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**4th IAS Conference
On HIV Pathogenesis, Treatment and Prevention
The Future of Global Financing of HIV Prevention, Treatment,
Care and Research
International AIDS Society and Australasian Society for HIV
Medicine, Sydney, Australia
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ANNMAREE O'KEEFFE: -of global financing of HIV prevention, treatment, care and research. I think all of us will be very aware that in the past several years a number of innovative approaches have been introduced to enhance global financing of aid to actually serve the whole purpose of dealing with HIV and AIDS. And of course, this introduction of new approaches has given us the opportunity to reevaluate traditional approaches to donor support. Now clearly the examples of this sort of financing include Gavi [misspelled?]. They include most importantly the Global Fund to Fight AIDS, Tuberculosis, and Malaria. And of course the Millennium Challenge Corporation. Today's panelists are going to discuss the challenges facing the global HIV financing, lessons that we've learned from experiences in this type of financing, and the options for the future. It's going to be my great pleasure to introduce the first two speakers and I'd like to start with introducing Dr. Michel Kazatchkine who is the executive director of the Global Fund for AIDS, Tuberculosis, and Malaria, as well as governing councilman of IAS. Dr. Kazatchkine was appointed Executive Director of the Global Fund in February 2007 and previously served as France's ambassador for HIV and AIDS and communicable diseases. Since 2004 he has served as Chair of the World Health Organization's strategic

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and technical advisory committee on HIV and AIDS, and is a member of WHO's Scientific and Technical Advisory Group on Tuberculosis. In these roles he has provided guidance on a broad range of strategic and policy issues, concerning the health sector response to these major infectious diseases. In 1985, Dr. Kazatchkine started a clinic in Paris specializing in AIDS which now treats over 1,600 people. Three years later he opened the first night clinic for people with HIV in Paris, making it possible for patients to obtain confidential health care outside working hours. From 1998 to 2005 Dr. Kazatchkine directed the French National Agency for AIDS Research and served as Head of the Department of Immunology and the Clinical Immunology Unit at the [inaudible] in Paris. He served as Vice Chair of the Board of the Global Fund between 2005 and 2006. Dr. Kazatchkine attended medical school at [inaudible] in Paris, studied immunology at the Pasteur Institute, and completed post-doctoral fellowships at St. Mary's Hospital in London and Harvard Medical School. He has published more than 600 research papers in leading journals. It's certainly my great pleasure to introduce Dr. Kazatchkine.

MICHEL KAZATCHKINE, M.D.: Thank you very much.

[Applause.] May I just start with quick remarks regarding the bio. Thank you very much for that bio. The clinic started in '85 and the evening clinic in '88. Not '95 and '98. And then,

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because this is an opportunity to say that, you said that my first post doctoral training was at St. Mary's Hospital in London, and I spent there a year at the bench, and ten days after I left, the same seat, the same bench was occupied by my friend Debrework Zewdie. So we did happen to train in the very same department at that time. Thank you very much Annmaree for that introduction.

If you ask me very briefly to state a few of the key challenges that I would see in international health financing, I would say that these challenges are challenges for donors, but there's also challenges for recipient countries. For donors, the main challenge is not only in increasing the resources, but in ensuring sustainability. And we need to ensure sustainability obviously because we just cannot ask from developing countries to submit applications to Global Fund to build national plans, to plan for hundreds of thousands of people on antiretroviral treatment without ensuring sustainability, predictability, and visibility of funding. That sustainability is not only a matter of a decision for a government. I think it's the entire mentality, the way we look at development, and development in aid that has to be changed. We can't go on with this sort of compassionate philanthropic attitude, here is our national budget, and a little of it will go to aid, to international aid. And development of aid we now

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know is an integral part of international politics and health as I said in my opening remarks on Sunday, is a key element of development and the necessary investment in development. So this is not philanthropy on behalf of the countries from the north. It's really building a globalized world in which development is an essential part and health is an essential component of development.

So on the donor's part, to me the key challenge, change the way we look at development in our governments, in our parliaments, and ensure sustainability in addition to increasing the resources.

On the recipient side, I would give two challenges. One is to translate unmet needs into effective demand. Many of us here in the audience are used to these figures. UNAIDS estimates the global needs for AIDS to be 18 billion in 2008, 20 billion or 23 billion by 2010, and the currently available resources are nine billion US dollars. But the gap that I see is not only a gap between needs and between available resources. I see two gaps. One is between available resources and demand. And the other gap is between demand and unmet needs. We at the Global Fund as you know are a responsive entity. We respond to requests that come from countries. And if we really want the Global Fund and this money that the international community invests in health to make the

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difference, to really eradicate malaria or at least reduce it to a manageable public health problem, to really impact on AIDS and come to universal access to treatment, prevention, and care, we need the countries to come with very ambitious, ambitious requests, and what we have seen, at least this year, and I must say I'm a little disappointed in that, is that the total applications that came to us, requests that came to us, in so-called round seven in 2007, were not very different from round six in 2006. But that's not the way that we will get to universal access. So how do we do? And that's the challenge. How do these countries do to really increase the demand and translate the needs into the demand? This is an effort for countries and it is an effort for all international partners, UN agencies, bilaterals, to work and NGOs, to work with these countries to build the demand. And the second challenge I see for developing countries and for recipient countries is also to take their share of building the sustainability, and their share of building the sustainability I see primarily in engaging into financing and building progressively health protective schemes and health insurance schemes. Yesterday evening at one of our symposiums, we were given the example, Rwanda, where seed money a Global Fund grant allowed to start a health protection scheme called Mutual which really is I think the best way to ensure sustainability at the country level.

