The Future of Universal Access - Part 2
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STEPHEN LEWIS: —evident the various roles that are occupied by our panelists on the screens and I think I will let that suffice for introductions so that we don't lose time in this session, although I'll make reference when I do introduce the individual panelists.

May I have an opening comment or two? I'd like if I might to set a context for this by making reference to the fact that just a little earlier today there was a quite unprecedented press conference held announcing the extraordinary breakthrough on microbicides [applause]. It's very rare at a scientific session, as colleagues have told me, that you will have the room packed, two overflow rooms, people in the halls and a standing ovation after the presentations are made and it does give the sense, I think, of the centrality of this conference and the tremendous importance it's assuming when you have the microbicide breakthrough which speaks of course to the rights of women and the notable presence of science at an international AIDS conference.

It is, as Michel Kazatchkine was reminding me, by no means the only dimension of this conference. We've had the remarkable embrace of treatment 2.0 and particularly treatment as prevention. We've had the extensive signing of the Vienna Declaration. We've had a quite fascinating study with enormously important and positive implications around men who

have sex with men, and we've had the microbicides. So, at least in my visits to conferences over the last eight years, my first was Barcelona in 2002, I've not quite seen this kind of collective impact of content before. That makes I think this session on the future of universal access all that more important.

At the end of the last session, which I may say was a fascinating one, brilliantly orchestrated by Mark Haywood, but with very strong interventions on the part of all the panelists, Mark left us with the following observations: That everyone agrees that universal access is necessary, it is a matter of principal, and that HIV as universal access can lead to a number of other health services.

There was some dispute on the economics, but there was in Mark's word at the end, if health is a human right then it carries with it certain country and state obligations. And it was generally conceded by all that we can't give up lest the momentum fade away and return to those desperate conditions of the 1990's when as Dr. Peter Mugyenyi said, and Peter runs the largest treatment center in Uganda with over 32,000 patients. He said, if universal access—if we cannot afford the treatment under universal access, can we afford the carnage?

By the way, Eric he made strong reference to the health system strengthening that he had received from PEPFAR in the course of his work in Uganda. So what I'd like to do is enter

into a conversation rather then a series of presentations. And I'm hoping that the panelists can intervene initially and then we can get the conversation going. I'm going to approach first, Paula Akugizibwe, who you will see is coordinating ARASA's regional TB and HIV treatment literacy and advocacy program, hoping that Paula can set some of the stage for where we are and where we should go. To be followed by Dasha Ocheret, who is the coordinator of the Steering Committee of the Eurasian Harm Reduction Network and its drug policy coordinator as you doubtless divine.

Then I think it would be useful to ask Ambassador Goosby, I'm always resentful of carrying the term Ambassador, because I used to be an Ambassador too, Eric, and I'm a Canadian and when you finish your diplomatic tenure you lose your title and you are then mortally obscure again. So I have that undercurrent of competitiveness.

Of course Eric Goosby is the Global Coordinator for the PEPFAR Program, which we are all familiar with. And then I'd call on Michel Kazatchkine, who is head of the Global Fund to intervene. I think Michel may wish to address some thoughts to Dasha, as Eric may wish to respond to Paula.

Finally, a very good friend, Dr. Mphu Ramatlapeng. This is an interesting panel because Dasha and Dr. Mphu, and Michel are all absolutely fluent in Russian. I did not know that the Minister of Health in Lesotho is fluent in Russian but

she is, and therefore we may move from English to Russian interchangeably, just as a matter of providing versatility for the audience.

With those opening comments, Paula, if you want to bring us into the views on where we are in terms of universal access in your mind and where we should go.

PAULA AKUGIZIBWE: Well I think we've all heard the figures over the past few days that explain in epidemiological [misspelled?] terms where we all need universal access, we're not nearly where we need to be. This was the year when all hoped to be celebrating achievement of the universal access goals but instead we've seen less then half coverage of that.

But, at the same time, even though this progress is not as extensive as we would have hoped, it's come with some very important gains. We've seen a decline in the number of AIDS deaths. We've seen hundreds of thousands of children being born free of HIV, which 10 years ago would have been unthinkable. We've seen many of the ripple effects of this investment in HIV across health systems. Its impact on other morbidities such as TB. We've seen a reduction beginning in maternal mortality as a result of access to HIV treatment, although this mortality could be much more greatly increased if we scaled up universal access.

And I've also started to learn a lot about how we can improve our response, about how we can really leverage the

investment in HIV to help strengthen health systems, to help our progress in other MGDs. How treating earlier from CD4-315, and we just learned could decrease mortality by 75-percent, could decrease TB by 50-percent. So we've made all these really exciting developments and we'd hope that because we're not where we need to be and we've learned so much that this would be the year in which we would redouble our efforts and use all these new tools that we have to start really accelerating progress.

I think the political landscape at the moment is responding counterintuitively to how we'd expect them to and instead we're seeing this slow down and this desire to start focusing in other areas to start really nurturing the rate at which we scale up HIV programs.

The implications of this, if they're not addressed, is that global finance hopefully is replenished in October. If PEPFAR continues to cut back on its commitments, we'll unfortunately undo all the progress that we've seen to date.

STEPHEN LEWIS: Fair enough. One of the things in the previous panel was an absence of precise definition of universal access, but I assume that in cosmic terms you mean treatment in care and prevention, et cetera. Are you pessimistic about what the future holds? Where we are at this moment?

PAULA AKUGIZIBWE: Well, I think if the current political statements that we're hearing from major leaders and from our own African governments, if those continue to be what dictates the way that we respond with funding with policy, then unfortunately the landscape is looking quite bleak. It's looking quite cynical.

We're hoping that at a reason because if you look at the scientific rationale behind all of these arguments they don't really make any sense. We're hoping that reason and that an appreciation of the fact that health is a human right and a good economic investment will change the way that the trend is currently going. But, unfortunately, I think being here for the past couple of days, and I'm sure that a lot of people share my sentiments, I'm feeling quite cynical.

STEPHEN LEWIS: Do you share the cynicism, Dasha? You come from a part of the world which is not usually addressed so frontally at an international AIDS conference. Do you want to talk to us a little about that?

DASHA OCHERT: Well, thank you. I would say that I am rather pessimistic about where we are now in talking about the region of Eastern Europe and Central Asia and not too optimistic about the future of the universal access.

Universal, the meaning of this word universal for myself when I talk about our region is that all people should get access to HIV prevention or treatment no matter who they

are and they may be using drugs, they may be illegal migrants, or they may be homeless people and unfortunately, when you talk about rights to health, of these vulnerable groups in our region the access to treatment and care is still rather low. I would say that we are totally dependant on the global fund financially. And that's very important from the political point of view.

I originally come from Russia and this country is—well I wouldn't say it's a rich country, but I am sure it's got enough resources to give prevention and treatment to people who need it in the country.

Unfortunately, Russian government is not so much committed to invest into HIV treatment—I mean, not just antiretrovirals, but the whole range of services that are needed to ensure access to treatment. I mean needle exchange for drug users, case management, counseling, peer support, groups, all these kinds of services are not so much supported by the national funding and may actually disappear if the global fund stops giving money to the Russian Federation to continue its programs.

In the other countries of the region, I see more or less the same situation because though we see some progress in acceptance of harm reduction from the national stakeholders, this acceptance is sometimes just words. It may be even reflected in some of national legislation but still we don't

see that any funding in most of the country's national funding is spent for substitution treatment, for needles and syringes, for peer educators. Sometimes countries just want to fund drugs and laboratories. That's maybe like one point.

I would say that in Russia we already have a crisis in treatments. Today we have a gap in this year of 2,000 patients who had to stop HIV treatment because they just don't get antiretrovirals—

STEPHEN LEWIS: Stop treatment?

DASHA OCHERET: Yes.

STEPHEN LEWIS: 2,000 people?

DASHA OCHERET: This number may be 14,000 people next year.

