The Future of Universal Access – Part 1
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MARK HEYWOOD: Thank you for coming to this session entitled, "The Future of Universal Access – Part 1." Just so you all know, this is really a two-part session. In the next hour and a half, we are going to have a discussion about the past and the present of universal access, and to do that we have four distinguished guest speakers who I will introduce you to in a minute.

After we've discussed the past and present of the universal access, there will be another session that starts at half past four this afternoon that will discuss the future of the idea of universal access, and the way these two sessions have been put together, is that they are intended to complement and to build on each other. So I would appeal to people in this session to please try and stay for the session that will begin at half past four under the moderatorship of Steven Lewis.

We're fortunate today – I made a joke before we started, but to help us have this deliberation, we have four activists. An activist's activist [laughter] Kieran Daly from the International Council of AIDS Service Organizations; an activist doctor, Dr. Peter Mugyenyi from Uganda.

A doctor who has been with us in this epidemic in trying to challenge this epidemic and get treatment to people

for very, very many years, and who has been very influential in shaping the global and the African response to HIV.

An activist economist in the form of Professor Nicoli Nattrass from the University of Capetown – there's claps for Nicki – an economist who has used the science of economics but does a lot to make economics accessible and economic argument available to justify human rights and to justify the very principles that under lie the notion of universal access.

And finally, an activist priest, Reverend Robert Vitillo from Caritas International. Caritas International is a Catholic church-based organization that provides medical services, treatment services to many, many thousands – tens of thousands of people across the world. So we have four different perspectives that we are going to bring to bear on this discussion.

The way we're going to structure the discussion is that I'm going to ask a number of questions to each of the people that we have with us, and then we're going to try and pick up some of the threads, some of the issues, some of the debates that are currently raging around universal access.

Universal access seems to be a theme of this conference. Many of the presentations, many of the sessions use the term universal access, but I often wonder whether – or how many people know what we're actually talking about; what is this strange fish called universal access?

If we know what we're talking about in this room, does the world know what we're talking about when we talk about universal access? And why is universal access necessary when it comes to HIV?

After all, poor people around the world don't have universal access to other medicines and to other treatments. They don't have universal access to malaria treatment; they don't have universal access for antenatal services, so why should we exceptionalize HIV and have universal access to HIV prevention and treatment services?

So let's dig a little bit into this idea of universal access and let's start with Dr. Mugyenyi from Uganda, who as I said a few minutes ago, is a practicing clinician. And I want Dr. Mugyenyi to explain to you – to explain to us – where did this thing come from and why, from his experience as a doctor in one of our countries from Africa, was it important to deal with the HIV epidemic? Dr. Mugyenyi, you've got five or six minutes to convince our audience, and then we will bring another perspective to bear on this discussion. Thank you very much.

PETER MUGYENYI: Thanks. Stand up?

MARK HEYWOOD: Please, sir, you can sit down or stand up, whichever you're most comfortable with.

PETER MUGYENYI: Thank you, Chair, for giving me this opportunity to share with the audience the experience we've had

with HIV/AIDS. I'd like to start by taking you back. The reason why I would like to take you back is that, regrettably, memories are beginning to fade.

The reason why memories are fading is perhaps not surprising. People like to forget unpleasant things and they like the pleasant things to stay. That's how hope builds in us. But, perhaps, what happened in the case of HIV/AIDS should never fade from our memories.

I take you back to early 1990's. It was a grave situation, particularly in Africa, the continent where I come from. Africa was not alone. There wasn't much that could be done for HIV/AIDS. There was no treatment. But a revolution took place in 1995/1996 where for the first time the most effective treatment for HIV became available.

Then, from there on wise, the world was divided in two. We had the world which would access this life-saving treatment and we had the world which could not, and this constituted what was described at the time as a moral and ethical dilemma.

That was back in 1996. As treatment became more and more effective, as demonstrated by a response of patients, there were such flamboyant words that came to describe the magic of these drugs, one of which was called "Lazarus Syndrome."

People given up for the dead resurrecting as a result of antiretroviral therapy. Meantime, in Africa and results-

constrained countries who could not afford the miracle that had become HIV, remained in a dire situation.

Not only did they remain in a dire situation, the numbers were increasing, the carnage became a crisis. It could no longer be swept under the carpet. It, indeed, constituted a moral imperative for the rich countries but to watch and do nothing as millions of people were decimated.

The turning point came in around that time, 1996. The leaders of the G-8 met, that famous meeting, and they said – they declared that the world should start moving towards universal access. And this is, perhaps, when this word started to come again. Since then, universal access has been getting different descriptions depending on people's conception, but mostly depending on people trying to give an excuse for an objective that is noble, that's universal access.

It's not very difficult language. Universal and access are self explanatory, but people started saying of this universal access we couldn't do this. Anyway, the leaders of the G-8 dedicated themselves to universal access and they set a time table.

The time table was by the year 2010. That is last year. And they didn't go with that alone, there were other ambitious goals set, the millennium goals for health. These were noble objectives; they remain noble objectives, but we are

where we are right now because we all know we didn't achieve those. Missed targets.

But these missed targets could now be reactivated to move us to another level.

Now, another turning point in universal access came in 2003 when [inaudible] of two programs started taking effect. These two programs was the ground-breaking PEPFAR program and the Global Fund for HIV/AIDS. These two programs made my country Uganda, and most other countries – developing countries – do for the first time what – up to that point – had been described as impossible in Africa.

Excuses has been the theme. At that time, it was said Africa could not have antiretroviral therapy because of the various challenges which could not "be overcome." One guy, famous fellow, made a statement – actually, I remember two statements which are very, very critical – but one of them was that Africa cannot do antiretroviral therapy. They require precision timing. Africans have no watches. If the sun doesn't come out there today, they wouldn't know how to take their drugs.

Another one had a worst comment, and I remember it vividly. It was that if antiretroviral therapy – he was trying to justify why Africa could not access treatment – that if antiretroviral therapy was a glass of water, Africa could not afford it. Anyway, the impossible happened. What we had all

the time being stirring the world was that we have a crisis in Africa, a continent with a list of resources, but if we could get the resources to treat the people, would be able to treat them without much problem, would be able to scare up treatment and would be able to save lives. That's precisely what happened.

If I take the example of my organization, the Joint [inaudible] Center, when funds from PEPFAR came available, it was thought within a year would be here and put 5,000 new patients on treatment. That is just my organization. Within that same year, we put close to 28,000 patients on treatment as one single organization, and this has been repeated in may other countries across Africa and some of them are approaching record numbers, like Botswana which has the resources. South Africa, if you are here this morning, the Minister of Health of South Africa is talking a different language from the previous Minister, and South Africa now has one million people in treatment.

