

**International AIDS Society:
2nd IAS Conference on HIV Pathogenesis and Treatment
Controversies – The Non-Public Sector is More Important Than
Government for Expanding Access to Treatment in the
Developing World
July 14, 2003**

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ELHADJ SY: ...controversy, because we're trying to bring in different perspectives that may be complementary, that may be contradictory. They may be simply controversial. And we want to structure the professional (unintelligible). The fanatic or the debate will be introduced by two speakers, and then we will be opening up to an interesting debate to all the public. The first speaker is Dr. Alex Coutinho, who is the Ugandan Public Health Physician and Executive Director of TASO. TASO stands for The AIDS Support Organization, that is the largest care and support organization in Africa, with approximately 30,000 clients with HIV. Alex has been working on HIV/AIDS in Uganda and in Southern Africa since 1983. He worked for 12 years with the private sector in Swaziland, setting up HIV/AIDS workplace programs. He served on several international Boards and is the Vice Chair of the Global Fund's Technical (unintelligible) Panel. Alex will be introducing the perspective of the nonpublic sector, which he believes is more important than government for expanding access to treatment in the developing worlds. Alex, please.

ALEX COUTINHO: Can I have the slide projected on the left screen, please? Thank you. Thank you, and good evening, ladies and gentlemen. It's my pleasure to be here today to talk about this particular topic. But before I start, Mr. Chair, I would like to express my disappointment in the

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organizers for putting this topic in the controversy session, because, as far as I'm concerned, there is no controversy about it at all. The nonpublic sector is indeed more important than governments for its finding access to treatment in the developing world, and so I really feel it shouldn't be in the controversy session. Nonetheless, since it is in the controversy session, I will try my best to explain exactly why I don't think it is a controversy. That picture, by the way, is the TASO headquarters in Kampala, Uganda. Before I proceed, we need to talk the same language, so I just need to define these four key phrases and words, so that we understand the perspective from which I am debating this particular topic. My understanding of the nonpublic sector includes the civil society, the NGO worlds, the private sector, and it also includes, particularly in Africa, faith-based organizations that are often running hospitals. So that would be my definition of the nonpublic sector. More important means exactly that--that the nonpublic sector is more important than government. It does not mean that government does not have a role. It does have a role, but civil society, nonpublic sector has a more important role. And if finding access does not mean that everybody receives treatment, but that access is expanded far beyond the numbers that are currently accessing treatment in the developing world. And for purposes of this debate, the word "treatment" will be restricted to access to antiretroviral

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therapy. Now, earlier this morning, Ernest Dacor (misspelled?) talked about bottlenecks to expanded access to treatment in Botswana, and I would like to put my own list of bottlenecks that I consider that are currently restricting expanded access to treatment particularly in Africa, but in the other parts of the developing world. Some of these bottlenecks include the price of drugs as well as the price of testing—testing for HIV, testing (unintelligible) for counts, as well as other forms of laboratory testing. The leadership and policy environment in many countries is lacking to support expanded access to treatment. Stigma and discrimination is a huge, huge (mic off) problem. We often assume that if treatment is available, that people will come running. Botswana is the typical example that shows that, in fact, this does not happen. The demand and availability for voluntary counseling and testing is a key bottleneck. The actual demand for HIV/AIDS medication by people who are HIV positive can be a bottleneck if there is no demand. The health infrastructure is a definite bottleneck. But often, more important are the community structures to mobilize people to come forth for testing and treatment, as well as community structures to provide support for HIV positive people once they are on treatment. Obviously, skilled human resources can be a major bottleneck. Financial resources--and this morning and afternoon, we were talking about the \$10 billion—are a very important bottleneck but are

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one bottleneck among many. And government bureaucracy is another bottleneck. So, in fact, government often provides a very important and serious bottleneck that is difficult to overcome. So if these are key bottlenecks, and if we agree that these represent the most important—there could be others—what is the role of civil society, of the nonpublic sector, in trying to overcome these bottlenecks? Well, nonpublic sector has been at the forefront in advocating for price reductions, policy change, and drug donation schemes. We've not heard much about government pushing the agenda for this. It's really been left very much to the nonpublic sector to do this. The advocacy for the rights of people living with HIV and AIDS, and monitoring of any discrimination, is something that is really being done very much by the nonpublic sector. And the importance of this cannot be emphasized, because, unless we reduce discrimination, stigma, and denial, there will not be people coming forth to receive antiretroviral therapy, even if we provide it free of charge. And however much money we pour into Africa to buy ARVs, unless we remove this environmental stigma and discrimination, those drugs could sit there unutilized. And the people who are well positioned to work in this area is the nonpublic sector. VCT is obviously a--voluntary counseling and testing is obviously a key entry point, to determine if somebody is HIV negative or positive. Who is providing the most voluntary counseling and testing in