STEPHEN LEWIS: So obviously the caution that Paula expresses, you use the word cynicism and the lack of optimism which you express are deeply rooted and well-placed.

Eric, how do you deal as someone who is at the center of all of this? How do you deal with this unsettling sense that right at the moment when we think we can break through and move forward, there is a tendency to move backward? Okay this is a—I have utterly no objection to what are called actions—they never had actions in my day. I'm so old in the tooth. But I would wish only not that you not have the action, but that the action does not prevent the audience from seeing the panelists. It seems to me that that would make sense, if it's

possible to do it on the side? [Applause]. That would be much appreciated. If you wish to stand and show heroic endurance by holding the signs up for the next hour and a half, that's okay. You can lower them down just a little, thank you very much, so that our panelists can be seen and heard. There will be opportunity for people who are taking the action of course to ask questions during the question period. Eric?

ERIC GOOSBY: Thank you, Steven. Thank you for putting the posters so we can be seen by the audience. I guess I would say that the commitment that we have is a global commitment. One country is not going to be able to respond to all the needs on the planet, but rich countries need to respond more than poor countries.

That movement from resource-rich to resource-poor is something that we need to create conduits to maximize, to increase, and to hold constant. Indeed, we need to ask our countries that are most heavily burdened by this infection and by multiple health issues and socioeconomic issues that they too play the part for the populations that they're responsible for.

It is a shared responsibility that I believe we need to increase our cry and expectation that all contribute as much as they can because of the continued expansion of that unmet need. The unmet need that has been articulated in both Sub-Saharan Africa and Rwanda and Russia and Eastern European countries and

the Central Asian Republics continues to grow. It continues to grow in many of the Eastern European and Central Asian regions unchecked because there's a consideration that de-prioritizes the form of transmission as being worthy or not worthy of being responded to as a medical illness.

That difference that we have in holding countries accountable is facilitated by programs such as the Global Fund, mechanisms that allow resources to go from resource-rich to resource poor. It is our best hope at moving those resources to where they need to be. I think that large funders, such as the United States, have stepped up to the plate, need to continue to step up to the plate and need to increase their ability to put resources, not talk on the table and to maintain them. Talk is cheap; actions speak louder than words. We understand that. I believe the United States has struggled to not only maintain but to increase its ability to respond to this ever-increasing burden of unmet need.

I also would say that our ability to address the portfolio of needs that are present. We need to be open to expanding our resource availability to those disease processes that are facilitated and spread, such as HIV, Hepatitis B, Hepatitis C, through the sharing of needles. That we need to understand that the nature of addictive disorders, addiction to opiates is the natural history of that disease is one of recidivism and that our medical delivery systems need to

incorporate that aspect of the natural history of that disease by having strategies that are ready, able and competent in embracing those individuals when they fall back into active use, but still be ready to return them to medical care when they are able and willing.

That type of comprehensive care needs to be linked to social services and just as importantly to medical services. I guess I would say Stephen, that the move from an individual country acknowledging that its unmet need is so large it needs to be supported and helped by others. It needs to have conduits for those resources to move. The Global Fund is a wonderful example of that type of mechanism bilateral relationships, though, need to play a part, need to sustain, need to increase. I would say that the United States is fully committed to doing that. Our understanding and discussion within this Obama Administration is to look for every opportunity to engage on all fronts.

The economic decline has slowed the rate of accrual of resources available for this function, but it has not diminished the will. I am confident that as our resources become available, we will shift them directly to this effort.

STEPHEN LEWIS: So you use a phrase like diminish the accrual of resources for this function meaning money to deal with HIV and AIDS and you concede that it's been slowed. Do you also concede the point that many are making that the

increase in PEPFAR funding, which I think was 2.2-percent this last year, is nominal compared to the expectation that emerged from the promises during the election campaign and from the congressional commitments in 2008. And that in 2010, 2011, maybe even into 2012 there is some considerable anxiety that things may begin to move backwards. I take your point. If and when resources become available, you will extend them. But what happens in this interim, in this critical period when we may be able to turn a corner and when there are so many lives—I mean Peter Mugenyi, who after all, has supported PEPFAR very strongly in the past, Peter in the first session drew a very ominous picture of what was happening in Uganda, even with some additional monies which may now come available.

ERIC GOOSBY: Well I think that we need to look at the facts. When the Obama administration came in, we were at 1.8 people receiving antiretrovirals. We now are at 2.5 that are PEPFAR related. We have committed to, in our plan for PEPFAR II, to go above 4 million patients on antiretroviral therapy.

STEPHEN LEWIS: By?

ERIC GOOSBY: By 2013. So by the end of 2013. This commitment is total and complete. Talk is cheap; actions speak louder than words. We understand how the virus moves through populations. We have just presented a guidance to allow PEPFAR resources to now be used for needle exchange and drug treatment [applause].

This is a sea change in our ability to find resources and make them available where they should be. We have continued to increase the number of patients that we cover in that time period even during this economic decline, like no other source of bilateral resources going into any countries on the planet.

I guess I would say, you're right to challenge; you're right to hold us accountable. But it's also time for us to look at who else is on the planet and available to be challenged in the same way around the infusion of resources. That's not to advocate our responsibility; it is to allow us to be additive in our ability to respond to the unmet need. We need the help. We will not do it alone.

In addition to that, our country partners, as much as they have suffered through this epidemic, as much as we are responding to them, also need to engage with their populations in a way that continues to support this effort in their own country. As they are able, with multiple unmet needs competing—and I understand that—increase their support as much as they are able. We want to look for every opportunity to support them in acquiring the skills and capacity to do it in an excellent way, to identify and find the efficiencies that are available and sitting there from management to procurement to motor pools to the whole panoply of opportunities that we need to take.

Michel and I have talked exhaustively about where we can find those opportunities, how we can converge our resources to be additive at the country level; under country leadership to follow and enhance the ability for the country; both government and civil society to play the role that they need to play.

STEPHEN LEWIS: Fair enough. I think in defense of the activist impulse, they have been equally strong on the default of the G8 generally. They do tend, as we all do, to look to the single largest superpower with the greatest resource possibilities but they have been equally tough on the G8.

ERIC GOOSBY: I hear you and appropriately so. We are now at a point where we are over 50-percent of the response globally to global health, U.S. support. Not to toot a horn, but to just state the facts and we are committed to increasing that effort. It will go up over the time of the Obama Administration in this term and then hopefully in another term. The commitment is there; it's a matter of getting the resources to it.

STEPHEN LEWIS: I take—I have a sense that you may be challenged on some of it in the course of this discussion but I want to turn to Michel Kazatchkine. And maybe Michel as you respond about the Global Fund, which you yourself have said on a number of occasions, is in an alarming situation in terms of the replenishment. We must round up the money. Perhaps what

Dasha had indicated as well about Russia and Eastern Europe you might address.

MICHEL KAZATCHKINE: Thank you Stephen and good afternoon everyone.

STEPHEN LEWIS: Can I ask you—I'm sorry Michel—if any of you saw Michel Kazatchkine's face portrayed on the screen at the opening, you will know that he was at least once in his life, a kind of matinee idol. I would therefore feel badly if you were prevented from seeing him now in his momentary longevity. So could you just array yourself along the platform here? Thank you. Go ahead Michel.

MICHEL KAZATCHKINE: Thank you, Stephen. Let me first follow on what Paula said. The first point I'd like to make is that indeed, as she said and as Dasha you said, we've made huge progress and let's not just put that aside because to me what has happened in the last 10 or rather the last 7 or 5 years is this huge ability of scaling up treatment that we have witnessed and that some of us and some of the experts in 2002, even 2004 in Bangkok, would not have thought possible and would not have predicted.

I take it as a very important event because it demonstrates the feasibility and so universal access is not a sort of elusive concept. It's something that we should be able to achieve; that we could achieve. I don't want the debate to

come back to, it's too expensive, it's not possible, we'll never be able to make it.

