No Resources, No Results!
Kaiser Family Foundation
July 23, 2010

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JOANNE CARTER: Okay, let's get started. Thanks everyone for being here on last day of the conference. I want to welcome everyone to this session titled No Resources, No Results, kind of says it all. In my view the issues we will address in this session are the most important ones at this conference.

My name is Joanne Carter, and I lead an advocacy organization in the U.S. that happens to actually be called Results and I also serve as a board member to the board of the Global Fund to fight AIDS, TB and Malaria representing developed country and NGOs.

Just for the brief context of this session, we're at a moment, as you all know, we're at a moment of enormous opportunity where we've shown what's possible in the scaleup of treatment and prevention and where the new data shows that universal treatment coverage can have tremendous benefit to the population as a whole, including synergistic impact on maternal and newborn and child health and through dramatic reductions in morbidity and mortality and also through greatly decreased risk of new HIV transmission.

When we've also shown the impact of evidence-based prevention and new strategies for women in particular. Where we've shown the potential of a mechanism like the Global Fund to fight AIDS, TB and Malaria to support a massive scaleup of

response in ways that engage all sectors and build country capacity but also country aspiration.

At this very moment that we're seeing the potential aggressive scaleup to universal treatment coverage and evidence-based prevention to actually bend the curves of these epidemics. We're also facing this moment of enormous risk of donor retreat. In acknowledgement of what we've heard this week and heard and seen these last many months it's really more than a moment of risk, it's a moment of emergency, of dire consequences already.

With programs not taking new people into treatment, with waiting lists, with people sharing meds and with people dying and with proven effective prevention programs losing funding, and many of the most at risk people left with little or no support. We need a comprehensive strategy to ensure that we have the resources to achieve results but we also have, and it's worth having some real discussion about this in the session today, a very short and incredibly important window of opportunity between now and late September.

Building on the messages from this conference and from this session and leading to the UN Millennium Summit in New York on September 20th through the 22nd and the Global Fund Replenishment Meeting about 10 days later. We have an opportunity to actually change the trajectory of the resource scenario in order to change the trajectory of the epidemic. I

want to be realistic, we're not going to solve all the problems, the resource mobilization in this session, but I do hope we can accomplish a few important things.

Strength in our ability to make the case for more resources to achieve greater results, identify progress we've made and be fully clear how that progress has depended on resource scaleup. Identify the new resource needs based on the new WHO guidelines and other recent data and identify gaps, and articulate what will be possible in terms of collateral benefits and breaking the backs of the epidemic with more aggressive scaleup of treatment and prevention.

Making the case for action now and more resources now, identifying some of the costs and consequences already being felt with donor flatlining of funding. Reinforcing the key role of the Global Fund and its full replenishment, exploring other ways to find resources, including more effective use of existing resources and being able to also bend the curves for treatment in terms of treatment costs.

Finally strategizing together on some next steps. The way this session's going to run is first Cate Hankins from UNAIDS is going to give us a presentation that's going to briefly outline a kind of where we are currently in terms of donor funding, what's been accomplished, donor funding to date, the kind of flatlining, the worrisome flatlining that we're seeing right now. The implications of the new WHO guidelines

and some other thoughts for us to discuss and then we're going to have a discussion among the panelists here.

We have actually a great group of folks, and it'll be an informal discussion where I'll ask each of them to make some brief comments and then commenting on Cate's presentation. Then a little bit more discussion and then we'll take questions and comments from all of us and I hope we can come to some smart points around where do we go from here, what do we do next.

I think I'm going to ask Cate to come up first and then I'll introduce the rest of our panelists when we open it up for discussions, so first Cate Hankins, Chief Scientific Officer, UNAIDS. Thanks a lot Cate.

CATE HANKINS: Good morning, and thanks Joanne. I'm going to sort of run through some key figures to kind of get us started in thinking about some of the issues that we're going to be needing to address. We know what we have to do. We have to scaleup prevention treatment care and support. We need to get resources to countries so that they can implement.

Collectively we've made remarkable progress and I'm going to review a bit of our progress so that we feel a bit positive about where we're going before we start to look at the gaps and then we begin to look at the opportunities. 5.2 million people are able to access antiretroviral treatment now and we have millions of children that are orphaned by AIDS that

are receiving essential services. Health systems are being strengthened but there is much more to do. I guess the basic point that I want to make is that now is not the time to slow down the response, it's the time to accelerate it.

We know there are competing issues, climate change and others, and yes there's been this global economic crisis, but the funding needed to scaleup the AIDS response is tiny and I'll show you a little comparison compared to the money found to bail out the banks as we saw last year.

Let's have a little look at these. As I said collectively we've made remarkable progress and I'm going to focus in briefly on antiretroviral treatment, incidents of new infections and human rights. Here we see the graph of the scaleup of progression in resource limited settings, it's actually up to 2009, now 2008 like the title says.

The number of people accessing antiretroviral treatment has increased twelvefold in just six years. Treatment programs are operating, however, in an uncertain economically constrained risk-averse environment. The new WHO guidelines moving to a CD4 count of 350 cells for treatment initiation have increased the numbers in need by 50-percent.

Globally two out of every three people who need treatment are not accessing it. Fully 10 million people are waiting for treatment now. Globally new infections are outstripping expansion of treatment availability. I'm sure

you've heard it five times if not 10 or more. For every two people who start taking antiretroviral drugs, another five are newly infected. This is an enormous global challenge. We've made great progress, but not only are we not keeping up, we are increasingly behind.

We need a prevention revolution to break the trajectory of the epidemic. There's no doubt about the enormous benefit of treatment for people living with HIV and their families, and I think you may have seen this comparison before from this young man in Haiti.

This is what's called the Lazarus effect. The time between these two pictures was six months. It's absolutely extraordinary. However, the rate of scaleup in some national programs is slowing. Countries such as Malawi, Zimbabwe and Kenya, as well as Uganda are requesting assistance for emergency drug supplies. Uganda has begun placing new patients on a waiting list. As many as seven million Africans with HIV who should be getting treatment are not.

Let's look at something a bit more positive. Young people, and they're leading the prevention revolution. HIV prevalence among young people, aged 15-24 years has dropped more than 25-percent in 15 of the 25 countries most affected by HIV.

These young people are waiting longer to become sexually active, they have fewer partners, and increasingly,

they're using condoms if they have more than one partner. Here are examples from Côte-d'Or on the left and Ethiopia on the right. For the first time reductions in HIV prevalence among young people have coincided with the change in sexual behavior patterns. This is a breakthrough that is essential for altering the trajectory of the epidemic.

Now I just want to mention a little bit about combination prevention, drawing together behavioral, biomedical and structural strategies and matching the dynamics of specific epidemics, it's marking some success. This know your epidemic, know your response strategy involves modes of transmission modeling, epidemiological reviews and country specifity, prevention program reviews and a resource analysis to identify the gaps and the misalignment and stimulate more cost effective allocation of resources.

The basic question is, "How can the highest coverage be achieved for which efficacious and cost-effective prevention approaches and tailored to what specifics of the epidemic?"

Now let's look at some of the advances in Human Rights. The recent advances include the gay couple freed by the Malawi presidential pardon. The decision of the Delhi high court to strike down an anti-sodomy law dating back to their early days of the British Rage, and that's a legacy that all of us, living in commonwealth countries have had to confront. We've already done it or we still have to do it.