But I'm going to close my introductory remark HEYWOOD by bringing you to the present. The present is a very critical time. Once again, we are facing some of those prospects which we faced in the mid 1990's.

We are beginning to hear a language which I thought we would not hear about, and this is the language of moneywasmo

[misspelled?]. It is too expensive; we can't do it. We are beginning to see people doing the soft options.

They know what needs to be done. It is universal access and they are now saying we are now going back to the time when some people are now once more saying we need to choose what we need to do, what we can afford. They are not saying what we should all be saying, that at this critical time, we have more scientific advances. These scientific advances are quite impressive, but of which we know we can treat everybody. Secondly, we know treatment is not merely treatment. Treatment can be used as part and parcel of other preventative armaments that we have now.

We have exciting new drugs and research continues, and some scientists now talking even about finding a cure in the future, but starting by doing the science today. So this is the critical time which we face now, and as we face it, we need to know that this is not the first time these kind of issues of things being impossible have a reason.

And this is the kind of time that we once again needed to raise up and be able to say we can do it, and we need to get commitment, not only of ourselves – because here I'm talking to the converted – but we need a commitment of all governments; we need a commitment of the international community, and we call upon the leadership of rich countries once more to know that an emergency has not gone away.

We have a financial crunch and it has been swallowed by increasing resources – it is being swallowed by increasing resources and AIDS, more than anything else, requires that resources be increased so that we can continue on the move to our solving this century's most devastating health problem. Thank you. [Applause].

MARK HEYWOOD: Thank you, Dr. Mugyenyi. I understand from what you're saying that universal access is a moral imperative. I understand that, maybe, it's a human right, I can understand your perspective as a doctor your desire to keep people alive, to keep people healthy, but the world doesn't work on moral imperatives. The world works on politics and it doesn't seem like universal access was ever a political imperative.

And one of the questions I'd like Kieron from ICASO, the International Council of AIDS Service organizations to take us forward from what you've said, is to explain how – was it ever a political imperative? You lobbied for this, Kieron. Did you lobby for the right thing? Did you think about what you were lobbying for?

Did you lobby for a concept that means anything? What does universal access mean? It sounds wishy/washy to me. How do we measure it? But, most of all, how do you get the political will that is necessary to help us to achieve Dr.

Mugyenyi's ideals? Kieron Daly from ICASO, please enlighten us.

KIERON DALY: Thanks, Mark Heywood. [Applause]. I'll stay sitting down, but I think it's funny the way you asked the question as if it's not a political imperative, 'cause the irony is, it was meant to be, and Dr. Mugyenyi talked about the G-8 committing to universal access by 2010 in 2005.

Then again, universal access commitments, not only to treatment to prevention, care and support in the universal – the Ungus UN general assembly, and the political declaration that came out of that, which you're right, many activists were out there pushing for that political commitment from governments around the world.

And it is very much – I agree with your point, it is an political imperative. It was words on the paper; it was – we were pushing for something – there was mobilization and there was, you know, the success of ramping up treatment to the level it was.

It wasn't anywhere near what we wanted in 2005/2006, but there was political momentum coming from many different countries. And even the G-8 and other commitments came from some of the big government and influential governments saying, yes, we're going to commit to universal access, but no definition.

And I think this is why in 2010 right now, we have – we're nowhere near achieving universal access. And I would say universal access being about access to the quality services for all those that need them. And it's not necessarily by everyone getting everything; it's really about those that need the HIV prevention treatment care and support services to access them.

Now, this political leadership has certainly waned and we're in an environment right now where AIDS is on the wane within the donor and, maybe, national government commitments.

But also, it seems that the momentum for pushing, and the leadership for pushing for real universal access as we may understand it, is lacking as well. So the process was – following the 2006 political declaration, within that there was a commitment for the UN system to work with national governments to come up with ambitious targets for universal access.

They worked and defined it themselves and country-driven processes that made sense to actually set targets, ambitious targets. But when there was no definition – I suggested a definition just now – but there was really no definition, so it was really out there for anyone to come up with what they thought.

And UNAIDS were there to support that at the country level. And in 2007, my own organization, ICASO, did some

analysis, but many other organizations did analysis on what those targets looked like.

And what came back was very clearly that many governments not only were defining universal access essentially as a little, slow incremental on their AIDS programming, but also that it was acceptable to exclude many of the populations that actually needed the services.

So, you know, who would say a target of zero percent access to services for sex workers or people who use drugs as a target – i.e., they didn't set targets for some of the most vulnerable populations. In an epidemic in Eastern Europe, for example, where there's no commitment, no targets for harm reduction, needle exchange, opiate substitution therapy, that's not universal access. And that's some of the most blindingly obvious issues.

So it's this lack of direction in universal access in terms of what the political leaders saw it as, but also that lack of support by the technical agencies that were meant to be helping governments, you know, drive towards a more comprehensive access to services.

And the interesting thing is – I would – 'cause I know you just want some introductions here, but the interesting thing is that we had a discussion yesterday, we had a little session and we titled it "Fool Me Once, Shame on You; Fool Me Twice, Shame on Me."

And I think it is that we got sucked into pushing and advocating – activists around the world – pushing for universal access and we were fooled by the commitments put on paper by governments that they actually meaningly thought universal access was achievable in 2010. So we're now in a situation – and I know we're not looking forward – but we're now in a situation where we're now talking about 2015.

But until we look back at what happened and why we failed to achieve it in 2010, because of that lack of clarity on what universal access meant, and that lack of leadership and what I'd put on top of that – and Peter talked about it a little bit – the lack of any kind of financial strategy for achieving universal access.

There was no commitment to the money, and we're now facing that right now because now we're struggling to get money for the Global Fund; we're struggling to increase PEPFAR; we're struggle to get the money. And that's because there was no financial strategy in the first place for us to understand how much money really was needed to achieve universal access. Thank you.

MARK HEYWOOD: Thanks, Kieron. [Applause]. Thank you very much. Maybe we can ask the question a little bit later and ask Kieron to, perhaps, think about this for a few minutes, about whether it's too late to properly define what we mean by universal access.

And to then hold the world and the world's political leaders to a definition that we determine, and a reasonable definition of universal access. Maybe another thing that we should think about – as you say, we shouldn't be fooled twice – is that we should, perhaps, look at costing universal access rather than waiting for governments to cost universal access.

But that brings us to our third speaker this afternoon, Nicki Nattrass. And, Nicki, I want you to try to answer whether universal access was ever realistic from an economic point of view, I mean, Dr. Mugyenyi said universal access is a moral imperative, but does that make it an economic imperative?

He said that one point people said if ARVs was a glass of water, Africa couldn't afford it. Well, you know, so can we afford universal access? And help us with this because I remember an old Russian revolutionary who said, "Politics is concentrated economics," and if we don't understand the economics of universal access, we'll never get to the bottom of the politics. So, fill us in, please.

