

**Conference: 15th Annual International AIDS Conference
Funding the Response to HIV/AIDS: Why Are Donors
Not Working Together?
July 12, 2004**

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HANK MCKINNELL: ...and on this panel with Dr. Franzen who heads the unit for Human and Social Development with the European Commission. Dr. Franzen, thank you for being with us.

It was four years ago in Durban that the world seemed to wake up finally to the reality that HIV/AIDS was the public health catastrophe that all of us in this room know it to be. Since Durban, and much like a flywheel gaining momentum, the global donor community, both public and private, is now pledging, moving and dispersing funds and materials at unprecedented rates. This rush of donations, while still not enough and while urgently needed and generally welcomed, has created its own set of challenges. Our task this morning is to offer concrete recommendations on how this global response can be more effective and more efficient, and we have assembled for that purpose a world-class panel that Dr. Franzen will introduce in a minute here.

Most of you know there is now a set of agreed-upon principles for donations called the three ones. These principles, call for one agreed-upon HIV/AIDS action framework to guide the action of partners, one national AIDS authority with a broad mandate and multi-sectoral participation and one agreed-upon country-level monitoring and evaluation systems. These principles lay out an excellent framework for making

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donation systems more effective and more efficient. Most of us agree with the intent of the framework, and the value of turning them into realities. But we also recognize that there are many decades and many miles ahead of us, and many questions to be answered. How can already overburdened governments balance the multitude of donor expectations? How do all sides keep up with the sheer weight of paperwork and reporting the donors demand? Do we need to balance the need for good governance and accountability with the need to rush aid to some of the world's most remote locations?

These are some of the questions I hope our panel today will take on. Before we turn to the panel, let me put two somewhat controversial issues on the floor, and present my points of view on two that spark passionate debate. First is the issue of donations in kind, or donations of services by the private sector. Some believe that such donations impede a nation's ability to build its own infrastructure. My experience over three decades is exactly the opposite, that wisely employed, donations of products and services can help jump-start local efforts to build infrastructure. They also give donors an opportunity to re-deploy cash to other priorities. In all cases, certainly, donor programs must be developed in close partnership with host governments. We all know that's a prerequisite for success.

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Second is the issue of donor reliability and sustainability, often directed at the private sector. The same questions, of course, could be asked of governments, which change from time to time, and NGO's, which don't have the financial supports they need, and of course, the international agencies. It's easy to say that corporations could change their minds and disappear, but I don't think that's unique to corporations. My view is that there is no such thing as a sure bet or a sure thing on this planet. I would point out, however, that Pfizer, one of the donors is 155 years old. Many other major corporate donors share this record of stability. What you might not realize is that private sector donations exceed government donations, so we are going to have to find a way to work together. We all recognize that more effective and efficient coordination of donor initiatives will maximize outcomes and reduce duplication of efforts. We also want to avoid hampering local decision-making and we do want to keep funds flowing to those in need.

So how do we move ahead? I know our panelists have given this much thought and have experience in this area. Our format this morning is each of our panelists will make a brief presentation, no more than five minutes, and then will open the floor for questions for questions and clarifications and further comment for another five minutes, and then we will have

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to go on to our next speaker. Then I do believe we will have 15 or 20 minutes at the end for a more general discussion. I hope that will be a lively discussion. I personally must leave at 11:45, which is the scheduled end of the session. If the discussion is still as lively as I hope it will be and our panelists are willing to stay a little longer, I will leave you in Dr. Franzen's capable hands. Within the bounds of civility and the free exchange of ideas, this session is designed not to avoid controversy or difficult issues, but to address them head on. That's the kind of session that is the most valuable, so let's get started and I'll turn it over to Dr. Franzen.

DR. FRANZEN: Can I speak from here? No. Okay. Here. Good morning everybody. [Distant applause.] We seem to have clapping already, from next door. Good morning. I will, as we have started a bit late with the session, and we would like to hear also not just from the distinguished panelists, but from the audience, I would like to start immediately with the session and getting into the debate. This session is to be a debate. We already as co-chairs represent public sector and private sector here together, and I think this will be a signal for strong partnership, even stronger partnership in the future. We have five panelists. I'm sorry to say, Mr. Prasada Rao, Health Secretary of India isn't able to come to this panel, so we will start right away with Mr. Pradful Patel,

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Vice-President of the World Bank, South Asian region. His position is going to be that "It's not the donors; the countries don't want the donors to work together!" WE want to listen to his introduction a maximum of five minutes, please. We plead with the speakers to keep the introduction of the debate to maximum five minutes, then I would like to have the audience comment or take other positions or questions for five minutes more so that we'll be ten minutes maximum per speaker. I hope that we'll have still a debate possible at the end of the session. Mr. Patel?

PRADFUL PATEL: Good morning. I should add to the introduction that I am from Uganda. I hope that many of you will have listened to the speech made by the President of Uganda this morning.

My subject is "Why are donors not working together?" Let me begin by first stating a reality that I have experienced in my work in the World Bank, which is that so far I have not found a single country which wants the donors to work together. So, it's not the donors, it's the countries that don't want the donors to work together. Two decades fighting this epidemic have taught us a very clear lesson. HIV/AIDS is not just a health issue. HIV/AIDS is a development issue. As such it requires a multi-sectoral response. It cannot be left to health ministries alone. Its impact is just too significant. If you

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are a public official in the business of education or infrastructure or public administration or just about anything else, this means you too. If there is not national cooperation across a broad front of governments, the fight is doomed to be less than effective. We need all disciplines to work together. We also need all actors to work in concert, national and globally. That means donors, governments, civil society, including people living with HIV/AIDS, the scientific community, the business community, and often also the religious community. Countries need to coordinate a national multi-sectoral response, and donors need to be an integral part of that response. This understanding has brought us together here in Bangkok. HIV/AIDS challenges us to become true partners. We have different backgrounds, different ideas and different experiences, but we gather here as one with a shared goal: we want to reverse this epidemic. We want to prevent new infections. We want to provide care and treatment to those in need.

Today we have increasing resources, and increasing number of donors and an increasing number for rapid and more comprehensive action, so how do we ensure that all resources are used effectively and efficiently. The to core issue then is not whether coordination of donor support is a good thing. The question is how to achieve it? What are the barriers to

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coordination? I would argue that if donors are not working together well enough the issue is leadership, first on the side of governments. The governments must take the lead in ensuring that donors collaborate and coordinate with each other in the interest of the country. Be tough with the donors. Don't let the donors get away with going it alone.

