In-Country Ownership Solutions for Leadership and Accountability
Kaiser Family Foundation
July 23, 2012

[START RECORDING]

LUIZ LOURES: I'm sorry, all of you. I didn't see that I was live. My name is Luiz Loures. I am from UNAIDS, and I'm moderating the session this evening. We have a very distinguished panel and a very important issue, in-country ownership.

I like the panel because of the construction. I think we have different perspectives on the issue of country ownership. We have with us Dr. Raj Shah, we all know for many of you, the demonstrator of the United States Agency for International Development, USAID. [Inaudible] 8,000 people in 80 missions across the world. Very welcome. It is a pleasure to have you here.

Minister Kesete Berhan Admasu from Ethiopia, my friend for some time, and we met recently in Ethiopia, and I just joined in the African Union Summit, and I'm sure you have things to say about that when you talk about country ownership.

Anthony Pramualratana from Thailand. Sorry, Anthony. Basically from the private sector, a corporate man, and I think you'll be extremely interesting. I have particular interest to see his views in terms of the country ownership.

And dear old friend of mine, Yolanda Simon from the Caribbean. Yolanda is an activist. We all know she was on the front line of the response since the beginning, and [inaudible] at least or like a few in this conference Yolanda know about

you people and that you want to see [inaudible] in terms of country ownership.

And then we have Teresa Guthrie from the Centre for Economic Governance and AIDS in Africa that you walk us through how to use modeling to define country HIV related illness and assessing country whose use and abuses of these sorts. She's bringing the two to the panel.

To frame this panel and this discussion I think we need to refer to the context stuff that is response today that it's a very different world from what we saw just a few years ago. Let me share with you an example, the *Columnist*, the magazine. About ten years ago there was a cover on the *Columnist* where the title was Africa, the Hopeless Continent, and inside, in the report, in the main report in this issue, a lot was related to the AIDS epidemic and they backed off the epidemic in the continent.

A few months ago the same *Columnist* published a different cover, and the title was Africa is Rising, and the content was not unrelated to what's happening in terms of the response to AIDS but as well what's happening in terms of the economic development, and as you know very well six out of the ten countries that are growing more today global wide there in Africa.

This [inaudible] change, and the world has changed. The cries is that we see in the north [inaudible] in Europe.

It's a very different take if you go today to a country in Africa or other place in the south. At the same time, and that's not new for any of you, I think is the tone of this conference, the progress in terms of AIDS response that we have observed and managed in the last 10 years use treatment as an educator 18 million in treatment today. We still have seven million to go, probably the most difficult to us but we are far ahead than we were just a few years ago.

Prevention is the same, rates going down with the most effective countries, new tools and the opportunities to prevent are coming out, many of them being discussed in this conference from prevention of sexual transmission, to prevent [inaudible] transmission, and others.

There is progress. That is no question. On the other hand, as I mentioned, there is a crisis out there. The classic model of supporting the AIDS response probably is being challenged today. I don't know for how long it can hold, but it's clear today that the notion of a donor recipient is probably not too valid anymore. You have the money. I have the problem. You give me the money, and they help me to try to fix their problem. It's not that simple anymore.

I think we have a different dynamic today, a different context. Most positive developments but that's [inaudible] of us how so to review the paradigm was that we had years to respond to it, and among them and is in that context that I see

[inaudible] and that's why this discussion is so important because if we don't change the paradigm out of discussion, out of hope that we heard yesterday and today to go to the end, you're not happy.

We may get short. We may stay [inaudible]. We are visualizing the end, but we still have a way to go. I was moderating earlier today the session with Elton John and the panelists. Well, that discussion was from a different perspective but in the same direction. What you take to take us to the end but to the end that we want, and it's not any end. In this case we had discussion that the only end that we accept is going to the end by not leaving anybody behind. That was the message from the earlier session.

More for us to go. I think it can be a very interesting discussion this evening, and I have great pleasure to invite Rajiv to give us the introduction earlier [inaudible]. Rajiv, you have the floor. [Applause].

RAJIV SHAH: Thank you. I very much appreciate the opportunity to offer introductory remarks to a panel that I believe is tackling one of the very important concepts of this meeting.

The basic preposition that in order to genuinely turn the tide we all will have to do things differently to enable and support real country ownership, real strong local institutions, and real sustainability even as we work

aggressively to add to the number of people who are being treated to implement the combination, prevention, strategies that Secretary Clinton spoke eloquently about this morning and to genuinely fight to turn the tide against AIDS.

I'm so excited that the panel includes so many diverse participants from around the world to share their experiences and their stories and to help us, through those stories, understand how we can do a better job in supporting genuine country led efforts to turn the tides against HIV and AIDS.

I'd like to start just by sharing with you my personal story. I'm very honored to have the chance to participate in this conference and to participate in this conference here in the United States as Secretary Clinton welcomed everyone here this morning.

I first had the chance to meet with and work with patients who were suffering from HIV on a visit in the late 1990s to Mozambique, and I had traveled from Seattle to Beira in Mozambique, visited families who had HIV and really learned about the challenge of the epidemic and the tremendous stigma, social consequences, and human health consequences patients suffered through the eyes of a wonderful Washington State based infectious disease doctor, Dr. Stephen Glaser who had put a lot of effort into really making sure that we were able to identify and support those HIV patients that we could in that small community in Beira.

Through that I was really inspired to see what an American doctor could do, someone with compassion and commitment and someone who was willing to travel around the world and spend his time and his institution's resources to really try to help people who at that time couldn't' turn to other institutions for basic lifesaving support, and I took away from that a tremendous amount of personal inspiration and commitment to tackling HIV/AIDS, and as a medical doctor myself to applying the skills of modern medicine to the challenges of global health around the world.

Now, we've seen in contrast to that situation over the past three years the number of people that we, the United States, directly supports on life saving treatment more than double from 1.7 million to four million. We've seen the number of people we support to get testing and counseling increase to more than 9.8 million pregnant women, and today we're trying to completely eliminate the transmission of mother to child of the virus by being even more aggressive and comprehensive in our outreach in that regard.