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the developing world? It is the nonpublic sector, creating awareness and demand for medication, especially antiretrovirals, what I call demand creation. Do we assume, as governments often do, that if we put drugs in hospitals, people will come looking for them. There are examples of hospitals that have stocked up nevirapine, and that nevirapine expired because people did not come forward. And so, to create demand, demand for services, is often something that the nonpublic sector has far more experience in. The provision of health infrastructure itself, in many African countries, is primarily (unintelligible) through mission hospitals, private sector, and nongovernment organizations. Let us not assume that all hospitals in the developing world are government hospitals. I believe in Zambia a large proportion of hospital infrastructure is actually outside of the government sector. If we got community mobilization, sensitization, and deployment, all these functions that are very important for scaling up access to treatment, this is all work done by the nonpublic sector. But rather—yes, by the nonpublic sector and not by governments. If we look at training counselors and community workers, again, it's not governments that are doing most of this training; it is the nonpublic sector. And even though, in the long run, it is governments that access funds, who has been doing the advocacy? Who continues doing the advocacy? Who was on the stage with Nelson Mandela, asking for \$10 billion? Was it

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government or was it civil society? And finally, many governments often don't treat HIV as a national emergency. They treat it like any other disease. And HIV is not any other disease. And again, it's the nonpublic sector that continues to lobby governments to treat HIV as a national emergency. Let me, very briefly, run through a few country experiences. In Uganda, 65% of voluntary counseling and testing is provided by the nonpublic sector. An estimated 10,000 out of the 200,000 people needing antiretrovirals are on treatment. And of them, every one of those 10,000 is from the nonpublic sector. As yet, there is no public provision of free ARVs by the government. As we heard this morning, in Botswana all 110,000 people in need of ARVs can theoretically get free treatment, but as of December 2002, only 3,500 are doing the scheme, and as of July, only 6,500. And one must ask yourself, if government in Botswana is providing free ARVs, why don't we have expanded access? Could it be that Botswana has got a very, very small civil society sector compared to countries like Uganda? South Africa still does not have a scheme for free delivery of ARVs. Those accessing ARVs do so through the nonpublic sector, through insurance schemes, mining (misspelled?) hospitals, and a few beneficiaries, including NGOs like Médecins Sans Frontières. And it is NGO activists who are playing a key advocacy role to get legislation passed to provide free antiretrovirals. India, which has about

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100,000 people who need antiretrovirals, probably has less than 2% of them on antiretrovirals, and yet it is the largest producer of generic medications, including antiretrovirals. So why, why hasn't the government of India then not used the cheapest medication available in the world to scale up antiretroviral therapy? And I have been told that it is the civil society that is pushing pressure on government to utilize this strategic advantage that India has to provide antiretrovirals to more people. Let us look at the critical path analysis for ARV delivery. I have pulled out what I consider to be the key steps needed to scale up ARV. We start at the top left-hand corner with risk awareness. People must feel that they are at risk of HIV. They must believe they could be HIV positive, and that will generate a demand for voluntary counseling and testing. That means the individual then has to go to VCT (misspelled?) services. So voluntary counseling and testing services must exist, and not just exist, they must be of quality that guarantee confidentiality, and the results should be unambiguous. Now, once somebody tests positive, they don't necessarily become open about HIV status. In order to do so, there must be a reduction in stigma and discrimination within their community and within the country. That will lead to some openness about the HIV status and could generate a demand for ARVs. It's going to be very, very difficult to scale up antiretroviral programs in an atmosphere

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of secrecy, because most of those antiretroviral programs require a large number of—a chain of people to support the individual, particularly to be drug adherent. And then you need antiretroviral services. And all of this will lead to scale up antiretroviral delivery. If I had time, I would show you that for every one of those steps in the critical path analysis, the role of the nonpublic sector is much greater and more important than that of government. Finally, any scaled up delivery of drugs, especially of antiretroviral drugs, will be challenged by equity. With few resources and expensive drugs and services, governments are challenged on how to deliver free services equitably. And often, they don't know how to respond to this challenge, and it leads to inaction or delays responses. The nonpublic sector, on the other hand, has less of a mandate to provide universal free drugs, and so the challenge of equal equity is easier resolved in the short term. And as such, the nonpublic sector is more important in its finding access to treatment in the foreseeable future. And we need to ask ourselves. This is a village in rural Uganda, about 250 kilometers away from the capitol. Who is better placed to scale up treatment in this particular area, to visit these communities, to provide counseling, to ensure adherence? I believe it is the nonpublic sector and not government. Thank you very much.