Just as Paula said, in the last maybe 36 hours here I've seen somehow the temperature decreasing a bit and I've seen people saying, in the first part of this session, universal access, we should really question whether we should go for it. You're absolutely right, Stephen. I think it's Mark Haywood's chairmanship that brought it back at the end of the debate. But let's be very careful about not doubting and not putting any doubt into the ultimate goal of achieving universal access.

Of course, to reach universal access we need a number of things and I'll go for two. One is the resources and the second that's following up on Dasha's comment; human rights and making sure that all of those who need, including the most vulnerable, and those who are in difficult context and political context have access to treatment and prevention.

The resources we need, and yes you're right Stephen, I'm concerned. I'm concerned about the replenishment of the Global Fund. I would also like here to say that the way we put our numbers, and everyone has heard about the 17 billion figure, the 20 billion figure, that the Global Fund has put forward. These are not irresponsible figures. These are not just huge figures of estimated needs to achieve universal access. These are figures based on extrapolation on what we

know the countries are capable of using as in terms of resources to scale up.

So the 17 billion figure of the Global Fund is based on the simple following calculation. It means if we were to continue all of the programs for which we have already committed, and if in addition to that, countries were to scale up their effort at the same pace as the pace at which they have been scaling up in rounds eight and nine—2008 and 2009—that means it will bring us to 17 billion.

If the countries were to be able in the demand they express, because the Global Fund is not again putting theoretical numbers. It's putting numbers that are the requests from the countries and countries that succeeded in obtaining a grant from the Global Fund. There are countries that can demonstrate the feasibility of what they request. And when I look back, 85-percent to 90-percent of the targets that the countries have set for themselves and our grants have been achieved with the programs. These are very realistic numbers. If the countries were to be able to even accelerate further, that would take us to the 20 billion figure. These figures are not just coming from a hypothetical need. These are figures that I believe truly represent the capacity of countries to scale up, so we need to find those resources and this is why I am indeed very concerned about the Global Fund replenishment.

Finally, let me say that Dasha, I know the region fairly well and I'm just sad about what's happening. I hear about people not accessing treatment. I hear about people being denied harm reduction in a country where 70-percent of the cases of HIV infection are directly or indirectly linked to IV drug use and a country that remains, Russia, just like an isolated island in the world that doesn't see or denies the most compelling scientific evidence which is that harm reduction prevents HIV infection in IV drug users.

So that is why, in addition to finding the resources, we need to fight for human rights. We need to fight for those countries moving to the comprehensive strategies that we know will protect people and will help people access the services and the treatment. There's no better place than Vienna, because it's east/west and there's no better time than this conference because the theme of this conference is on human rights.

STEPHEN LEWIS: But, let me just take it with you frontally. If I hear you, if I divine what you're saying, we're at the moment in real jeopardy of not getting to the 17 billion, let alone the 20 billion. If we don't get to the 17 billion, if I hear you properly, it means that there will be a decline in our capacity to respond. We won't continue on the curve upwards, even along the process we're now moving.

Then, if I can bring you back to Ambassador Goosby, or Eric if he'll permit me to use the familial, if the United States is going to give 1.1 or 1.2 billion dollars a year, which now seems likely, we will never get to the 17 billion under present circumstances, nor will the other countries of the world respond in sufficient amounts if the United States contribution to the Global Fund is that low. Is that fair? [Applause]

MICHEL KAZATCHKINEK: Well, first, you're right. If we were to be below 17, that would mean that the Global Fund will be able to continue funding all of the programs for which we have committed. It would mean that, in addition to that, countries would come with new efforts and new requests, but the pace at which they will be able to scale up will be slower than what we've witnessed in the last two years. That's what it means.

Now, I know that FY-11 in the budget, there should be something like 1.125 billion in the U.S. budget. I've heard some of the figures from Europe, but let me say, today is July 20 or 21—I must say, I'm so tired here, I'm a bit confused—

STEPHEN LEWIS: It's actually the 19th, and you're catching up.

MICHEL KAZATCHKINEK: Thank you, good. The replenishment conference is on October 5 and the Millennium Development Summit at the UN is on September 21. So, we do have

time. We have time for advocacy after Vienna. We have time for pressure. Even if the FY-11 budget of the US, or of what the German Parliament would have voted for 2011 in the current climate, or if another Parliament would have voted for 2011 would be what it is, it doesn't mean that a leader cannot pledge more for 2011, '12 and '13, in what will be three-year pledges at the Replenishment Conference. [Applause]

STEPHEN LEWIS: Okay, Dr. Mphu, why don't you give us reflections on what you have heard?

MPHU KENEILOE RAMATLAPENG: Oh Stephen, thank you. I really think universal access for us is not a luxury that we are looking at. It's something we really must reach. Unfortunately, hearing my colleagues here, hearing Eric and hearing everybody around, it looks like without the adequate resources, this might be very difficult.

We must remember what this meant to us who are coming from the epicenter of this epidemic in Africa. It meant we had to look at very, very weak or non-existent health systems. Whether you're talking off human resources, whether you are talking off structure that's for clinics, or whether you're talking of drugs themselves, this was difficult. We're starting from zero and moving upwards.

Now, countries have done a whole lot with the help of the Global Fund. By the way, Stephen, it was the Health Ministers of Sadar region have recognized Global Fund as the

most important vehicle of access and resources to be able to roll out ARVs. It will be able to strengthen health systems for retention of health resources. We look up to countries of the north, the G8, we look up to the U.S. government really to make sure that these resources are available moving forward. We have heard about stories from Uganda of people getting off treatment who really were already on treatment. What does this say to us? We are going to have infections from people, from resistant strains to the very drugs that we have now.

Moving forward, we want to make sure that we now are able to access second-line drugs. So what do we need? We need to start negotiations now to lower the prices of these drugs. We need to have enough resources to be able to get them. At current rates, it's going to be very difficult for countries to enroll people on second-line drugs.

This whole scenario does not bode very well for universal access, even by extension to 2015. Our plea, I think, to PEPFAR is to reconsider, as the economic status changes moving forward to 2012, 2013, 2015, to pledge more resources for this program that you have started that we feel is very, very important for the world.

We want to make sure that replenishment of the Global Fund in October is adequate. We would like to make sure that that actually does happen, even if all the resources come into the developing countries where to come through these two

vehicles. For us, I think that would be enough because they're vehicles that we now know and they're vehicles that we understand.

So it is important for us to keep the promise. More importantly, for us, yes, we welcome health activism, activism that talks to our leaders, that talks to also to our leaders in Africa to keep the Ubuntu promise of 15-percent because this will give us the respectability. This will make it sure that we also are doing something for our own people.

I think that is all, Stephen.

STEPHEN LEWIS: Well, you will know Dr. Mphu that I've spent a good deal of time in Lesotho, and I love the country. I've watched the enormously courageous struggle in the grimmest of possible years when you were struggling with a prevalence rate of 30-percent and higher. It was staggering the consequences in human terms. And here's a little country that has managed to find its way into a mode of survival, although it continues to be a tremendous struggle. Right at this moment when you are dependent on the Global Fund in significant measure, most of the people in Lesotho live below $1.25 a day, we are in the position of not achieving the targets of the replenishment. That is a harrowing and frightening fact.

MPHU KENEILOE RAMATLAPENG: It is.

STEPHEN LEWIS: I don't know how else to describe it when you think of a country that has made such an effort to survive.

Paula, you will have been frankly [misspelled?] festering in your seat possibly about intervening in this. Why don't you do so? Respond a little to some of the points that Eric made, which he made with obvious efforts at making it a cogent case.