NICOLI NATTRASS: Yeah, I guess that's the million dollar question. We had to look back at the past. What's really striking is the incredible increase in money for AIDS that happened in the 2000's. We went, pretty much, from, you know, less than a billion at the turn of the century, to 10 billion a year by 2007 or so, and that was a dramatic upscale.

And that seems to have been driven by political commitments; clearly, I think there were a couple of big political victories that were won by the activist community. One of them was, I think should be Peter Piot convincing the UN that it was a human security issue; and the other one was global activism across nations that seemed to be putting pressure on countries around the globe.

And then, fortunately for us, it kind of fitted into George Bush's conservative care agenda, and he went running with this notion with PEPFAR. And I think PEPFAR – like you were saying – plus the Global Fund 2003/2004 really injected a lot of momentum.

Now we know that history. The question for me is, why did that happen? I mean, you could say, yes, there was the political will and it was – we were lucky that these arguments were won, but I think what was really behind it was that we were in the middle of the longest boom in capitalism since the post war – the early post war period.

Now the economists look back on this and say this was the great moderation. We sustained growth everywhere. Even Africa was growing strongly. Gordon Brown, the old head of the U.K., the Prime Minister, was basically saying the business cycle's gone, you know, we've dared, we can move beyond this.

There was this notion that somehow growth would just keep rising, there'd be a sustained rise in productivity and

profitability, and we could actually fund a whole lot of human rights things.

Now, that I think was the reason why we got that commitment to universal access even though it wasn't properly defined and was left to country governments to define. And, certainly, by 2008/2009, when we started getting that big global crash, suddenly people woke up and thought, whoa!

The business cycle's back; we can't just keep expanding these commitments and, certainly, we can't expect productivity to keep rising so that we can actually pay back or keep the tax dollars rising to fund that access.

So that's why we've had this turn backwards from universal access, and that's why we're seeing this drop in political leadership. And what I find interesting just looking at these big number questions was, you know, from 2008 – '07, '08 and '09, UNAIDS would come up with big numbers, so I remember the one for 2009: we need 26 and a half billion dollars; we've only got, you know, 16, we need another seven and a half billion.

These are the kinds of numbers that were being thrown around and we were kind of pushing for: fund the gap. Now, when you look at the UNAIDS' outlook, there's no big numbers being tossed around and that, I think, is interesting. People are not fighting for numbers at all.

It's now at treatment 2.0 says UNAIDS and it's about doing more with what we've got. And I think that's something we've really got to take on board.

And Clinton's saying yesterday that you're very lucky. PEPFAR's flat lined, that's lucky. You should be supporting the Americans for flat lining it – for not cutting it. So it's actually – and that's quite an important thing, we've still won that victory.

It's a amazing in this kind of end of the great boom that we've managed to keep the AIDS funding where it is without it going down. So trying to push for more in that I think is kind of unrealistic at that stage because we've got the economy hitting against us.

And the other thing which is interesting about this report I just want to draw your attention to is on page 60 – I don't know if you've had a chance to read it – but they say that in 25 countries which absorbed 25 percent of resources for AIDS, where 85 percent of people are living – that's 25 countries – and of these just under half – 12 – should be able to afford it all themselves.

So UNAIDS is no longer fighting for a big number and they say there's a whole bunch of countries where the AIDS response only costs 25 percent of GDP and you guys should fund it yourself.

And that includes Vietnam, Pakistan, India, Ukraine, Thailand, China, Argentina, Mexico, they're all there, and the countries which are now being put forward as being the deserving countries are pretty much the African countries, most of which are in sub Saharan Africa.

So the other big challenge facing us right now, I think, is that there's a growing split between some countries being seen as more deserving for what little resources are out there and it looks like it's kind of Africa versus the rest. And I don't think we've really come to grips with what that means for us politically and economically yet.

MARK HEYWOOD: Thanks, Nicki, before I let you off the hook, just a couple questions I want you to try to respond to. The first is, surely if there's not the money, there's not the money for universal access. Do you agree that there's not the money for universal access, and, secondly, is there an economic cost to giving up on universal access?

I mean, is the economics only in the money that we must forward find, or is there a cost to letting people die, to letting our hospitals start to fill up again. I mean, do you accept the arguments that are thrown out there to justify limiting these ambitions?

NICOLI NATTRASS: I still think we can get universal access and I think it's something that we can fight for, and I think it is affordable. And what I actually like about the

UNAIDS approach now is it's very much on we can do things smarter and better, and that they are – and this is not just a slogan – there really are huge gains that we've made.

For example, the drop in cost of second line treatments down to below $500; the fact that we get a single pill out there in developing countries for under $200, I mean, a year. That's fantastic, and I think we can actually do it.

And I think that nurse-driven programs and all of these innovations that are coming through in this conference can make this affordable. What I was just merely pointing to is that the kind of international push for the big number which is somehow – we add up all the global needs and then we go to the international community, we ask for it.

I think that day is over. Now the focus is very much on working smarter and the focus is also much more at the national level because its activists now have to ask their governments, put the money in, use these really cheap and efficient products, and get people on board.

So I certainly think it can be done. I'm really heartened by South Africa. It was wonderful listening to our Health Minister this morning, and he was saying we can afford it and we can do it.

I think if a lot of countries can follow his lead, we're there, because in the end universal access has to come from the national governments supported by activism where

necessary. But the days of the big number, you know, and getting it funded through huge international initiatives, I think that those days are over. They went down with the big boom from 2000.

MARK HEYWOOD: Thank you. Maybe we'll debate that a little bit further in a few minutes, and I'm sure there's some views on that from within the audience. Father Vitillo, one of the things Nicki said was, you know, the flat lining of PEPFAR should be seen as a victory, which brings us to the present and I'm interested to know from your perspective in Caritas, what flat lining actually means, and perhaps Dr. Mugyenyi can also speak from the perspective of Uganda after you, you know, what are you seeing?

Are you seeing continued growth in the numbers of people receiving treatment? Are you seeing something different? And do you, perhaps, as a man of the cloth, or whatever, have a different view as to something other than economics and politics that should, perhaps, condition and guide the way we frame universal access.

I haven't, for example, heard anybody use the word human rights in this discussion, the human right to health. So would you just help us a little bit with these issues?

FATHER ROBERT VITILLO: I hope that I have a view that goes beyond politics and economics, but includes that as well, because it also has to be grounded in reality. But, first of

all, my involvement in universal access came from the ground from visiting in, first of all, in Uganda many, many years ago in the 1980's, and then in many other places in the world where people, of course, were dying, hospitals were full.

I remember being in a hospital in Masaka where the patients were out in the lawn in front of the buildings because there was no longer any room when they had two adult patients to each bed and there was no more room. I think many of us were involved and knew those terrible times.