ELHADJ SY: Thank you, Alex. My next speaker is Daniel

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Berman. Daniel has worked for Médecins Sans Frontières' Access to Essential Medicine campaign since 1999. That was a campaign which was advocating for improved access to existing medicines and increased research and development for diseases that most affect people in the developing world. Before joining MSF, Daniel was the Vice President of the public relations agency, Manning, Selvage, and Lee, where he represented pharmaceutical clients, including Roche, Pfizer, and Pharmacia, and Upjohn. That is probably the only one here. He was responsible for promoting (unintelligible) and relations with AIDS activists, and his background is a Masters of International Affairs from Columbia. Daniel was, in fact, telling us if there is anything controversial, he wants Alex (unintelligible). Thank you.

DANIEL BERMAN: I'd like to start by looking at an imaginary NGO, and that imaginary NGO would be called Replacement Medical International. It would be in every city, town, and village. It would have the power to set national treatment guidelines. It would determine eligibility for poor people, distribute drugs nationally, negotiate with vendors on a national level, and, of course, it would have sustainable funding for its entire national effort. But, unfortunately, RMI remains a fantasy, because, of course, there is no international or national NGO that has the human or financial resources to replace a ministry of health. It just doesn't exist. And after all, isn't the responsibility for health,

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doesn't it rest with governments? And I think it's interesting to look and say, well, what is the role of nongovernmental organizations? And I think there are certain things that they can do and certain things that they can't do. For example, for sure, there can be individual programs and individual projects. They can offer technical assistance of the government. They can join with local NGOs to push reluctant governments to act. But, as I mentioned with this imaginary NGO, there's no way that they can devise national treatment strategy. But, most importantly, what about declaring universal access? Can an NGO do that? And I think that's one of the key things, in terms of the role of an NGO versus a government or a nonpublic sector entity. Universal health care or universal access is only something that a government can provide or decide on. So, what I want to do next is just very quickly just—I'm not going to look at all of these cases, but I want to look at the political will in endemic countries, and see how that affects availability and affordability. In other words, if you just look at that small part, just treatment access and availability of treatment, let's see which government, or the power of the government, what can that mean? So let's start with Thailand. Okay, just briefly, there's 755,000 with HIV/AIDS. And I want to point your attention to the place of first line treatment, because I think this is really where governments can make a difference. I think Alex was saying that NGOs can play a

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strong role. I definitely agree that NGOs can play a role, but look at what Thailand did, and tell me if an NGO or nongovernment sector can do this. The 30 bahts scheme. Government decides okay, from now on, access to health care costs less than a dollar. So for a doctor's visit and the medicines you need, this is the new policy. I'd like to know a nongovernment organization that could do that. And so, what happened at the beginning is it's only ARVs and dialysis that are excluded, and obviously that's not acceptable. So what that meant—and still the government took the next step, there really wasn't a chance for universal access. It's true that NGOs and people with AIDS associations pressured the government. I would see that this is definitely a role and a critical part. But it's only when that pressure led to a government action that things started to change. And, in this case, the real key, the linchpin, was local production, because what happened was the treatment that's produced in Thailand went down to \$29 a month. All of a sudden, that low price enabled a national program. It was possible. But what if local production isn't possible? That brings us to Cameroon. No, they don't produce ARVs in Cameroon, and, in fact, there's almost a million people with HIV/AIDS. But yet, the price of therapy is 277 per year—that's per year. Why? Strong government intervention. In fact, the way they did it was they have a national procurement agency. It's called Senamni

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(misspelled?), and what Senamni does is it pulls the purchases for the entire country, something that would be very difficult for nongovernment sector, and, in fact, this allows strong negotiations with producers. So they've become the sole buyer. What has that done? It's made a dramatic—this graph is very simple, in fact, because if you look at the blue line, it shows how the costs went down, and if you look at the red line, you see how access shot up. So in other words, because it's essential buying and this very strong role of the government, prices fell and access skyrocketed. So there was the political will, and this is a really important point, they enacted the Doer (misspelled?) Declaration. The Doer Declaration says that the Tripps Agreement, the WTO, can and should be interpreted and implemented in a manner supportive of WTO members' rights to protect public health. Cameroon did it. They didn't look at whether drugs were patented. They decided to go ahead and use generic drugs. I come to my last example now. What does it mean when there's no government leadership, and the government's not willing to act? What happens then? South Africa—50 million people in the country, 4.7 million—everybody knows the story. But maybe you don't know that the cost of treatment in South Africa is \$2,007, because there is no real public sector in terms of access to treatment. There's an exception, of course. The exception is just one program, and the program is with the MSF and the provincial government. MSF

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offers the full continuum of preventive and treatment services, and this is an exception, not the rule. So it shows that the nongovernment sector can treat patients, but can't really impact on a national level. So what's happening, because of this lack of government leadership, since 2001, MSF has been treating with affordable ARVs in the public sector. But the nongovernment sector can't deal with the fact that more than 600 people die per day in South Africa. So the conclusions. Strong government leadership is essential to tackle the AIDS epidemic. Without positive input from wealthy countries, endemic government leadership just won't be enough, because in addition to national governments in endemic countries, the international community, other governments, need to also play a role. They need to provide the funding, and they need to support the Doer Declaration, so that countries like Cameroon or like in Thailand, where they are fighting to use generic drugs, the international community supports that action, and that can really make a difference. Finally, I just want to thank my colleagues in different projects, because everything that I mentioned came from countries where we are working, so Thailand, Cameroon, and South Africa. Thanks.