And who are these leaders? They are leaders willing to take a firm stand on the fight against HIV/AIDS, and they are at the highest level at both national and provincial levels, in business community, media and the arts, to give some examples. They are leaders who will develop a vision and strategy for their country. They will mobilize all sectors, key-line ministries, NGO's, people living with HIV/AIDS, businesses. They are leaders who will take vision into action. They are leaders who will demand better results, and demand accountability from all sectors. They are leaders who will exploit the knowledge of external partners, who will value global experience and lessons learned, and who bring these lessons into their countries without fear of rebuke. Easier said than done, but our world has seen such leaders. Leadership is possible.

Let's get back to the question: Why are donors not working together? I want to argue that donor coordination, if you are lucky enough to have it, is great, but not good enough

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by itself. First and foremost, this effort requires leadership in the countries, and then the question becomes, "How can all of us here with our different roles and different experiences help to make a space for this leadership?" We can begin, donors and countries alike by recognizing the serious challenges. Some countries mistrust donors and donor coordination. Suspicions arise. Would donors with a unified voice not push their own agendas? A country could rightly feel this, and fear losing control. After all, aid-dependency is a serious issue for some countries. Would a country's needs be subsumed by donor's own interests? Would national programs lose flexibility? Would a diversity of views be dampened? These are all real fears. Many countries are skeptical of the benefits of donor coordination. To deliver its benefits, donor coordination cannot be a tool of control, not by governments and not by donors. It should be used to ensure we make best use of all the resources available, avoid expensive duplication, ensure that gaps are filled, mobilize financial, technical and human resources, enhancing our effectiveness in the response. This goes back to the earlier point, a multi-sectoral effort involving all actors.

Donor coordination needs to ensure accountability. Can we all see results and impact on the ground? And can we see these results through the lens of our partnership, not individual lenses? Countries need to come to understand that

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donor coordination with their leadership is fundamental. This challenge is too big, the loss too great for us to waste time and resources in a fight about how we can come together. For their part, donors need to recognize this leadership, good leadership, genuine leadership. When that is in place, what donors need to be is good partners. Good partners make space for good leaders. Thank you.

HANK MCKINNELL: Thank you, Mr. Patel. There are microphones in the center of the aisle if you would like to ask a question or make a comment, please go to one of the microphones. And please excuse us. Because of the lights, we're having trouble seeing here. Just step to one of the microphones if you'd like to ask a question of Mr. Patel or make a comment. And please introduce yourself.

MALE SPEAKER: Sure. I'm [inaudible] Roy; I'm a medical student with McGill International Health Initiative in Montreal. Mr. Patel, you work for the World Bank, and I just wanted to know, wouldn't you agree that any donor would be far more effective if these countries were relieved of the crippling and odious load of debt they suffer at the hands of the World Bank and the International Monetary Fund? [Applause.]

PRADFUL PATEL: Yes, I do agree with you, and I should tell you that a lot is being done on the debt issue. It is a very complex issue. I would not agree with your proposition

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that this is caused only by lending from the World Bank and other multilateral organizations, but the effort that is going on right now to reduce the debt burden, not only through the HEPIC Initiative but also in the IDA 14 negotiations for replenishment of the next round of concessionary funding to the World Bank, as a very big element of that. But your basic point, to reduce the distractions, to get into developmental issues like HIV/AIDS, to proceed more effectively on the ground is one that I very much agree with.

HANK MCKINNELL: Okay. We'll take two more. Microphone 4, and then 6.

MR. HERMAN LOPOGO: Thank you very much. I am Herman Lopogo, chairperson of the Tanzania Commission for AIDS. I tend to agree with the speaker, that coordination is important. Our own belief is that it's for the country to get their acts together in the first place. Get your policies in place, your strategies in place, your programs in place, and then hand them over to the donors. But don't let them start playing games with them. Allow them, only in as far as it's going to improve you're programs, but also get their acts together, so in addition to having our own together, what you have done is let the donors meet as a donor group. They do it in Tanzania once a month. But left on their own, they may get up to some tricks, so every other month I meet with them as the co-chair, just to

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make sure that they keep in line. And the thing that we are to remember, most of us who are the recipients, the donors that are with us in the country are not the donors. They are working for the donors; they are not the owners of the money. Somebody else gave the money; they are only working for them. And so we make sure that they toe our line, rather than us toeing their line. If you let them on their own, they will do their own things, and that's where the problem comes. Thank you very much.

HANK MCKINNELL: Thank you for that comment. We'll take 6 and then 3, and then we'll have to save other questions for the end of the session.

STEVEN DEKAY: Thank you very much. My name is Steven Dekay. I'm with the Joint Economic AIDS on Poverty Program in South Africa. While I agree with the speaker, I think that the paradigm has changed. In South Africa we have a program where we have a multi-donor corporation. We have USAID, UNAIDS, OSAID and DIFIT [misspelled?] working together to finance our research projects in South Africa. We've done it for three years, and it's working perfectly well. The problem is when some of the donors come with pre-established priorities without adequately involving the countries, when they assume that they know all the issues better than the country in which they operate. Also, secondly, I think when the meetings of the

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donors are called, they do not involve the private sector, the foundations, and these are people that probably have more funds and could understand the flexibilities that exist within the countries. Thank you.

HANK MCKINNELL: Thank you. We're in agreement. Last question.

BROOK BAKER: My name is Brook Baker, and I'm from HealthGap, a treatment activist organization. My question again is for you as a spokesperson for the World Bank. The question is about the World Bank position with respect to public health sector limitations and expenditures in developing countries. It's quite hypocritical for the World Bank to talk about donor coordination and harmonization on the scene when the same organization in its other arms is limiting the effective uptake of vastly increased funding in public health expenditures in developing countries. These countries will not be able to deliver AIDS programs in the public health sector unless they are able to increase salaries for health workers and dramatically increase spending in the public health sector. Why in the world is the World Bank still imposing limitations that force governments not to accept global fund money and not to dramatically increase their internal funding? [Applause.]

PRADFUL PATEL: Let me first of all say that what is said about the accepting global funds for HIV/AIDS is not true.