PAULA AKUGIZIBWE: Well, I was listening to the comments that were being made and thinking about the money that's being offered, and I was thinking about my gym membership, because I'm quite committed to the gym, I'm quite committed to fitness. I'm so committed that I actually bought lifetime membership a year ago. Unfortunately, I never actually made enough time to go to the gym and keep my membership active. They called me a couple of weeks ago and said that they were going to cancel my membership. I said, no, I'm still committed. I'm committed to fitness. I want to come. I want to sign up for the six o'clock classes. And he said, well… Unfortunately, regardless of how committed I am and how much I want it, I haven't done it. So I lost my membership.

I'm telling this story because we have heard a lot about how the U.S. remains committed to universal access, committed to scale up, but the bottom line here is we're

talking about numbers, and we're talking about the actual money that's being put on the table. If the money that's being put on the table is less than the inflation rate that we're seeing in the region, and we're still talking about scale up, that is irrational. That commitment doesn't mean anything to people without the resources to purchase the treatment that they need to stay alive.

If people could take words and that could keep them alive, that would be great. But right now, we're trying to talk figures and we're trying to understand how, within the current amount of commitment that we're seeing from the U.S. government, they can claim that they're still committed to scaling up treatment to universal access.

The same applies to African governments, just like you said. Of course, the United States will not be expected to respond to all of the world's needs. The G8 needs to step up. The EU needs to step up. They've been decreasing the commitment to the Global Fund even before the economic crisis started, although that is not the pretext.

And as for African governments, in 2001, they said that HIV should be the top priority for the first quarter of the 21st century, HIV, TB and other infectious diseases at the top of the national development plans that health should get 15-percent. None of those commitments have actually translated

into concrete action. We haven't seen that many. As a result, millions of people continue to die unnecessarily.

The cynicism that we're feeling isn't because we don't have the means to achieve universal access. It's because we don't have the will.

For me, I really want to question this concept of commitment and how we can continue to claim to the committed in the face of the obvious evidence that people are being turned away from clinics because they can't access treatment.

After speaking to a researcher who was in the free state in South Africa last week, where some PEPFAR sites have shut down, and people who have already been in treatment are being turned back from the government facilities because they cannot be absorbed. Now that is a criticism of both the U.S. government, as well as the South African government who had billions and billions to invest in the World Cup, which like I said I enjoyed greatly, but it cost a lot of money and we don't have the money to treat these people who are being untreated. They're being switched back to D-14. We're taking steps backward counterintuitive, like I said, in the face of all the opportunity that we have to make such significant progress. It's heartbreaking.

So I really want to understand better what this commitment actually translates to. We spoke a couple of weeks ago, you told us that the mandate of PEPFAR's access screen

[misspelled?] is going to expand, and you listed a few things. I've been trying to find my notes, but as I recall, you included cardiovascular disease, hypertension, diabetes, TB, maternal and child health, a whole spectrum of conditions. But then you also later said that funding over the next two years is not going to be robust. My question was, how can you expand the mandate without expanding the resources correspondingly? To which you responded, we'll find efficiencies. Again, these are nice, noble philosophies and nice, noble words, but what does it actually mean? So I'd really like to get some clarity on that.

ERIC GOOSBY: That's fair. Well, let's talk specifics. [Applause] I think that the idea that talk, really, is easy, actions speak louder than words is the theme. We have given $585 million to South Africa. When South Africa was in a position where they have mounted most of their antiretroviral and treatment response themselves, they have paid for their antiretrovirals for the most people on the planet. Over five million people have benefited, who are infected from HIV in South Africa. They have over a million people, a million two plus, on antiretrovirals. That's the most that any country on the planet has done. An extraordinary achievement.

When they were looking at stock-outs, we were able to support them in that effort with $60 million in '09 and another $60 million in '10. We have been able to move our resources to

help and support country efforts whenever we could. South Africa's ability to continue programs in the free state, those are South Africa's programs, they're not PEPFAR programs. We have tried and will continue to try to work in every way we can with South Africa to maintain and increase their ability to expand their services for treatment as effectively and as efficiently as they can.

But going from in terms of what the United States has done, we started at the 1.8 when the Obama administration came in. We're now at 2.5. Our numbers of people who come into care per month has increased over that time period, because there's enough money in the system already to continue to scale treatment. We have committed to going over four million patients on antiretrovirals from two-and-a-half now up and over four million by the end of '13. That commitment is real.

At the same time, and I say this, Paula, because it's the truth, the numbers also tell us that the need is large and continuing to increase. We are absolutely at the point where the dialogue needs to change, where we need to look at each other and look at the resources that are available on the planet, continue to challenge political systems to give more, but we also need to distribute that cry to every country on the planet to contribute.

We, right now, are somewhere around 53 to 55-percent of the effort in global health. But, country after country we're

in in Sub-Saharan Africa, for the HIV/AIDS response, we range from 50 to 60 to 70 to 80 to 85 to 95-percent of the HIV/AIDS effort. Country after country, supported by U.S. dollars, year after year. Not sometimes, not intermittently. In addition to that, all the patients that are queued up and are on antiretrovirals in past years are continued on those drugs with the additional patients coming on board.

So I hear what you're saying. We are absolutely part of that effort. I think you would agree. We will continue to increase the volume as much as we possibly can. That is a commitment from the President. We need to turn our cry, continue to yell at the United States, absolutely legit, but we need to turn to our colleagues in Europe, our colleagues all over the planet, China, Saudi Arabia, everywhere, to look into their own ethical commitment and responsibility to respond to this global need.

It is not the burden of one country; it is a partial burden of the entire planet. I hope that the United States and other countries can continue to increase their contribution to mechanisms such as the Global Fund or through bilateral relationships that they have with programs in country to continue that expansion of service capability.

There is no question in my mind that efficiencies are going to go up significantly with a move to country ownership because it will be cheaper to deliver the same quality care

without the in-between aspects of indirects and moving people from North America, north/south movements, all of those costs are going to diminish. We're still going to need international NGO's to play a role, but the role they should play should be focused on the expansion of the capacity of the country capability and not on bringing an external capability in that can easily leave.

PAULA AKUGIZIBWE: Well, firstly, I mean, to say that the external capability coming to the country for long part was a part of the strategies that were used by donors such as PEPFAR. I do agree that countries need to take more national ownership, but something that I think we have tried and tried to emphasize, at least from organizations working with advocacy in the African region, there's a whole lot of people who are gathered in Campania now for the African Union Summit whose main purpose is to call on our leaders to give us more money for health.

But to come back to your point, because I don't expect you to answer on behalf of African governments and I think it's a very, very valid criticism. I think it's disappointing, and I think it's embarrassing that African governments fail to keep the commitments to health when they have a lot of money to spend on other things. I'll get to that later. You see, I have my dollar bills.

But I think it's important for us to clarify that nobody is expecting, because this is something that comes up repeatedly, nobody is expecting the United States to carry the weight of the world on its shoulders. That is not the request that's being issued here, that's a Hollywood philosophy, it's not the reality. [Applause] All the people are asking is that you keep the promises that have been made and the commitment that you claim to hold in rhetoric translates into your dollars to save lives.

To say there's enough money within the current pot to keep setting up treatment is something that blatantly can be contradicted with what we've been seeing happening with cases like Uganda. The memo that was issued instructing that no new patients should be put in treatment until others fall off, whether it's due to loss to follow-up or to death. There's no clearer indication that there is not currently enough money within the pool to keep that scale up.

STEPHEN LEWIS: The two of you have a distinct difference, but Michel you wanted to say something.

MICHEL KAZATCHKINEK: Yes, just a few things here. First, I'd like to say, indeed, with Eric for brainstorming hard on these efficiencies. I'm quite sure that within the next year or so, we'll be able to have a lot of efficiency gains by seeing how the PEPFAR funding and the Global Fund

funding can come together much more efficiently under the country leadership and country ownership.

I would also like to say that we have to be careful because people often talk so much about efficiency gains that sometimes that could serve as an excuse not to come with additional funding. There's no way that the efficiency gains that we will be able to make will make it for the difference and for the gap that still needs to be covered in funding.