ELHADJ SY: Thank you, Daniel. Thank you, Alex. I don't know if there's any controversy here. The audience will tell us. But there's certainly some tensions here. Instead of always working together and complementing each other,

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government and nonpublic sector seem to be competing. Is it competition for resources? Is it a competition for prestige? Why--why are they competing? Instead of sharing the burden of care, it looks like they are trying to shift the burden to each other's shoulder. Why is it that? And in the midst of all these questions, we are talking about huge numbers of people needing access to treatment, and you believe that you are more important than the other, but then why in the developing world, in Africa in particular, we are only having 30,000 people on ARVs, and how important are you, individually first, and how can you tell us, you know, how are you more important than the other? This will be my first question before I open the debate to the audience.

ALEX COUTINHO: Thank you, Mr. Chair, and thank you for providing me the statistics that actually reinforce my argument. Of the 30,000, only 6,000 from Botswana are actually getting free ARVs from government. The others are getting it from the nonpublic sector. Most of them pay. So what would lead you to believe that the current situation is different than what needs to happen in the future? I think the nonpublic sector is much more attuned, much more responsive to emergencies, and HIV/AIDS is an emergency; it is not business as usual. We hear rhetoric from government that also says this, but what's the reality on the ground? If we really want to scale up access to treatment, if we want to mobilize the

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private sector to provide treatment for all its employees, we really need to provide the resources for the nonpublic sector to get on and do its work rapidly, and that's why I think it's more important.

DANIEL BERMAN: It's interesting to mention the access in terms of the reality today, because I think Uganda is a good example of a country where there are large numbers relatively speaking, more than other countries, significant numbers of patients, but those patients are all self pay. I mean, people with the money have access to care because they pay for the care. But what about people that can't pay? And that's where the government's role is so critical. Because if you create a network and a system, even if the care is delivered by the nonpublic sector, it's only the government that can take the money on a national level and then distribute it, and actually set up a system, like they're doing in Uganda, where there's a subsidy of 25%, 50%, 75%, but the government is setting that up because they're the only one that has the right to make that sort of calculation of who's eligible.

ELHADJ SY: Thank you. Now, we want to extend the debate to the audience. Any view, comments? Do you have a mic? Okay, those who want to intervene, please, can you stand behind the mics. I see one in each aisle and one in the middle. So the lady on the right aisle.

FEMALE VOICE: Thank you very much. Mine is a comment.

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Thank you. Mine is a comment. I come from Uganda, but I'm working in Namibia. And I think, as the speaker rightly said, we have to complement each other. I've seen two situations that are really different. In Uganda, the civil society's big, and such a thing can work, and it's workable. But in a country like Namibia, where the government employs most people, the government is the sole provider of so many things, then the civil society really doesn't have a big role to play because it's still very small, and they don't even have the money. The government has more money and it has more mandate and it has more access to the public. And then, the other point is, you will find a situation whereby government institutions are clashing. Actually, I would like the second speaker to clarify on that, because I've found this in my present situation at work, whereby I'm working in a planning commission which plans, makes policies, budgets, and provides the money, and there's a bit of friction with the minister of health, so (unintelligible) and what are you doing about it, and thank you.

MALE VOICE: I just wanted to correct something said by both speakers, who I think misrepresented their positions slightly. But it's a debate, it's meant to be artificial, and I understand that. Alex, in fact, I think the Botswana example you raised was fascinating, because the 6,000 patients that are being treated in Botswana, free of charge, are being treated by

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a nongovernmental organization. It's not by the government. ACHAP is a partnership of government, industry in the form of Merck, and philanthropy in the form of the Gates Foundation, and it's a separate entity from government itself. So it's actually a nongovernmental with the three participants all being married. That too is a success of the nongovernmental model. Daniel, you had mentioned that it isn't possible for NGOs to act outside of national treatment standards, but surely you're wrong about that, because Médecins Sans Frontières does that all the time. In South Africa, in Capetown, you are providing antiretroviral treatment, despite a government that would surely prefer you were not doing so. In Burundi, I believe, and I hope I'm right, but please correct me if I'm wrong, MSF was basically told to leave Burundi because you started providing combination malaria therapy, which the government didn't want to use. So, in fact, MSF was keenly involved in pushing the envelope of policy, and you said that's something NGOs can't do. It seems like you're doing it.