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Economists have told us for a long time that anticipating on cost is less expensive than coming and paying after the tragedy is there.

So these are my introductory points. Thank you.

ANNMAREE O'KEEFFE: Thank you very much, Michel. I'd now like to ask Dr. Judith Auerbach to be our next speaker. Dr. Auerbach is the Deputy Executive Director for Science and Public Policy at San Francisco AIDS Foundation where she is responsible for developing, leading, and managing SFAF's local, state, national, and international policy agenda. Prior to joining SFAF, Dr. Auerbach served as Vice President, Public Policy and Program Development at AMFAR which as you know is the Foundation for AIDS Research where she managed it's public policy office in Washington, D.C., and coordinated programmatic activities across the Foundation. Dr. Auerbach received the 2004 Feminist Activist Award from Sociologists for Women in Society, the 2005 Mentor Award from the Public Leadership Education Network, and the 2006 Research in Action Award from the Treatment Advocacy Group. It's my great pleasure to introduce Dr. Auerbach.

JUDY AUERBACH, PH.D.: Thank you. Thank you. In the brief time that we have to make our introductory remarks, I'm going to identify three challenges, but they're all related to research. The first has to do with ensuring a sufficient

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commitment of resources to HIV and AIDS research in an era that's very focused on treatment and prevention scale up. And I think everyone here's familiar with the Sydney Declaration. Most of us have probably signed on to it at this conference, which asserts that good research drives good policy and programming. UNAIDS also advises policymakers to know your epidemic as a first step in mounting an effective response. But good research can only drive good policy if it's conducted, and the epidemic can only be known if it's studied. Both of these declarations are another way of underscoring the importance and necessity of an evidence based approach to HIV and AIDS policy and programming which everyone here I'm sure supports and endorses. But it's very important for all of us to allow for a more complete definition than we currently use. The more complete definition of evidence that runs the gamut from rigorously evaluated community experience to qualitative content analysis and all the way through to randomized control trials which is taken to be the gold standard. The Sydney Declaration calls for at least ten percent of all resources for HIV programming to be allocated to research with a very strong emphasis on operations research. Which is clearly essential in an era of scale up, a very important area of investigation in relation to the implementation and scale up of new technologies for prevention and for treatment. But there's more to research

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than operations research at this point in time. And so in addition to implementing efficacious, therapeutic, and preventive interventions that are already in our repertoire, all of which we have to remember are less than 100 percent effective, we must continue to discover more and more effective strategies to build this evidence base on which rational and humane public policy and programs must be based. So it means we have to ensure a sustained commitment to funding biomedical, clinical, epidemiologic, social, behavioral policy and operations research, all applied and basic. And we really must not pit one area of research against another. And we can't take it for granted that support for research will always be there. Looking at the United States National Institutes of Health for example, a place I worked for a number of years, which is really the most well endowed medical research agency in the world, and one that is actually quite beloved by the United States taxpayers, that agency has seen declining budgets in recent years for AIDS and other health areas in real terms. And so for example in the most current funding year, the Congress allocated NIH a half percent increase, which when biomedical inflation index is at 3.7 percent, means effectively a cut in research, including AIDS research. So this has got significant implications for the kind of science, the amount of science being conducted and of course the scientists engaging

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in it who are seeing severe cuts to their research. So that's the first challenge, sustaining the commitment to research.

The second is building and sustaining research capacity in low and middle-income countries. The Sydney Declaration I think ought be expanded to explicitly include research training and infrastructure and capacity building in low and middle income countries. There are significant research findings being presented at this conference. We've already heard many of them, and there are many more to come. Coming from, for example, HIV prevention studies that are conducted in developing countries where there are sufficient incidence rates in order to be able to assess intervention effects. But most of the presenters of these findings are researchers from the developed world who certainly have the best intentions, and they also have the appropriate skills, scientific skills and financial resources to be able to conduct such studies. But they're not indigenous researchers in the sites in which they work, and their research usually is funded by non-local sources. So this inevitably poses controversy, some of which have been raised in sessions here at the conference about cultural competence, ethics, community engagement and ownership of results, not to mention raising the legacy of imperialism in many locales. So for research to really address the needs in communities, as they identify and define them, rather than an