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The point you are raising about the public expenditure I think that everybody agrees that in reviewing a public expenditure or the budget of a country that it is absolutely critical that that budget is within the fiscal framework that the country can afford. So I think you are raising two different points. The World Bank does pay a lot of attention to the public expenditure framework of a country to be within the fiscal framework of the country. But I should also say here that on HIV/AIDS, these constraints have been removed. All of the funding that the World Bank is providing is on grant terms, including for paying for salaries and recurrent expenditures.

I think I can come back to the point about how countries really need to have one unified position, take control of this agenda, and then insist with the donors, including the World Bank, that the program they have is the one that they want to implement on the ground. We'll get to the issues that are raised.

DR. FRANZEN: Thank you Mr. Patel, and thanks to the audience for active participation and a lot of interesting suggests already for the further debate. I would like to introduce our next speaker, because he is going to speak from the perspective of a coordinator at the level of a country that is dealing with quite a lot of private and public donors. Mr. Bizwick Mwale is the Director of the National AIDS Commission

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in Malawi, and he's going to defend the position that donors have their pet projects and don't want to build capacity for effective coordination. Maximum five minutes.

BIZWICK MWALE: Hello. Good morning Ladies and Gentlemen. I will move away from my prepared Powerpoint presentation in the interest of time. You might as well switch it off. Mr. Chairman, let me thank you so much for inviting Malawi to contribute to this debate on the funding that responds to HIV/AIDS.

Why are donors not working together? As you are aware, the HIV/AIDS involvement in a very clouded arena, comprised of many players including donors, with different interests, ideologies, demands and expectations. However, Malawi and its government partners have made substantial progress towards realizing the principle for donors working together in support of the Three Ones. In our case, the Four Ones. That is one agreed HIV/AIDS framework, one national authority, one agreed [inaudible] system and one financial mechanism, as far as Malawi is concerned. This is a basket funding. How has Malawi achieved this? The answer is simple. Two donors, Canadian Cedar and Norwegian Agency for Development, (NORAD) supported by the UN family are two [inaudible] to invest in the creation of the National AIDS Commission, which quickly became a focus for all partners, actors and donors in the HIV/AIDS. The Malawi

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government in collaboration with some funding partners, namely Canadian Cedar, DIFIT, NORAD and the World Bank has established a pooled or basket funding arrangement in support of the implementation of the National Strategic Framework through an integrated annual work plan. This is regarded as the best practice in terms of coordination, minimizing duplication, and significantly reducing administrative and reporting requirements. However, contributing to the notion that donors don't want to build capacities for effective coordination, what is clear from my own perspective and experience in Malawi, donor behavior has a strong bearing on empowerment of the national authority for overall coordination within the agreed framework.

So far, my observation has been—and there has been some tremendous improvement towards this—donors become too involved in the day-to-day management of the national commission. The demand by donors to review and agree on issues before they are considered approved by the NAC board makes the board redundant and disempowered, particularly issues relating to institutional support. Donor preoccupation with financial accountability add to the expense of program implementation, and is increasingly including NAC's from scaling-up the national response. Donors want coordination, but many of them don't want to pay for coordination. Lack of agreement on approaches and key issues

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among the donors themselves has also led to delays or problems in program implementation and coordination. Donors both at country and global level are always competing for prominence and usually do not want to work together, for fear of overshadowing each other. There is a silent superiority battle among the donors themselves, which makes it difficult for them to genuinely work together. Their superiority is lodged the best when power at the global level, level of financial contribution, and personality. Many donors operating at the country level do not have the appropriate authority to make decisions. I think one example made early on was that most of the so-called donors are employees of other donors somewhere. So constantly they have to refer issues to their headquarters. This results in various delays, because the headquarters do not have an idea what is applying at the country level. Donor support to countries is usually decided in the donor countries themselves, and the recipient countries have to design their requests to suit the donor support, which may not address priority interventions. Many donors are driven by their own national ideologies in program approach, design and implementation at the expense of scientifically proven approaches and responses. Many donors have strong ideas about what the countries they support should be doing about HIV/AIDS. However, where they do not find this well articulated, the

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easily become drivers and stick to areas of their interests. This approach only precludes the coordination and undermines the local leadership.

Finally, direct or substantial focus on civil society actors by some donors makes it difficult to accept an adherence to a national HIV/AIDS framework. Not only does this entail the risk of unilateral and inefficient decision in resource flows and utilization, but coordination, accountability and monitoring also become problematic. In conclusion, Madame Chair, the place for the Three Ones has the potential role to substantially raise donor commitment and harmonization to support a country-driven HIV/AIDS response. However, whatever harmonization efforts are undertaken, they must not compromise agents of action on the ground. They must not compromise inclusiveness and participation of all donors and other development partners. They must not compromise national ownership, coordination and leadership, and above all they must not lead to donors ganging up against the nationally defined program of action. Thank you very much.

HANK MCKINNELL: Thank you Dr. Mwale. Questions, comments? I guess you were so convincing, everybody agrees.

BIZWICK MWALE: That's because I'm not a donor.

DR. FRANZEN: Thank you, Mr. Mwale for sharing your experience with us, and I think you brought up a lot of elements that

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can be very useful for the general debates. I would like to hereby introduce the next speaker, Mr. Mark Dybul who is the Deputy Chief Medical Officer in the Global AIDS Coordination Office, in the US Department of State. He is replacing Mr. Randall Tobias who could not be here for today. I'm sorry for that, but we are happy to listen to Mark Dybul, and his position is going to be, "Coordination is great, but there is no absorptive capacity in most countries and donors need flexibility to be effective." Please try to stay to the five minutes so we can debate. Thank you.

MARK DYBUL M.D.: I'd like to thank the organizers, the distinguished chairs and panelists for the privilege of representing Ambassador Randall Tobias, the US Global AIDS Coordinator. Unfortunately, Ambassador Tobias was asked to go to the Prime Minister's residence to discuss international HIV/AIDS, so he wasn't able to be here today, although he very much wanted to be. In a broader sense, I have the privilege to represent President Bush's Emergency Plan for AIDS Relief, the largest international health initiative in history dedicated to a single disease.

I'd like to discuss the role of donors. In our view, the role of donors is to provide resources, to emergently receive results in a sustainable and accountable way, and to ensure results through coordination, both internationally and more importantly at the local level.