China's launching of needle exchange and methadone programs among people who inject drugs and other examples such as the lifting of travel restrictions and the growing amount of resources allocated to programs to reduce violence against women. I guess one thing we need to argue strongly, and get cogently out there, and in front is that the idea that one of the biggest human rights issues facing the AIDS movement right now is the funding gap.

After years of funding increases, the global resources available for AIDS were essentially flat between 2008 and 2009. An estimated $15.9 billion was available from all resources for AIDS response in 2009, but it was only a 2-percent increase between that and the $15.6 billion in 2008. This flattening of resources ended a run, a double digit run annually in donor support for international assistance to low and middle income countries each year since at least 2002.

In 2010 we need $26.8 billion U.S. to meet the country set targets for universal access. We are $11 billion U.S. short. This rings a bell, we were $10 billion short at Bangkok, in 2004 at the conference when people were asking where are the $10 billion? Now we can say where are the $11 billion?

Let's have a little look at what governments have been doing. Governments have been making exceptional efforts, and over time have increased domestic spending on HIV, even in Sub-

Saharan Africa. This slide shows a snapshot of expenditures per capita by country. The darkest navy blue represents countries where annual spending for HIV is more than $10 U.S. per capita.

Spending is associated with both income and burden of disease. What is happening with donor assistance? For the first time, disbursements from donor governments were lower in 2009 than in the previous year, $7.6 billion vs. $7.7 billion in 2008. International aide accounted for 56-percent of Global Resources for AIDS in 2009, with United States remaining the largest donor in the world accounting for more than half, for about 58-percent of the disbursements.

Now one way of assessing fair share and I'm going to show you a couple of ways, is to compare the percentage of the worlds gross domestic product that a country produces with the percentage of all resources for AIDS that it contributes. Here we can see whereas Japan, Germany, France, Spain and Canada are contributing less than their share, a number of countries are making HIV a priority, including the United States, United Kingdom, the Netherlands, the Nordics, and Ireland.

Some of the latter call themselves the like minded development partners, in case you've heard that term before. Here we see the large differences in the choices that donor countries are making as to how to channel their development assistance. On the right hand side are those countries who

have moved away from bilateral funding and are contributing through multilateral mechanisms such as the Global Fund and UNITAID.

Over 70 low and middle income countries receive more than 75-percent of their international assistance for AIDS through multilateral organizations. Another 30 countries receive between 50 and 75-percent that way. This is why we need a fully funded Global Fund. Here are the growing gaps. This slide shows the International Assistance, domestic spending and resource needs by region.

In orange we see the donor countries and their contributions in dollars. Then for each of four regions we see how much is received in aide, how much is contributed by domestic spending and what is the size of the gap? It is clear now is not the time to slow down the response. Now is the time to accelerate it. The world needs to understand that unless the response is sustained, and intensified, we risk undermining the progress that we've made in the AIDS response, and in development overall.

To slow down now will only further widen inequities between the global north and south. We should be speeding up. Every day that we don't narrow the gap between the number of people placed on treatment and the number of people newly infected, is a day when we have failed to turn the tide. It is unconscionable that we are talking about how to avoid decreased

or flatlined funding when we need to ramp up investment to get on top of this epidemic.

We know that investing in AIDS is linked to individual and societal benefits and saves money in the long term. A decrease in funding has the potential to produce increased mortality and morbidity, greater transmission risks, treatment interruption and increased resistance, increased burdens on health services and reversal of economic and social gains.

The change in the new WHO antiretroviral treatment guidelines is going to increase the number of people in need of treatment as I've said. In terms of the financial requirements, it increases them by an additional $2 billion per year. This change makes economic sense. An early start represents long term savings. The benefits of earlier treatment include improved quality of life, reduced incidents of tuberculosis, of opportunistic infections, and maternal mortality with fewer children orphaned by AIDS.

A recent study in Lancet estimated that there were about 343,000 maternal deaths worldwide in 2008, but if there had been no HIV this figure would have been 280,000. Fully a fifth of maternal deaths worldwide in 2008 were attributed to HIV. We could make great strides in maternal mortality for the MDG5 if we got pregnant women with HIV infection on antiretroviral treatment now.

There is a growing body of literature documenting the impact of treatment as prevention and we've heard a lot about it during this conference, thus expanding the benefits of antiretroviral treatment from the individual to the society makes sense. If we could keep increasing our coverage on antiretroviral treatment, we'll maintain a declining trend and perhaps hasten a declining trend in deaths and in new infections.

We just can't ask or demand for more money. I know it makes you want to get out there and just really, really fight for it. We also, in an environment of scarce resources have to ask for more HIV services for the money. We need to allocate the resources for HIV better, we need to make strategic and sometimes hard choices. We need to improve our efficiency in the production of services. We must find and create value for money at every step in the production of HIV programs and services.

We need to improve how the money is spent, increasing the coverage of services will also produce a reduction in unit costs, and thus achieve economies of scale. Programming should be designed and adapted with a long term sustainable prospective in mind. Making the money work harder requires three elements. National and international collaboration to identify and address impending cashflow interruptions, provision of technical support to reallocate resources to

highest priority prevention and treatment programs and identifying bridge funding for aide dependent countries that are faced with funding interruptions.

I would argue that efficiency is not a choice, it is a necessity. We have a real opportunity and I think we should see it that way to improve efficiency of programming. To choose our intervention strategically and to focus them where they will have maximum benefit. At all levels we need to tie funding to performance by monitoring outcomes and implementing performance-based budgeting and contracting.

You know the old results-based management approach that has stood the test of time. Now among the initiatives and recommendations here are three that I'd like to highlight. We need to fund via the most efficient mechanisms, the World Bank, the Global Fund, bilateral funding. We need to fund the most efficient implementers whether they are national or international, private, governmental or NGO and we need to fund the most efficient technical assistance.

This implies a quantum shift in sourcing of technical assistance away from high income countries to middle income countries and low income countries, more south-south collaboration. From my personal experience I can say that using the UNAIDS technical support facility for Southern Africa to identify regional and national consultants for male circumcision policy and programming assistance is building up a

backstopping capacity for the region for now and for years to come.

There are several funding options. Some need to be strengthened, others should be explored and implemented. Almost half of global spending on AIDS is provided by domestic sources in low and middle income countries. This will at least have to be maintained if not expanded, particularly in middle income countries.

We need to develop models that analyze resource needs from middle income countries taking into account the current rates of economic growth, the eligibility criteria of the major donor funding sources and the potential for a stepwise replacement of international funding by domestic resources, particularly from governments. For years there have been calls for donor countries to increase their share to a target of 0.7 percent of their gross national income but few of them have achieved this target. Sorry.

Let's explore this financing through corporate partnerships has a huge potential source. There is the framework agreement on converting debt to health. There are airline tickets as a source of funding, either as a tax, such as the carbon tax, or as voluntary donations. UNITAID was founded with an airline tax base and has expanded to become one of the best examples of an innovative financing mechanism.

The brick governments need to become donors. This is Brazil, Russia, India and China. There are other options, such as the huge accumulation of wealth in the Sovereign Wealth Funds, and the Robin Hood tax which you've heard about at this conference and I would advise you to go to this website, it's a fun place to go, there are a couple of really fun videos on there, and it will tell you everything you need to know to be an advocate for the Robin Hood tax.

This is a second way of what is fair share. This slide shows international aide as a proportion of GDP. The U.S.A is further down this graph but it is worth recalling that if we were factoring in private sources rather than only government sources, the rankings here might well be different. Further increases in AIDS funding are realistic for many of bilateral donors.