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agenda devised by external public health experts, it must be conceived and conducted by local people. There's been a lot of attention to building the health care worker force, the health care worker force. To be able to deliver AIDS care and treatment, and a slightly quieter call for building the prevention worker care force, work force, but there's been near silence about building the research work force to pose an answer to these key questions in HIV transmission, treatment, and care, that are relevant and timely to the local context. And it doesn't just mean training health care workers so that they understand research methodologies and practices necessary for the effective delivery of treatment and prevention services, which is how it's articulated in the Sydney Declaration for example, and in the new report from the International Treatment Preparedness Coalition. It means providing rigorous scientific training across the board in all domains of science at the undergraduate and the postgraduate levels, so that people can engage in discovery and development implementation and evaluations of new and ever more effective prevention and treatment modalities that are appropriate for their social, cultural, and economic contexts. So training is challenge number two.

And the third challenge I've mentioned is integrating research into the lexicon of the global response, something

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that the Sydney Declaration, I think has begun to redress. If you look at one of the most detailed reports on global financing, the one issued by UNAIDS and Kaiser Family Foundation, that has recently been updated, it looks at international assistance for HIV and AIDS. And it says explicitly that the data included in this report represent funding assistance for HIV prevention, care, treatment, and support activities, but do not include funding for international HIV research, and explains that that's not related to treatment and services scale up or implementation. So in fact, it turns out it's very hard to obtain data on different countries expenditures for global AIDS research. I tried. It's not easy, even with Google. So the question is, why is this? Why is research excluded from an analyses of financing the response to the epidemic, when in fact it underlies the ability to respond at all. So I hope my co-panelists will discuss this a bit from their respective points of view. And this relates to a final point I'd like to make about the intended and unintended consequences of carving up the AIDS response and agenda into discreet pieces with discreet funding streams, which usually are some variation of research, treatment, care, and support.

I'd like to ask us to all think about the merits and deficits of maintaining that arrangement. It clearly has

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contributed to the historical pitting of prevention against treatment, an unfortunate counterpoising that we all say ought to be ended, but really has proven to be quite intractable. If we eliminated these distinctions and the funding earmarks that are attendant with them, what would be the consequences? Might we see greater efficiency including cost efficiency in our response? And what would be lost? So these are just three challenges among many that we face as a global community as we try to fight a beastly epidemic with financial means that are grossly unevenly distributed around the world. And so my final comment would be that in the end, it's actually not really about the money. It's really about using what's available most effectively. And fundamentally, I believe it's about who gets to decide what that means. So I look forward to the comments of my co-panelists and to what I'm sure will be a very lively discussion amongst all of us in the audience. Thank you.

PEDRO CAHN, M.D., PH.D.: Thank you Judy for your interesting comments. Now I will turn the podium to Debrework Zewdie. Debrework is the Director of the Global HIV/AIDS Program and The World Bank. Prior to this position, she managed the AIDS campaign team for Africa, and led the team which was responsible for one US billion multi-country HIV/AIDS Program [inaudible]. Dr. Zewdie has a career that was based as Michel said also with training in London. She has a doctorate

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in immunology. She has very important background work both in her home country, Ethiopia, as well as in the international arena and I will not take the precious time presenting the [inaudible] but rather allowing her to talk to us.

DEBREWOK ZEWDIE, PH.D.: Thank you Pedro. Two comments I would like to make before I go into the challenges facing the global HIV/AIDS financing. The first one, the increasing funding has been remarkable. I think we should acknowledge that. The second one is the more we delay, the more expensive it becomes. If you look into the funding earlier on, for example in 2001, for comprehensive prevention, care, and treatment, the world needed nine billion dollars. In 2008, we are going to need 22 billion. So it is within this context that I would like to look into the challenges. Number one, Michel and Judy alluded to it, sustainable and predictable funding. That's a major challenge in HIV/AIDS. I remember distinctly during the roll out of the three by five WHO called a meeting of finance and health ministers from Africa to encourage them to announce universal access to treatment. And the question they were asking was that's all fine. You asking us to declare universal access. Where is the funding going to come from? So this uncertainty of sustainable and predictable funding is one of the major challenges in the fight against AIDS, and it remains to be a challenge.

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Number two, the funding should come from a combination of sources. Global funding agencies, funding governments, innovative funding such as unit aid. I think these are the kinds of things we needed for a long time which we should appreciate and support. That's one source. And the second and most important source would be domestic sources. Countries have been putting their money in prevention, care, and treatment, but just like external funding, this needs to be predictable and sustainable. Funding for HIV/AIDS should be part and parcel of development funding just like you allocate resources for other development issues. There is something which is coming up which should be encouraged. This is insurance and the domestic mobilization of resources as we roll out treatment. I think that's something which for many years in Africa people thought it was impossible. It is possible, and it is shown in many of the countries, so this would be one of the funding that we should be encouraging.