And then, the excitement that something could happen in one part of the world, even if it was happening in the north. But then, as I visited people in the southern countries and worked with them, their questions – haunting questions – why should this be where you're coming from and not the rest of the world?

Can't you take me back with you so I could get those medicines? Can you bring me some medicine the next time you come? If you can't take me back, then take my children so they have a chance to live. So I think that's what we have to remember: the dream and the hope for universal access came from the people who were suffering and who wanted to live beyond everything else.

And that means that it's centered on peoples' human dignity and their right to have a basic standard of health –

all people, not just people in one country or another, or one continent or another.

I was – like Kieron, I was involved in the universal access task force of UNAIDS to try to develop this framework for universal access, and I have to say that during those days – and I think Kieron would probably agree with me – there wasn't a full political commitment to this. And there was great resistance, as Kieron said, to have some kind of a definition, or even to make it universal.

I remember several governments around the table fighting that word universal and wanting to set some smaller limit, and their reason – which I found quite illogical – was there might be some people who won't want the treatment and so, if we say it's universal, then we'll be forcing them into taking this treatment. So even at that point there was not, I felt, a full political commitment.

Also, as things did begin to open up through the funding mechanisms that have already been described, then I remember the anxiety of people in the faith-based organizations throughout the world about rolling out this work, because they said, if we take a commitment for these people, we have to be sure that we can maintain them on treatment forever. They already knew that governments might change their priorities.

But they were part of the community and they were not going to abandon these people. And that great anxiety and

reticence, we had to work with and now I feel guilty that I assured them that there probably would be a long-term commitment to this universal access which now seems to be much more uncertain.

So I think that as we look at the history, we have to ground it in the reality of the people and then, when we also look at the future, I hope in the next session they'll ground it in the reality of the people and not just stay with abstract principles or political expedience.

The other thing is now what's happening in the field. Well, what I'm hearing from our Catholic church organizations, but also a wider study that was done by the Ecumenical Advocacy Alliance of the experience of may faith-based organizations involved in treatment, care and support and prevention programs, is that, certainly, there's a change in priorities. Many of our people running treatment programs are being told not to take in any new clients.

Some people who were already receiving medication are now no longer receiving it. Others – when a whole family comes and mother, father and children are infected, they're being told one person from the family can come on. Now, in many cultures that will not happen. They will get one dosage of the medication or one supply of medication and they will share it and then no one from that family will benefit from it. So there is some real big, big problems that we're facing.

And I think some of the problems are that we never treated seriously – not only the definition, but also the mechanism. In spite of the wonderful new mechanisms for funding, I think things are still very much centralized, especially by government policy.

I remember being at a UNAIDS meeting and one government minister from a country that I won't name came up to me and said, Well, you know, we've got the money in place; we've got the medicines, but our people aren't coming for them.

And I had just been in his country and I said, Well, maybe it's because you're insisting that you distribute this medicine only through the government hospitals and your government hospitals don't get out to the rural areas and our church people have to accompany the patients 100 kilometers or 200 kilometers and they have to pay for the transport because the people don't have the transport money, so you need to de-centralize. I think that's something we have to look at for the future.

Also, an equitable share of the funding. The Global Fund – and I'm one of the activists that pushes for full funding of the Global Fund – but the Global Fund has given 5.4 percent of its money to faith-based organizations, when faith-based organizations in sub Sarahan Africa cover 30 to 70 percent of the healthcare there.

There's a disconnect in that kind of flow of money. We need to address that. We need to get the money and the resources to the community groups including faith-based organizations, and many others that are there in the community and that don't leave when some government decides we're not going to fund you anymore.

And then, I think there needs to be a lot more efficiency in the fund transfers. It's very interesting that the funding schemes and also the bilateral donors insist on monitoring and evaluation, and well they should.

But they insist on that for the local organizations and, yet, very often the big money comes into the Ministry of Finance and it sits there for a very, very long time and it never gets out to the community groups. And the community groups that don't have the money are expected to advance money to be able to buy the medicines and do the distribution, so there are things that don't work right now in the present system.

We need to fight for more money, for continuation of the funding, but also a better and more efficient way of using those funds.

MARK HEYWOOD: Thank you. Thank you very much. [Applause]. The one question I want to come back to – maybe ask Dr. Mugyenyi, and then we'll talk to the people out there. Does universal access make sense to you, doctor, from a medical

point of view? Is there a medical rationale for universal access, I mean, isn't is just okay to treat some people, not treat other people.

That's the way we've done things in Africa for, you know, for a pretty long time and, I mean, you're a doctor – you're not a doctor of AIDS, you're a doctor of medicine, so isn't there really a conflict between universal access for people with HIV, but not universal access for people with cancer or diabetes in our African countries, and deal with those things, please.

DR.PETER MUGYENYI: Thank you. To answer this question, I'd like to touch on the point by Nicoli when she said that the days of the big numbers are gone. I'm excited to clear this statement because it is big numbers that we have in Africa.

We are talking about over 25 million people living with HIV/AIDS in Africa. And if we use the old criteria of 200 CD4 we are talking over six million people in the need of treatment, and they're not getting it. And if we talk about 350 CD4, we are talking about 15 million people in resource-constrained countries, of which about 13 million are in Africa.

So to come and to say the days of the big money is gone, Nicoli, is like what we had before in 1990's. Nobody believed that the numbers that could be treated would be

treated, and I think this is something that we can't, right away, take out of our mind.

If we cannot afford to treat people, are we going to be able to afford the carnage, the death? These deaths were not people just conking off; these are the people which Reverend Vitillo had talked about. They were filling hospital beds; they were fitting under the beds, the corridors. You had to do a round – a ward round – stepping over patients lying in the corridors. How much money has been saved?

Recently, journalists came back to one of the hospitals which he had visited before and found some beds empty and his words were, I can't believe this is the same bed – this is the same hospital I visited in 1990's.

We are talking about a situation where antiretroviral has almost abolished pediatric AIDS in Europe and third world countries. How much does it cost to treat a child in a lifetime? How much does it cost to raise an HIV-infected child with no mother? What is the economic benefit?

So there is a lot of things that we don't measure that are very important. Let us look at South Africa. South Africa is not an ordinary African country. Its economy alone is almost equivalent to the entire economy of the Sub-Saharan Africa, just one country. Right from the beginning, there was never any question of South Africa not being able to afford antiretroviral therapy.

They had the most incredible denialist government. The minister, who kept telling people to take beet roots. Now, we had a minister here from South Africa. Almost overnight South Africa is talking the opposite language to a previous minister. The previous minister used to say, this treatment is not affordable by South Africa. Years later, we have a minister who is saying it is affordable.