They have the space for an immediate increase in official development assistance. We have to recall the contributions from OACD donors will remain the main source requiring a high level of political support and advocacy. Private sector and innovative financing mechanisms will complement, but not replace public sector funding. Finally, how much is too much?

Let's get the conversation going by asking this. Is the $27 billion U.S. required for the AIDS response this year too much? Is the gap that we are trying to close of $11

billion too much? Of course it depends on your comparators. In 2008 international resources from bilateral aid amounted to $7 billion, the bonuses paid to London financial staff were $8 billion, estimated spending on Valentine's Day was $12 billion, the war in Iraq cost almost $200 billion.

It depends on how you value a human life. Are we really asking too much? What will it take for you? What will it take for every one of us to think strategically, raise our voices to advocate, and take action for the funding of what I would call a decent response to AIDS? Thank you.

JOANNE CARTER: I'll just stand up for a moment and then we'll kind of get into the discussion. I would just ask as we kind of move into this discussion, and then the dialogue with participants that maybe we think about a few things that emerged from Cate's presentation. One is, again, it seems so obvious, but it's just the link of progress to money. There was an American poet, Ogden Nash who once said "Money doesn't always buy happiness, but it's funny, did you ever try to buy happiness without money?" We need the resources.

Again, second the impact, the impact that can be had with aggressive scaleup and implementation of the new guidelines. The importance of holding onto the gains that we have made and the danger of retreat, the importance of building country capacity and continuing to encourage aspiration and not make demand invisible.

I think you made key point about efficiency and, I think seems like a priority for all programs, but, and I think you're saying the same thing, not with the aim of doing more with less, but actually doing more with more, and having impact.

Then I think thinking about innovative financing as well as what do we need to do right now around institutions like the global fund. We have a great set of panelists today and I'm going to introduce all of them and then ask them, in order to just make some initial responses and then get into a bit more of a discussion.

Our panelists today are Minister Mphu Romathlapeng who is the Minister of Health of Lesotho, as you know really leading Lesotho leading work in the world, both on the HIV response but also on TB and HIV. Alexey Bobrik who is Executive Director of The Open Health Institute and is leading and managing the Global Fund supported GLOBU.S. project, Eric Goemaere from MSF South Africa, a pioneer of access to medicines movement, and founder of the MSF Khayelitsha sight, and Michel Kazatchkine, Executive Director of the Global Fund.

Minister Romathlapeng, I'm going to ask you if you would just make some initial remarks, really talking a bit about what's been made possible in your country both by domestic but also by international support, where you still see the gaps and what could be had and the danger of donor retreat.

MPHU ROMATHLAPENG: Thank you, thank you very much for inviting me to be part of this panel. We've had tremendous response in Lesotho, we have had to basically to start rolling out what was a dream actually happened. We were able to roll out ARV's in Lesotho to pretty much everyone who needed to be on treatment. We have a nest-driven model. That means we are able to roll out ARV's at the primary health care center. Pretty much everyone was able to be involved who wanted to be part of the program.

Withholding resources from treatment, what will it mean to us? It means all the gains that we have had will be eroded. We have already started two years back, we started enrolling people on treatment at 315 in Lesotho. We are aware of the reduction of the number of cases of TB, we are aware of the number of people who are able to be on treatment for a long period of time.

If we are going to now regress, it means we are not going to be able to implement the new guidelines, it means it will be on, we will have to have another set of evaluation, meaning we'll have to enroll the sickest and the dying. We will have to withhold treatment from people, we'll have stock outs, and basically we'll have eroded everything else that we thought we would have gained by enrolling people on 350 CD4 and higher.

We'll have a sporadic treatment. Once you do not adhere to certain guidelines then you know it'll be who, and uses what guidelines? If I know you, you'll be enrolled, if you know you are very sick then you'll be enrolled on treatment. This is not what we

want in Lesotho, we want to have a program that is decent, like you said, we want to have a decent response to this epidemic and we have shown that it is possible.

We are able to offer continuum of assistance throughout the whole continuum of care, we want to enroll, we start at before antenatal, to use contraceptives for people are wait for youngsters. We want to make sure that antenatal is also a place entry point for treatment and care for young women and mothers.

We want to make sure that during delivery, this is part of the program because we have a very decent PMTCT program. We want to make sure that the mother baby package that we help to implement will be able to be carried through. For us, this will be a great loss. It will be a shame for the world, for us to regress on all the gains that we have had.

We would like to, first of all address our principals, heads of governments of the AU to really not to regress and to keep the promise of the Abuja Declaration and keep to the 15-percent. We want to address also the G8 to keep the promise and make sure that we have all adequate resources that we need, we don't really need $17 billion, we need $20 billion to make sure that we are able to offer living human being all the resources that they need to be able to have this epidemic under control. Thank you.

JOANNE CARTER: Thanks very much, and Alexey if you could make some comments just about what you're seeing, about issues faced by GLOBU.S. and other harm reduction programs in

Russia and the region, the need for sustained funding, I think you also said you wanted to address, perhaps issues around innovative financing which would be great.

ALEXEY BOBRIK: Okay. Dear colleagues, it's a great pleasure for me to be here, and it came to my mind that the first opening session, during the first day was "Is it the end of AIDS diplomacy?", and now at the last day we are discussing the issue of funding. Basically it's all shows that we are the turning point where the crucial time in fighting HIV/AIDS and especially in the middle income countries like Russia or many other parts of Eastern Europe.

On the one hand, we see remarkable success in scaling up HIV prevention, antiretroviral treatment. On the other hand, a substantial portion of that success is based upon external funding provided by international donors, and now when the external donors are leaving it creates many uncertainties and worries for people who devoted their professional or personal lives to fighting HIV/AIDS. Many colleagues in our countries refuse to accept this new reality.

Let me be provocative and state that we are already in this post bubble world and the sooner we adapt the better. Maybe what I am saying is not politically correct, but we should face the fact that probably, the period of exponential growth in HIV related funding is over. Regardless of whether we are able to prolong the presence of the Global Fund in our

region or not, we should review and modify the way we did our business over the last several years.

No doubt that sustainable funding is crucial for continuation of services for retention of the staff and we have several options in our disposal, like we have to explore new financial mechanisms, we have to explore new potentially new cost effective methods of HIV prevention and we heard about several breakthroughs in basic science this conference.

We should greatly improve efficiency of using existing resources. Yesterday the session on Eastern Europe, we heard how many savings can be done even with an existing funding. Definitely we should hold our own government responsible, not just donors, and finally all that requires new leadership and new advocacy. In other words, there are no magic bullets. It's time to reconsider our model, our countries have to pass the swim test.

It won't be easy but there is no other way. Thank you.

JOANNE CARTER: Next, Eric Goemaere from MSF, if you could, Eric if you could talk a little bit about, again, what you've seen in terms of progress that's been made possible, the consequences of stepping back but also the potential of what could be done if we could be even more aggressive in scaleup, in that not only in bending the curves of the epidemic but also smart ways to actually bend the cost curves for treatment.

ERIC GOEMAERE: Thank you Joanne, and thank you for the invitation. Actually I wish I was not sitting here, because of someone who has been in that fight for a long time, more than 10 years now, it sounds a bit awkward to be sitting here to defend a very successful story. Catherine has shown it. I've been in public health for 30 years, I think we never, ever have managed to show so good results for other diseases, but at least TB, malaria, infectious disease I mean, both at an individual level and as we start to show no at population level.