Funding should be to strengthen local institutions and to build capacity. It cannot only be to buy pills or diagnostic kits or condoms, it should also focus on sustainable local capacity building. The only way we can make a dent in this epidemic is if we help the countries to build sustainable capacities so that they can fight this epidemic. So the foundation of support should be a long-term development goal.

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It is not a single disease issue which the way the world has been looking at it.

So, how do we achieve all this? It's results, and results, and results. For a number of reasons. Number one, we need to show that we are effectively implementing existing resources. That's the only way we can justify the additional resources that we are requesting for. Everybody needs to see that indeed we are using every single penny on HIV efficiently and effectively. The second one which is complimentary to the first one, is we need to strengthen partnerships. It's a wonderful thing to see the Global Fund, PEPFAR, and the World Bank instead of having separate meetings, coming together and having a single implementation meeting a month ago in Kigali, Rwanda. These are the kinds of things which would help us overcome the challenge of segmenting countries and cutting down on inefficiency and ineffectiveness. So strengthening partnerships, making sure that we use the comparative advantages of institutions to the maximum. That's the only way we can become effective and efficient. The third point, we need to stop this unhelpful pendulum of supporting AIDS, neglecting health systems and then supporting health systems, and neglecting AIDS. It cannot be one over the other. It has to be both. You cannot have an effective prevention, care, and support for HIV/AIDS without building health systems. So it is

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an unhelpful paradigm where donor agencies and governments oscillate from one to the other and I think it is a responsibility of the global community that we need the whole. As long as we fund one, it's always half. The last point, we need to empower people. This is the only road to success. It's the people who are affected and effective. It's the countries who have the burden of this disease who should lead this fight. And every single support should be to empower countries, to empower people, to fight this epidemic and we should be behind supporting this fight. Thank you.

[Applause.]

PEDRO CAHN, M.D., PH.D.: [Inaudible]. And now I will turn the podium to AIDS Ambassador Paul Bekkers. Since 2005 Paul Bekkers has held the post of Director of the Social and Institutional Development Department at the Ministry of Foreign Affairs in the Netherlands and has served as the Dutch government's Ambassador for HIV/AIDS. His previous governmental and diplomatic appointment included service as Deputy Head of the Mission of the Royal Netherlands Embassy in Turkey, and as Head Deputy and Ambassador for [inaudible] Corporation within the Department of International Cultural Policy. He has served in various responsibilities for the Dutch government and he has completed courses of academic study

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in history and economics at the University of [inaudible]. So Paul?

PAUL BEKKERS: Thank you very much. Thank you very much Pedro for that introduction. As you heard, I'm contrary to the three specialists. I'm not a specialist, but at least I don't have a medical background, but I've become a specialist on HIV/AIDS, I hope during the last two years. And when I was asked to prepare three global challenges, but I also realized I was going to be the last speaker, I thought I'd better prepare a couple more because I knew some of them would be addressed, actually many of them are addressed already in the course of the three presentations. But let me try to add a little bit to what my colleagues have presented.

I think the biggest challenge, and it was implicitly stated already, but I think that the major challenge is the fact that HIV/AIDS risks to be drifted off the political agendas, and being replaced by other emerging priorities. It's simple. Politicians all over the world typically focus on short and medium term agendas. They are linked to the political life cycles. And the fight against HIV/AIDS will require a long-term political support without many visible political gains at the short and medium term. So that's not an attractive issue from a political point of view. In the last few years we've seen an unprecedented level of political

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support for HIV/AIDS. But this is going to be extremely difficult to sustain. Even more, when other political priorities are emerging, like global warming. Global warming is one of the emerging public concerns that will increasingly become a political priority.

I think another one, an important one, and Debrework just mentioned it is this what I would indeed call a competition between HIV/AIDS and health. It has progressed over the last couple of years, and we have to address it. Because the level of support and activism that has rallied behind HIV/AIDS has been unique and resulted indeed in the sharp increase of funding and at the same time, you see funding for health system strength fading. The broader health system has lagged behind. And it has resulted in unhealthy competition. I might even say a divide between health and HIV/AIDS. And now you see actually a turning point. The other way around. You see there's going to be much more focus on the [inaudible], meaning on health system strengthening as weak health systems are increasingly recognized as a bottleneck to achieving these health related [inaudible]. In the context of resource constraints that we are in the middle of, this is translated as taking away money from HIV/AIDS towards health systems. But the reality is, and I think that Debrework said it clearly, that we need much more money to fight HIV/AIDS and

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we need even more money to strengthen health systems. But it should be added to each other.

One issue that wasn't mentioned, the challenges of the Paris agenda. The Paris agenda is very important. We need to harmonize donor money. We need to align to local processes. [inaudible]. But HIV/AIDS is not integrated well in mainstream development plans and budgets. And I think UNAIDS with some success pleaded for exceptionality of HIV/AIDS and has set up principles for coordination and alignment at country level, specifically for HIV/AIDS. And the argument of exceptionality has also pushed for more flexibility with regard to HIV/AIDS financing, as related to say absorptive capacity, to fiscal space, et cetera. But what we see now is the growing emphasis internationally on implementing the Paris agenda and there will be much less willingness to maintain the specific flexibilities that we need for HIV/AIDS. This is going to be a debate which is going to be crucial the next couple of years.