STEPHEN LEWIS: That's always the intellectual ploy, Michel, that efficiency will compensate.

MICHEL KAZATCHKINEK: Second, Eric's and Paula's point is right. We're talking here and the dialogue has somehow focused on the U.S., but the U.S. is not alone. Europe actually represents 55-percent of the funding of the Global Fund. Europe has often said that it plays a leadership role in development. In general, it's the primary funder of development in general. So our advocacy and pressure should also be on the European donors. [Applause]

It should also be on the emerging economies. That was briefly mentioned. We're dealing with global issues. We're dealing with global epidemics. This is the time we're building a globalizing world, and without entering the discussion of global governance, at least we should show global solidarity when it comes to funding global health and fighting a global epidemic.

Indeed, I have been traveling to China recently. I will be traveling soon to India. The countries that are not rich or where there's many cities that are still very poor and much in need, but countries that generate a lot of wealth per day these days should and could, I'm sure, contribute to part of the burden sharing.

Finally, it's clear, we've known that funding of health is clearly a political issue, and politics is about choices. I just can't believe that the choices cannot be made to find $17 billion for the next three years for the Global Fund.

[Applause]

STEPHEN LEWIS: I'm itching, as moderator, to be inappropriate, but I'm containing myself, Eric. I want you to know that I'm exercising supernatural self-discipline. I want to invite the audience to ask some questions of the panel. So there a number of microphones. I think we should take three or four questions at a time. I'm going to cut you off in an arbitrary and authoritarian manner if there are extended speeches and pronouncements. Please ask a question or make the shortage of comments proceeding a question. But do not be extended so that the panelists have time to respond.

Let's just run through. You're fortunate. You're at microphone number one, so we'll start with you. Then, we'll move to two and five and eight, and we'll move to three, six

and nine. But we'll do it in sort of four or five chunks. Yes?

LABIB EL-ALI: I'll keep this comment to one minute.

STEPHEN LEWIS: Can you give your name?

LABIB EL-ALI: Sure. My name is Labib El-Ali. I work with RESULTS Educational Fund. I was a part of the small demonstration you saw upfront. I just want to clarify for the audience and the panel how the messages connect and how they connect to the presentations made today, quickly in a minute.

First of all, we saw the quite eerie but cuddly yellow creature walking around. That is a representative of the MOSOTOS Campaign, which was launched at this conference, and a lot of folks have seen. Paula, I believe, is wearing a button that says, "MOSOTOS equals death." MOSOTOS is more of the same old talk, opinions and speeches. It is a cry to recognize that that is often what happens at these conferences and that it must end.

To that end, we've heard Michel explicitly say what it is that the Global Fund needs over the next three years in order to do the work that will get us somewhere along universal access and the goals that we need, that it's at least 17 billion. We say it's at least 20 billion, but that's what he's looking for. In order for that to happen and, no, the ask is not the U.S. bear the burden of the world's pains when dealing

with these epidemics, but we need leadership from the U.S., and that means six billion over three years.

Lastly—

STEPHEN LEWIS: You have exhausted your minute.

LABIB EL-ALI: Oh, okay.

STEPHEN LEWIS: So, we're not getting to lastly. Katie, go ahead.

KAYTEE RIEK: My name is Kaytee Riek. I work with Health GAP in the United States. My question is, again, for Dr. Goosby. I'm wondering—you make the point that other countries need to start to step up. But the evidence coming into this conference and in this conference is clear that starting treatment at 350 CD4 count provides a greater benefit to patients and treatment provides a huge benefit with relation to HIV prevention.

But because of PEPFAR's virtual flat funding, countries are not able to act on this evidence. They are trapped providing suboptimal therapies using suboptimal guidelines. Will PEPFAR revise upward its treatment targets based on this evidence?

STEPHEN LEWIS: Thank you. Microphone five.

SUNAM ONODIO: **H**ello, my name is Sunam Onodio [misspelled?] and I represent here the EU Civil Society Forum on HIV. My question is to Eric as much as it is to Michel, and it's in considering the problem of fundraising that's needed. I

think that right now, we can opt for two solutions. One is to raise more money. But, the other thing is to renegotiate because the social point is not being tackled here and it's the profit of pharmaceuticals and patents. Maybe if we are able to access treatment much cheaper, then we could solve a lot of problems without having to put more money on.

STEPHEN LEWIS: Thank you. Microphone eight. [Applause]

ANDREAS TAMBERG: Thank you. My name is Andreas Tamborg. I work for the Global Fund, and I'd like to ask a question of Ambassador Goosby and my own executive director, Michel Kazatchkinek. You spoke of efficiencies. Is there sufficient flexibilities in your discussions to perhaps envision a pooling of funds for certain countries or regions whereby a country-led response could draw on PEPFAR resources within the context of a Global Fund application and Global Fund implementation? Is that a realistic way to achieve certain efficiencies that would enable us to get further along the road to universal coverage? Thank you. [Applause]

STEPHEN LEWIS: Thank you. I'm going to—Eric, you were asked whether you would redefine the targets according to the early initiation of treatment as suggested by WHO, and there was the reference to the pharmaceuticals and then the pooling of funds. Can you deal with those fairly rapidly so that if there are others who wish to get into it?

ERIC GOOSBY: We have set our new targets for above four million people coming on treatment. In that, we honor the country decision making in country to decide what their target is, what their trigger for initiating antiretrovirals is. We, PEPFAR, do not establish that. But we do say and feel that the appropriate use of resources is best used addressing the most sick, that the patients who are coming in with T-cells below that really should be targeted and triaged in front of antiretrovirals before somebody at 350, assuming there aren't enough resources to pay for everyone.

We think that pregnant women, that people with active tuberculosis, that newborn babies who are HIV positive, that patients with active pulmonary TB, I said, are in a special, unique position to warrant also being put on antiretroviral therapy regardless of where there T-cell counts are.

The idea that the pharmaceutical companies are a source of savings has been a constant theme of discussion in every meeting that we have had for the international AIDS meetings. It continues to be an issue. I think it should be pushed. Pharmaceutical companies have matured in the way they view their costs and how they distribute their costs to rich countries versus resource poor countries. We are in that dialogue with them. The formulation of new formulations that allow for a one pill a day type administration and for pediatric formulations are also a big part of that. Costs have

gone down and ranging in the PEPFAR family of countries from the high-200s up to the mid-700s. Those are costs that still can be lowered.

It's a misconception though to think that we're up in the 1000 or the 1100 or the 1400, which is where PEPFAR started.

STEPHEN LEWIS: May I ask Michel to handle the pooling?

ERIC GOOSBY: Okay.

MICHEL KAZATCHKINEK: Yes, could I just say something on the drugs? Of course, I think none of us five would say that we just need to raise more money and not move in areas where we could move, such as decreasing either the price of drugs or the price of services. Let me just put in two numbers here. When it comes to first-line antiretroviral treatment, the mean cost of that for the Global Fund when we buy the drug is around 120, 150 U.S. dollars per patient per year.

If I now add to that the cost of services, the cost of delivery, of moving the drugs through the end user, our mean number is 467 U.S. dollars per patient per year. There are huge standard deviations around that number. We may have efficiency gains there. But I don't think that we will gain much—very significant amounts of money.

When it comes to second line drug and Minister, you discussed that. There's a huge space for negotiation. But not only for negotiation, I think we've lost somehow some of the

energy on the notion of global public goods when it comes to drugs for global epidemics and for life saving drugs. [Applause]

The Doha cycle of negotiations is still uncompleted. So there is a political goal there as well. On the polling, Andreas, I couldn't see you. I just heard the voice. I think that's exactly the lines along which we're working with PEPFAR and with Eric.

STEPHEN LEWIS: May I say for the interest of the audience, I may have this slightly wrong in the articulation. But I'm right in the initiation of it. Just today, Health Gap and a group of activists, non-governmental organizations filed a formal complaint with the United Nations' Rapporteur on Health dealing with the fact that the American Administration in concert with the pharmaceutical industry is violating the World Trade Organization rules on intellectual property rights to protect by patent the rights of pharmaceuticals against the availability of generic drugs.