In each area the American people are leading boldly through

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compassionate action. In provision of resources, President Bush has embodied the passion and commitment of the America people in the fight against global AIDS through a consistent drumbeat of leadership. In 2001 President Bush provided the first gift of any country to the global fund. In June of 2002 President Bush announced the International Mother and Child Initiative, a five-year, \$500 million initiative dedicated to reducing mother and child transmission by 40 percent in 14 focus countries. And then in January of 2003 President Bush announced the President's Emergency Plan for AIDS Relief, which encompasses the previous two initiatives and massively expands assistance. It's a five-year, \$15 billion initiative, focused on 100 countries throughout the world, where the US has bilateral HIV/AIDS programs, but with focus on 15 countries in Africa, Asia and the Caribbean to fully roll out care and treatment services. However, the United States feels that the commitment of money is not sufficient with people dying every day, with new infections and orphans each day, we need immediate results, and so the President has focused on treating two million people, preventing seven million infections, and caring for 10 million HIV-infected persons and orphans. And the Emergency Plan is moving rapidly. The Mother and Child Initiative in the first twelve months of receiving funding of \$70 million has led to 380,000 women receiving voluntary counseling and testing, 34,000 women receiving prophylactic antiretroviral therapy, and averting 5,000 infections. But more

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importantly, we're developing capacity. Fifteen thousand individuals in 14 countries were trained in Mother and Child prevention activities and 900 centers were established. The President's Emergency Plan, within four weeks of the President receiving funding only five months ago, \$350 million was put in the hands of service providers, and the President announced a few weeks ago that an additional \$550 million was at work. Eight hundred and sixty-five million dollars in five months, at work in 15 countries, and \$2.4 billion will be put to work by the end of September. Within this five-month period we have moved very rapidly. Within days of the initiative we were providing antiretroviral therapy to 300 people in rural Uganda. Within weeks we double the number of people on therapy reaching 700 outside of the city of Kampala. One of our partners has reached 500 people with antiretroviral therapy, and those were only 220 a week in two countries. In rural Kenya we have treated 400 people. These are isolated anecdotes from only four partners of our very rapid movement. We have ordered drugs in all 14 countries and we've begun delivering therapy five months after the initiative. We are on the move. As we are moving rapidly, President Bush's Emergency Plan is working closely with our international partners, the Global Fund first among them. We provided the first gift as I mentioned, the first second gift. We are the largest single donor, providing approximately 35 percent. A way to think of that is, a third of all Global Fund grants come from the United States. That is an essential

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part of the Emergency Plan. We provide technical assistance in country to the fund, and Secretary Thompson serves as its chair. We sit on CCM's in country, and we are delighted to be participants in helping the Fund succeed. We work with the World Health Organization, the 3 X 5 Initiative is an important aspect of what we do. We have close technical relationships on safe blood, HIV and tuberculosis, and training protocols. UNAIDS is an organization we support wholeheartedly and we're one of the sponsors of the announcement of the Three Ones a few weeks ago.

There is so much to do; we need to all work together. Private groups, public groups, whether it be the Gates, the Rockefellers, the Clinton Foundations, Medicines Enfantier, the Pfizer Foundation, anyone who can contribute must work together. More important than working with our international partners is how we work locally. We are guests in the countries in which we operate. Everyone on this panel, except for the gentleman from Malawi are guests in the country where we operate, and so we must support the national strategy. The US Government is humbled and honored to be working shoulder-to-shoulder on the ground for almost 20 years in several countries, working on HIV/AIDS for more than 20 years, and the President's Emergency Plan is an expansion of that. A primary purpose of the Emergency Plan is to build capacity in country, both human capacity and physical infrastructure. If we achieve the 2, 7 and 10 goals without developing capacity for sustainability, we will have

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failed, and so we are focusing on laboratory and physical structure, on training, and we have put contractual language in all of our awards, requiring our partners to develop capacity. Our goal is in five years to have as few non-local personnel involved in the Emergency Plan as possible, and the capacity that we have developed through the Mother and Child Initiative is a clear indication. Already we have over 1,000 partners through the Emergency Plan, and 60 percent of them are local partners. HIV/AIDS is a complex disease, and so disagreement is not only inevitable, but necessary and health, and with 8,000 people dying each day, every one of them a family member or friend, passion and anger are also inevitable. If disagreement is respectful and understanding, even when in the end we go separate ways, and if passion is channeled well, we can find common ground and work together. And so disagreement and passion will be powerful tools in the fight against the pandemic. We are trying to channel our energy in this way, and there is so much to do. So from President Bush to Ambassador Tobias, to all of us working on behalf of the American people, we look forward to working to get the job done, to turning the tide against HIV/AIDS. [Applause AND BOOING].

HANK MCKINNELL: Microphone 3, please.

MARK MILANO: I'm Mark from Act Up New York, and HealthGap. I think I speak for many at this conference when I say we are sick and tired of seeing the US government use this conference as a PR-

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GREGG GONZALVES: We need to document this work and describe it and catalog it so what is invisible takes shape and form for our governments, donors and ourselves. Second, we need to solve the mystery of political awareness. If there's so much capacity in the community why hasn't the government tapped into it as of yet? Documenting the work of the community is a first step, but there's a high hurdle in getting governments and donors and international NGO's to acknowledge the role of the community and to work with us as equal partners. WE know what a shamble the Global Fund's country coordinating mechanisms have been, and it's well-described in a report of the Global Network of People with AIDS. We are only tokens, or without influence. Some of these bodies are not represented at all, and the Global Fund has refused to require our real participation in these processes at the country level. Until a few weeks ago, the community didn't even have a vote on the Global Fund board. We need to change the way we do business. This means that bilateral and multilateral donors, agencies, international NGO's and others need to brig community into the discussions on AIDS programming, and just stop talking to the ministries of health alone. Governments need to bring community groups to the table, and not only their tired, staid old semi-official community groups, their handpicked groups, but the multiplicity of voices of communities in their countries. Thirdly, we need to reveal the missing lessons of