ELHADJ SY: Okay. Let me go back to my right, and we'll come back to you.

CHARLIE GILKS: I'm Charlie Gilks from World Health Organization in Geneva, and I'd just like to point out that all treatment programs require health professionals who have been trained. And the big crunch issue, that I don't think either of the presenters have discussed, is the almost exclusive role

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of government in providing the training programs for the nurses, clinical officers, and doctors. There is actually, in most countries, a legal requirement that only the state can license these people and provide their training. And it seems to me that whilst the NGO sector can be very good, flexibly and rapidly and quickly responding to an emergency, which you mentioned, Alex, this is an emergency, but it's a long-term problem as well. And it's government's role, and sole role of government at the moment, to start increasing the necessary training for the people who will provide treatment now and in the future. And I don't think NGOs or employees and large industrial concerns have any role in taking that training function over from government.

ELHADJ SY: Thank you for highlighting the training component. And we take, over on the left.

MALE VOICE: I am (unintelligible) from Ghana. I work in the private sector. But my feeling is that, although we are recognizing the important role that the private sector is playing in the HIV-combatting HIV, that government role is critical, looking at the enormity of the problem that Africa, in particular, faces. There should be more divide between the private sector and the public sector. They must play a complementary role. It only appears that we have governments which are important in the face of the enormity of the problem. And if governments were actually (unintelligible) the expected

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role, at least we wouldn't be scratching the surface of the ice pick. We would have been doing much, much better than the results that we are showing. At least, experiences from the countries cited as successful stories show that without the government commitment, those results would not have been achieved. That is my contribution. Thank you.

ELHADJ SY: Thank you. (unintelligible)

BERNARD HERSCHEL: Yes, I'm Bernard Herschel from Geneva. There is another angle to this, and that is the role of the international organizations. And there, you can again distinguish a super organization of the private sector, for instance, MSF, and super organization of governments, for instance, WHO and UNAIDS. So, Daniel, if you look, for instance, at the role these organizations had in lowering prices and changing the rules of trade, would you argue that the super organizations, depending on governments, were more important, or was it MSF? And maybe Alex would have an opinion of that too?

ELHADJ SY: Let me just say something about the rules of the game before we proceed. So, now we're clearly asking Daniel to--you've asked him a question. You asked him to tell us why government is more important. And he's here today wearing this government hat and not speaking on behalf of MSF or, you know, the civil society he would like to speak for. And we have asked Alex to give us the perspective of a

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nonpublic factor, even though there may be things inside that may not reflect, you know, what TASO wants to hear or what TASO is doing, for all of us to see the different perspective and have, you know, he not need to discuss that. So, shoot at Daniel, if you want, but don't shoot at MSF. That's the rule of the game. So, let me take-

ANDREW MITZAPIRA (misspelled?): Andrew Mitzapira, Botswana National (unintelligible) Program.

ELHADJ SY: Can we just give the opportunity to the (unintelligible) to speak, and every question will be answered. I just wanted to remind ourselves, you know, which hat we are wearing, but this does not exclude any question.

ANDREW MITZAPIRA: Yes, Andrew Mitzapira, Botswana. I see it as two sides of the same coin, with the government and the private sector needing to form public/private partnerships to drive us getting health access. And Botswana has shown that by having the government setting forth a policy and providing funding in part, and then the development partners like Merck, coming in through ACHAP, to help with recruitment with providing (unintelligible). It's not actually ACHAP provides the therapy. The government does provide the therapy, and ACHAP is a development partner. So what we need is public/private partnerships, two sides of the same coin, to drive it together. Thank you.

ELHADJ SY: Thank you. Let me give an opportunity

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briefly to Daniel and Alex, and I come back to you. And sorry for letting you stand for a while. Daniel first.

DANIEL BERMAN: Okay, I'll try to answer a couple of the questions. I'd like to put the question together that Amir Atron (misspelled?) and Bernard Herschel mentioned, because I think there's a similar theme there, because Amir was saying that MSF doesn't really follow the government's line, that we might do something different. But I think also--the reason I think these two questions are related, in both the cases of what drugs were used, or in the dynamics of the prices coming down, I think the NGOs collectively can push governments to do one thing or another, but it is extremely difficult. I mean, it's actually the objective in South Africa is to get the government to change their policy. But what I'm arguing is that it's not a sort of string of NGOs that are going to be able to really impact access. All NGOs can do is show that it's possible. In terms of the dynamics of prices, I think that it was definitely the international movement that forced governments, and especially the rich governments, and the companies in the rich countries to change their habits. But now, the focus has shifted, because now the power rests at the national level. Now that the rules have been changed, if governments don't act, then, in the end, patients don't get access.

