need help and PEPFAR's helping us a lot, Ambassador Goosby knows but 80-percent of the HIV/AIDS programs in the country, we pay them and we keep on expanding so that we think we must reach a situation where if we ask for help, it shouldn't be to buy drugs. We should be able to do that on our own and a lot has happened between us and the treasury and the president after the World AIDS Day announcement to move towards that.

The second thing that we did with the help of the Clinton AIDS Initiative, the Global Fund, PEPFAR, etc., we had discovered that were buying the most expensive ARVs of any country in the world regardless of having the biggest rollout.

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Through that, we've been able to slash the prices by [inaudible] 53-percent.

We cut it down by 53-percent meaning that we can treat two times the number of people with the same budget. That even makes ownership of the programs much easier but we like to own them because we think it's sustainable. We believe when help comes, it doesn't mean you fold your arms and say they takeover. It means they push you. We don't want to become wheelbarrows, a wheelbarrow, you pick it up and push it.

When you leave it there, it waits for you there until you come [Laughter], want to be pushed a little bit of a distance and we start on our own. That's how we understand the issue of ownership.

The issue of involving community, our primary health care model is actually to do that. The primary care model we're trying to, we're even dividing it at the old level, there are about 4,000 managed [inaudible] wards in South Africa. We want to put 10 primary care agents in each ward. These people are nominated by the community and trained by us and working for us but chosen by the community.

In other words, you go to them and ask them. In every rural community specifically, when they've got problems, they know who they go to. That person might not be having any official status but they know that if there's no order, if

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somebody's sick, if there's no transport, if some woman is pregnant and is giving birth, there's no transport.

There's usually somebody who is unelected but always do that work. Some people are usually chosen as counselors but if they don't make it as counselors, you can use them as primary health care agents. That will help you to involve the community.

For instance, the fact that pregnant women must be treated at 14 weeks rather than 28 weeks for prevention of mother-to-child transmission will only work as far as the women who are pregnant coming in to test. If you don't know them and they're not coming in to test or communities don't mobilize then it won't help. So it will only work if communities know who is pregnant, whether they've tested, if they're positive, are they on PMTCT, etc., etc. So the involvement of communities is very key in that regard.

The issue of retention, I'm sure you are aware that the World Health Assembly debates this issue on an annual basis. Even this year, it will be there in Geneva because almost every country's suffering this issue of migration of health workers. The WHO passed a resolution about retention on what we need to be doing.

We are implementing that resolution but we are also having bilaterals. For instance, we had a huge bilateral with the UK about them to try their best not to take nurses from us

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because and if agreed, when I was in the UK in March, there were about 78 nurses left from South Africa, when just before there were about 1,700.

So it's working when you negotiate but also we also are seen as, while we are complaining that the Western countries are taking doctors from us who are poor but many African countries are complaining that South Africa is taking their doctors and they're poor. So it depends who's [inaudible] each other. So we have got protocols, for instance, within [inaudible], we've got protocols that we must not actively recruit workers, health workers from around other countries. It doesn't usually work because some of them are there.

For instance, I've got lots of Zimbabwean doctors in South Africa. I didn't recruit them, they came [Laughter]. So in that case, I said look, this resolution can't apply. I'm just going to employ them but it causes problems within [inaudible], they say no, everybody shouldn't be coming out.

So at the nurses' summit, we are going to discuss with the nurses the strategies for retention. What is that which the nurses believe government must do in order to retain them so that they don't go away? That definitely is going to be on the agenda. It's going to be under training.

What type of training, for instance with these mortalities, you may say I want to train more midwives, more primary health care nurses, more pediatric nurses, etc., etc.,

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and we want agreement at the nursing summit from the nurses themselves but then they'll tell us what should I do as a Minister to retain them in their positions so that they don't go away but it's not something that we think will always work 100-percent because it is a contradiction between two United Nations' agencies here, the World Health Organization and the International Labor Organization.

The International Labor Organization says it's a right of every worker, health worker or not to work anywhere they want in the globe and it's their right. Then the World Health Organization says look don't recruit from developing countries. It's dangerous. So between those two, we're trying to survive [Laughter] because we subscribe to both of them.