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history. While the professionals, the government bureaucrats, donors, health officials and international NGO's may feel some satisfaction in their role in combating this epidemic, it has been the AIDS community that has been at the forefront of all the major advances for people with AIDS and those at risk. We've developed the concept of safer sex and needle exchange; we first started using PCP-prophylactics, we set up the first program to make sure that people had the information they needed, and the care they deserved. We transformed the role of patients and forever changed the field of public health. Even the WHO's noble and needed 3 X 5 campaign was born out of our struggles around the world to put treatment access on the agenda, when so many didn't think it was possible, feasible or wise. Finally, we need to confront the mystery of legal and policy failure. With all this capacity and skill, with all this history of accomplishment, why are communities still at the margins of response to AIDS in so many places. My sense again is that professionals are loath to accept the role of people with AIDS as central actors in their own fate. They would rather see us as patients, carriers, and victims, clients for technical assistance or charity, rather than key participants in decision-making programs. If this is to change it has to be done by legal mandate or policy prescription, both on the international and national levels. Legislation and regulation authorizing AIDS policy making needs to ensure adequate and real participation of people with AIDS and community organizations, with

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verifiable indicators of this participation. Donors, multilateral agencies, NGO's need to incorporate provisions into their programming and grant making that lock in community participation in decision-making processes, and directly fund community organizations in the developing world to provide AIDS services without Northern NGO's or international NGO's or ministries of health as middlemen or intermediaries. The Global Fund has directly funded the Thai Drug Users Network in this country, but that kind of direct and substantial funding to community organizations in the developing world is mostly an exception to the rule. The rules need to be changed. All of this sounds simple—documenting the work we're doing, describing our history, building consensus on the country level for community involvement in AIDS programming, both in service delivery and decision-making and enshrining this participation in legal and policy frameworks at the national and international levels. Sadly, in 23 years of the epidemic, it has not been done on a large scale, particularly in the developing world. It takes a commitment to do this, and it will take political pressure to move governments, donors, international NGO's, bilaterals, multilaterals to finally make good on the promise of the greater involvement of people with AIDS and our organizations in this work. This is political pressure that many of my colleagues will gladly provide as we have little time to lose before the war on AIDS is lost.

HANK MCKINNELL: Thank you, Greg, for very important

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comments. We clearly will not succeed in this fight unless we involve the community organizations. Very important suggestions for us all. Questions or comments for Greg?

PAUL DAVIS: Hi. It's Paul Davis. I'm from HealthGap in the United States. Yesterday, Senator John Kerry, President Bush's opponent for US presidency in the US presidential campaign pledged to double US contribution to \$30 billion by 2008, which happens to represent the US fair share of global needs. He also pledged to stop using AIDS to stop pandering to conservative election year constituencies, like big pharmaceutical donors, anti-condom extremists, etc. Irrespective of other donors, Mark, will the Bush Administration meet that challenge and pay our fair share of \$30 billion by the year 2008 with a great increase to the Global Fund? Or will he instead, continue to undermine the Global Fund as you have since Day One, and pushed drug company monopolies in the poorest countries, limiting AIDS funds for condoms, syringes access and comprehensive family planning?

HANK MCKINNELL: I'm not sure that was a question for Greg.

PAUL DAVIS: No, that was a question for Mark Dybul.

HANK MCKINNELL: That will come at the end of the session.

This is for Greg. Microphone 3.

ROBIA MCKAI: Is it on?

HANK MCKINNELL: Yes.

ROBIA MCKAI: I'm Robia McKai and I'm the Senior Vice

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President for Programs at the Catholic Medical Missions Board, a faith-based organization. I'd like to congratulate and thank GREGG GONZALVES. He has started how to think outside of the box, and for those of us who are holding this placards etc., audience, we must unite together to show some kind of solidarity and leadership, so let's think outside of the box. More than the Global Fund, many other donors are needed so that there is an effective response. As Greg has pointed out, 50 percent or more of the health care in every country is given by NGO's, civil societies, and faith-based organizations. And I'm afraid the Global Fund Strategy—which is good—must change. The country coordinating mechanism is really government-fueled and there are really no places, because those partnerships do not exist in the beginning, just like Greg has said. So we need more than one organization, more than one donor to fund. I'm not pro-USAID or pro-US, but I want to tell, take the association of NAPHA, National Association of People Living With HIV/AIDS. Seventy thousand of them are going to benefit from PEPFAR track 1.5 and Broad Reach and some other partners like us, we've already got. So please, audience, it's very easy to make some little placards and bash other donors. Think outside the box. Where is our leadership as audience? Thanks.

HANK MCKINNELL: Thank you. Thank you. Good comments. Our next speaker will actually address the Global Fund. Yes. Microphone 3 again.

FEMALE SPEAKER: So, Greg, to the extent that a country's

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Global Fund, Country coordinating mechanism excludes PWA, voices to the extent that a country's national AIDS response plan does not include working through PWA organizations, what are the mechanisms to make this happen, this leadership that you're talking about that's so essential?

GREGG GONZALVES: Some of the protest we've seen in the audience today will make it happen unless we build a world-wide movement that ensigns the right to health on the country level. None of our efforts are going to succeed if we're talking about political mobilization to mobilize people with AIDS on the local, provincial, and national level in countries to demand their inclusion on the CCM's, to demand their inclusion in decision making for AIDS programs in countries. And we need the support of international organizations, the EU, the US government, the Global Fund and others to put this pressure on countries to bring communities to the table, but we're going to need to demand it from the grassroots up. And it means protesting, not here, but in countries all around the world.

DR. FRANZEN: Thank you very much for these comments, but all of these comments and discussions really bring us to the next speaker. I would like to introduce therefore, Dr. As Sy, who is Director for the Global Fund, and who is going to probably reply to some of the issues already raised and talk about country ownership that is the key.

DR. AS SY: Thank you. Good morning. I'm standing for

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Professor Fitchem, the Executive Director who unfortunately could not be with us this morning. Let me start, Madame Chair, by stating that if we talk about the Global Fund, maybe we should broaden the definition and perspectives of what donors are and then who the donors are. Individual are contributing to the Global Funds; private sector and private foundations are contributing to the Global Fund. Developing countries are contributing to the Global Fund, as well as developed and rich countries including the United States as Mark stated, the European Commissions, and then countries of the G8 including Europe. So indeed, it's a partnership, and my question would rather be, how do partners work? Or, how are partners trying to work together to achieve the common goals, which is making a great impact on HIV/AIDS, tuberculosis and malaria. And the levels of collaborations are many. I mention first the mobilizing resources because resources are needed to make a difference. To design proposals to be submitted to the Global Fund for funding, to implement programs, because what really matters is what do we do in countries, and in communities to respond to the real needs of people. But also, how do we monitor those programs? How do we measure results? How do we make sure that the investment that we are making are really making a difference and provide us for a basis for renewal and scaling up those programs? If we look at each of those stages, they do provide a huge opportunity for collaboration. Collaboration in providing technical support, to design the programs and implement

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them. Collaboration in strengthening government structures, CCM's, which you already mentioned and making them work so that we ensure that there's going to be a real oversight of the programs that are going to be owned by the real people. Collaboration by sharing information and sharing our programs to avoid duplication, as it has been the case in many countries, where when programs are going to be submitted, be it to [inaudible] donors or the World Bank, then we check our prospective programs and share information to make sure that we are not funding the same activities.