ALEX COUTINHO: Thank you, Mr. Chair. I'll address

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about three or four of the questions that were raised. Charlie Gilks raised the issue about training and capacity building. And I do concede that in Africa particularly, government has traditionally taken the role for training doctors and nurses. But in my own country, Uganda, we are starting to see a trend where private universities are now also taking up the mantle of training nurses and doctors. And it's also important that to support access to treatment, it's not just doctors and nurses. There's a large (unintelligible) of community workers and counselors that need to be trained, and currently, the government in Uganda, has no such curriculum. Furthermore, most of the training that takes place in government institutions, there is very little in-service training curricula regarding HIV and AIDS, so, in fact, many of the workers who are trained by government institutions have to be retrained post training in HIV and AIDS. Then, there was a comment about governments playing the expected roles. Somebody said governments are more important if they play the expected roles, and that is exactly the problem. Too many governments are not playing their expected roles, and so, what should civil society do--sit back and watch on, while the ship sinks? Or should we recognize that in this particular case, in this particular epidemic, we are more important, particularly because governments are not playing their expected roles. There was a question of international organizations--WHO. But

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let me add, what about UNAIDS? Who's driving their agendas? Historically, WHO, the agenda might have been driven very much by governments. But the agenda of UNAIDS is not driven by governments, it's driven by a much wider range of players, of which the nonpublic sector is very important. And increasingly, WHO's own agenda is also driven by other players other than government. Thank you.

ELHADJ SY: Thank you. Back to the audience.

MALE VOICE: Hello, I'm (unintelligible) from (unintelligible), India. I'm happy to hear this debate, because we need to get over this debate as soon as possible. My concern is about the roles which we all talked about. The countries like India, which has no political will per se—strong political will, per se, have got a problem of NGO—(unintelligible) NGOs with subquality care. So the government has to play a role of monitoring and, to the extent, laying down the policies and the guidelines, and, of course, the very important aspect of training, because it is not in the private hands. And so, I just think that we all know that this is not an ideal world, but still this debate will go on. But everybody has a role to play, and we cannot just underestimate any role. Thank you.

FEMALE VOICE: I would like to support my colleague's opinion from India. I'm (unintelligible), and I'm going to talk on behalf of India also. If the government has no

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political will, as my colleague has said, and has no expertise in providing antiretrovirals and vision and funding for ARVs, what training can they provide, and when will they provide, and should we let our 4 million who are infected die, until they dial up their vision, their political will and resources, and start treatment? In India, all the expertise in the (unintelligible) and training comes from the civil society. That is the truth at this time. And we provide drugs have been manufactured, all the potential drugs, and export to the whole world, but we have no national plan or regulations in the quality control of these drugs, neither we have national plan for training or we have national guidelines for treatment of patients. At this time, I would like to support Alex's point of view, that until our governments develop vision and political will, I think it's the civil society who's leading the efforts.

ELHADJ SY: Okay. Yes?

NIMA LASHOU (misspelled?): Nima LaShou from Montreal. I think it's the role of the government to assure every basic human right of the population, and the health is a basic human right, so it's to the government to assure the distribution of the care and the health right of the population. But the civil society or the NGOs, what we can do is to assist the government when he needs some assistance. We can push the government, when he doesn't want or doesn't will to do a treatable—to have

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a treatable politics, we can push him. Or we can distribute the care that are (unintelligible) by the government, or the government decides to give care, but he doesn't have all the (unintelligible) necessary for that, so we can do this part of the distribution of the care. But assuring the basic needs of the population is from the government. But I have a—and the problem is that private sector, by definition, is based on profit. But when we talk about care, we talk about the distribution of the profit, and private organization doesn't have any mandate to do that and any will to do that distribution of the profit. And I just have a question to Alex—I don't see that—Coutinho. And when you talk about civil society, are you talking about advocacy groups or are you talking about the private sector, because I think it's very different. They don't have the same mandate. They don't have the same objectivity, sense of view. Thank you.

ELHADJ SY: Thank you.