Insurance schemes were mentioned. I think that is important. Because I think another challenge we have is to tap all the resources of the private sector. Public private partnerships are evolving. Many more developed. But I think it's just the beginning. We need to have much more structural partnerships. And one could be on insurance schemes. And because my colleagues I think Michel and Debrework mentioned

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insurance schemes, I just want to give an example of a recent more structural health system strengthening as far as insurance schemes is concerned. We developed a so-called health insurance fund in the Netherlands. What happens is that private sector health management organizations develop low cost insurance packages. And those low cost insurance packages include treatment for HIV/AIDS. But low-income groups cannot pay the premiums that are necessary to be part of these insurance schemes. So this health insurance fund which is a conglomerate of co-private companies with our government will help people to pay the premiums for the insurance schemes which means that [inaudible] women and farmers can now be part of an insurance scheme. And so far, it has been successful. We started in Nigeria. It will probably hopefully soon expand to other countries. And of course in due time, because this is planned for five years, it has to take over by, integrated in the local community and taken over by the government, and Nigerian government has recently stated they will actually double the money that was put in by the Netherlands government, which is 20 million euro.

PAUL BEKKERS: So that's good progress, and I think this is the way we have to go forward. The challenge, coming back to the issue, the challenge is to tap more on the resources of the private sector and strengthen the relationship

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between the public and the private sector, especially as the private sector plays an important role in health care providing in many countries. Thank you.

PEDRO CAHN, M.D., PH.D.: I would like now to open the floor for comments, so each member has the opportunity to agree or disagree, preferably disagree with other members of the panel.

MICHEL KAZATCHKINE, M.D.: Well, I would certainly disagree with Judy, but I'm sure this is not what you meant when you said at the end it's not about the money, it's about who decides how we spend. It is also very, very much about the money. If we really want to reach universal access, if we want to strengthen health systems as we organize money for the three diseases, I fully agree with Debrework's and Paul's comments. It's not either or. It's all together we have to build systems as we invest into the fight against AIDS and also malaria and TB. If we want to meet the costs of the drugs, commodities, assets, it is about the money. It is very much about the money, including for funding research, as you said yourself. This is where I would disagree, but let me just add one concern that I think none of us has put so far, which is a concern about cost, because we talk about challenges in finding resources for each other and how should we increase our resources, but we should also think about what we spend our

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resources on, and there is a big challenge there. The challenge of the cost of second line drugs, either for AIDS or TB. And the challenge, I think, an underemphasized challenge of the cost of diagnostic tests. It's, I don't know, five, eight years at least that we've been talking about alternative [inaudible] methods to enumerate CD4 cells. Actually Pedro and I, I think met for the first time maybe ten years ago on this topic in Buenos Aires. We've been talking about alternative methods and cheaper methods, fewer methods to measure viral load or to let's say assess viral load. Perhaps we don't need to know whether it's 3,512 copies, but know whether it's somewhere between 500 and 10,000, yes? Or over 25,000. And no progress is made. And I see no progress at these conferences. So we do have to, and that goes through research, and that also goes through market considerations for ways for us to improve competition to have generic manufacturers come into the market to support prequalification and the prequalification process at WHO. Because if we look at the history of the decrease in price in first line treatments, it is the competition, and it is the generic competition that has really brought the prices down. We need that for second line, and we need that for diagnostic tests.

JUDY AUERBACH, PH.D.: Could I respond very quickly because that was a plant, because I knew I was sitting next to

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the head of the Global Fund, so I left out the word it's not only about the money. But I actually think the question about who's making these decisions is quite essential. But what I pose back as a question to you and Debrework and Ambassador, can I call you Peter? Paul. Not Peter. Sorry. Paul. Is picking up on your point about cost Michel, about the question of fairness and proportionality. Just whatever comments you have about whence comes this financing, and what's the appropriate way to think about relationship between donors and recipients and really what's an appropriate and fair share. Stumped?

PAUL BEKKERS: Well, actually, we're talking about challenges and we're talking about money. I think it's good, we have to focus on the challenges, but we also have to be a little bit more optimistic. Because yes there's going to be a big constraint on the money, but let's see what, let's look at a positive side of things. I'll still mention the political issue. But if we also acknowledge the fact what is happening with the GA for instance, the commitments they've made, coming up to, trying to live up to the commitment of 0.7 percent GDP, which means, which is a development that's taking place right now. Other countries have the 0.7 percentage of the GDP already allocated to overseas development. If other countries would do so also, an enormous amount of money will become

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available. And part of that money will be allocated to HIV/AIDS also, to fight not only HIV/AIDS, but also the other diseases. So the whole context of the discussion will change. Another issue related to that is if we see the situation of say China and India. Those countries are now still receiving money to fight their epidemics, but soon that will change, too. They will turn into actually they don't need the money anymore, they will become independent. They will actually become part of the donor community themselves. So the whole context of money will become in a different [inaudible] or a different atmosphere. I just wanted to add that.