This is important progress, but in order to truly win the fight we need to address the reality of how we got here. We didn't get those massive and rapid increases in coverage by supporting wonderful, well-meaning American doctors to go abroad and treat patients as we were originally doing in the late 90s and the early part of the last decade. We got there

by relying on partnerships, genuine partnerships with strong local institutions. Today when we reach these kinds of very high coverage numbers it's mothers helping other mothers by sharing their own personal experience in the mothers to mothers effort.

It's community health workers, often HIV/AIDS survivors and patients themselves knocking on doors in the communities where they're from going house to house and ensuring that other HIV positive individuals have support as they go through and maintain their treatment regimens, and it's our partnership with laboratories and scientists around the world that allow us to do clinical trials that have brought to the fore many of the great breakthroughs that are now making the end of AIDS a possible endpoint.

These types of efforts are fundamentally about empowering local institutions and local partners, and we know that if we're actually going to achieve the goals that are set out by this conference, that were articulated by President Obama on World AIDS Day and by Secretary Clinton this morning, we will need to push ourselves even further to find and support the kinds of local leaders that will transform the face of this epidemic in country after country.

Country ownership starts with strong political will, and we were pleased to see the recent U.N. AIDS report that showed that domestic funding for HIV and AIDS has now exceeded

international investments. In just one year low and middle income countries increased their own investments by more than 11-percent to $8.6 billion, but we know money is not the only part of genuine country ownership.

We know that too often we continue to invest in systems and partners that are very high cost and that don't often create the space for health ministries and local institutions to hire and retain the best talent, to grow and develop their own capabilities, and so at USAID we have, on behalf of the U.S. government, implemented a set of reforms we call USAID Forward to help us move more resources directly to local institutions, to help turn our officers and our missions into scouts that are out looking for partners and engaging with institutions that have the capacity to grow and develop, and we're changing our own systems to make sure that we can monitor and evaluate and report on results from those local investments.

For example, we're partnering in Afghanistan with the Ministry of Public Health, which in the last nine years has expanded coverage of basic health services from nine-percent to 64-percent and help bring down the rate of maternal mortality faster there than anywhere else in the world.

In India we're partnering with companies in the private sector, insurance companies like Star Health and Allied Insurance to develop insurance products that cover people

living with HIV and AIDS. So far those insurance plans have covered more than 5,000 people living with HIV across five states in India.

In this past June we launched the Call to Action in Child Survival to bring together communities that work on HIV, preventing mother child transmission with those communities that work in Malaria and immunization and other areas like child nutrition because we know ultimately our commitment to these individuals, whether they are AIDS patients or whether they are young children that are newborn but at high risk of losing their life in the first five years, needs to be comprehensive if all of us are to live in a world where people survive and thrive.

So as we hear from our partners and as we see the trends in the decade ahead, I would just ask the panel to consider and those of you at this conference to think about what are those things that we could do differently to help effectively support the growth of local systems, local institutions, and local leaders?

How can we make sure all of this wonderful capacity that we've help build over the past decade that is today treating eight million AIDS patients can ultimately fall under the control, the management, the vision, and the aspirations of country leaders, whether they are in the civil society, in the private sector, or in governments themselves, and how can we

build on this trend of making sure that in countries we recognize bringing about an end of AIDS is not just a donor priority that is done in partnership with countries but is rather the core development challenge facing so many countries around the world and critical to long term economic and security and stability for all.

So I thank you for the opportunity to be here at the opening of this panel. I look forward to these comments to come, and I look forward to the years ahead where we will change not just what we're trying to do, which is to end AIDS, but how we do it, which is to find those great local partners and institutions that we know will be the leaders in walking across the finish line. Thank you. [Applause]. Thank you very much.

LUIZ LOURES: I think Dr. Raj would start with the panel. I think it's very important that I think it's very positive to see additional development. That means so much in terms of the [inaudible] across the world and [inaudible] showing the opening, to evoke, and to adapt to its own program to the change environment of a changed world, and that's what we hear from Shah. I think in his openings and his invitation to hear from the country experience of what's happening today.

The next speaker is Minister Admasu, Minister of State of Health of Ethiopia. As I mentioned before I had the opportunity to be in his country just a few weeks ago when the

African Union had the opportunity of its summit a new [inaudible]. That's basically calling for him to share his responsibility and the global [inaudible].

It's basically [inaudible] come and they're searching for a different paradigm to respond to AIDS that both sides take into consideration they still measure needs and measure the steps that we need to make, but definitely incorporate that countries are [inaudible] taking more and more responsibility its own response.

The example of [inaudible] itself, and Minister Admasu will speak on that. It's clear. Example, South Africa we hear the [inaudible] president yesterday. We have several examples across the world by many [inaudible] do highlight, mainly the examples he offers.

Here's a moment of shared responsibility. Here's a moment of [inaudible] but from the [inaudible] the objective is the same and [inaudible] on the ship is the pillar, is the fundamental pillar for these agendas to go forward, but let's hear more about it.

Minister Admasu, you have the floor. If you want to speak from there, from here, it's up to you. If you come here, I think people like to see you better. [Laughter]. [Applause].

KESETE BERHAN ADMASU: Thank you, Luiz. I would like to thank the organizers of this meeting for creating this

important platform to discuss and share perspectives of donors, implementing countries, private sectors, even societies about country ownership.

My country, Ethiopia, is among the countries most affected by the HIV epidemic. We have an estimated adult prevalence of 1.5-percent. It has a large number of people living with HIV, which is estimated to be around 800,000 and about one million AIDS orphans. Despite this mounting challenge the global response has been a reason for hope and optimism in fighting the epidemic.

Application of effective and feasible preventive interventions to avert infection, use of heart, and sustained global and national commitment continue to register success in the response to the epidemic. These interventions have rendered tangible results.