Incidents, TB incidents is going down in a lot of places, and HIV incidents is going up, so it's a success story. What are we defending here? If I was a CEO of a company and from the shareholders presenting my results I don't think you would fire me. Well, we are obliged to defend ourselves because the curve is flattening as you showed very nicely.

We call it in MSF, punishing successes, and that's probably what it is about. What kind of improvement can we do on the technical side, definitely I would say we can go further into efficiency, but keep in mind that already we have done, in terms of efficiency, miracle, miracle. In Dr. Romathlapeng's country, you know it's far away, it's not Doctor any more, at treating patient is nurses or lead counselor that are seeing patient for the maintenance face.

In terms of cost per patient, I wonder if we can still bring it down, we are busy cutting on the monitoring. We try to

sanctify as much as possible, to the point that it will collect in the North that we are doing double standard medicine. There is a trade of day, and I don't think we can win a lot of care.

On the prevention side, I am absolutely adamant that this attendance here in this conference to reenter this dichotomy, prevention against treatment. "Hey guys, shouldn't we be doing more prevention?" It's an old debate. This debate was in existence 10 years ago because for the one who have been into that fight you would remember that in the 90s we were doing a lot of prevention.

Actually we are doing even more prevention today, but what I've absolutely no doubt on my side, is that the, for the moment the best preventive tool that we have is treatment. Is treatment as prevention. Results of this means increasing the treatment target and you will see the impact at population level. Of course they are future, and we need innovation and I was very interested to listen to the talk of Toni Fuchi [misspelled?] about eradication, but you all realize we are not yet there.

Circumcision, we will all do circumcision, but it will not show any impact for 10 or 15 years. We all know that. The problem is to, in 10 or 15 years, the same politicians who are talking decision will not be there anymore. They are not interested in the long term, don't be fooled there. They have a short life and they are just interested in commitment now.

My position, and I'll come back, as will be my next point is that I love the fair share. I think that it's not good enough to

target the United States, they have done a lot, and they should be doing more, but it's, we'll do a big refer, we'll do all the small ones in every single country including this one. Austria is not committing anything to the Global Fund. While we are sitting in Austria, all countries have to contribute and make a big refer, and if possible in a sustainable way.

Short face share, and we need to have proper indicators so that we understand, I've seen some score boxes done there in the media center, country per country and, that is in the short term. In the middle term, sustainable finance of mechanism, like tax, some people say tax and treat. It's not very popular to say so, but sadly as you said rightly Catherine, the Robin Hood mechanism of similar mechanism. That's not my field of expertise.

This will only happen if there is a strong advocacy in the countries. Countries in the south are doing already. Some of them are doing their fair share. South Africa where I live typically was not, now they are doing, so Lesotho has been doing it since long summer naught and in the North, same thing. A robust advocacy to hold them into account. Thank you.

JOANNE CARTER: Thank you, thanks Eric, and your point about the success story that we have, it just, the MSF report it was punishing success was, I mean it's just kind of a craziness that we've had this enormous, showing this enormous success and right at this moment, you know, we're still having to fight for resources is just insane.

Moving into the resource issue, Michel, if you could just, again, just give us more specifically the context for this moment in terms of the Global Fund, in terms of the role it has, but this time, this really key time that we have to actually ensure full replenishment and what that would mean.

MICHEL KAZATCHKINE: Thank you Joanne, and good morning everyone. A few things, and actually Eric you said a lot of the things I would, I wanted to say, so I'll elaborate a bit on what you have said. Let me first say I really love the title of this session.

I'm actually, and some of you may have heard me using that expression often. This is, we can elaborate a lot on efficiencies, we can elaborate at lot on models, we can, but no resources? No results, and no impact.

Second thing I'd like to say is that this conference is a lot about human rights and I've been hearing some voices saying, so, it's about human rights, and how the AIDS movement is a basically and fundamentally a human rights movement, and then it's turning into a discussion around financing. I would like to say that, that's precisely what it is, funding for health is a human right issue.

What the results we're all acknowledging today, and they're so evident, there's just nothing to add as you said Eric, is are results that actually have shown that we're capable of scaling up to an extent that many people were doubting just a few years ago, and that's a victory of human rights because it's the victory of the key human rights that is the right to access health.

It is a major public health success, it's also a human right success. By the way, of course we've scaled up the number of people on treatment, we've scaled up access to prevention tremendously but as some of you said, we've also impacted a lot on health system strengthening, as you said Joanne on maternal and child health, and one of the interesting things for me at this conference is that, apparently we ended this ridiculous debate about health systems vs. AIDS or TB or Malaria, I haven't been hearing about that anymore.

My second point is really, this discussion and this fight for convincing people with evident evidence is really a fight for human rights. I see no contradiction. Third point, for those of you in the audience that may be a bit confused because all of these numbers are circulating there, I'd like to say there's no contradiction in any way between the sort of figure that Cate was showing saying there is an estimated need of $26 billion per year to fight AIDS that it is all of what we would need to achieve universal access tomorrow and the sort of number that you hear from the Global Fund which are numbers that I'd like to remind you are hypotheses on what we at the Global Fund would expect or will expect countries to come up with when they send us our requests.

Global Fund is not the only funder of AIDS and that's why these numbers do not overlap. Actually I would have wished they would overlap. In the period of 2008, 2009, 2010, the Global Fund received from its donors $10 billion U.S. The demand that came to

us, that is the amount of TRP validated requests, the demand that came to us was 13 or slightly over $13 billion.

This is why we have been saying, and many of you have been saying with us that there was a deficit in the Global Fund. Because the demand was above what we were actually able to disburse.

Now, for the next period, 2011, 12 and 13, we're putting one hypothesis which is a $17 billion scenario in which countries would continue scaleup at the same pace as they've been scaling up in the last three years. That takes us to a $17 billion scenario for three years and then a hypothesis where countries would scale up even faster which takes us to the $20 billion scenario and I thank you all for supporting that scenario.

That also means that any scenario below $17 billion would clearly be a scenario in which the rate that countries scale up is slower that what we've seen in the last three years. My third or fourth point, I can't remember, is really to follow on what Eric said, and about this discussion on efficiencies.

I'm all for efficiencies, I've seen how painful and difficult has been the process is round eight and round nine of the Global Fund, of negotiating with countries a reduction in the cost of the interventions without changing the targets. We went for a 10-percent overall efficiency gain, in some countries we achieved 5-percent, in some countries we achieved 15, or even 17, but we tried our best not to change any targets.

That's a real efficiency gain. Eric, I fully agree. I mean, is it a system where the cost of delivering treatment, antiretroviral treatment to a patient, including the cost of drugs, the cost of delivery, the diagnostics, the laboratory, the health care workforce, infrastructures, the supply chain management, where the final cost, the mean costs that the Global Fund is currently $460 per year per patient?

I agree with you, I think this is a miracle! When you think that, in my country, France, we're spending, and your country, Belgium $7,000 per year per capita on health, and in the U.S. it's $12,000 to $14,000.

I take it we could, perhaps bring this down from 460 to 420 and I agree with Alexey, I've seen Shauna's [misspelled?] slide yesterday. Sometimes we're paying outrageous prices on drugs in Eastern Europe as compared with what we should be able to pay. I'd like everyone to be clear, it's not what we'll save, at least on the current global fund prices that will in any way cover the gap that we have. Please don't make, I mean see the limits of that debate on efficiencies.