PEDRO CAHN, M.D., PH.D.: I'd like to add to the challenges at least to one, is the health care worker crisis, which is really putting a big problem in front of us. We are collecting as a community, we are collecting the money. We are trying to distribute it in the fairest way as possible, but at the end of the day we see that in many countries health care workers are dying because of HIV/AIDS or those surviving are working in very bad working conditions with low salaries, and the final point of this process is that people are migrating from developing countries to developed countries. And it's really a paradox to see that some countries are feeding a lot of money into the Global Fund or funds like PEPFAR, like the US, and at the same time they are taking human resources to the

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countries. So this is a battle that I would like you to comment on.

DEBREWOK ZEWODIE, PH.D.: This is not new to HIV/AIDS. The [inaudible] issues. What is new is the HIV/AIDS epidemic disproportionately affected. They very same people who are trying to fight this epidemic, and there are many of the countries in the developing world now you don't even have emergency treatment for these health care professionals. So that's the problem on the one hand. On the other hand, the problem is so what do we do? The segmentation is not what is helping in looking at this. You fund prevention, care, and treatment. You don't fund the salaries, for example of these individuals. Or you don't have emergency programs in place. For me the fundamental issue is how do we make sure that HIV/AIDS becomes a development agenda? If we succeed in doing that a number of things will happen. Number one, instead of funding agencies, and agencies like the Global Fund running around with a lot of anxiety making sure that the money that is required is obtained, developed countries and developing countries will plan for it when they plan their development budget. So it's not something which they think afterwards and say x amount should to go HIV. That's number one. Number two, it is also part of development to take care of the skilled manpower that you have in country. If curriculums in medical

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schools in many of these countries have not changed to date to take care of the fundamental issue of the disproportionate infection in health professionals, if education programs and projects in countries are not taking the disproportionately infected teachers and students, then we're not addressing this epidemic the way we should address it, which would take us to sustainability and predictability. And finally, when we look at the brain drain issue and I alluded to it in my talk yesterday, the first thing that comes to everybody's mind is economic. A physician from country A is moving to a northern country because he or she wants to get more money. That's not the case. Yes, that's one of the reasons, but there are a number of fundamental reasons. The person is going to get infected. He's not going to get any medical provision. The person has children, who like every parent would like to see a better life for them. And there are a number of things. There is also a security and stability issue. So unless we go into the core fundamental problem of brain drain, if we only try to segmentally address [inaudible], we're not going to solve it. And this didn't happen because of HIV/AIDS. It was an existing problem. The only thing AIDS did was to bring it to the front and we just see it now and it is a huge crisis on our hands.

JUDY AUERBACH, PH.D.: So Debwork, would you - sorry, are we supposed to do this, yes - would you include in your

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category of the brain drain the scientific brain drain as well as slightly distinct from health care practitioners per se who obviously have scientific training as well, but other kinds of scientific skills and training. I mean they're equally disappearing from developing countries for the same reason, and so would you include as part of the development agenda the building of research capacity?

DEBREWOK ZEWDIE, PH.D.: Absolutely. It's fundamental.

PAUL BEKKERS: I agree with what Debrewok was saying, but I think you said it's economics, but not only economic. But economic is actually the major driver of people when it's relief. When you talk about children, looking for better education, for me that's also economic. And I think it will come back to the basic question that Pedro was raising. I think, I'm representing a donor country, and I think we all should follow, I think it was the UK who made, who now has a legal system that makes it extremely difficult for health care workers, be it nurses, be it doctors, or be it researchers, but I'm not certain about that, to come to their country. And we have to be very, very restrictive in our own policies. Otherwise, we will continue to work in a brain drain, and also locally with other programs we have to be extremely restrictive and look at ourselves. On the other hand, as it is an economic

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driver, I think by simply giving schemes locally, giving them opportunities for lending, we have started a program in Zambia for instance, people tend to not be willing to go to say other countries if they just have a little bit extra to look forward to by staying in a country, people do want to stay in their own countries. So we have to invest in those kind of retention schemes.

DEBREWOK ZEWDIE, PH.D.: Pedro, may I disagree with Paul for a minute.

PEDRO CAHN, M.D., PH.D.: Please disagree.

DEBREWOK ZEWDIE, PH.D.: First of all movement of people is a human right. I do not believe in restricting people from moving from A to B. There are other ways, for example, instead of restricting people from moving to a northern country, the northern country should start subsidizing the training of health workers in the countries. Because these people who are trained, [inaudible] resources in the first place. [Applause.] So there are ways of addressing this and the frustrating part is we have been segmenting it to unhelpful places. There is a lot to be done to keep people in country. It's economics. It is security. It is human rights. It's a whole lot of things.