From the early days of the epidemic Ethiopia has shown commitment to prevent its spread and mitigated the impact. To this end it has rallied support from national and global partners, including mainstreaming of HIV prevention programs to public and private sector businesses and engagement of committee based organizations.

During the early years the government adopted a national AIDS policy and developed and implemented several effective strategies. Despite the multi facet of challenges caused by HIV/AIDS Ethiopia has demonstrated that with country

ownership, commitment and effective strategies there is hope for reversing the trend and minimizing the impact.

These concerted efforts have yielded encouraging results in reversing the rate of new infections and in mitigating the multi-faceted in parts of the epidemic. In fact, recent reports show that Ethiopia is one of the few sub-Saharan African countries demonstrating more than a 25-percent decline in new HIV infections. NAC surveillance data shows that prevalence of new infections among pregnant women, 15 to 24 years of age, has declined from 5.6-percent in 2005 to 3.5-percent in 2007 and 2.6-percent in 2010. [Applause].

Likewise latest data shows that use of preventive methods in the number of people who have tested for HIV and utilizing treatment in care services has increased. For example, the number of people who were tested for HIV in 2005 was around 40,000 people. In 2011 we have managed to test ten million individuals for HIV. [Applause].

There has been much debating of global community on how best to accelerate such positive outcomes. The notion of country ownership has surfaced in many of these conversations. Country ownership is the surest way for developing countries to chart their own course of development and overcome the challenge they face in building effective and productive states, but what exactly do we mean by country ownership?

Drawing on our experiences in Ethiopia I can point to four key steps for making country ownership a reality.

The first step is planning. Countries must start with a clear development plan, but they also need to elaborate and attain the roadmap for realizing it. In Ethiopia our vision is to become a middle income country over the next ten to 15 years, and our government has clearly articulated the strategies for how to get there.

For country ownership to be realized development partners must allow countries the space to identify their own needs and priorities and develop their own plan as they see fit, but countries should also be open to ideas and seek to tailor proven practices to their own particular circumstances. Once a well-considered national plan is in place, however, partners need to support the plan if country ownership is tried.

We remained open to ideas throughout the planning process. We invited partners, contributions, and benchmark based practices from other countries. This is a must besides the state to this real ownership. A very good example of country laid planning and implementation is our flagship program, the Health Extension Program.

When we set a vision of setting up a committee based health service delivery using a cadres of committee health extension workers, we said this has to be the pillar of the

health system. We want it to be, and we decided to train 30,000 Health Extension workers and deploy them across the country.

When we set this vision, some of our partners were skeptical by just considering that Ethiopia doesn't have the means and the capacity to train 30,000 Health Extension workers and deploy them in just five years, but we benchmarked it from other countries.

We tried to define equivalent standards that is tailor made to our needs, and we also decided to make it an integrative service delivery. So with that clear plan, clear vision in mind, we started training the Health Extension workers, and after five years we ended up training 34,000 Health Extension workers and deployed them all over the country. [Applause].

So the second critical step for country ownership is resourcing the plan. Hence, two countries must take the lead, and because resources are limited, careful prioritization is crucial. In creating our health plan we defined two alternative versions. One version is the best case scenario, and the second option is a best case scenario.

In crafting a resource constraint means that we cannot implement our broader and more ambitious plan, which is best case scenario, we go with our contingency plan, which is the

best case scenario, which focuses on the most pressing priorities.

Even more important is the way in which resources are channeled. Flexible and predictable funding forced our accountability and ownership by allowing countries greater leverage in responsibly managing the resources. Direct support is the ideal mechanism in view of the enhanced flexibility and control for these countries. In Kaiser's way, our partners, choosing a mechanism is not budgetary support.

We have negotiated ways in which the funding can be used to benefit the whole health system. We have even used vertically raised funds that are those in market for these specific services to strengthen our health system. For example, about 25 to 30-percent of HIV is grants from the global fund to work for HIV, TB, and malaria, and 15-percent of resources from PEPFAR has been used to build our health system.

The third step is implementation in which countries must also be fully engaged. Some have argued that countries lack the capacity to implement. If so, the most efficient and sustainable solution is for partners to strengthen existing capacities within the country rather than replacing them with [inaudible] structures. If existing national systems and processes are inadequate, partners should work with countries to fix it.

The fourth step is monitoring and evaluation. Partners should also help countries to build their capacities to track performance. Mutual accountability between countries and partners require a solid result based framework based on clear outcome targets that must be defined and agreed to at the outset.

So in Ethiopia what we do is we have what we call a district based planning process, which ensures top down and bottom up alignment of our plan, and we use a balance of the score card management system to track our performance and so on.

So this is very important to ensure that we and our partners are held accountable to a mutually agreed results framework. Ownership reinforces commitment, and commitment in turn yields results and assures long term sustainability. In Ethiopia we couldn't have achieved such encouraging progress in our health sector without this type of genuine ownership and the space to pursue our approach to service delivery on the basis of health systems strengthening.

These practical steps to our country ownership are neither new, nor particularly difficult to understand. Countries simply must own all these estates for the effect of development aid to be maximized. What seems to be missing is partners' full commitment to country ownership. Partners have a wide range of interest that hinders them from fully embracing

country laid processes, but a decisive shift has to happen now if the MDG targets are to be reached.

We urge all our development partners to move forward in a new spirit of candor and partnership to make country ownership a reality. That way achieving the MDGs will become a reality too. Thank you very much. [Applause].

LUIZ LOURES: Thank you, Minister Admasu. It's a clear presentation that to go for country ownership you need vision. You need a systematic approach from planning to implementation, but Minister Admasu raised one point that I think is particularly important is on terms of accountability. Going forward their results based on country ownership should be measured through the results that country ownership is facilitated or making it happen.

I spoke before about a new international [inaudible] to take us to the end of the AIDS based on shared responsibility and global solidarity, but of course this agenda cannot be done only in the framework you have [inaudible] to have discussion between the north and the south. I mentioned the case of the African Union but it's fundamental that to see the sides to be incorporated in this discussion to [inaudible]. It gives a very clear hope.