What is actually not mentioned is that wait between the first minister and the current minister made AIDS treatment, according to economists four to five times more expensive then it would have been if it had been treated earlier.

So South Africa right from the beginning could have treated AIDS. I agree with Nicoli that we have to be smarter. This is not a contradiction to remain committed to universal access. We need to be smarter. Africa is not a continent, which must depend on donors forever.

This is something that we reject. To have an emergence in our midst, they who do not want this emergence to last forever. We need to be helped as we help ourselves to fight not only HIV/AIDS as we increase our economic capacity to be able to take on more and more.

An example is my country, which is now able to treat more people. Recently they committed to about 90 million dollars in addition which they would not have afforded if we did not get relief of treating the huge number of people who

are literally bringing the entire country to a standstill. There are broader issues on this than merely saying it is expensive. It becomes much more expensive if you do not tackle this very catastrophic situation.

MARK HEYWOOD: Thanks Dr. Mugyenyi. [Applause]. I know Kieran wants to say something, but I think perhaps as we have a little bit of a debate going here between the doctor and the economist I should let Nicoli quickly respond.

Don't take too long because I also want to hear from out there in a second and then I will ask Kieran.

NICOLI NATTRASS: Just to clarify what I was trying to say Mark the days of the big numbers are over. What I meant was the day when we would be mobilizing at a conference for and get an extra 7.5 billion for global AIDS. That discourse seems to be gone. It is a discourse more about that we all need to work smarter.

UNAIDS is not actually differentiating between different kinds of countries. Actually, Africa is regarded as the place that still needs lots of support. I am in agreement with you. What I just find really interesting is that the UNAIDS's new approach which is to say, let's see, how big is your economy? How many HIV positive people do you have?

In the case in South Africa, we have a big economy, but UNAIDS says because South Africa has the highest number of HIV

positive people in the world. South Africa still needs support.

UNAIDS calculates we need about 3 billion a year, we get about 1 billion from the government. We get another billion from America and according to UNAIDS South Africa's government needs to put in another half a billion and we need to get another half a billion from elsewhere.

Even South Africa is seen as deserving even though it is a huge economy, precisely because it has so many people. They applied this formula right across all countries and come up with which ones are more deserving. You really should take a look on page 60 and have a look at that, at which ones they see, they are red and green.

The other point though which I am trying to make about national political activism is that there is a lot of criticism out there in the advanced capitalist countries about foreign aid and aid for health.

The foreign aid equation goes like this, while we are protecting foreign aid budgets when everything else is being cut, when we know that when you give one dollar of foreign aid to any country they actually move the money in effect to other areas. They also point out they do this in health.

There is a study in the *Lancet, which* shows. If you want to get a dollar into the health system in Africa, you have to give an African government one and a half dollars. What is

happening is effectively they cut what they were going to put into health themselves and they move it to education.

That is normal politics. The only way that you can get that full one dollar fifty into health would be if people in the country say no, we want it all there. Aaron Motsoaledi said this morning, he said, universal access requires universal support.

That is really important. If we do not have people on the ground pushing governments for the whole time that money will get lost into other causes and you will get resistance from people about giving extra money for health and aid.

MARK HEYWOOD: Thanks Nicoli. What you are saying is it is not an argument against universal access.

NICOLI NATTRASS: No.

MARK HEYWOOD: What you are saying is that we need greater citizen civil society activism at national level to hold governments accountable for the money they receive and the money that they spend. Also, greater activism at the local level to continue to insist on developed country support to developing countries. There is no way that developing countries like Malawi or Zimbabwe, or other countries can meet the need, the financial Uganda, the financial cost.

You have to remember that we live in a world where Africa was raped, plundered, and set back by colonialism and by

neocolonialism and by structural adjustment, etc. These are all things that we have to throw into the pot.

Kieran, just say a few things because then it is time that we get other opinions.

KIERAN DALY: I just wanted to disagree and agree with Nicoli. I think the issue of big numbers and we are not calling for this. The opening, the demonstration was about those big numbers. If you heard, part of the call was a minimum of 20 billion for the Global Fund. That was just one call. We know 20 billion is not even enough given the new WHO guidelines around early initiation of treatment.

Even the big numbers we are asking for is not even universal access. It is out there and we are calling for it. You reference UNAIDS and I think that they have not in this report got the costing. That is a failure. Really. What was going on? They just didn't do it. It is a new strategy. They just did not do it. [Applause] I know they will probably admit, oh yes we should have done this. I do not think it is a change in the approach and it is something that we need to push for, that global money. It does exist, it is there and I appreciate it is a different environment but it does not stop us asking and pushing.

I do agree with both yourself and Mark's comments. Our African activists are out there. Our Asian activists are out there. Our eastern Europeans, you should see it here. They

are talking about for example; the Global Fund should remain global. The Argentineans, the Russians, the Eurasians, they are saying we still need the resources. Our governments aren't doing it. We need resources at the country level so we can do our activism to hold them to account.

You see the ARASA campaigns and Polar [misspelled?] one of the opening plenaries was talking about that. We need to push and get activists on the streets in developing countries. They want to do that. They do not necessarily have the resources. It also has to be tied to this global task. It is this false dichotomy that we always get into these arguments about. We need to do both.

MARK HEYWOOD: Thanks Kieran. Let me stand up because I can't see. Is there anybody out there who wants to now make a comment or a short contribution? Do you agree with universal access? Do you think it is a bunch of what? How are we going to resolve these conundrums? We have four activists here who to some extent can't even be on the same page at this level. How are we going to win?

We all agree on universal access, but we have some homework to do if we are going to win this battle. It is a battle that is not an academic battle. It is a battle that at this moment in time is about 10 million lives. We've got to do a little bit better.

We will start off at microphone one, then we will go to microphone four, then two, then three. Microphone one please. Questions and comments, but not 10 minutes. Thank you.

DAVID BANGSBERG: Very good. David Bangsberg from Harvard Medical School, Mass General Hospital. Thank you for your comments Dr. Mugyenyi.

I remember visiting your country when people were dying waiting for treatment in 2000 pre-PEPFAR. Now the treatment has scaled up with the help of PEPFAR and the Global Fund. Most people know the benefits of treatment. How do you think the people in your country will respond if wait lists, return and people die waiting for treatment?

MARK HEYWOOD: Thank you. I am going to ask the panelists to just note these questions and we will come back to them in a minute. At microphone four please.

DEBBIE DEBOUT: Debbie Debout with Ecumenical Advocacy Alliance. I just am curious if someone could answer the question you have asked of why universal access is clear for HIV needs, but not for Malaria, cancer, other medical issues.

MARK HEYWOOD: Thank you. Thank you very much. We must certainly answer that question panelists. Number two.