Here I also have a question to Cate actually, because I know Global Fund is representing about 20-percent let's say, 20, 25-percent of the overall AIDS funding. PEPFAR is representing let's say 30 or 35-percent, but together perhaps we're about 50-percent, and you, and I look at your slide with the pink and the light blue. There's still 50-percent out there. I know that basically every

patient on treatment is primarily supported by countries and/or Pepfar and/or Global Fund.

I'm asking those 50, those other 50-percent, where are the results? Where is the efficiency? Isn't there a lot we could ask there? Perhaps rather than putting more and more pressure on this 460 for them to become 420. I'd like this debate on efficiency, which I adhere to to be set in the right frame.

Finally, again, there's no way we will move forward without further resources. After we've really strengthened the credibility of our request, with one the results, the impact and third, the efficiencies in all areas of delivery on AIDS. There's no way we will escape the fact that we need more resources and Alexey, I take it we need to move in different and new directions, this is the whole philosophy behind treatment 2.0 and so on.

Again, let's be very careful. We need those resources, and so I'd like to thank you all in the audience, because throughout the week, I've heard from you in many sessions and many instances, and in the corridors so much support for a fully funded Global Fund, so thank you for that.

JOANNE CARTER: If I could just take the moderator's prerogative for a minute just to build on what you said Michel on a couple of points. I mean one, I think what we're hearing is that efficiency is, should be a given for every program but it's not a solution.

I mean programs are already, in many cases, I mean some cases efficiencies to be found, but in other cases, you know we can't get blood from a stone, programs are being incredibly efficient already and it is not a solution to the problem or resource mobilization, and second I can certainly speak from the U.S. point of view that the flatlining, potential flatlining of resources, because that's not a reality, it's a potential.

It's a real challenge, but it's actually not an objective reality, it's a political decision. I mean your slide, you know, looking at kind of the different decisions we're making, you know absolutely lays that out, and Michel I want to maybe go a little further than you did in terms of challenging us to look at efficiencies of existing, not even just programs underground but existing institutions.

And, you know I'll throw it out there, I mean looking at comparative efficiencies and programs and, you know including some of the data that came out from its own internal evaluation of the World Bank's programs and I think we have to be straight and look at, you know where programs are working, and where they're not. I'll put that out.

Then just to say, if folks have any thoughts, folks on the panel, any thoughts that were stimulated by what your colleague said, we could do, if you want, one more round of quick comments, of if you don't feel like you have any comments

to make right now, there's a lot of smart people in the audience and it would be great to get a dialogue going. Any quick comments on what you've heard?

CATE HANKINS: Michel, this lady should respond to Michel. I think when you look at where the focus of the talk about efficiency lies right now, it is, obviously on Global Fund, on PEPFAR, on the visible donors, and that's because they have very active constituencies that are tracking what's happening, they want good value for money, they're quite prepared to walk away if it's not, if they don't perceive it to be good value for money.

I think one of the things we have to recognize is that, you know there are increasing domestic resources going to AIDS in all of the countries we're looking at, and that's encouraging, but we have to create the same kind of, and stimulate the same kind of demand for efficiencies, the same kind of accountability, in countries coming from citizens.

We need to think about, all of us in our own countries, how to actually educate the public to demand better services for the money.

ERIC GOEMAERE: On this, what efficiency, of course there's no space any more for waste of money, there's no space for corruption, there's no space for cars that have been bought here in the, with Global Fund money. We know the stories exist, they're tracked down, actively, by activists, the activist in the sort that

are typically harass attack who are watching each of those government, they're doing their job as well.

I don't think there's a lot of fat there, honestly. Where in the place, in the world where I live, there's not much. My point when you say Catherine, tie funding to performance, is that I become nervous when performance means efficiency. As we shared such rightly, it can bring us to double standards, right? Typically, I mean the most clear debate that we are facing for the moment is the debate, the most obvious one is D40 against enough of it.

In the name of efficiency, I've heard a lot of people say, well probably it's better to stick to D40, that is a kind of short term dollar driven efficiency, with no vision in the long term. As we're speaking now, other people are presenting results from Lesotho, in terms of cost efficiency of Tenofovir compared to D40, it's a very short win.

We all know as clinicians that in the long term, we're going to handicap the patient and we're going to limit the survival with D40, so I'm just scared that we fall into that trap, that efficiency becomes the smoke screen for double standard. If we have won something in this fight against HIV, it's no double standard.

That's what we said 10 years ago when some people, I remember Kampala in 2001, September 2001 was saying, "No guys, you are crazy, you cannot do that in Africa, we need to build a basement, we need to build primary care, it doesn't even exist, primary care" and we said, "No, no, we're going to do it, and we will do it with

the same standard and the same drug as in the North, and we'll break the patent if necessary." We did it! I'm just scared that now this double standard is reemerging. Thank you.

MPHU ROMATHLAPENG: Thank you Eric, I think basically what we, we have said is that HIV's exposed very weak systems that already existed. In fact, not only in our countries, also in the countries of the North. We don't have excellent, you know we don't have excellent models where to copy, we ad-lib'ing as we go along. Of course our sway, in havoc as you know our human resources was moving to the countries of the North, or to countries that were more wealthy.

What I want to agree with Eric is, we are sitting here trying to justify to the world that we need more resources, yet ours is a success story. We really have done a great job with Global Fund. There is no better vehicle that I've mentioned. I'm sure Michel you are tired of me saying this, but to be quite honest with you, there's very little space left for corruption when you're talking of Global Fund, or PEPFAR.

Our countries have lent a great deal of accountability when we are using global fund and, therefore I think it's been a great model, not only because it's a great vehicle for delivery of care and treatment, but also because it has taught us to be accountable even throughout, by the way in my country, they you know, care I mean ARV's are still purchased with majorities, 25-percent with purchase from the resources from inside the country.

We are applying the same mechanisms of reporting as we are applying with Global Fund, so I really believe that we can, I don't think that there's much to gain from what we've done. All we are saying is, we want to continue yes, we will try by all means to be as efficient as possible, but I don't think there's a lot left where we, you know, we won't gain much, you can only squeeze an orange so much.

I don't think there's any more juice coming out of it. For Heaven's sake, let us agree and appeal to our funders, to the countries that have been very, very generous to continue doing the same and add just a little bit more.

ALEXEY BOBRIK: Michel, I just want to stress that I am not questioning the need for further advocacy or additional resources. Let me put a direct question. Who will pay for fighting HIV in Russia in 2012? The answer is simple. The Federal Government, and our ability to advocate for more resources is limited, as you know the situation in that region. Basically, I am talking about Plan B, because Plan A is almost over.

Donors are leaving, middle income countries, including Russia and many others, we, those who stay in those countries, and who care about fighting HIV should be realistic with what we have in the foreseeable future.

I am just trying to explore opportunities that we have in order not to lose the key achievements that we had over the last several years.

MICHEL KAZATCHKINE: Just two things. First, Alexey, I think it's, it's not a matter of Plan B and Plan A, Russia is a special case. It's an OCAD country; it's a G8 country, so yes the answer is Russia has to take care of its people.

That's what, and the issue there is an issue around whether Russia is really politically committed to fight AIDS in the country that one has, one of the fastest rates of growth of the epidemic and whether Russia is committed to fund prevention, and whether Russia is committed to deliver treatment to those who are most in need among the marginalized populations. There is a huge issue there, and it's not a Global Fund issue, I agree.