DR. MICHAEL SINCLAIR: Ambassador Goosby, do you want to comment on the pace of ownership, the transition, and the extent to which that is sort of a mapped out strategy as opposed to one that might be expedited through funding constraints?

AMBASSADOR ERIC GOOSBY: Well I think that South Africa really is taking a regional lead and presenting itself as the responsible orchestrating, convener of resources as they come into their country and I think are creating the institutions that can identify accurately scientifically that unmet need and a process in place to prioritize that unmet need to make the correct allocation decisions.

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We are very gratified at South Africa's embracing of this leadership position and are hopeful that they will be the model that we look at as the United States government in dealing with our partner countries in the transition from a more typical bilateral dominated entry in that emergency response that PEPFAR represented as we move into a more sustained response that ensures, better ensures that the services are there for as long as they're needed.

We believe that the country ownership is the key to that pivot, enables and positions the country to successfully play that orchestrating role with all these divergent resources to address what is still a significant unmet need. We believe that the partnership frameworks that PEPFAR has used as a tool to have these discussions map out a five-year commitment on part of the country and on part of the United States government and with our colleagues in the Global Fund and as we now move into a different dialogue and relationship with them to really allow us to identify synergies, cooperations that save money, that are smarter, and allow us all to save more lives in this effort.

I think South Africa really does typify stepping up to that plate, embracing it and moving forward with it not as a separate entity but in a real partnership with U.S.G resources that we are quite confident will be a model for that type of transition.

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Resources being what they are, budgets being what they are, they put the external pressure on us to move but they don't tell us how to do it and we still have the ability to be smart and strategic in how we allow these resources to move to programming.

DR. MICHAEL SINCLAIR: Jennifer, I wonder in that vein, the Minister is going up to the Hill in a little while whether in the context of the evolving political environment and perspectives on global health funding and the U.S. government's commitment to global health funding going forward whether you have some suggestions for some of the kinds of concerns and issues the Minister might address?

JENNIFER COOK: Well I do think that you want to highlight the track that you're on, which is moving away from direct provision by the U.S. and U.S. intermediaries of services, of antiretrovirals and so forth to the, as I said before, catalytic investments that the U.S. is making in South Africa. I think South Africa is an emerging economy. It's very important to the United States.

If you look at the Obama national security strategy, South Africa's mentioned frequently as a big new partner for the United States to engage with. You have Secretary Clinton and the State Department and the White House very keen on renewing and reinvigorating that relationship. It's always

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been a strong partner but I think the last administrations both here and in South Africa didn't always see eye to eye.

I think there's been a real shift in the relationship. I think your role and President Zuma's role on health has been a big factor in that but there are other things as well. So I think there's a lot of willingness from the White House and State Department to push for that improved relationship.

As I said, the PEPFAR transition that's already happening is something to be on track, the kind of catalytic investments. I think of ways of engaging, at a broader than government to government level, that's the kind of model that you're talking about, med school to med school, researcher to researcher. You have tons of wide-eyed, young public health graduates from the United States flocking to South Africa.

So there's a constituency here that's really interested in public health and in South Africa and because I think South Africa can play that regional role and a model role on some of these really tough challenges, the tradeoffs, the HIV/TB intersection, the family planning HIV intersection. I think that's a place that we're going to continue to invest in even if the financial aspect of the relationship declines somewhat this year, maybe next year. I think those are the things to emphasize.

DR. MICHAEL SINCLAIR: Thank you Jennifer and Ambassador. I think that both those comments are very good

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note on which to conclude this session. I think, I'm sure Minister, you have sensed from both the attendance here and the remarks that South Africa remains of very high interest and importance.

I think that there is a great sense of wanting to be able to celebrate South Africa's accomplishments always. So just as we celebrated the World Cup and it wasn't only South Africans who celebrated, I know many, many Americans who don't care a hoot for soccer really thought it was fantastic that South Africa had been able to pull it off in the fashion that they did.

I think here again today you have demonstrated that tenacity that perseverance, and style that Americans love to celebrate about South Africa. So we thank you very much. We wish you good luck. You have a long way to go and thank you for being here [Applause].

[END RECORDING]

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