EDWARD RIVER: Edward River from UCT. I would like to actually speak as an activist more than an academic. What I think is that there was a particular set of historical and

political circumstances, which allowed us to win the battle on Global Funding for HIV/AIDS or to win a temporary victory.

Those circumstances have changed. What I am not hearing enough of is activists analyzing where they can bring pressure that will have results. It won't help to scream harder and harder. This is a moral imperative. How can you go back on the commitment that you made? That won't change the minds of policy makers who respond to certain incentives, structural incentives that are brought to bear on that.

I would like to hear from anyone on the panel that would like to reflect on that. Where we can find the points where we can influence this.

MARK HEYWOOD: Thank you very much. Let me go to number three and then to number nine.

MALE SPEAKER 1: A couple of quick point. Fist of all, the Global Fund released a statement a few weeks ago in which they said that they need 17 to 20 billion dollars over three years. I might not have my numbers exactly right. I think that is about it. We have to ask how we get that many. It means putting more pressure, not just on Obama, as has been happening at this conference, but on the U.S. Congress to try to explain to U.S. voters why it is important to fund AIDS and why it is important to fund healthcare.

Not just the U.S. The European Union, Japan, and other countries like China. China is becoming a huge world player.

It should be contributing substantially to the Global Fund. We should be putting pressure on the Chinese government to do that.

Most importantly, from an African point of view is we have to start getting our own governments to meet their commitments to start committing 15-percent of their budgets to healthcare.

I just have to take Kieran up on one point. I am not as optimistic about activism as he is. I look around and I see an activist bureaucracy that has developed where activists look to which conference they are going to hop to next.

Where were the activists protesting in Uganda when Global Fund money was stolen a few months ago? [Applause] Where when a Malawian man and his transgender partner were arrested? Why were they protesting in Cape Town? Where were the protests in Malawi? The same thing with Zambia with Global Fund money that was misappropriated there.

We have to get activists in Africa and activists that come to this conference to start mobilizing on the ground. Organizing people in communities, to start taking on the wrongs that the governments are committing.

MARK HEYWOOD: Thank you very much. [Applause] Number nine.

GEORGE: Good afternoon. My name is George and I am from Brazil, Sao Paulo. I wanted to share an experience we had

in 1996. Our health authorities won't buy a general therapy for us. The secretary of health told us well we have to give vaccines to little children. If I give money to you, the children won't get vaccines. That is what they told us.

We said, if you have money, because Brazil was doing a kind of a supporting many banks which were bankrupted and corrupted, either put in lots of money on that. If you have money for the health of the banks, you should have money for the health of Brazilians.

I think that now it is the same. [Applause] You have trillions of dollars and Euros for the banks corrupted, bankrupted and you do not have billions to treat people all around the world. I think that we have to take advantage of this situation showing that all of that money that has arising, trillions, not billions, for this all of the sudden situation.

MARK HEYWOOD: Number three.

PAUL BAR: My name is Paul Bar and I come from Lesotho. I followed with what Dr. Mugyenyi gave us. I remember I was reminded of one of those mass tombs, which we were given by the World Health organizations, which were three by five in diameters, which determined how many people we were to treat in this certain given time. This was one of the milestones, which helped us make progress in providing treatment for our people.

As the panelists talk about whether we can achieve universal access. For some of us it looks like we have no

alternative. We have to achieve universal access. It is the only way we can hope to save our nations and probably the only way we can save the world.

Even as we talk about the finances that we need to treat those multitude of people with treatment one of the big questions that we are faced with is that of the human resource, which we need to treat to multitudes of people that we need to treat.

I would be interest to find out what the panelists feel is the best way or is the approach that we can make towards access in human resource for health. That is an area that we need. It seems to me in as much as we need the finances, we need that human resource. Is there a way that they can help us out in access in this so that we achieve universal access, which is a must for us.

MARK HEYWOOD: Thank you very much. We are going to go to number six and then to number eight. I think there are two people at number eight and then back to the panelists. Number six microphone.

MATHEW VALLONE SULIMAN: My name is Mathew Vallone Suliman from Johannesburg. I just first would like to quickly agree with the colleague there that spoke about holding local health systems to account. In Uganda in 2006, they were burning expired antiretrovirals in the medial health stores at the same time as there were stock outs in rural health centers.

These types of things pass without comment, whereas they should have created outrage.

I want to ask the panelists if the whole universal access agenda where we have really been pushing AIDS, if they view this as a Trojan horse in which we can get other health issues through or if the activist community has not in a sense done itself a disservice.

Where now PEPFAR and the public health establishment is going, well there is disproportion of money going into AIDS compared to maternal health or cardiovascular diseases or all of these other things. Do you not think in a sense we have been creating these disproportions or are now the space to the universalized movement?

MARK HEYWOOD: Thank you very much. Before we proceed, I just wanted to say that because of time, I would take the people who are standing at the microphones, which is four people that I can see, but after that, we will have to go back to the panelists.

Starting with number eight, eight A followed by eight B, and then number two and then number six and that will have to be the limit. Thanks.

SOMI NEN: Hi, Somi Nen a youth activist and a medical student about to graduate in an African country. However, I feel it is morally wrong to ask anyone or any country for

funding if we do not do it ourselves. How many African countries have adhered to the Abuja Declaration?

I feel it is a global responsibility for HIV/AIDS, there should be a priority for healthcare nationally before we ask for more funding. The people who we supposed to be making noise are not the Global Fund but our countries first. [Applause]

MARK HEYWOOD: Thank you very much. [Applause] The second person at microphone eight.

MURRAY JOSE: Hi, my name is Murray Jose and I am from Canada. I just want to reference some of the dialogue and links that Bill Clinton and others have made between broader health and specifically maternal health and treatment in the context of HIV/AIDS. Specifically how unacceptable it is and how much I think we need to hold our governments accountable when people like Canada's Prime Minister.

Embarrassingly enough he put forward maternal health dollars with restrictions to keep that money from being available for the full spectrum of needs and that will have a direct impact on treatment and the kind of conversations that we are having today. That is the kind of thing that we need to be acting out against and calling for change on. Thank you.

MARK HEYWOOD: Thank you. Microphone number two.

JOANNA BERGIN: Yes. Joanna Bergin from Canada. Just a reminder that this last year Canada managed to find enough

money to create a vaccine for the H1N1 virus that I believe covered 25 million people of which most people did not go for the vaccine. Then they proceeded to try to send this vaccine, which has not been tested over a long period of time to developing countries to try to recoup some of their losses.

I think we need to remember that the countries are not benevolent countries. They take far more out of Africa in terms of resources and wealth then they put in, in terms of aid. We do need to keep demanding from the countries. I am from Canada. They need to be morally accountable for how they talk and the action and the resources that they take out as neocolonialists and what they say they are putting back in. [Applause]

MARK HEYWOOD: Thank you very much. The last speaker.