For a number of middle income countries, I would put it differently. I think in middle income countries we have to be in a transition phase and, I do not see, and we had other discussions in this conference on this, I do not see the Global Fund, you know stopping tomorrow, abruptly. I see more of a mixed model where those countries would co-contribute to the fund and continue to be recipients of the fund.

Depending on where the country and depending on the time in between now and 2013 and 2015, I see progressively the cursor move closer to the donor side or the net donor side when it's currently now more to the net recipient side. That's how I see things.

Cate, maybe I wasn't clear enough, I fully agree with you, domestic resources have to increase, and they are increasing, I don't know whether people realize that countries are the number one funders

of all of these programs. When it comes to tuberculosis, it took me some time to realize, but it's something like 80-percent of the TB money is actually the countries money.

The international donors is much more. It has to, and the Abuja targets have to be met because the countries have to show that they take their share of that global solidarity effort, even if in absolute amount of dollars, that will not necessarily be what will make the difference.

My question was to all of the red countries to the left of your slide, that countries that spend most of their money on bilateral, and I'm asking that that bilateral investment, I'm asking what is this producing in terms of results, what would be the impact if that was to be flatlined on the lives of people, and isn't that an area where we could find reasonable efficiency gains, and perhaps a few of the $5 million, $6 billion that the Global Fund needs in the next few years.

JOANNE CARTER: Then I want to invite questions, from the audience there is a set of mikes, a few or so, we probably don't have time for 20 questions but, if you know a handful of folks can get up to the mikes we can, and I would suggest that we take, maybe three questions and then the folks can respond and let's keep thinking about this issue of resource mobilization and we how do we actually do that collectively, why don't you go ahead first? Yeah.

NIKOLAI VIRTE: Thank you. My name is Nikolai Virte, [misspelled?] I am from Mauritius Island. As one dealing with HIV in other cities in other world, first of all I would like to, of course, totally support this idea of this Robin Hood tax or the Tobin tax that just take the money where it is and there is money around the world speculating from a bank to another and this is totally painful but of course I must also be realistic about the fact that it needs a global political will and this is very difficult to achieve.

However, coming from a middle income country, to my knowledge, Mauritius is the only country in the world that have initiated something to take the money where it is and has introduced last year two-percent corporate social responsibility compulsory tax that forces each and every company to dedicate 2-percent of their profit, after tax to action in direction of environment, education, [inaudible] delegation and health strengthening systems.

Of course now we're looking for results, it's only this year that we, these monies started to be channeled to the civil society and we, as members of civil society will be very vigilant and I think the private sector has also to be very vigilant of where this money's going to be very accountable to the government.

This is an [inaudible] that has to be observed, and really, I think the world is watching us now, on this program, and hopefully in two years I'll be back and tell you more about it, about the result that we'll have on this tax but it was an idea to share to other people here and activists at their country level, because it's

all about the political will and maybe sometimes at country level it's easier to get this political will. Thank you.

JOANNE CARTER: Yeah, thanks for that real life example of something that's happening. Next, thanks.

ANNE PATTON: My name is Anne Patton, [misspelled?] I come from Canada, a donor country that's falling far short of its fair share. One of the tensions we have in Canada is between the domestic response and what is given to international development more generally, and HIV/AIDS more specifically.

That's one struggle. We even have tension between funding for domestic response at the community level, and funding for HIV vaccines for example. My question to you is, and Cate, your slide of highlighting the way we spend our resources really highlights for me that scarcity is a myth. Right, and I think that's the kind of the starting premise that we, we all need to keep in our minds that scarcity is a myth, clearly the resources are there.

My question to any of the panelists is if you had two minutes in an elevator, maybe not even 30, what's your elevator speech to a Minister of Health from or a Minister of Development from one of these donor countries or even the Prime Minister or the President. What's your elevator speech to get across this message of the myth of scarcity?

JOANNE CARTER: Thanks, back at Mic five.

MEDJA RORAMIDARORANGA: Thank you very much, I am Medja Roramidaroranga, [misspelled?] I am from Uganda. I have lived with HIV for 26 years, so I have seen a lot of it. What I'm seeing in my country, I don't know whether it is happening in other countries, is that HIV work is more being whether transformed or turned into commerce and even at worst, casino.

The whole thing is no longer but about fighting HIV, if we are asking about resources, are we also asking ourselves how we are using the resources, and what are we going to to do to improve on making sure that the money that is collected, that is sourced, is used specifically to fight HIV and AIDS instead of enriching certain individuals, thank you.

JOANNE CARTER: Thank you. Mic number four.

STEVE KRAU.S.E: Okay, thank you, my name is Steve Krause, [misspelled?] I'm with UNAIDS and I'd like to just make two quick comments. First of all, thanks, some very good presentations. Michel has talked about efficiency gains and I think one of the points I'd like to point out here is under his leadership he's made partnership one of his key mantras, and I think that there is absolutely no doubt today that one of the places we've made enormous efficiency gains is the partnership that he and the other Michel in terms of collaboration between the Global Fund and the UN system and civil society.

If you recall, that wasn't always the case early on, but today the efficiency gains that we have made in real

genuine partnerships between the global fund, between civil society and the UN, I think it has never been better. I can honestly say that that collaboration is genuine, it's daily, it's almost like great sex, it's frequent, it's safe, and it's on a regular basis, and it's, so I applaud the leadership on that.

Second point is, Michel has repeatedly this week, and wisely so suggested that we need to look to the bricks for additional funding and I couldn't agree more, Brazil, India, China, Russia. I'd like to extend an invitation for all member states to not just limit themselves to that. I would love to see where a 192 member states of the UN are all donors to the Global Fund.

We have a precedence for this, UNFPA. When the administration of the White House in 2000 changed and they disfunded UNFPA we went from 66 donors to 65 donors. Member states from the South said, "No, we're going to invest in reproductive health", and they became donors, so today we have 181 member states who are donating to UNFPA.

I think that the same challenge should be given to all of us in this room, and I would love to see for example Swaziland, and Lesotho all become donors to the Global Fund and to become, not, so we move away from the rhetoric of donor and recipient into a genuine partnership of all member states. Thank you.

JOANNE CARTER: Thanks. Let me take just some, maybe some very quick responses to that first set of comments, and then we, it looks like we have a good amount of time for some more so any initial responses, any elevator speeches? You've got to be good at that.

MICHEL KAZATCHKINE: Well, I'm becoming used to elevator speeches and that's not the way I put things to the leaders, or in people I meet, but I'm saying is look at what has been achieved. No one thought the world would be able to, countries would be able to achieve, and it's being achieved again, at a cost of $400 per year per capita to save a life and have a person back in the productive circuit and the mother with her child.

This is what we could do, by 2015, if we were to have the resources, if the countries were to have the resources, this is what we, and I go through the list I shan't go now through that list, but you've heard about it. It's really about saving millions more lives with treatment, preventing millions more infections, and virtually eliminating PMTTT as we've been discussing a lot during this meeting.

Then I would turn to the leaders to are you sure that you're making the right choices when you're flattening or deconsidering decreasing official development aide.

Are you sure that it is the right balance that in the globalizing world your country would devote less than 0.35, or less than 0.4-percent of its GNP to, to development, and then I'm saying, that's a follow up on my question to Cate, are you

sure with the money you have your choosing the most efficient instruments to channel it?

JOANNE CARTER: Thanks Michel. Other comments?

MICHEL KAZATCHKINE: Here we go to the sixth floor.