And I can say from my own experience that these individual free trade agreements which the Rapporteur on Health has spoken to, these individual free trade agreements that the United States, Canada and the European Union are entering into with various countries like India are designed to maintain high prices for some pharmaceutical industry and to keep the generics out. [Applause] And that's going to have a—and it is

much—I think it's much to the credit of Health Gap and the others that they have filed a formal intervention of complaint so that this issue can be joined internationally. Because no one expected that one of the reasons I'm having troubles personally is that President Obama in his pre-presidency and post-presidency made it absolutely clear that the generic equivalence were primary and that the pharmaceutical companies would be confronted. And instead, the agreements have done the reverse.

That's why when you repeat time and again words are easy, action is everything; it's the distinction between the words and the action which is causing all of us a cardiac arrest. [Applause] I will allow you—I'm going to—okay.

ERIC GOOSBY: Steve. Steve, let me respond to that.

STEPHEN LEWIS: You might think fairness requires that you should respond.

ERIC GOOSBY: That's only fair. We are at about 95-percent generic for PEPFAR drugs.

STEPHEN LEWIS: So far. So far. Now—

ERIC GOOSBY: Total.

STEPHEN LEWIS: Now—

ERIC GOOSBY: Total. Well yes, now.

STEPHEN LEWIS: But if the generics are lost, you will not be.

ERIC GOOSBY: If the generics are lost, we are only buying generics for the most part.

STEPHEN LEWIS: For the moment.

ERIC GOOSBY: We're not going to go back to buying brand. I mean, I don't know how we would do that. We would say that we're going to stop buying generics and go back to buying—

STEPHEN LEWIS: It depends on what you negotiate and the rules of the World Trade Organization.

ERIC GOOSBY: It's not on our trajectory, table of discussion at all. We are looking for every area that we can find savings. I believe we've almost exhausted that area as an area that we will. But we will not go back to a brand purchasing strategy.

STEPHEN LEWIS: Okay.

PAULA AKUGIZIBWE: Well—

STEPHEN LEWIS: Go ahead Paula.

PAULA AKUGIZIBWE: I mean if you're moving towards a period of national ownership and countries are bound by these agreements that they have with the U.S. and the EU that ultimately won't—it won't be able to be flexible about what PEPFAR decides. They'll be bound by those agreements, right?

ERIC GOOSBY: You know, I have to say that I'm not exactly clear exactly how this would work. I mean in terms of the concern that you're expressing, I know that you must have a

concern around this. But, I don't understand it well enough to really answer your question but will. I—

STEPHEN LEWIS: Well, it's worth because obviously—

ERIC GOOSBY: I mean I don't see how the—what the Trips' Agreements as I understood them are when a country decides to declare that this is an emergency, urgent, disastrous issue that they need addressed, they can abdicate the buying and lower the cost of the drug kind of by that action. I don't believe that's in jeopardy. No one's going back on that. Or that's what you're saying is in discussion.

STEPHEN LEWIS: No. That's not the issue. The issue is patent protection for the pharmaceuticals and the gradual erosion of generic production. And the right to produce generics like a country like India is now at risk of an inability to continue producing the generic drugs on which Africa, for example, depends. There's a real risk there that is developing.

ERIC GOOSBY: Well I'll have to look into that, Stephen.

STEPHEN LEWIS: Okay. Did—?

MICHEL KAZATCHKINE: No. Well I wanted to say what you just said. But let me also give another example to which that I came across. Recently I was in China. I met with a number of patients. And, I learned that basically second line

treatment is unavailable in China. Unavailable because it's outrageously expensive.

And it's outrageously expensive because now that China has entered the World Trade Organization, China can not buy those generic drugs unless it would issue a compulsory licensing process which we know since the first Doha negotiations, no one has been doing it because it's so complicated and also because it's putting the countries in an uncomfortable political situation.

STEPHEN LEWIS: Fair enough. Let me go to microphone three. There's a very agitated person at microphone three.

MALE SPEAKER: Dasha, you are beautiful. Mr. Kazatchkine, I'm the director of the six antivirus treatment. And we need a grant for my country, Georgia. I don't know. I have 105 patients. Three babies and I understand but I have many questions. Why we do not need the funds? So, I ask you all please assess realistically and create conditions for everyone. My country is a small one.

STEPHEN LEWIS: [Inaudible] especially sympathetic because you've asked the question in Russian. Who was it directed to?

MICHEL KAZATCHKINE: Yes, to me.

STEPHEN LEWIS: To you?

MICHEL KAZATCHKINE: Yes, to me.

STEPHEN LEWIS: I did—go ahead.

MICHEL KAZATCHKINE: It's about the fact that Round Six in Apcassia is ending soon. And that our colleague is not seeing continuity of funding because there wasn't an additional round to take over. Let's—I suggest since this is in a more restricted language conversation that we take it right after this session.

STEPHEN LEWIS: Dasha wanted to say something about this.

DASHA OCHERET: Well, I would actually say that it's very important for our region that we may have and the number of countries that may not be eligible to the Global Fund money is growing. And as I've already said, in some of the countries of the region, there is quite enough national resources for HIV treatment and prevention. But countries are not going to spend them on effective treatments. They aren't going to spend them on opioid substitution treatment.

If we do not invest in advocacy, if you do not put political pressure especially on Russia to admit the substitution treatment works, it puts the whole region in a very vulnerable situation in having no or very limited access for HIV prevention care for the most vulnerable groups such as drug users.

MICHEL KAZATCHKINE: I can't agree more. And, I think everyone knows my position on eligibility around the Global Fund. And I do believe when I look at how the Global Fund

funding has been determined in moving harm reduction or at least needle exchange in Russia, in Georgia, how it has started the entire access to treatment; we need to find a way that in a number of these countries we continue to fund programs that they remain eligible.

But because as you say, there are also countries that can contribute, they actually contribute to the Global Fund and contribute to the program in such a way that the burden doesn't stay on the outside donors. And that's, I'm sure, is negotiable.

So to me, the debate around eligibility of countries in Eastern Europe or Latin America or some of the countries in the Middle East is not about yes or no based on, let's say, the OCD or the World Bank classification. To me, the debate is how these countries can both contribute and receive so that the Global Fund with its flexibility, its ability to fund the civil society is capable of continuing the work that is really bringing the services to those in need.

STEPHEN LEWIS: Thank you.

DASHA OCHERET: Yes. And I would just probably just make a very small comment that international funding and Global Fund, it's actually a way to develop and support the civil society in our region which did not exist 15 years ago and is still vulnerable. That I would say that's without international support, at least in Russia, the civil society

may die. And we see that it's started not because of financial problems certainly and not because of financial crisis but because of political issues. But we know that money and power.

STEPHEN LEWIS: Kevin Decoca [misspelled?] on mic six.

KEVIN DECOCA: Thank you. And thanks very much for the discussion. It's pretty evident I know—I think inescapable that global health for the foreseeable future is going to have to receive global financing. One mechanism that hasn't been mentioned are these innovative financing schemes. Because the only one with any scale is [inaudible]. I just wonder what your political comments on those mechanisms are. How useful they could be? What they could add? How much we could raise? How important they are? Thanks.

STEPHEN LEWIS: Thanks Kevin. Microphone nine.

SHARON ANN LYNCH: Thanks. This is Sharon Ann Lynch with MSF. I just have three quick comments. One as Dr. Ramatlapeng could tell you, Lesotho changed its national protocols two years ago, Eric, to upgrade to [inaudible] for the first line and also earlier initiation at CD4 350.