GU.S.IMO MALA: I am Gusimo Mala from Sierra Leone. The issue about the United Nations, the professor was referring, have implemented for UNAIDS in my country. Normally if they do have enough funding, they always send the sensitive funding they have.

In our countries, and I happen to come from the least developed country in the world according to the UN 2009 development index report. We can put pressure on our government back home, but we also need the supports of all of the people outside of the country to also help us put pressure on our government. Thank you.

MARK HEYWOOD: Thank you very much. Just before I return to the panelists, I would just like to ask a question. Is there anybody out there who disagrees with universal access as far as we understand it? Is there anybody there? Can you put your hand up if you disagree? Let me put it another way. Do you all agree? Yes. Are we sure?

I think it is quite important that we know that we all agree, because if we agree, then it is something that we are going to have to fight for. I want to be able to convey that agreement to the next session that we are unified in the view that people have a right to access appropriate medical treatment.

We have heard your questions. Let's go back to the panelists now, starting with Dr. Mugyenyi. What are some of your responses? Because time is short, I am going to ask you to be three minutes or so each.

PETER MUGYENYI: First, I want to express my admiration for the quality of the questions and for the comments. They have been wonderful and to the point. This is very reassuring to me because to this audience, it looks like we are talking more or less the same language.

Very briefly, thanks David for your question about people who have been accessing treatment for example in Uganda and now suddenly some of them are being turned away. In answer to that question, and it was raised earlier I would say where

some of the people and in some cases from the same family, some of the people accessing the treatment where others are not accessing treatment. For example, if father is accessing the treatment, but now there is a shortage of funds and the mother is not accessing treatment. That kind of situation is a recipe for chaos and danger. This is not just a careless statement. These are scientific statements.

We found out recently that the habit died out of persons trying to share drugs was creeping back. There is no African mother who would take a drug when her teenage daughter cannot access treatment. Inevitable they started sharing out. This sort of situation leads to resistance. We have scientific evidence to show that you cannot have adherence when drugs are not accessible. If you do not have adherence, scientific evidence shows resistance is going to occur.

So that others can answer on other questions, perhaps I should touch on one very important question that was raised. Is it only AIDS? What about malaria? What about TB? What about this? The answer to that is not to say we should take money from AIDS and put it to those other conditions. The answer to that is that we need to increase the funding for health.

Just to elaborate a little bit, AIDS is a security issue. The AIDS treatment on the other hand has been one of the programs that in my country you Uganda I would describe as

the most successful strengthening systems. In my program, we do not have a project that treats only AIDS patients. We have tried to use it for funds.

For example in my program to retain healthcare providers, like my colleague from Risutu pointed out. We have increased health workers returning to the profession. They could not stay there because they had no drugs to give patients.

We have also had, it has brought some facilities like a treatment of infection and malaria that treats other diseases. It is not enough. We can build on the achievements to make it not only entirely an AIDS program and make sure that the strength that we build within our system is available to tackle other programs as we look for funds from our own resources and donors to increase the care.

Perhaps just one thing. Hints keep coming about corrupt politicians steeling drugs, steeling donor money and so on. This is intolerable. All countries should always prosecute people who do that. One thing we should not do when politicians steal donor money. We should not punish the patients. [Applause]

MARK HEYWOOD: Father Vitillo, your thoughts.

ROBERT J. VITILLO: I would like to address the issue also that Becky Johnson and some of the other questioners

raised about why universal access just for HIV and not for other illnesses.

I think that we have within our view and our objectives for universal access to development that all of the issues should be included. I know that many of the activists around the TB world are learning a great deal from HIV activists and are now trying to implement that in their own activism.

I think we have to eliminate the vertical programming but also we need to challenge ourselves as activists to eliminate the vertical advocacy that we do as well. Sometimes, against other groups that are working on issues that are very similar.

I think we need to join our hands and forces if we really want to address some of the major structural health and development problems in the world.

MARK HEYWOOD: Thank you. Thank you very much. Nicoli.

NICOLI NATTRASS: This notion that we have given billions and billions to the banks, why cannot we give it to people for health reasons, I think we really have to understand how many billions we have given to the banks.

We have just given, well not us, but the OECD has given as much money to Greece in the last month or two as we gave to the U.S. banks. The result of his is a deep burden that is

unprecedented. We have not seen debt to GDP ratios like this ever.

To just carry along as if we are blind to this economic crisis around us I just think is just bad politics. That is an important point because look at the UK. They have been told, prepare budgets that are 40-percent lower on social security, on everything.

Are we going to ring fence health, are we going to ring fence foreign aid? President Obama is doing the same thing. He does not have 40-percent cuts, but he is protecting health and he is protecting foreign aid. We are lucky that they both of these countries are protecting foreign aid and health is pushed to the top of the agenda.

For us to start demanding more money on top of that, I think is incredibly dangerous. The danger we run as activists is we are going to lose the moral authority.

One of the big voices for the backlash comes from a man called Mead Over from Washington, Center for Global Development. He has done a calculation, one of these big number calculations and he says, wow, if we push everyone who needs to be on treatment 95-percent coverage, by 2016 he says, half of all of the U.S. foreign aid in total will go on antiretrovirals. He sits back and he says, isn't that ridiculous. It is ridiculous.

You are not going to get anybody out there, I do not even think in this room who thinks that half of U.S. foreign aid should go on treatment. Let us forget about prevention and everything else. At some level, there is a reasonable misquotient. We have to take people with us when we argue for treatment, which is why it is really important to go for this Treatment 2.0 as UNAIDS calls it to go much smarter.

We also need to go back to this question, why AIDS and not Malaria and all of these other things. Very important question and that is back to Matt Saladie's [misspelled?] point about universal access needs universal support.

Every activist needs to say, we need to work smarter and better, we need to have nurses driving our programs and we need to build our primary healthcare facilities. We need to get national health insurance. We want to develop health and we are going to use AIDS as the cutting edge. That way you build alliances. You get people thinking; oh, this is for us, not just for them.

Do not get up and say we want more, when everybody else is suffering. That is dangerous, bad politics and that really worries me, which is why I do not like the politics of the big number. I suspect that UNAIDS deliberately left it out. We can differ. Maybe they just did not calculate it. I think there is a good strategy.

Finally on the Abuja Declaration. Why have the African governments moved away from 15-percent on health? It is because they can get away with it. Why is that? Because their populations aren't necessarily wanting to hold the governments to 15-percent of the budget on health.

That again means that if you really want that argument, you have to build grassroots support, make alliances and get people to understand why 15-percent on health. To demand that it comes from outside and gets imposed on African governments is another form of colonialism.

Be very careful of that. You really have to balance the kind of national building up of grassroots activism with support rather than dictation from the national community.