You often hear about the hundreds of programs being funded already by the Global Fund in more than 120 countries. It all sounds great, but let me tell you that nobody in the Global Fund has ever been involved, as you know, in the design of those proposals. If there is any merit in the numbers and in the quantities of programs funded, this merit goes first to the countries, the CCM's first, and their technical partners who help them design program which were submitted to the technical review panel, and the technical review panel felt that those programs were good enough to be recommended for funding, and then later approved by our board. I dare to say, then, that there is nothing really like a Global Fund program or a Global Fund project in any country. What we really have is programs designed by countries themselves based on their national strategies, based on gaps which are identified, and then supported financially by the Global Fund, and technically by the many other partners, either from

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the UN, [inaudible] technical agencies, civil societies and the private sector.

Country ownership is the key in defining the programs. And that's why we base our supports to countries on two fundamental principles. The first one being to minimize the transaction costs for countries. I'll come back to it. And to build on what is existing to make those programs work. We try to build on what exists. Such [inaudible] because it is working. In many places CCM's are not called CCM's because they were already existing coordinating mechanisms that were responding to the need, and nothing happened but just using them and include tuberculosis and malaria works. In some places it's about improving what exists, and expanded both in quantity and quality, and enhance the responsiveness so that it can do the job. There are many other places, particularly in countries in conflicts or transition, where indeed, we have to create the CCM, which then later on serve as a basis for coordinating of many other health programs and was later on used by other partners beyond the [inaudible] programs only funded through the Global Fund.

Transaction costs are minimized through streamlining reporting systems, and also using articulation with the [inaudible] and basket fundings as it has been described by my colleague from Malawi, and also the use of agreed sort of indicators to measure progress and then to measure results within the national [inaudible] system. This is the basis of our adherence to these Three One

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principles, which is the One community framework, one strategic framework, and also one national authority that should address the epidemics. But as it is often the case, Madame Chair, the response to HIV/AIDS does reveal the situations in countries. If there are positive dynamics, traditions of working together in coordination and participation, they can be revealed and strengthened through new programs such as the Global Fund. In the opposite, we also witness situations, where because the real situation was dysfunctionalities, rivalry, competitions and in some instances, exclusion. These can be exacerbated if you go to scale and then you're coming in with new funding mechanisms. So the real talent is, how do we really strengthen those positive dynamics, and continue to empower countries and let them sit in the driver's seat for better coordination and greater efficiency. Thank you very much.

HANK MCKINNELL: Thank you. Questions or comments for Dr. Sy? Yes, Microphone 3.

DR. FETTERMAN: Hello. Dr. Fetterman from New York, USA. I was wondering if you could tell us what the annual budget for the Global Fund is at now? Dr. Dybul talked about a 3 billion a year budget for the US response, so what is the current budget on hand? What is your sense of raising more money? Where is that coming from? And is Pharma contributing to the Global Fund? Thank you.

DR. FRANZEN: Maybe we should take a few comments, and then you, as I expect a lot of comments or questions for

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further information, maybe you should also refer to other sessions where you have that available. But I saw Number 6 there. Please introduce yourself and make—

SHARON ANN LYNCH: My name is Sharon Ann Lynch. I'm with HealthGap of New York. It is amazing to me that we are sitting in a session on donors, and there's been no discussion of the money that's needed for global need. UNAIDS for 2005 has estimated that \$12 billion is needed. That is an increase of their previous estimation that 10.5 billion was needed. UNAIDS has estimated that \$20 billion will be needed in 2007. That is up from 15 billion. The reason these numbers are increasing is that donors have not given their fair share. They have not met global need, and therefore this is the cost of doing nothing. [Applause.] Also, in support of multilateral agencies and institutions, I just wish that they could defend themselves against attacks. I wish WHO could defend itself against attacks by the US and others in terms of undermining its pre-qualification program. I wish that when we talk about the Global Fund at a session on donors, we talk about the money that is needed. Right now, \$3.3 billion is needed in 2005, if Round 5 and Round 6 are going to launch. Otherwise, the Global Fund will have closed itself for any new business. We need to support multilaterals, because otherwise, this is your option: programs like the US where they cherry-pick countries, they

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cherry-pick interventions. And also, why not talk about the CCM guidelines? There are numerous comments here on the floor and from Gregg. People need to know that the PWA is who fought for the right to have a vote at the CCMN. Also fought for and designed guidelines so that the CCM would be composed of PWA's and that the working plan would be a good one and would be principled. However, in delivery—can I just finish?—in delivery to the Global Fund board, donor countries and recipient countries decided not to adopt these guidelines as requirements but instead as recommendations. If we want to open a door into shaping national policy for PWA's and community groups, try fixing the CCM's and if we want a better solution than what the US provides and other bilaterals, then fix the CCM's and—talk about thinking out of the box, thinking out of the box is fixing CCM's, bilaterals use the CCM's to support locally driven strategies, rather than dictating false prevention strategies and dictating [inaudible] policies that of course, prefer Pharma over affordable generic AIDS drugs. I'm out of breath.

DR. FRANZEN: Thank you very much. I think a lot of the comments are fully in agreement with what I as a board member or Global Fund speaker would agree with you, I think, so let's take another speaker or questioner at Number 3. Please introduce yourself.