Mainly three that he was talking about in response to AIDS is not new to any of us or any of you. They're to differentiate the response to AIDS, more than science, more

than technology, and look at what we have a major achievements in these two areas while it's actually the social movement behind it. Whereas this unique combination of taking [inaudible] scientific advance, and the social movement behind the AIDS that made us to arrive where we are today, to come as far as we are today and start to talk about the end of AIDS.

It's in that perspective the next two presentations are basically on this direction, to explore and to tell us how and in which ways science should continue to play a key role in terms of the [inaudible] issue. I would like to invite Anthony Pramualratana from Thailand, the executive director of a highly successful Thai business, the Thai business, the Thailand Business Coalition on HIV/AIDS. Anthony, you have the floor.

ANTHONY PRAMUALRATANA: Thank you. [Applause]. Thank you, Luiz. I'll just take around six or seven minutes. My title is called business sector solutions, and what I will be talking about today is a standard on HIV and TB prevention in the workplace.

I'm not a businessman, but I work with business, and the first question is I'm going to ask you why is what they asked me, and the simple answer to that question is why is because you want to do good.

In this day and age and especially in Asia corporate social responsibility and all of what that means is to do good, and businesses in Asia and around the world have many, many

slogans, some of them very meaningful and some of them very sincere, some of them maybe not, but that is to do good, and for the how is for the business is what we try and say that we need a measurable standard, a standard on HIV/AIDS and in our work TB management in the workplace that is measurable.

Throughout your organization, throughout your business, throughout your branches, within a country, and if you're a multinational throughout other countries, and here's an example of a well-known sports brand that uses one of their values to say that they will do things that are good on HIV and AIDS.

To do the right thing is one of their many maxims, and you may—throughout the world there are small meetings of businesspeople, and this is just one small example in Cambodia where people get together to do the right thing, to do good, and I think in conferences like this we sometimes forget that there are individuals who want to do good. They happen to work in the private sector.

That's so we won't blame them on that, but they want to do good, and small meetings like this happen around the world, and the questions they ask themselves are simple questions. They're not nuclear scientists. They're not physicians, and some of them are not highly educated. They're just good businesspeople.

They ask questions of what happens when coworkers refuse to work with a colleague that may be rumored to have HIV

or when they employ a person with HIV or when that person requests help or when that person wants to resign. So these are very simple questions, very shop floor questions.

However, at the country level sometimes business needs a helping hand, and here is an example from Thailand where the helping hand is a national code of practice on HIV/AIDS and prevention and management in the private sector workplace, and Thailand has developed a TB, tuberculosis, prevention management in the workplace, and this is the notification of the ministry of labor.

By the way these national codes of practice are related to the ILO code of practice and exists in almost at least 60 countries around the world. So I'm not inventing the wheel here. So what we have here are departments of labor, ministries of labor, ministries of public health. We are a small association, and the standard which I'm presenting to you today which is an HIV/AIDS prevention and management standard that is measurable, to influence and invite companies to join. We call this ASOT Thailand, and basically objective is to reduce risk behavior among employees, to eliminate stigma and discrimination and to support staff living with HIV and AIDS.

The standard has two steps. Step one is like a graduation from high school before you go into step two. Basically a company should not conduct compulsory testing, should not terminate applicants or employees, and should

provide some level of HIV/AIDS and tuberculosis education. Step two is a very standard procedure, and it's currently based on 100 points, and it's related to policies, confidential systems, guidelines, education, and community involvement.

So those are the two steps, and I think we all have programs in all of our ministries around the world, but we need a measurable standard which is cross country, but we need a measurable standard which companies and large companies, multi nationals, can use throughout their offices around the world.

In Thailand I'm just trying to say that we have done this, and it has worked with over 4,400 companies in 2012 alone, and of them close to 3,000 have been certified at what we call the platinum level.

Our plan is to engage other countries, possibly beginning from the Asian region or regional groupings to further develop these international standard, and this is, I think, one way that we can work with the private sector and government in preventing and reducing HIV stigma and discrimination and prevention using the private sector workplace to achieve this goal, and I think that's basically my presentation today. Thank you. [Applause]. Thank you.

LUIZ LOURES: It's exactly what I think we expect from the private sector. [Inaudible], we always knew them. They come, and their clear messages [inaudible] looking for his roots, and usually they are the ones that speak at the

[inaudible] and they are apparent. Thanks, Anthony. That was extremely interesting.

The next speaker is Yolanda Simon. Yolanda is from the Caribbean Regional Network of People Living with HIV/AIDS, and I think it's a special pleasure to have Yolanda with us because if there is something that we have learned as well during the last ten years dealing with AIDS, that people with AIDS better to have them on the table, better to have them in the decision making process if you want to move forward. That again is a unique contribution of the AIDS movement in terms of not only the response to the epidemic but beyond that.

Yolanda, the question for you is there how the experience of this society very [inaudible] of people with AIDS and you dealing with most effected populations, with the most vulnerable groups engage with governments, with private sector in terms of making country ownership a reality.

Yolanda, you have the floor. You want to speak there, here?

YOLANDA SIMON: I'll come there.

LUIZ LOURES: Okay, yeah. We'll see you bigger there, the TV. [Applause].

YOLANDA SIMON: Good afternoon. Are you hearing me? Yes? Are you hearing me? Good. I know it's the end of the day, but it's the first day of a historic occasion, and I promise you I will not keep you here too long. I know we all

PowerPoint fatigued by now, but I promise you I have ten slides.

LUIZ LOURES: Thank you.

YOLANDA SIMON: Three of them are of little consequence, which is the first one you're seeing there already. It tells you who I am, where I'm from, my topic.

LUIZ LOURES: We need everybody's support.