MARK HEYWOOD: Thank you Nicoli. I wish we had another half an hour to deconstruct your arguments, which I disagree with personally. I think we must be very careful about people who throw out scare figures. Very large figures that may be unsubstantiated and also people who contrast debt relief needs with the social and human rights needs of the most vulnerable populations of the world.

To fund universal access would not break the global bank. Funding universal access might cost a few tens of billions of dollars which is small change compared to the trillions and the hundreds of billions that are put into the world economy.

These are clearly issues that we have to look at because they clearly are arguments that are out there. If we do not win those arguments and combine those arguments with our own arguments then we are not going to make the necessary advances.

Kieran. You are from ICASO, you are an activist, tell us what you think.

KIERAN DALY: I completely agree with what you said and I think that is part of the story. I think to a large extent, I think we agree, again it is not this dichotomy, we agree that we have to have governments and we have to have activists working at the country level to stop the corruption, to get the investment in health, to get the 15-percent.

That has to happen as well as saying; yes, we can get that money. It can't be one or the other, it has to be both. I think there is agreement there.

I do want to answer, there were some questions around activists and whether we have to rethink how we are doing it and are we understanding how we are working. I think that is a good question. In these discussions over this week, we are constantly having it as activists. We are going through this week really trying to work some of this out.

I think for example Bill Clinton, was it yesterday saying that the activist were wrong to demonstrate against Obama. They got it wrong. That was not the way to do it. I

think it was really unfair. The activist knew what they were doing.

Part of it is to get, the take the people with us I think is what Nicoli said. It is to get their attention, the general public. It is also to work with congress. It is to work with the policy makers. Peter goes and talks to congress and others and says this is what is happening in Uganda. That is maxed with the activism in country.

Somebody else, I think, where are the activists. Are we just coming to the conferences? I can tell you most activists hate conferences. Actually, when you say where are the activists, you see them in Zimbabwe.

The Gay and Lesbian Organization in Zimbabwe speaking out, having its offices closed down. Having to leave the country and still speaking out. If they go back to the country in serious danger. Happening in Jamaica. They are out on the streets. The activism is there. It is not always so apparent when we come to the conferences.

Part of it is we had a conversation yesterday with a number of community leaders from different key populations, from women and girls, from sex workers, people who use drugs, etc. One of the things we were saying is what are our strategies now?

Interestingly everyone talked about working together. This was within the HIV community, but also the sexual

reproductive health maternal and child health. I think there is a real understanding that we have to reach out beyond that and call for greater funding for health, greater funding for education. It is the bigger plan. It sort of sits uncomfortably with some of Nicoli's analysis that you can't ask for those big figures.

We can only join together if we are all going out there and saying actually international development needs to be there. Governments at the national level need to be funding this. I think we do need to work it out. I do not think we all have the solutions.

I would say one last thing and that is in terms of you asked me at the beginning and then you did not let me answer it in terms of is it too late to define universal access? I do not think it is about the language and what is on paper. We know what works.

We know that in Ukraine people that use drugs needs access to certain services, opiate substitution therapy, etc. We know what's needed. Just do that. We can be asking for example UNAIDS as technical advisers to go to countries, push, and say, hey, this is what technically when your epidemic is what you could and should be doing.

A country process will work out. Are these appropriate targets? How do we achieve that? Where do our resources go? What external resources do we need? Having that financial

strategy that says this is how we pay for it. I think that all needs to go together. Finding new ways of doing it because we are in a crisis as it were.

MARK HEYWOOD: Thank you Kieran. [Applause]. I have just been asked to sum up what I think other conclusions of this session in three minutes in order to help the next session on the future of universal access. Let me try to do that very briefly.

My sense is that the starting point is that everybody in this room agrees that universal access is a necessity when it comes to HIV/AIDS and TB. Not only that universal access is a necessity when it comes to HIV/AIDS and TB, but as a matter of principal that people in this world should have universal access to necessarily healthcare services.

What we have done by pioneering and reviving the concept of universal access in relation to HIV is to cut a path and to reestablish a set of principles that should apply to all causes of disease, all necessary treatment.

What we are saying here is that the bar should be raised in relation to all health conditions, not ones more pulled back down again so that HIV can be equated with the neglect of other diseases and other conditions. That is what we are saying in relation to universal access.

There seems to be a little bit of dispute on the economics of health. Certainly some of us in this room believe

that if health is defined as a human right, and even Clinton yesterday used the word health is a right without perhaps understanding what he meant by health as a human right.

If health is a human right, then there are state duties and obligations to meet that human right. States accept other duties and other obligations. Something that is fundamental to life like health should also be accepted as a human right.

I would ask the next group to work on that basis. I think in this discussion, although we have said that there are problems that we left holes in the road when Kieran and others negotiated for universal access that perhaps we should have developed a better definition of what we meant by universal access.

There seems to be no doubt that the notion of universal access has been an important and a beneficial notion. Universal access has created the ambition that has driven investment into HIV and AIDS for at least half a decade.

Universal access as a principle has saved many lives. Universal access has brought about advances. As Dr. Mugyenyi said, universal access has strengthened health systems. Universal access has brought demoralized healthcare workers back into the health system because they are able to proactive medicine.

Therefore, the danger of giving up on universal access is not just the danger of giving up on a vision, it is the

danger that once you give up on that vision, and the drivers that mobilize people behind those vision start to fall away.

The world starts operating on a country-by-country basis, on my resources verses your resources basis again, and then we are back in a mess on HIV. We are not just back in a mess on HIV. We are back on a mess on Tuberculosis; we are back on a mess with infant mortality. We will see rising maternal mortality, and some principles that we have won with HIV for all people will be lost for all people if we do not succeed.

We say to the next group I believe, we believe in universal access as a human right. Clearly when you come to talk about the future of universal access, you have to help with strategies to answer the political objections to universal access. Even those political objections are ill founded. You have to come with strategies to answer the economic objections to universal access, even though I believe the economic arguments are ill founded and unjustified.

As you talk about, or as we talk about the future of universal access, those are some of the issues I believe that need to be on the table and that need to be considered.

Thank you very much everybody for participating in this session. I hope that you are marathon runners and you can stay for another hour and a half after a cup of tea. These are important questions as Dr. Mugyenyi and Father Vitillo and

Nicoli and Kieran will say, lives are at stake, rest in some respect on this discussion.

I do say that this discussion will also be continuing throughout the conference. For example, there is a session tomorrow night at half past six in session room four that is being organized by LACASO, the Latin American Council on AIDS Service Organization that will debate this issue.

Let's try to nail this down. Let's try to put this issue to bed in Vienna 2010 so that we can get past the nonsense and get on with the real business with promoting health as a human right. Thank you very much for your time and attention. Thank you. [Applause]

[END RECORDING]