MSF, at this conference, is reporting on two year outcomes. Because of earlier initiation and something frankly I've heard you speak out against, we've seen a drop in mortality of 60-percent, a drop in hospitalization of over 60-percent, a drop in loss to follow-up of over 40-percent. Haiti has just reported on a 50-percent drop in TB. They put the

cost and the time at $400 per patient per year in Haiti. By the time that someone would progress from being non-eligible according to old guidelines to being eligible.

So why—the question I would like to put to you; are you going to be champion and can you start today for ending double standard in care given that this is efficient? We can't talk about efficiencies without talking about what's right for patients especially when it comes to clinical outcomes.

And all of this talk about health system strengthening, I'm sorry, we're burdening the health system by letting people come back when they're sick in a wheelbarrow. Eric, we've seen it in Lesotho. We want you to speak out against it now in terms of ending the double standard in care and relieve the health system of the very sick when we can keep people walking well.

STEPHEN LEWIS: Sharon Ann, I'm going to have to ask you to end it there. May I? I'd like to give opportunities to the others. And you've asked Dr. Ramatlapeng to answer it. I'm sure she will. Yes, microphone four.

WYNN VANDERVILLE: Wynn Vanderville [misspelled?] from the European Civil Society Forum. My question is for Ambassador Goosby. We hear that there are still problems for organizations working with sex workers to receive funding from USAIDS. Could you please confirm that this is correct? Thank you.

STEPHEN LEWIS: And microphone two.

SHANNON KOWALSKI: Shannon Kowalski from the Open Society Institute. Eric, you've been talking about efficiencies. And we know that the Global Fund went through an exercise in Round 8 and again in Round 9 looking for 10-percent efficiency gains. We did some research on that. And what we found was that instead of real efficiency gains for the large part, often what we saw were budget cuts where NGOs and civil society organizations, community based organizations doing essential prevention and outreach work were the first to lose their funding. So I wonder if you could tell us more where you think these efficiency gains may lie.

And then secondly, you keep saying that the United States should not be shouldering the entire burden and that other countries need to step up. I'd like to know what advocacy you're doing with other G8 countries and other donor countries in order to make sure that the Global Fund's replenishment in October is successful. [Applause]

STEPHEN LEWIS: Thank you. And one last question from microphone three.

REBECCA HODES: Hi there. I'm Rebecca Hodes from the University of Cape Town. And there's a reason that Minister Ramatlapeng said that SADC health ministers support the Global Fund above PEPFAR because PEPFAR does things like creating

parallel mechanisms, expensive mechanisms, when it tries to implement its program.

Now you said that harm reduction programs, Ambassador, are now being championed by PEPFAR. But it's a shame, a real shame, that it's taken about 10 years for PEPFAR to make an about face on implementing those kinds of programs. So I'd like to ask, following from the previous question, how it is that PEPFAR is going to implement strategies within its own ranks to ensure greater efficiency among its own staff members and human resources rather than creating parallel mechanisms, its own [inaudible] offices, its own accountants?

STEPHEN LEWIS: Let's go to the panel. We're running out of time but let's go to the panel for brief answers, if I may. Does anyone want to speak to the international financial facility? Michel.

MICHEL KAZATCHKINE: Well I'd just like to say, it's an important question that Kevin rose. And then so, let's not escape that. We're all looking into innovative finance as a compliment and a potential large source of financing. UNAIDS is not the only one that is currently functioning but UNAIDS let's not forget, is currently based on 20 countries. There are 190 countries in the world. And some of the poor countries can also contribute to UNAIDS because when it comes to a tax, a levy on airline tickets, people—the high level civil servants

and businessmen from poor countries also travel business class and also travel by airplane.

So we've seen countries that are booking their first [inaudible] contribute to UNAIDS. So I call on more countries to join UNAIDS.

Finally, when it comes to the financial tax, the tax on financial transactions, there's a lot of talk about it here. We should all be behind that. I'm pretty convinced that it will soon come up where our collective challenges is that this money effectively goes to development and effectively goes to health and development at least in part and not to constituting another buffer stock to prevent—to help the banks be safe from crisis. [Applause]

STEPHEN LEWIS: A financial transaction tax of .005-percent on the banks would yield scores of billions of dollars which when the idea was originally put forward by the activists, was meant to go to global health. It was then diluted and suggested it would go to climate change. And now the countries that are willing to consider the tax are talking about using the money to defray their own deficits. So a brilliant proposition for raising funds has been virtually emasculated in the international discussion. And it is worth the activists getting behind the original intention for global health.

MICHEL KAZATCHKINE: Absolutely.

STEPHEN LEWIS: I think we have to allow Dr. Ramatlapeng to respond to Sharon Ann.

MPHU KENEILOE RAMATLAPENG: Thank you. I think I must confirm that we have had tremendous political will in our country. First we started with the "know your status" campaign. This "know your status" campaign was championed by all the leaders in my country. That is the King, the Prime Minister, the Archbishop, you name it.

This set the stage for improved awakened relationship in the health sector. One, we worked together with the entire international community to adopt guidelines. So everybody had ownership of these guidelines. In the [inaudible] we do not allow parallel structures to be set in our programs. We were previously not a receiving country. Now we are.

But PEPFAR is prepared to work with us in the facilities that we have in the country whether they are Christian faith based organizations or government based organizations. But we have an agreement with government and the faith based organizations. So it is up to a government, a country. It is up to a government to set the stage for implementation of the programs. We do not believe in parallel structures. But we—

STEPHEN LEWIS: You do not believe in?

MPHU KENEILOE RAMATLAPENG: In parallel structures. You know somebody setting up shop in a particular corner to

give us medication because we want replicable programs, programs that can be extended throughout the whole country. It's a small country with no resources so we want to maximize whatever resources that we receive.

I was very pleased to hear that you are saying in the countries where you will be working, you use home grown solutions and justices to with whatever is there. Because bringing people from the north, the bulk of the money from PEPFAR is actually going to the organizations that are U.S. based. So in fact, I'm sure this will be welcomed by all countries in Africa. [Applause] So I congratulate you, Ambassador Goosby, for having come up with that because that has been the thorn in all our countries. Thank you.

STEPHEN LEWIS: Dr. Ramatlapeng, though, let me bring you back to the question that Sharon Ann asked. Will you start treatment at 350 given the astonishing reductions in mortality that were quoted?

MPHU KENEILOE RAMATLAPENG: No, she was saying an already study, I started treatment at 350 since two years back.

STEPHEN LEWIS: Is that a—?

MPHU KENEILOE RAMATLAPENG: That's universal.

STEPHEN LEWIS: Now a government policy?

MPHU KENEILOE RAMATLAPENG: That's a government policy in the Lesotho.

STEPHEN LEWIS: Okay.

MPHU KENEILOE RAMATLAPENG: Before it was adopted by the [inaudible] we had already started from that because we weren't seeing a very high mortality. So we decided to adopt these guidelines as a country. And so we started at 350. Sharon knows because she has worked in Lesotho.

STEPHEN LEWIS: Yes, there's a lot—

MPHU KENEILOE RAMATLAPENG: Yes.

STEPHEN LEWIS: —of stuff that I—it's [inaudible] possible, isn't it? Yes.

PAULA AKUGIZIBWE: Yes.

MPHU KENEILOE RAMATLAPENG: Yes.

PAULA AKUGIZIBWE: I mean, I wanted to comment on Sharon Ann's point as well. And I think she also wanted to find out whether Dr. Goosby's incorporation got into his thinking.

STEPHEN LEWIS: Yes.

PAULA AKUGIZIBWE: Because I believe that PEPFAR is not supportive of starting people over CD4 200 with PEPFAR funding and treatment. And I think the most—it's possibly one of the most important points in that, we've been hearing about these efficiencies, right? It's the Holy Grail. In two years' time, we'll hopefully know exactly what this means.

But this is a concrete proposition of efficiencies that we could see right now of savings that we could have. If you're cutting a TB cost by 50-percent, you're decreasing

mortality. And we've seen that HIV treatment also is one of our most valuable of our medical prevention tools decreasing sexual transmission for up to 90-percent for CD4—for initiation of CD4 350. They are your efficiencies.