YOLANDA SIMON: Okay, and I'm pressing here, okay? Good. The second slide just reminds you where I'm from, the lovely Caribbean island where we have S-s-s and S. You know those four Ss? Sun, sea, sand, and sex. [Laughter]. So that's why we have to talk about HIV. Good. So here we are. Who are the most at risk populations? You know, there's a new trend. I call it a new trend called MARPs.

Now, most at risk populations, they are persons who are marginalized, stigmatized, and discriminated against. Now, in an ordinary world that could be a lot of us right in this room here, but when you put HIV and AIDS in the mix, then something else happens. You get such issues as other groups who are hidden or they are hard to reach and include groups such as sex workers, drug users, and prisoners, part of society that a lot of us don't like to talk about.

MARPs are also people living with HIV and AIDS because for those of us who have been on this journey for some time, we know that MARPs is one of those. You know in HIV we have all

these buzz phrases? It's a buzz phrase over the last few years because it's now the sexy topic to talk about, MARPs, but for those of us who would turn our minds back, we would remember that people living with HIV were MARPs. They were marginalized. They were stigmatized. They were discriminated against, but these days there seems to be a deliberate attempt to divide the two, and we must guard against that.

They have little or no voice and tend to be underground. The epidemic continues to have its greatest impact in these populations, and the presence of stigma and discrimination continues to impact on the health seeking behavior of those individuals and therefore highlight the gaps in the prevention services.

Do they have allies, and who are they? Well, in the NGO community, they are MARPs. In the community based organizations, they are MARPs. In the faith based organization, they are MARPS. In government as well as in private sector MARPs are integrated at every single level of society, and sometimes we tend to forget that. We tend to put them in a special category, but they're here. Turn to the person next to you.

Advocacy, in this Caribbean, in my Caribbean, we don't act up. Otherwise we'd probably be thrown in jail, but we do quiet lobbying and this can and have influenced a lot of policy changes. Advocacy must be at all levels, national, regional,

sub-regional and international. At the national level champions need to be identified, promoted, and supported. They are identified, but sometimes not promoted and even to a lesser extent supported.

Sub-regional advocacy, we keep talking about health systems strengthening. Now, this is a debate going on in the Caribbean because it's health systems strengthening versus government public health responsibility. There must be some balance.

Ongoing research led by MARPs and people living with the disease would support from the traditional institutions. Those are the Caribbean Health Research Council, the University of the West Indies, the Pan American Health, et cetera, et cetera, and this must become a priority. Capacity building of MARPs and people living with HIV in these communities must also be a priority to ensure country leadership for civil society. Policymakers should be approached with evidence based advocacy highlighting the prevention benefits of an enabling environment for MARPs and persons living with the disease.

To continue the local circumstances are situation specific. Too often we in the Caribbean, we transplant a lot of things from the north and Europe and all over the world and expect it to work in the Caribbean. This does not happen, and it continues to have little or no impact.

We need to stop that, and we need to look at what's happening in country and develop strategies to suit our realities. There must be continuous environmental scans. We must ensure that we reach target and impact the right people, the populations, and the right issues. At the sub-regional level, advocacy and solidarity is necessary to bring the bigger picture that is to mobilize resources and most importantly to galvanize political will, which is sorely lacking.

The role of MARPs and people living with HIV, there must be a closer collaboration and integration of MARPs and people living with HIV/AIDS organizations in the region. That is the Caribbean vulnerable communities, the Caribbean Regional Network, and CFLAG [misspelled?] just to name a few.

There needs to strengthen the relationship between the regional organizations as above and its national affiliates, the need to identify who are the allies and develop strategic partnerships with them. There's also a need to identify resources, to support joint and individual plans, and when I speak about resources I don't only mean about money but technical, emotional. They are different resources that are necessary. There's a need to develop a regional advocacy plan.

The way forward, in-country MARPs leadership solutions for civil society must include a state of the union report, which gives the other perspective and keeps watch on the

national understanding and presentation of the issues on the national, regional and international level.

Too often other governments, my governments in the region, they come to forums like this. They smile beautifully, and they agree to everything, and they will sign the declaration when we leave here, and then that's the last we would hear of it. They must now be held accountable, and we can't do it by ourselves. We need all of you to rally with us to make this happen.

MARPs are core components of the global response and must be involved at all levels, from leadership, to monitoring and evaluation. That they own and not ownership is given but is inherent. Some people believe that they are doing MARPs and people living with HIV a favor by allowing us to come to the conference and be part of a gathering like this, but it is alright to be here and to have our voices heard and listened to.

So in closing MARPs, people living with HIV and AIDS, continue not to be the problem but has always, always, always been part of the solution. I thank you for your attention. [Applause].

LUIZ LOURES: Thanks. Thank you, Yolanda. Back to the end of the AIDS and what it will take for us to go to the end, and it is definitely the theme of this conference we are having now. Almost 24 hours into the conference I think it's clear

that this is the mark for this conference in Washington is the end of AIDS we are going for, but, as I mentioned before and that has been very present here today, we need to qualify the end of the AIDS that we want.

We want to go to the end by not leaving anybody behind, and there was that have the risk of stay behind today are exactly the ones that Yolanda was speaking about. They are the most vulnerable, the ones that actually—we are here because of them, and we went so far. We came so far because of them because they were the ones that really started to move the AIDS response since its beginning in the AIDS.

We have a long way to go, and in any discussion, as I said before, the ones that are the most vulnerable, they need to be part for, and just before I move to the last speaker let me give you one example on the progress on treatment. There is no question we progress more than ever. We have eight million people in treatment today. We are past the tipping point.

We have less people waiting for treatment, the seven million that we have achieved today. However, if you take a look on the coverage of treatment in the regions where, for instance, this epidemic is primarily related to intravenous drug users, to intravenous drug use, the coverage rates are the lowest, like in Eastern Europe where it's last in therapy center of the people need to have access to treatment.

The same goes to women. The same goes to children. 30-percent of the children in need, they have access to treatment. If you compare that to access by others, that is a huge differential.