JOANNE CARTER: Can I just, on the innovative financing, can I just say one thing which I think some people are aware, which is while we've still got a long way to go on something like a financial transaction tax, there has been massive progress. I mean, not just great civil society campaigning but massive progress in the last nine months that nobody could have predicted. You know, you've got governments like France and others actually stepping up on this.

You got the IMF two weeks ago saying that the donors could afford $90 billion, do they? I mean the financial institutions, you've got the leading group saying we should start with a levy on wholesale currency transactions and frankly, even in the U.S. which has been dragging its feet on this, you've got a senior member of Congress, who just before this conference started introduced a bill calling for this currency transaction tax with 40-percent of the money going to the Global Fund.

There is some reality out there to this. Microphone number four.

FEMALE SPEAKER: Thanks, I appreciate the need for resources in some countries, or increased resources but I'd

like to draw attention to other reasons for decline of resources. I work in a country in Sub-Saharan Africa which I prefer not to mention that has experienced stark decline in resources over the past two years.

The reasons for that are because the country's incredibly corrupt and that's why they're not able to get Global Fund money for example any more. What do we do with these people? We deal with corruption every day, and it's extremely frustrating. I think that the question of resources is inevitably linked with the question of politics and corruption and I don't like the title, I think it should have been no resources, no good governments, no results.

JOANNE CARTER: Thank you. Microphone number three. That's you.

EPHAN OKAYKARA: Thank you very much. This must have been one of my most stimulating sessions. My name is Ephan Okaykara [misspelled?] from Nigeria. I am, I have come with the 10 years of working in health care services and in putting in my little bit and then had to run because I was feeling depressed and thought my little bit wasn't working.

Here I am, more than 12 years in the public health system doing civil society work and activism, and then it seems like it's time to run again. Reason being that the world's [inaudible] in this conference that treatment is a principle to prevention now and when I look back to the kind of work we do

most developing countries, I see that we are still struggling with [inaudible] and the governance issues, my take is specially to Catherine, shouldn't we be looking at the shift where most of our work begins to look at good governance and response mobilization internally?

Because I seem to agree with a couple of people who have made the comment about getting something from each region, each country, no matter how little, because if there was not to be severe drought, or some environmental problems, each nation of the world does some kind of famine or subsistence famine that give them food.

Nobody waits for all the food and water they need to come from outside. We seem to be struggling that, even the little that we have in most countries are not being used for the people. Now we are talking about moving back to treatment, and some of us are struggling to which treatment?

It's probably going to take some of us many to begin to work through the process of getting the treatment out and that means demand means some prevention that we're looking at we'd still be lacking the most developing countries. I worry that we should a shift in a program and maybe a little bit of it to community level behavior change communication but most of it looking at governance issues, resource mobilization internally.

While we ask our colleagues from the North to keep pushing that the donors continue to come because we definitely will need them, even to live red on the work we do. Thank you.

JOANNE CARTER: Thank you very much. Mic number one.

CAROLINE DOLO: My name is Caroline Dolo, [misspelled?]I come from Kenya, and I work with the Red Cross. I guess I can't overemphasize the issue of governance because it seems to be a major issue. Issues around governance and accountability.

For me this was really cultured by the first, one of the past plenary presentations that we had from ARASA. In coming from Africa, I couldn't help feeling so humiliated by the kind of wasted that we see with what resources we have. I must, of course, appreciate that our governments have done a lot and having been in HIV for a long time, I can see that a lot of progress has been made.

Again, I feel that we can do more. This, I am going to ask this specific question to the Minister for Health. I mean, we recognize this accountability is a major issue, but I'd like to understand what are the mechanisms that you have right now, in Africa, I mean in terms of maybe the African union, or NEPAD, to put pressure on our governments to be able to be more committed to help in HIV.

Just like to be sure that there are mechanisms that are going on, because that's part of what I have missed out in this

conference. We've talked a lot about accountability, but I think I would have liked to see more in terms of the mechanisms. It's possible that this could have been other presentations that I probably did not attend.

Besides putting our Minister from Africa on this port, I would also like to understand what mechanisms, the UNAIDS or the Global Fund is also putting in to ensure that our governments are more accountable. Of course I've seen some challenges in my own country where this drop of the Global Fund has had very severe impacts at community level where some people are not accessing their medication, or they've suddenly had to change their medication and again, that's having effects on them.

For me, again, the other thing I would like to know is, that yes, governments are providing a lot of funding for some of these activities, but do you have a process that you have started whereby maybe you provide for matching funds as a way of also empowering governments, because in the long run, they have to take responsibility for the health of their governments as our speaker from Russia has said. Thank you.

JOANNE CARTER: Thank you very much. If we could just take, I'm going to take the rest of the comments but if they could be really brief because then we'll give a chance for those speakers to respond, so Mic number three.

JACQUELINE BITWARD: Thanks, my name is Jacqueline Bitward, [misspelled?] I'm from the Netherlands. Both the Minister and Michel mentioned the Abuja commitments, the African union is having their summit as well this week, and there's serious word that the African leaders want to drop the 15-percent commitments.

I think it's going to be increasingly difficult to convince the owners to put $20 billion in the Global Fund if at the same time African leaders are stepping back from their own commitments.

Maybe the Minister can give some reflections on the 15-percent target, is that realistic, or unrealistic, and then a question to Michel, the Global Fund is talking more and more about cost sharing and co-financing so maybe should it become a requirement for the Global Fund if countries want funding from the Global Fund that they have to have a plan in place to work towards a certain percentage of their own budgets to go to health? Thank you.

JOANNE CARTER: Thanks Jacqueline. Microphone number four.

KOLOMO KOMONOSI: My name is Kolomo Komonosi [misspelled?] from South Africa, from NAPWA, association of people living with HIV and AIDS. My first question will go to Catherine. I want to find out if there are any studies conducted or to be conducted regarding the impact of a budget

cut to personnel or particularly the NGO workhouse and volunteers because we have to face the fact that funding for HIV and AIDS has also created employment opportunities and also is part of a cutting cycle of poverty.

If there's a problem with funding, it means now we are rebuilding that cycle that is quite dangerous. My second question, I think is directed to anyone who can pick it for Global Fund. I want to find out if it is a farfetched possibility to add to the issues of a poverty allegation in the Global Fund, because if we talk about sustainability of treatment programs we have to talk about issues that will ensure that there is adherence, and issues of poverty.

A lack of food, is one of those issues and what has been frustrating me in this International Aids Conference is the fact that there is a deliberate silence around that issue, particularly for a poverty stricken countries like Africa, thank you.

JOANNE CARTER: Thank you. Then last comment or question.

HARRIET PULLMAN: My name's Harriet Pullman [misspelled?] I'm from South Africa. First question to Michel, while I understand the need for a coordinated country response, I think in the context of the need for rights, in the context of a plea for better governance, I think civil society has a really important role to play as watchdog to government, and

that's a very difficult role to play when in fact, you depend on government to be part of country proposals.

You can't actually play that role, be referee and player at the same time. My second is a comment, and I guess a question as well and that, I think within efficiency we need to be talking about capacity building. I think it was the ACCRA Declaration and the Paris Declaration where donors made a commitment that sustainable development really did need strong local institutions, strong local service providers and I'm not seeing capacity building as a core agenda item for future funding. Thanks.

JOANNE CARTER: Thanks a lot. I'll just ask the speakers to, Minister, do you want to start? Thank you.

MPHU ROMATHLAPENG: Thank you very much. I think the first question that was directed to me was on whether there are mechanisms that make sure that governments are held accountable? Well now, let's just say that, in, the UA has encouraged governments to be part, to be peer reviewed. The peer review mechanisms of African countries and you as a country, your own country has to offer to be peer reviewed by others.