PRATHINA NADU (misspelled?): I work on the day-to-day implementation of the National Antiretroviral Quality Program in Botswana, and there's just two very quick points that I'd like to highlight regarding the number of people that are being treated in Botswana. In under 18 months, there's close to 8,000 people on treatment. And if the argument is, why isn't there more people and why isn't access being expanded, then one reason is because not enough people know their status. Hence,

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our focus is to encourage people to go get tested and know our status. The other point that I want to make is that even if we could afford to give treatment, and everyone knew their status tomorrow, that would be an impossible task because we would need trained people to do this, and you'd need to scale it up. It's basic project management rolling out of the program. And then, of course, a third point—and I want to back up Dr. Andrew Mitzapira, who's actually a site manager in (unintelligible). One of the key successes for the Botswana program is really because of the public/private partnerships. The government took the decision to offer antiretroviral therapy, and they formed strategic alliances with various agencies--Harvard University, for instance, in terms of training and development; the Bill and Melinda Bill Gates Foundation and ACHAP; Merck, in terms of some of the project management, and so on. And the point I really want to make is perhaps this debate needs to move to how we can collaborate and work together and really work as partners, and maybe motivate one another to move forward. Thank you.

ELHADJ SY: Thank you. Yes?

BEN (unintelligible): I am Ben (unintelligible). I am working in the Caribbean area, both in Martinique and Haiti. And I'd like to make a comment on the absolute necessity to have private sector working hand to hand with the public sector. If we look at the experience in Haiti, we were

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managing this problem for more than 20 years, the expertise was mainly in the private sector, and up to now, the (unintelligible) group was a (unintelligible) group working in Haiti, has always worked when all governments--and from '85 to '94, we had a lot of different governments, but we were keen to put heads out of the political turmoil, and we knew that for the country, the only issue is having to work very hard between public and private sectors. And this is the reason of some successes we have had in Haiti, the only reason. Thank you.

ELHADJ SY: Thank you. We'll take the lady next.

ITO MARGARET (misspelled?): I'm Ito Margaret, from Uganda, but I work in abnormal situation, in a conflict area of Southern Sudan. I think it is good also to bring in to attention, we have been talking of how government and private sectors work. But in Southern Sudan, which is a conflict area, the attention of NGOs and adult civil society at the beginning was only emergencies. But until the Libyan authorities came up and stood strongly and advised the NGOs and other civil societies that we have a problem, it is not only the war, but HIV/AIDS is a second killer. That's why everybody got more (unintelligible), and their activities now, you can see (unintelligible). So I would like to say that the government has also in some--especially (unintelligible) of normal situations, they will play a great role for the problem to go ahead. This is what I would like to bring.

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ELHADJ SY: Thank you. Now, one, two, three. I have three speakers. I'm going to take them together. Yes, in the middle.

JAMES CARY (misspelled?): My name is James Cary, and I'm from Kenya. I would like to contribute that, though we talk about access and we talk about free, in reality the ARVs are not free. Somebody somewhere has to actually pay for them, either a donor or taxpayers, through the government. One of my big concerns about focusing access in the nonpublic sector is the issues of cost, because nonpublic sector players, in providing health care, tend to be very expensive, including the not for profit actors. When you provide through government, the costs tend to be lower. And what we are hearing is that when both cooperate, when there's a partnership between government and nonpublic sectors, then we have the most success. But the success can only come if the government actually takes leadership, because we have not seen any successful programs, national programs, where the nonpublic sector takes leadership. I think the example was shown. Countries which have been successful are those where the government actually takes leadership, and I think that all of government is really key in this, that it must take leadership. It's one which is able to provide the access at lower costs, because though we say that we can provide them for free, somebody has to pay, and if we provide at higher cost, then it

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will not be sustainable.

ELHADJ SY: Thank you. Speaker.

CRAIG MCCLURE: I'm Craig McClure. I work for the International HIV Treatment Access Coalition. I'm a Secretary at WHO. And the IHTAC partnership believes that only through a full and meaningful partnership of associations of people living with HIV, NGOs, governments, donor governments, developing country governments, foundations, the business sector, and multilateral organizations, working together internationally, regionally, and at country level, can treatment scale-up really work. And that only through catalyzing a change, so that all of those partnership organizations work more effectively together, with the fundamental foundation of scaling up treatment, that local communities of people infected and affected by HIV are involved in planning and implementing treatment programs, can we be successful at scaling up. Would you concede that a partnership of that scope is the most effective way to scale up? And would you concede that a key element of all the pilot projects that have been successful thus far have involved the engagement of local community up front in the planning of those programs?

ELHADJ SY: Thank you. Next speaker.

GAZAL (misspelled?): I'm Gazal from the International Federation of Red Cross and Red Crescent Societies in Geneva. The International Federation is a big international

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organization, where we get involved whenever there is human (unintelligible) and disaster, natural crisis. So from our experience globally, it has never been possible for us to do an effective work in any country where government is not collaborating, definitely not (unintelligible). After all, the authority and the responsibility in a given country lies in the hands of the government. We have to make distinctions between a dormant government, the government that's not acting, and the potential role of the government. A government that is not active, NGOs and civil society can play a role in lobbying and bringing that government into its position so that it can act. Mobilizing the community, mobilizing the greater mass within the country is in the hands of the government. I don't think it is possible for NGOs to do all this mobilization, and also do all community activities, coordinate it in an effective manner. I do admit--I do admit very much the roles of the NGOs are playing, but it is not replaceable. The authority and the responsibilities that lies within the government cannot be replaced. So I think that the dialogue of the discussion can very well be handled if we can say that NGOs and other organizations can play an effective role in collaborating with the government, rather than replacing.