PEDRO CAHN, M.D., PH.D.: Michel.

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MICHEL KAZATCHKINE, M.D.: Just two things. I'll not come back to the debate on the health work force, and I basically agree and I'm not sure you're disagreeing so much, the two of you on this. But just a very practical comment, because there are sometimes misconceptions about the Global Fund and I'm sure that in the audience there are a number of people from countries that may apply for funding to the Global Fund to help sustain their national programs. The Global Fund is not only funding commodities and drugs, yes? In fact, we're spending over 55 percent, maybe up to 60 percent of our money on what we would call, agree to call generically, health system strengthening, including funding for the work force. Yes? So when you do work with your respective NGOs and governments in writing applications to the Global Fund, there is no reason not to be ambitious on the work force part as much as on systems in general, as on the commodities and drugs part. The other comment was to follow up on what Paul said about the emerging economies. When we think of sources of funding, we shouldn't only, we should also consider the growth of wealth. And I really would like to put it to everyone that as the wealth of our world grows and grows fairly rapidly, part of that growth should go to support a more social and human globalization and of course, as you may know, the wealth of the world grows by around 2,000 billion dollars per year. And the overall NGGs

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[misspelled?] you know, we believe, we estimate it would need 50 to 75 billion per year so it's less than five percent of the annual growth and wealth, so this is, it's untrue to say that all of that is unaffordable. It's absolutely untrue. And when we talk about the increase in the wealth as a source of funding, of course we have to think of the countries with the most rapidly growing economies. Some of these are in this region. And Paul maybe behind your comments was something which I think is remarkable, that was a decision of Russia last year at the Global Fund. Russia that is doing much better as previously, as everyone knows, economically, has decided from being a recipient of Global Fund grants to become a recipient and donor. That is, to go on with it's Global Fund grants, but at the same time to commit to reimburse before 2010, the 400 million and something US dollars that they had received from the Global Fund. And I hope that we will have other examples of such kind in the near future.

PEDRO CAHN, M.D., PH.D.: Let me add to your latest comment that I fully agree with you in terms of growth of wealth. The problem being in our world, distribution of wealth. I can give you the example of my country having a GDP growth of about eight percent a year during the last five years, and the uneven distribution of wealth is still there.

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So we need a political [inaudible] in order to make this available for everybody.

MICHEL KAZATCHKINE, M.D.: That is why I'm saying that part of that growth of wealth, in order for it to build a more, as I was saying, social globalization, has to be distributed, redirected, towards the poorest. And the most vulnerable.

PEDRO CAHN, M.D., PH.D.: Okay, we have a couple of minutes to open the floor for questions. [Inaudible].

MALE SPEAKER: Yes, I just had a question because I've listened to you all talking about the need to really integrate HIV and AIDS into the broader health and development agenda, and I think where the HIV movement gets nervous about that is the HIV movement has been able to energize the movement for health in the way that no other advocacy movement, no other civil society movement has. So what I think that everybody recognizes of course for sustainability, for universal access and sustaining universal access, we need to integrate our movement into the broader health and development agenda. But the question is, if we start to do that, can we energize the health and development agenda which has quite frankly, been fairly moribund in the last 20 years, and can the same passion and energy that people have been putting into HIV and AIDS for 20 years be put into leading a movement for development and health?

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MALE SPEAKER: I mean, Craig, again it's not either or, as Debrewerk was saying. So, it's not us switching from AIDS activism to activism for development. It's really us continuing with the AIDS activism and with AIDS activism on TB and malaria, but integrating into our activism advocacy for systems and for health work force, and again fighting against those who try to disassociate us. Because what does it mean for Cameroon, and specifically talking about Cameroon because we had very strong statement from the Cameroonian Minister of Health recently at one of our meetings on this. What would it mean for Cameroon to separate health systems or advocacy for health systems from advocacy for HIV/AIDS, TB, and malaria when AIDS, TB, and malaria represents 70 percent of the disease burden in Cameroon. So in fact if you advocate for more resources to channel prevention and treatment of AIDS, TB, and malaria in Cameroon, you necessarily advocate for more resources to build systems and enhance their work force, the health workers of course in Cameroon. They just cannot be disassociated. So let's, I think, I follow you're, I understand you're concern. We all are concerned with this. Let us be very, very careful. I am convinced that some people are trying to, you know, as I said to disassociate us from in-between ourselves and go into debates and fights that we want to avoid at any price.

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JUDY AUERBACH, PH.D.: Well I was going to say I think part of Craig's question has to do with why AIDS activism has been so effective. It's because we were talking about a disease from which people are dying. I mean, the extremity of it, the urgency of it, I think helps explain how the mobilization could really occur. I think it's a much harder sell. Of course, it varies. But compared with advocacy around health systems. I mean that's a real yawner for most people. So.

PEDRO CAHN, M.D., PH.D.: Paul?