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JIM KERN: I'm Jim Kern from Atlanta, Georgia, USA. Thanks to all of the speakers. This week the Institute of Medicine and the Academy of National Sciences in the United States issued a report on scaling up treatment on the global AIDS epidemic, which called for not only a much larger response, but an immediate response, and most importantly a sustainable response, one that would be decades long, not merely a few years long. This will require political commitment on the part of obviously many, many donor countries and many individuals. One of the concerns that the report identified was the harmonization of monitoring and evaluation. We all would agree that scaling up treatment means not only numbers of people who are on programs, or numbers of drugs that are initially made available, but how many people in the long run have a prolongation of life, and a decrease of morbidity and mortality. That means that we actually have to have testing and counseling for people. Many of these 40 million people know that they're infected, and we have to have people who can be counted as alive and well as a result of the programs. That means that programs, whether they're Global Fund programs, WHO programs, or bilateral programs such as PEPFAR, most of the PEPFAR programs have to have the same monitoring and evaluation system. So this is a question to the Global Fund and to the United States' representative. Is there an effort between the

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two of you at least, to harmonize your monitoring and evaluation systems in the countries you're working in?

DR. FRANZEN: Okay. I will ask to reply to several of the comments, and then we will open up the total debate. Is the question number 3 also for the Global Fund?

FEMALE SPEAKER: No, I'll wait for the opening.

DR. FRANZEN: Okay, thanks.

DR. AS SY: Thank you. Let me just let me address the last statement about the need for harmonization and evaluation, and I fully agree with that. Have efforts been made towards that? Yes, indeed, and there is a monitoring and evaluation tool kit which was worked on together between the WHO, UNAIDS, the Global Fund, CDC, USAID and the World Bank to try to address those specific issues with regard to what are the most critical indicators to be used to measure coverage, outcomes of programs, and then on a longer run, also impact. This is one of the main principles of the Three One principles, and the tool kit was already available and the result or the end objective of that is to together work with countries to have a national M and E framework that will be also consistent with those indicators that we all agree on to measure our activities and programs.

The question related to the budget was so [inaudible] made at the same time with the comments made about the needs

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for next year. Contributions so far have been voluntary ad hoc contributions to the Global Fund, and budget has been looked into in contrast with the proposal that came to the Global Fund and recommended for funding so far. And as you know, Round 4 was about a billion dollars, and the current budget could cover that, and fund it fully as was recommended by the GRP. The next steps will be to work on our replenishment mechanism that would give the Global Fund, and more importantly the countries and CCM's which are drawing the proposals, the predictability of the funding over the next years, and the number of Rounds that could be funded. And if Round 5 indeed becomes a reality as was stated by the previous speaker, and for 2005 the need will be 3 billion US dollars. We hope pretty much that the replenishment conference will be a great contribution towards meeting that goal.

DR. FRANZEN: Thank you very much. Mark, can you just briefly respond to that one issue?

MARK DYBUL MD: I would just say that we think not only of the Global Fund and the US government, but World Health Organization and World Bank and all people need to have one indicator, and we're all fairly far along there. We have uniform agreement on a set of indicators, and that was announced when UNAIDS made their Three One announcement, so I think we're pretty far along on that one.

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DR. FRANZEN: Thank you very much. I feel a bit awkward here as a donor of the EC donor, and EU donor representing 25 governments and the commission and not speaking out on any of this, but this was not my role here. My role is chairing, so I just would like to make a position at least that we are supporting harmonization, cooperation of 25 plus 1, and all of the other donors; it's possible. And the leadership and the ownership from the countries. In the countries we respect that we see the countries as a broad partnership, including all of the key partnerships, including people living with HIV, but I would like to plea here, and what we are also trying to include more young people and more women in the CCM's, and in the partnerships at the country level and globally. And I have to speak out because I'm very happy that our representative from the gay community had to defend women here in this audience, and I cannot not do that myself as the only woman on the panel here. [Applause.] The other issue I do want to raise here, and I do hope we have the opportunity later on also, is European Community together with European member states provide 60 percent of the funds to the Global Fund, and we are very strongly committed to accelerate and increase that, and also try to make a sustainable system for predictable financing in the future so that we don't have to go to the gamble for the moment, of will we or will we not have a next Round. So we are

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very hard working on this. We are not there yet, but there is progress, I believe, and never as fast as we would have wanted. But I don't want to take all of the time of the debate. I just wanted to make a few points. I promised the woman at Number 6 to comment. Please.

ELIZABETH MADRA: I'm Elizabeth Madra from Uganda, Ministry of Health AIDS Control Program. I've got two things which the panelists have not brought out very well, especially those representing the donors. The issue of human resource capacity has not come very well, although under PEPFAR a lot of training in terms of capacity building has been a mission, but then how do countries get support to sustain and maintain these human and resource skills built by the donor funding? Often it is [inaudible] donor funding to countries which again draw away this skilled manpower from providing services within the public sector. How are we going to support that? How will the donors help to sustain and maintain, and administer this manpower in providing service in the country without [inaudible] having so many brain-drain?

The second issue which didn't come well is the issue of integration. Often these same resources being given to countries tend to create unproductive competition in the name of supporting maybe the NGO's or the civil societies. Indeed we do accept working in partnership, but we shouldn't really

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create competition to weaken the government system, which will remain there to account on behalf of all the partners being supported. The issue of integration needs to be respected. Otherwise there is going to be this unproductive competition. It will not be healthy for the people, especially in this area of AIDS where we are providing treatment. The health workers could get confused, patients get confused, the NGO's also will get confused. So these are the two issues I was trying to raise which didn't come out very well. Thank you.

DR. FRANZEN: Thanks to adding these points. They are very important, obviously, and I hope that we can debate them over the next days or so. There is one more comment I will take from speaker number 3.

FRANK JOHNSON: Frank Johnson from the United States. I think we all agree with the principles of harmonization and cooperation, and that's always a good starting point on a global basis, but I also think competition is very important in areas where we don't know all the answers. I would love to see these programs evaluated not by how much they spend, or how much they promise to spend, but as Jim Kern began to allude to, the cost to deliver a year's worth of treatment effectively per person, the cost of a year of quality adjusted life bought, and the cost to prevent a case of HIV/AIDS that otherwise would have occurred. We're nowhere near that for most of these

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programs. Thank you.

DR. FRANZEN: So competition is included in the debate. Shall I take another? I do think we need to finish quite soon. We are already getting over time. I will take two more there, and speaker number 3, then I will give the opportunity to some of the panelists that feel some replies are warranted, for example on human resources, some capacity building areas or some of the other suggestions.