So the efficiencies of being seen many years down the line when the people who are currently in power who are making the decisions won't be sitting in office. So that's not how they're thinking. And this is precisely why our approach to global health needs to be a wide spaced approach that isn't vulnerable to political and financial expediency but is based on the fact that we recognize the rights of health now and 10 years down the line.

If we were to invest in treating people earlier now, we would see these efficiency gains in five years. It would be indisputable based on the data that we already collected from programs today.

STEPHEN LEWIS: Thank you for rescuing—

[Applause]

STEPHEN LEWIS: Thank you for rescuing my misunderstanding. But, what about that, Eric? I know you've said HIV positive pregnant women and people who are very ill, et cetera. But what about the major contention which is being put here that you—not only do you have a significant saving of lives and a reduction in mortality but you have a very real efficiency?

ERIC GOOSBY: I think that the decision to have the trigger to initiate antiretrovirals is the country decision. PEPFAR is supportive of the science which has shown for a very long time that 350 is better than 200. The problem that we are confronted with and the way that we have thought through this particular dilemma is that when we look across all the countries that we're in—the 30 countries we're in—our average CD4 at point of entry is 138. In many—and that's the average. In many countries, it's lower.

We understand that the provider who's in front of that patient should be telling the patient the truth, that it is better to start at 350. There's no question about the science there. The problem is is that you now have the dilemma as a policy maker. What are you going to do to your medical delivery system? Are you going to position it so it triages the sicker patients to the treatment before the less sick or not?

And what PEPFAR wants and insists is part of the process is that the sicker patients, there be a mechanism to identify a triage mechanism the sicker patients so they get in front of the antiretrovirals first. We are at a position where when the resources expand to the point where we can treat 350 for everybody, then that triage mechanism doesn't need to play. But unfortunately, there's not one country except Rwanda where you're above 250 even, okay, in terms of average entry of CD4

count. So that's where our position is with that. We do not argue with any country deciding that they want to trigger at 350. But we want you to focus on the sickest first.

STEPHEN LEWIS: Would you have the resources to go to 350 if you were in a position to do so now?

ERIC GOOSBY: Yes.

STEPHEN LEWIS: You would. Okay. Well, I think that's important to remember that. And there was a question, if memory serves, about OSI and the efficiency study. Was that Global Fund efficiency study? I'm sorry. Where is the representative of OSI who took the microphone? Were you putting that question to Eric or to Michel?

SHANNON KOWALSKI: It was actually a question to Eric—

STEPHEN LEWIS: Right.

SHANNON KOWALSKI: —about where he saw additional efficiency gains. But I think he's addressed that.

STEPHEN LEWIS: Right.

SHANNON KOWALSKI: My other question to Eric was, is he going to—what advocacies is he doing with G8 and other donor leaders in order to ensure that the Global Fund's replenishment is $20 billion in October?

ERIC GOOSBY: I guess I would quickly answer that with the Secretary of State has accepted the burden of putting a diplomatic strategy together to attempt to engage all of our embassies and at the G8 and the G20 discussion, a discussion

around shared responsibility. That shared responsibility theme is directly speaking to this issue. It is something that she and the President and his time in both of these meetings will bring to the table.

I think that the—on a country level, we have engaged with every country at both the president and the legislative levels in each country that I go and visit around our need to engage as much as possible in supporting both Global Fund replenishment and in, for those countries that we are working in, maintaining or increasing their contribution to services for HIV/AIDS and TB.

STEPHEN LEWIS: On the other hand, in the G8 reference to the Global Fund, the so-called Muskoka Declaration, although the Global Fund is in the Declaration, there was no reference to the amount of money that would be raised for the replenishment. And therefore, the advocacy within the Global Fund or within the G8 must be to some extent inadequate on all sides. My country of Canada is hopeless, for example.

Let me just ask about the question from the University of Cape Town on the parallel systems.

ERIC GOOSBY: If you read the five year strategy for PEPFAR which we wrote when we started this position, it addresses that specifically. The need to look at how our resources move into country, who moves our resources, how that

matches a country's vision of their unmet need and prioritization of that unmet need now needs to align.

It doesn't mean that we don't see a role for the international, multinational NGOs. They played a central role in engaging in a rapid deployment of capability. That role will continue to be needed. But what we need to add to that toolbox of service capability is the ability to mentor and exchange and enhance capacity of in-country systems, governments as well as civil society.

We are committed to country ownership both in PEPFAR and in the global health initiative as the central piece that frames everything because it's our belief that an empowered capacitated country leadership can orchestrate the divergent funding lines that are coming in and best decide how to prioritize and how to make allocation decisions even though those resources may be much greater than the country's own contribution to that effort. Every country we're in is an example of that. And that commitment is in writing and is where we're going for both PEPFAR and global health initiative.

STEPHEN LEWIS: There is—on the screen in front of me, it says Stephen, please help us wrap this up. We need to let people go. So allow me to wrap it up.

I have learned some things from you today, Eric. I have learned about the conduits to maximize. I'd never heard

conduits to maximize before so I appreciate the strange and arcane language with which this discussion is addressed in.

I want to say to everybody and to the panel in particular much thanks for the discussion. Undoubtedly, people are frustrated that certain issues were not adequately joined. They never are in a panel like this within the timeframe. But it is much appreciated.

I'm going to exercise, if I may, a brief prerogative of the moderator to say to Eric, because obviously PEPFAR has been a center of contention although not of acrimony you will note that your constant mantra of talk is easy and action is what we measure is what is at the heart of the anxiety, Eric.

In the presidential election campaign, President Obama, Hillary Clinton, the present Vice President Joe Biden, all signed a declaration committing themselves to $50 billion for AIDS alone over a five year period. And the reality is, of course, is that we're nowhere near that. And therefore, the talk that was voiced in the campaign compared to the reality afterwards of the action is what causes the cavernous gap in believability that so worries those on the ground who watch things slipping away.

The President yesterday made the point that when President Obama—President Clinton made the point that when President Obama took office, he immediately encountered a tremendous financial crisis. And therefore, it was necessary

inevitably to dilute the promises. But just as it sticks in the craw of so many in South Africa that billions of rands were available for stadiums but not for public health, so it obviously sticks in the craw of the health activists that billions upon billions are available for stimulus packages and bail-outs, trillions indeed. And that the tiny amount that Michel Kazatchkine is talking about of $17 billion over three years is somehow unavailable. Indeed, the addition billion dollars a year for three years from the United States cannot be pledged.

And if you want to understand, Eric, why the agitation and the anxiety, when those realities are translated onto the ground and you have reports on the front page of the *New York Times* about Uganda as we did, admittedly responded to, then that merely reinforces the sense of that this is still an emergency which is not being dealt with and that universal access is desperately needed. And the future of universal access is obviously at stake because we are facing a crisis.

May I say one more word just on personal terms? I want to say a word on behalf of the activists who have turned themselves heart and soul into these struggles. There's a tendency to depreciate their work, to make mock of demonstrations, to make gratuitous dismissals of the entries they make and the materials they produce.

I was—I'm not going to deny it—I was disappointed in President Clinton's analysis yesterday at the plenary because I thought it was fundamentally unfair. And running through my mind were names like Mandela, Martin Luther King Jr., Zachiachmet [misspelled?], Juan Gari Mati, Gloria Steinem, Sharenna Bodee [misspelled?], Graca Machel, even Eleanor Roosevelt. They were all activists. They all attempted to achieve social justice by agitation, by advocacy, by putting their beliefs and convictions on the line.

There are endless numbers of people to do it through the normal establishment processes. But the activists, they're more urgent. They have the sense of emergency. And fundamentally, if you will forgive me, they should be applauded. This session is over. [Applause] Thank you everyone. [Applause]

[END RECORDING]