Just believe the message. We go today, but we cannot compromise, and let's not fool ourselves that we can go blank. We need to go bring everybody together with special attention to the [inaudible]. Let's make the transition here because now I'm going to invite Teresa Guthrie from the Center for Economic Governance and the AIDS in Africa. The shift towards a new regime, towards a new paradigm as we are looking for it, where country ownership is the pillar which to be done very carefully in a system [inaudible 00:54:0].

Investments play a key role, not only because there is a crisis outside there that is a global crisis today. The financial environments change, and the fiscal environments change very rapidly, but more than that because it counts to all they need to mobilize more of these in the office but for everybody being affected account and being showed up here, being South Africa, being a major donor as we heard before from Raj in the U.S., for all of us these much investments are crucial.

We want to use the money with efficiency to get the best results, bring everybody together in terms of benefits, and for that is where I see the importance of country as

instruments that can guide us not only in terms of investing, terms of monitoring results but also how to go all the way to be accountable for what we are doing that was highlighting the presentation, and that's why Teresa is going to talk to us about HIV modeling for [inaudible] solutions, and with that I think we have a very, very complex perspective of what we are already talking, of course, where [inaudible]. Teresa, with you? [Applause].

TERESA GUTHRIE: My name is Teresa Guthrie from the Centre for Economic Governance and AIDS in Africa, and I'm going to be talking a little bit more broadly than just modeling and actually talk about the generation of evidence that actually empowers countries to govern their own response.

So I'm talking about this as an additional aspect that all the other presentations have already mentioned, and that's specifically with regards to financial information, and that is because we believe without a doubt that governments need information in terms of estimating the need in their country, the resource requirements, their etiquette of decisions to ensure that there is efficient and effective spending on effective program and ultimately to ensure transparency, accountability and good governance.

But in addition we believe that society needs to be capacitated to enable them to monitor their government's allocations and their spending and the impact or the output of

the services delivered, and with this evidence we believe that governments can take leadership and full ownership in their response.

What I wish to show you is a very simplistic visualization of the fiscal data cycle. Just to highlight some of the data requirements based on our experience in Eastern and Southern Africa we found the states to be critical to governments. So the first, as I mentioned, is actually estimating the need that they have in their country and costing that, having good unit costs, and also being able to model the impact of their choices and have cost effectiveness in [inaudible] to help them make those choices.

That then goes to where they can actually do some sort of financial GAP analysis. Now, that assumes they know what is the current and future projections of the money available in their countries. With that financial GAP analysis they can then mobilize resources from within and outside the country and also then allocate budges accordingly and hopefully within the investment framework. The challenge here or the difficulty is often knowing the development partners' longer term commitments and being able to monitor those over time.

Then, of course, there's the execution of their budgets, and here we need without a doubt stronger financial information systems that allow for detail tracking of expenditure according to their priorities and also against the

budget or the intended spending. At this point, as well, we can measure what the actual spending of donors are in the country, which is often very different from the commitments or even the disbursements made.

From there, of course, there is the need to actually monitor the outputs of that spending and the quality of the services and whether they were achieved their actual objectives, and at this point there's the internal performance auditing, but there's also community level auditing of their services and their quality, and then in theory we look to the longer term impact of that spending and whether we actually had impact levels on the HIV prevalence, incidence, mortality rates, and so on, and it's really important at this stage that we do cost benefit analysis to ascertain whether we've made the right choices, and that in theory leads back to the first point of informing, again, what their needs are and what their choices and therefore what their budgets are.

So because of the shortage of time I'm just going to flick through a few slides. They're just give you examples really of how this data has empowered countries in the East and Southern African countries but in particular in South Africa.

There were the 2031 estimates that were very important for countries to model going forward for the longer term impact in Asia and Thailand. In South Africa there were the ART cost estimates done by the Boston University and HERO, which really

helped the government to come to terms with how much the ART program was going to cost.

South Africa recently launched its new NSP, a very ambitious plan, and we costed that for them, but initially we tried to show them what their options were. This shows some various scenario options that they could choose between.

The obvious one, most impactful one, is the green one, the more comprehensive option, and it was the only one that really brought the new infections down below half, and that was their plan, and it is also, again, here the green bar shows you the option that brings the HIV prevalence down to around 10-percent.

That's a very hopeful scenario, but of course if they choose that, the green bar there, it's going to cost them more than the others, and they had to really come to terms of if they wanted to have the longer term impact, where would they need to put their money, but this slide, I think, showed them and encouraged them that if they did have that comprehensive approach, the treatment spending, the red bars, would eventually come down, and that was what had them buying, and they thought this is the way to go forward.

Recently, as well, we costed the new NSP, as I mentioned, and this just shows what the resource estimate needs would be from about two billion this year to about four billion in 2016, the bulk of it being ART. We then need to compare

those are the forward projection cost estimate with what actually has been spent in the country, and here the National AIDS Spending Assessment has been a very powerful tool being promoted by UNAIDS across the globe but in East and Southern Africa in particular, and in South Africa we recently undertook the National AIDS Spending Assessment there, and I believe that this concurrent session now it's being presented. So I'm hoping there are more people at that one.

We then compared what was actually being spent with what we thought would be needed in the following years to measure that funding gap and then provided the government with various scenarios for meeting that funding gap. So this just shows you in East and Southern Africa the proportions that come from the public sector, which are the blue, and the red proportions, which are the external and the very small private sector proportions, and it just shows the range.

South Africa and Botswana are on this side being predominantly funded by the public sector and obviously giving them greater ownership down to Uganda, Zambia, and Mozambique high dependency on external aid.

In South Africa particular we look backwards to say, well, what was spent as what was thought to be needed in the first NSP, and we found that the prevention and PMTCT were underfunded while HCT or VCT, as it was called then, was overfunded but only because there had been a massive drive by

the South African government, and interestingly, too, you can see that the treatment was far more the actual spending than had been anticipated, partly because of the CD4 count being raised for eligibility.