My own country was just reviewed last year and there are several other countries that are in line to be reviewed. I know this is the second time when South Africa will be, there will be a second round for South Africa, this particular AU Summit.

Issues overall of corruption are very, very difficult. Yes, individuals are corrupt, the whole world over. When countries have programs that encourage corruption, then we call them corruptive, you know that they are, they are corrupt, but I don't know how many countries would agree with the notion that really they are corrupt. That they have got programs that advocate for corruption. I don't think there are many that are like that. It is up to the individuals of that particular country to make sure that they do not elect these countries, and that, you know they are held accountable.

When it comes to issues of matching funds, I agree entirely. I think just like in the United Nations, or in the AU, all countries should be, no matter how small an amount but must be able to pay into the Global Fund, those who want to be part of the Global Fund. I think that should be encouraged. I don't think amounts would be the same, but I think if we all want to be part of that process we should indeed encourage our countries to go forward for the Global fund.

And the Abuja Declaration, I just heard it this morning, that our governments might feel that they should, they would want to retreat from that promise. I will also be at the AU Summit tomorrow and I want to make sure that we will, some of us, some of the Health Ministers will be at that Summit. We will try and advocate for our countries to, not to renege from that promise, it is a very noble thing to do and I agree, it might encourage others to retreat.

When it comes to Global Fund, and whether does it, whether the poverty alleviation programs, I think it depends on the country. In my own country, I know for a fact that we have had a very enviable program that was directed at orphans and vulnerable children where we were able to actually even build houses, small houses and where the agricultural programs that are directed at these particular households, this is actually on the Net, one can actually see it on the Net because it is a very impressive program.

Because of this particular program children remained in school, children were able to live in very reasonable and, you know households. It's in a, in one particular village, and this is, I believe this a program that can be replicated, I don't know whether this was a standard Global Fund program, but if it is, then I will say yes.

Global Fund has programs that alleviate poverty. I think that's about all. Thank you.

JOANNE CARTER: Thank you.

ERIC GOEMAERE: I would like to try my luck on a hard one which is the issue of corruption and governance. The situation 10 years ago was the following: Countries were trapped, underdeveloped countries, low income countries rather were trapped into what people were calling fiscal space. They were allowed under pressure of certain parties that you know well I am "F" in the World Bank mostly to, not to spend per capita more than a mere $2, $3.

Altogether we had a raging epidemic of HIV, malaria and TB. We knew that it would require a huge amount of money. It require a huge amount of money, hundreds of millions, in a country with not existing good governance. There wasn't one solution, is that it was not to do it.

Wait for those countries to adopt good governance. Some people were saying, similarly, let's wait to build primary health care. Other people were saying no, we cannot wait for that because this is going to decimate a big part of our planet. There is no middle measure, and there were two, for me two major types of intervention.

One intervention was the Global Fund, and the Global Fund principle was, as far as I understand, and I'm not a member of the Global Fund, I don't have the chance to be part of that free sex party that Michel Betta [misspelled?]. I admire the Global Fund because where I worked Global Fund came to the rescue to scale up.

What I could see directly, the principle is that the money is A: Ring fenced, it's for precise target, government people have to present their own program and with very precise target, and they are monitored on a regular basis on those targets.

That was one way of doing it. Another way of doing it, mostly illustrated by the Pepfar model is to go parallel. To go with their own agencies, to have more efficiency and to make sure that the money was properly monitored, but as we all know it didn't create a

lot of local capacity as it was said by one of the speaker, and create parallel system.

Hence today, they are coming back to more and we salute that, local capacity creation of capacity but what I'm very nervous is when one, they allude this into health system strengthening. There I would be a bit more careful saying we lose one of the principle precise focused target results and monitoring of those results. Health system strengthening, we go back into the old model of you know, diluting the money, and I think this potentially can be a bit dangerous.

I personally think that the Global Fund way of doing things was probably the best compromise and, of course there is corruption, but is that a good reason to condemn a big part of the world, because a few individuals are corrupted not to have access to minimal essential care against infectious disease, I don't believe so.

Just to finish on that, of course we will not succeed with a robust governance at all levels. It goes up to the local clinic. Somewhere when, a question that we raised 10 years ago were How do you think that we will, you will succeed with antiretrovirals, a sophisticated intervention at primary health care level while it failed, it failed in so many countries, just doing essential primary of care level. Too many empty dispensary there.

The answer to that is there's another way to do business. The other way is that we have to empower people living with HIV, there is a strong accountability there, and a strong pressure from

every single clinic up to government level and at international level. I think that's the only chance we have to succeed.

JOANNE CARTER: Thanks very much. We're about at time but I want to ask definitely for like, some final comments, Alexey, no? Okay. Cate? Michel.

MICHEL KAZATCHKINE: A few things on this, and I'll go very quickly. On the corruption, the sad thing is that when you ask your question I could think of several countries from where you could come, although you didn't name yours. That's, clearly we're not only talking about Africa here. Let me just say the following three things. First the Global Fund has zero tolerance when it comes to corruption. That's the way it has to be.

I can also tell you, for me as Executive Director, because it is my decision, taking a decision of temporarily suspending a grant is a hugely difficult decision to take, for the reasons that are Kenyan colleague just mentioned, because it is disruptive.

My second point is that there isn't, we shouldn't think from, after that debate that we should first build governance, and once we have good governance, you know we can come with funding for health. We have to do everything at the same time.

The third thing is that bad governance is not only in the poor countries of this world. I think the way the rich economies protect themselves is bad governance at the global level. Jacqueline's question point is, I think absolutely valid and in the discussions around eligibility of the global fund, this is something

that can be brought in. Let's not open a technical debate, but thank you for that point.

On the civil society, I agree with you, and actually you're sitting right behind Ottman [misspelled?] who attended one of the sessions earlier in this conference where that was debated by Bernard Rivers and others, yes there is attention, civil societies increasingly are recipient of the funds and the primary recipient and how can it be still on the CCM and being both, you know a decision maker and a recipient?

There is attention; there are technical solutions to that. There are places maybe where we'll still live with that tension but it's not a very intelligent answer that I'll give you but I still think the negative impact of that tension I think is outweighed by the positive impact of having civil society as part of the CCM and the decision making process.

JOANNE CARTER: Thanks Michel. Cate, any?

CATE HANKINS: So if I can just quickly reflect back not all but at least some of what I heard, from this initial session and the discussion. One, not to punish success, two to use success and new data to drive resource mobilization, three, that we should maximize the use of existing resources, but not as a substitute for new resources, though obviously clearly a key issue in places where those external resources are not necessarily going to be there.

Related to that, ensure that there are mechanisms to protect the most at risk in middle income countries and upper middle income countries. Be smart about that. The key role of civil society, both in oversight of corruption, I mean not that it should only be in civil societies hands but there's a key role there, and for resource mobilization internally, but also the importance of external mechanisms that are overseeing to prevent corruption.

Finally maybe the biggest point which is, in a sense, as someone put it, challenging the myth of scarcity that resources needed for these programs are absolutely available and that we need to make the case from a public health and human rights standpoint but we also need to demand this politically and step one of that in this short window that we have is fully funding of at least $20 billion for the Global Fund. That's what I got out of this session.

JOANNE CARTER: Thanks everyone for, thanks to all the panelists.

[END RECORDING]

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.