PAUL BEKKERS: Yes, I do appreciate Craig's question. But just in addition to what Michel was saying, if you look at the [inaudible] of universal access. UNAIDS has assisted 130 countries in trying to get the process going and they did a little research, sort of like how they have found the process. And many governments came up with like, we can't maintain this process of having AIDS addressed separately. So from governments themselves, this request comes, it's integrated. We have to integrate HIV/AIDS and the human resources for health debate and the health [inaudible] debate. It has become part. I don't really think we have an option after becoming part of an integrated multi-approach.

PEDRO CAHN, M.D., PH.D.: Microphone four please.

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YASMIN HELENA: My name is Yasmin Helena [misspelled?]. I'm a consultant to the IAS and an AIDS activist. I'd like to ask Michel a question, and it's an issue that's been alluded to, Judith raised it, and you partly responded to it, but I'd like to ask it from a different perspective. And it's a somewhat political question, and the question is this. What is the influence of giant donors on shaping and potentially distorting the public health agenda, and the reason that I ask is we're in a remarkable position where we have Sorrows [misspelled?], we have the Bill and Melinda Gates Foundation, we have the Global Fund, and I do wonder about the differentials of power when we're negotiating with national governments in resource limited countries and in terms of challenging their independence, their sovereignty, and I wonder whether you could comment a little bit on your interface and your dialogue.

MICHEL KAZATCHKINE, M.D.: Thank you Yasmin. It's very easy for the Global Fund to answer that question because the Global Fund is not a top down mechanism. So the Global Fund is not saying here, we have this huge money and we will decide to invest it in this or that country in this or that area of health and this is the way we mean we should spend it. And please you country should come to the negotiation table and somehow come to a compromise and agree on what we want. This

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is not the way we work. The Global Fund is a financial mechanism that is only there to fund what the countries themselves decide to do. So there is no distortion of the countries policy or national program. It's in fact a support to the national program. So we're there to respond to the countries' requests and to fund them. So from that perspective, it's very easy to ask the question. Now when, if your question deals with the way bilateral donors, be them public or private with increasing weight, may indeed induce distortions, I would follow you. Yes there is a risk of distortion and there is, there are problems whenever the decision are not country owned. This is why I would encourage the big foundations, whoever they are, to indeed when it comes to funding implementation of care, treatment, and prevention of the three diseases to join the multilateral venture of the Global Fund.

PEDRO CAHN, M.D., PH.D.: Thank you Michel. Microphone two please.

FRANCIS YBOA: Thank you. I'm Francis Yboa [misspelled?] from Ghana. I would like to take this opportunity to really commend the four speakers. I think you've really addressed issues that are relevant to us. But I would like to emphasize in three areas, which I think is so important for those of us from developing countries with

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medical researchers from developing countries. One is the issues of who decides how funding is allocated and where. We all know that it's very political when it comes to allocation of funding for research and to some greater extent, those of us from developing countries, we find it so difficult to really just get access to funding. Because obviously it's the politicians who decide that and Paul made a very important comment that we need a lot of political support when it comes to that. Because at the end of the day you realize that yes, funding is made available whether domestically or from the Global Fund, but it's the politician who actually decides where it should be. And it's important that we get them involved. I'll be surprised, even here, whether there is any politician here in such a forum which is so relevant. It made me surprised there is none. And number two, to ask it's also important that funding is also directed into infrastructure development to sustain relevant research. Because most of the time you know funding are made to countries and you go the rural areas and there are no infrastructural development to sustain even basic research which is relevant to rural people. And that makes life very difficult and none of us, even though we would like to go and do research in the rural areas, we realize that because of lack of basic infrastructural research facilities and logistics, you can't do that. And finally as

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Professor Zewdie said, the whole issue of brain drain is a big issue. We shouldn't belittle that, okay. And we shouldn't look at it as just in a very small myopic view. We should take the holistic approach. I was trained in the UK. And after ten years it was relevant that I go back home and it's been very telling. A whole issue comes forth, politically, I mean you look at all [inaudible]. Security, a whole lot. So when we're talking about this, I believe it's important that we broaden the holistic sort of measures which can really make sure that people are trained and sustained where they are and able to make the most of the funding that is made available to these countries. Thank you.

PEDRO CAHN, M.D., PH.D.: Thank you for your comments and [applause] I think that we'd all love to stay here and continue this discussion. Maybe for our next conference we will allocate two hours instead of one hour. I would like to thank [inaudible] Annmaree O'Keefe for chairing this session with me, and all four speakers, and you for being here with us. I think that we are clear that we have a lot of challenges, but I would like to recall Michel's talk in the opening session when he talked about hope. Also Paul stated the positive note, and I think that all of us, we have a mixed feeling of the urgent need to improve our efforts, but also that we know that we are in some way having more firm grounds to build up because

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we have made very important progress in regards to access to care, prevention, and treatment. We are following behind, but we shouldn't in some way forget what happened just six or seven years ago and the situation that we are now. So it's more work for us, but I think we are on the right path. Thank you very much.

[Applause]

[END RECORDING]