It's also useful to see what are the different partners doing, and this just shows you the public sector being driven by treatment, a treatment here being not only ART but also all the other range of treatment and care interventions.

The private sector was mainly treatment, and in this case was mainly ART. The external partners, also importantly supporting the research agenda there, but overall the total, and this was in 2009. You can see the predominance of treatment and actually the relatively small proportion on prevention activities, and over the years it was actually decreasing.

Also in South Africa we could compare the ART unit costs per province and showed a wide variation. So the government were able to say why has the Northern Cape, on the far left side, why are they spending 5,000 rand per annum versus [inaudible] which is spending two and a half thousand per annum, and then they were able to compare that with prevalence rates and the factors that contributed to those variances, and interestingly this beautifully colored graph shows the prevention choices in South Africa across province.

No particular trend can be seen there, and nor can one see if the actual investment framework priority prevention areas are being followed. However, in each province there were particular reasons for their choices of spending on prevention, and these were important drivers that could not be ignored.

Also useful is to know for the countries is are they actually targeting the right groups, and in the Eastern and Southern African country where it's a generalized epidemic we were not surprised to find that the spending on people living with HIV/AIDS was the largest proportion. However, it was useful for the governments to know that the actual spending on most of risk populations was very low.

So the financing gap, I'm moving on to the next section, is to show you here that in theory we would have a financing gap in South Africa in 2012, 13, of about four billion rand, but when you broke it down, it was important to see the variation within the interventions.

So on the left hand side are the ones where we actually thought we might have overspend in compared to the cost estimates, and there in theory you had overspending on OVCs. That's the blue part, but that was because of our foster care grant, and actually apart from that the spending on OVCs was relatively small, but here of concern is the under spending or underfunding that is likely to occur for ART treatment and for TB treatment.

This enabled the government to say, well, we need to look at what can we do to meet these gaps, and we provided them with various scenarios. I won't talk to all of them. They were stagnated, minimal growth, maximum growth where we thought maybe the external aid would come in at 35-percent increase, highly unlikely, but let me just show you two of them.

In the mixed case scenario where the government contribution rises by 22-percent, which is real according to the MTF allocations, and where the private sector contributed 20-percent of the need, and donor contributed 20-percent increase per annum. We had a very small funding gap. So in this mixed case scenario perhaps we reduce the funding gap.

That may be unlikely so we also modeled for them if we had innovative domestic funding options, alternative funding options, then perhaps we would be able to completely overcome the funding gap, and within South Africa where there is the potential fiscal space of alternative funding options such as the currency conversion tax, the financial transaction tax, even possibly an earmarked AIDS levy, these are all options that the South African government is now considering.

So in conclusion I'd just like to say that we believe without a doubt that one of the most important factors for true internal local government ownership is the generation of sound and objective evidence that allows them to make better choices and inform all their policy and allocation decisions.

Also importantly the research agenda that drives these choices in a generation of data should be aligned to national priorities, and in many countries where it is the external aid that supports research it is important that those agendas are aligned with the national priorities.

What is obvious from the data I show you is that aid dependency and its unpredictability and lack of long term commitment seriously hinders the countries' ability to future plan. Without a doubt I believe the most important thing is improved public accountability and transparency with regards to their budgets, their spending, and their outputs, and most importantly to improve their financial systems, and this should happen before we spend or send more money into countries.

Also importantly though, not only on the public side, is to improve the transparency of the external partner spending and what their commitments will be and whether these are actually aligning to the national priorities. We do need to model those alternative funding options that I mentioned to ascertain what is their real impact, what's their potential to contribute, such as the national health insurance, the transaction tax, the currency conversion and so on, but they are important options for governments to take greater power in their leadership role.

Also importantly is greater transparency from the business sector. So I really appreciated that contribution

from Anthony and the development partners. Last but not least, building the capacity of civil society to monitor their government spending and building the capacity of local and real in-country agencies and organizations, so as was said right at the beginning PEPFAR looks for local partners to join forces with, and I really believe that those need to be truly locally owned in order to ensure their ongoing sustainability and impact in those countries. Thank you. [Applause].

LUIZ LOURES: Thank you, Teresa. Financial management has become one of the major challenges and needs in terms of sustainability of the AIDS response. There's a direct consequence of the increasing on the money available from international institutions and as we hear here more and more from domestic investments, and this challenge, it's particularly important because, as you know well, in most of the countries the leadership in terms of guiding the response to AIDS lies on the health sector, and the health sector not necessarily is equipped to deal with the amounts and volumes of resource that are coming to support the response to AIDS.

I think it is, including terms of technical assistance, I have the opportunity to speak here recently to a PEPFAR coordinator in one country in Africa, and she was raising exactly that, that in her view the major gap was in terms of the technical support for financial management, much more than, for instance, in terms of the managed drugs, and so that I

think the knowledge that's much more incorporated saw it in every country where we are today.

We do have a few minutes for a few questions. I'm opening the floor now and inviting you, please, come forward if you would like to interact with the panel. The floor is open.

MALE SPEAKER: Hello?

LUIZ LOURES: Please, the lady on my left side. Please come to the mic on the floor, here. Move to there. Could, please, somebody guide the lady to—

Thank you in the audience, the ones that did help. If there is any other question, please start to join the queue, and then we go.

SAMRAWIT YITAYEW BIYAZIN: Thank you very much. My name is Samrawit Yitayew Biyazin from Ethiopia. I'm presenting you with disabilities here. My question is do you think that persons with disabilities should be considered amongst at risk group by International AIDS community? Do you think they need to be considered as a group at risk by International committee? If you don't, why not? Thank you very much.

LUIZ LOURES: Thank you. I'd like to take an additional question from anyone on the floor before going back to the panelists. I think I don't see any. I'm sorry. Please, on the right, go ahead.