HAMMOND ROITA: Thank you. I'm Hammond Roita from South Africa, working in a program in a rural district of [inaudible] in the eastern [inaudible], one of the provinces that has been promised money by the PEPFAR funding. We with the Department of Health and NSF, the Nelson Mandela Foundation run twelve clinics providing antiretrovirals to 250 adults including 15 children, of which 90 percent of the adults are female. When PEPFAR got their funding, they put pressure on government officials to take over those very clinics to make easy victories and big claims to having lots of people on treatment. I want to ask the PEPFAR speaker to comment on that. Secondly, in terms of capacity building, the Department of Health has asked PEPFAR many times to fund capacity building at district level, and provincial level, because of other clinics running, there is no security of sustainability if it cannot be run at the district level. PEPFAR has not committed any money towards

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that. Can you please say what you can do about the Eastern Cape in South Africa? Thank you.

DR. FRANZEN: Okay, one more comment, please, short.

LUCY SLEIGHTER: Yes, hello, Lucy Sleighter from the United States. I'd like to ask Mark, our US Government representative to please respond to the issue that both Gregg raised and Mr. Mwale from Malawi raised regarding the extent to which the PEPFAR Initiative is empowering unity and nation AIDS coordinating organizations at the government level within the countries that you are funding to address their own priorities and goals and not the priorities and goals that the United States has outlined.

DR. FRANZEN: Okay. Thank you for that comment. I would like to ask Mark first to respond to some of the specific questions, very briefly please. Further details can be done bilaterally, then I will ask Gregg and the World Bank representative, Mr. Patel to get into for the capacity building maybe.

MARK DYBUL MD: On the last question, supporting the national goals, our purpose is to support national strategies, so there are some things the national strategy would like us to do that we cannot do, but we will not do anything that the national strategy does not want us to do. So we work as the US Government under the national strategy within the confines of

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our own restriction.

In terms of the Eastern Cape, I'm not familiar with that program. I'm a little confused by the question because my understanding of the purpose of the NSF clinic at least in Kailitra [misspelled?] is to turn it over to the public health system, so if we're helping to expedite that, given the fact that the public health system is supposed to provide most of the therapy, I'm not sure that's a bad thing, but I don't know enough of the specifics, and I'd be happy to put you in touch with the people there to do it. In terms of the capacity building, as I mentioned, that is a fundamental aspect of what we are doing, whether it be training, developing community health aides, building physical infrastructure, which is something we're doing in South Africa, or providing free service training, so all of those things are things that we are funding, want to fund, and are looking for opportunities to do it. Please, if you talk to me I can—

GREGG GONZALVES: Well, you have a third of the money for PEPFAR dedicated to abstinence only prevention programming. You have yet to see a generic fixed-dose combination approved by the FDA. It's coming, you keep saying to me, Mark, but it hasn't happened, so you're not doing what the countries want, you're not doing what the people with AIDS want. You're doing what George Bush, Claude Allen, Bill Steiger and the rest of

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the conservative right wing wants to do in the United States.
And you're forcing it on countries.

Second of all, about the IMF and the World Bank, they have to lift health sector restrictions on public spending. There are plenty of doctors in Kenya and nurses that can be utilized to scale-up but the budget caps enforced by the IMF and the World Bank are keeping them from doing it.

PRADFUL PATEL: Let me just very briefly address the question of capacity building. In fact, underlying this whole conversation about donor coordination is indeed the issue of how we build capacity on the ground. What we have found in the design of our projects, it's not really about money, it's about creating the capacity at the ground level, particularly now, when we see most of these programs are decentralized, not at the central level, but at the ground level, the community level. The issue of actually making the capacity needed to deliver these programs has become the biggest challenge that is being faced, and as everybody here knows it is not about just delivery of [inaudible] it's actually delivering the drugs and all these packages through the logistics and through people that are working at the ground level. What I can tell you very briefly is that in the projects that we see, second generation of projects, for example in Africa as we do second generational projects in the World Bank, the design of those programs is

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shifting much more to the building of the local capacity.

While I'm speaking, I should also say on the issue of monitoring and evaluation, the challenge has really very quickly come to one single monitoring system that allows, and this is the issue of accountability to both the public as well as to the donors, that monitors progress in our world using just one system, to show that a performance of the national response, to specific activities in a program, and also how generally the whole implementation process for the HIV/AIDS becomes more efficient. Thank you.

DR. FRANZEN: Can I go into some responses from us, and then the last speaker. Okay?

DR. AS SY: Only on capacity can we address in two different ways. By the time CCM's design their proposal and they identify it as a problem it could be included in the proposal and the guidelines for proposal design, fully accept that, and it could be fully funded as once component for the proposal to be submitted. That's one. Two, even in cases where the proposal has already been funded, and then during implementation one comes to the realization that one needs to address human capacity to guarantee the success of the proposal, there is enough flexibility again to accommodate that in looking at the budget lines, and targets and indicators that were set, and provide resources for that within the approved

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budget. I think my colleague from Malawi can even talk about that, because we went through that similar exercise, and that's something that can be done electively, easily if the principle recipient and the CCM's wish to do so. Thanks.

BIZWICK MWALE: Thank you very much. Indeed, the issue of capacity in the HIV sector is a critical issue, particularly now that we are trying to scale-up the treatment program. Malawi, like other countries in the developing world are losing staff, trained personnel in large numbers. Some of them are going to Europe or America for greener pastures. Of course there are others that are dying because of the epidemic, but the big chunk is likely going for greener pasture. I'm mindful that Malawi has already developed a six-year human resource plan in corroboration with the donors, and they have bought into this arrangement. It needs to be funded. We have had an opportunity to contact a global fund to see how base we can reprogram the resources in order to address the capacity building initiative. I think it's a critical area. It's an area we need to move fast. However, let's not spend time debating or using capacity as a scapegoat. We should scale-up. Let's do capacity as we move on. Thank you very much.

Okay. On these last great words I would like to conclude with just three very brief remarks, because I think this says it all, let's not use capacities or absorptive

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capacities as an excuse or a scapegoat. Let's tap into the capacities that are out there. And country level in the capacities that we have forgotten to use sometimes, or to tap into, the communities very greatly presented here. Let's look at communities in a very wide way. People living with HIV, but also young women, very often not included sufficiently. Let's look at donors, not just from public donors, but public/private banks, foundations, NGO's. All of the donors need to work better together and all of that needs to be more demand-driven from the countries, from the people. We have to respond to the demand coming from the people rather than driving from the donors. Thank you very much for a very active debate, and see you further off today.

[END RECORDING]