ELHADJ SY: Thank you. Alex, you have one minute to, you know, pick and choose the questions that you think to be most relevant, answer them, and 30 seconds after that to tell

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me what you really think.

ALEX COUTINHO: Okay, thank you. First, a clarification. I was asked if, by civil society, I included the private sector. The term we were asked to debate is nonpublic sector, which does include the private sector, and includes the private sector for profit. In fact, civil society does not generally include that private sector for profit. Now, what do I really think? Because, of course, this debate is official in a sense and has a very useful purpose to take extreme ends, so that we can start understanding where both sides are coming. Of course, there has to be a partnership. This should be obvious by now. But within that partnership, there are two very important things that we must do. We must understand within that critical path analysis that I showed, that not both parties, government and nonpublic sector, can be more important than the other at one particular critical part, and we should not assume that throughout that critical part, either government or the nonpublic sector is more important than the other. The second is that we need to be conscious of the bottlenecks, and we need to work together to overcome those bottlenecks, and we should not let official pride stop us overcoming those bottlenecks, because I am government, it is my responsibility to do this. Some of those bottlenecks could be best overcome by the nonpublic sector. That's what I really believe. Thank you.

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ELHADJ SY: Thank you. What do you really think, Daniel?

DANIEL BERMAN: Well, before I say what I really think, I just wanted to address one question on community. I think my colleagues that are here today would all agree that in places where it's really working, it's people with AIDS and it's the local community that drives the whole thing, that drives the process. But I think what I really think is that reality is pretty muddy, that there is-in fact, the roles are intertwined and that I really do feel that governments really need to set the framework, and if they don't, the overall access in the country will never reach universal access, like it has in Brazil. But we have to live in a real world, and in many countries, the real access today might be through NGOs, through the mission hospitals, etc. Last comment is, I think we do have to be careful of confusing the private sector and the public sector. And sometimes, public/private sector means that public resources are being governed by those who have the products and are selling them. And that's why the AII, the Accelerated Access Initiative, I think, failed so miserably, because in Uganda, for example, or in Senegal, you actually had a committee, and let's call it, in my opinion, a fake NGO, that decided what drugs to buy, and on that fake NGO were companies. And so, I would like to leave you with, let's not cloud the role of the government and the private sector by talking about

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public/private partnerships. Yes, those partnerships need to exist, but there needs to be some healthy separation of roles.

ELHADJ SY: Thank you. The issue is indeed the expansion of treatment in the developing world, and quite often, when we talk about the developing world, we characterize it through strategies, through constraints, and through bottlenecks. All this is true. But the question which is rarely asked is, what about the opportunities that one may still find in those (unintelligible) countries that may be extremely difficult. Again, if we talk about actors and stakeholders responding to the epidemic, we have this tendency to see government as one block, or public sector as one block and the nonpublic sector as another one. And the question is, you know, what about simply the people--you know, people which react when they face a situation of emergency--in this case, HIV/AIDS and access or lack of thereof, developing strategies that could be coping mechanisms and try to do that can lead to access in a proper manner. But sometimes just take, you know, whatever is happening that can lead also to more problems than solutions. How can they be involved really in this partnership? And this is the very last and key words. Both our speakers and, most importantly, people from the audience mentioned partnership as one of the key elements, the key words around which one may be able to develop a real strategy, a real response to these questions. And (unintelligible) partnership

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may be way it should begin, partnership between men and women, because it's about HIV/AIDS in the developing world, partnership among sexual partners at large, partnership here between people who are infected and needing treatment and those who are not or simply do not know that they are. I mean, what kind of network for solidarity could be built more for the community, family and at national level to ensure that people may want to know; to ensure that if there is access available for the program, people may want to go; to ensure that there is an environment which is supported enough, so that stigma and discrimination will give the place, you know, to support and care, so that (unintelligible) access to treatment. And finally, as you all say, partnership between government and civil society, partnership between public and nonpublic sector at large, with the very key questions that you ask yourself, both of you, meaning, what can each of these partners do and what can't they do, so that we can clearly lead to a real collaboration and complementarity among those partners. It's only four minutes beyond scheduled time. I would like to thank you very much, Alex and Daniel. Thank you, the audience, for your participation. And please join me to thank very much (unintelligible).

[END OF RECORDING]

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