JAMIE FREE: Thank you. My name is Jamie Free [misspelled?] from the United States. I have a question about

the metaphor of ownership that's being used here, and I wanted to get the panelists' reaction to the idea of a different metaphor which would have slightly different implications, and that's the idea of authorship that the countries, instead of talking about whether they own their programs, it might be an interesting idea to talk about the authorship of their programs in terms of recognizing the creativity, which often gets passed over it seems to me in thinking about how these programs come about and how they're structured.

We can talk about whether or not the countries buy into them and own them in terms of an investment, or we can talk about where the programs actually come from and recognizing the creativity that comes up from those countries, the grassroots, the community based organizations, the government ministries, and recognizing a lot more about the importance of recognizing that agency, that creativity.

LUIZ LOURES: Thank you very much. I think these are the two questions. Yolanda, would you like to take on the first question, please?

YOLANDA SIMON: Can I respond from here?

LUIZ LOURES: On the question that the lady asked about—

YOLANDA SIMON: Can I respond from here?

LUIZ LOURES: I think so, yeah, please. Go ahead.

YOLANDA SIMON: Hello? Are you hearing me? Yes?

LUIZ LOURES: Go ahead, yeah.

YOLANDA SIMON: Okay, good. I thought that was such an excellent question, and to be honest I am not sure where people with disabilities where they are categorized. What I can tell you is that the debate about MARPs it is heavily weighed on the side of men who have sex with men, sex workers, and drug users.

I think it would be wonderful if persons who are different can come to the table and let their voices be heard in unison. I think what needs to happen is a lot of advocacy to put that question to those in positions of power to be able to respond to you. Where are you on the continuum? I don't know the answer. I'm going to throw that back at you because you represent UNAIDS, and I don't know where UNAIDS have categorized people with disabilities.

LUIZ LOURES: Yes, ma'am, you are back to the moderator, and you cannot do that. You're not supposed to. [Laughter].

YOLANDA SIMON: I don't know.

LUIZ LOURES: But anyway now I think we follow, Yolanda, your views on that. It's, again, to go to the end of AIDS, nobody can be left behind, and I think this is the point to take, and it's not that much an issue of groups, but it is more an issue of risk situations, and in the case that if the people with disability, that is not so a unified universe.

If they engage on risk situations, of course they should be taken on board as potential mark, but definitely no question and I think that is a trend today in terms of response to AIDS that people with disabilities, they deserve special attention, and more and more they are engaged in the discussion.

I think in this conference there was—if I'm not mistaken there was a preconference event specifically on that, and there are sessions throughout the conference that deal with people with disabilities, but, again, we learned that during the last 30 years. It's a lesser issue for the groups is more an issue or if engaging or situations are in risk, but resource diminish the importance of taking vulnerability in the center of the response.

Admasu, would you like to deal with the second question? Would you like to start and then you ask Anthony and Teresa for final words, and we close up then? Admasu?

KESETE BERHAN ADMASU: Can you hear me? Okay, like I say we really need to think about the four steps which I consider as critical steps to force their country ownership.

Of course with planning we would need to engage various actors in the country including committee based organizations, committee at large, and so in Ethiopia what we do is we have this district based planning process, and in this district based planning process we use the MBB tool to identify both

[inaudible] at the committee level, and we invite all committee actors at that level to identify problems, and we try to sort of prioritize based on the problems that are identified at the committee level, but various people define country ownership differently. For us it's countries leading all those four steps.

Some people consider country ownership as partners coming in and talking to government authorities, informing them about programs that they want to implement in a given country, and this communication between a partner and government authorities are sometimes referred as country ownership, which in our opinion is not the right way to nurture country ownership, and the whole process has to be led by countries, those four steps.

Of course programs, interventions, have to be benchmarked from success stories elsewhere. We don't have to reinvent the wheel, but all the time countries have to take the leadership from the planning to financing, implementation and monetary and evaluations. That's critical.

LUIZ LOURES: Thank you very much, Admasu. Anthony, a very short final comment to add. We start to go over the time that we're allowed to be in the room.

ANTHONY PRAMUALRATANA: Thank you, Luiz. Thanks for that question. In Thailand there is no ownership, and I think there is authorship, but right now I think maybe I'm not

qualified to sit on this table up here. There is authorship, but my job is to develop ownership, and so ownership comes from, I believe, that strategic partnership between government, between private sector, but it has to be led by individuals and what I call individual commitment, individual diamonds.

So we do not have ownership yet. There may be programs in government which says we do this and this. We do have a standard, but in my definition that standard really has not been owned by any individual sector in the country. Thank you.

LUIZ LOURES: Thanks, Anthony. Teresa, over to you?

TERESA GUTHRIE: Thank you. I think I enjoy the idea of authorship and creativity. It's difficult to quantify from financial perspective, but I do think that when countries are given the financial power and flexibility, they can author their own response, and I think it's important, as the minister from Ethiopia mentioned, direct budget support is a very critical funding mechanism that would allow for real country authorship and ownership.

The global fund is another mechanism that has allowed for countries to identify their own issues and to respond to those issues in the way that they felt was important. There are other funding mechanisms that are less flexible and have not allowed true country authorship. So I think it's an important concept we could move towards and try and measure the progress on.

LUIZ LOURES: Thank you very much, Teresa. That brings us to the end of this panel. I thank you each panelist with us just for being with us. I think the message here is that country ownership is not a rhetorical issue anymore. It's a reality. Countries are building capacity. Countries are monitoring what's happening. Countries are learning and feeding back and going all the way from governments to civil society to science to private sector. That's what we saw here, and we saw it already begin the perspective of the donor countries in terms of helping engage.

This discussion actually will continue PEPFAR is promoting from 6:30 today in the meeting room right in the convention center, a discussion of country ownership using global partnerships to accelerate health system transformations. It's a very interesting problem I think most of you saw.

There was that [inaudible]. I think it will be never enough to talk about country ownership because this is where the future of the response to AIDS is, and this is where that's the roads. There is no way. The road to take us to the end of AIDS goes through country ownership.

Thank you all very much. Good evening. Enjoy the rest of the conference. [Applause]. Thank you.

[END RECORDING]