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XVII International AIDS Conference
Where Are We In Achieving UNGASS Targets?
August 4, 2008

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VUYISEKA DUBULA: —Everyone who have made it to this session, this session is about Where Are We In Achieving the UNGASS Targets? First, before I can introduce the panelists, this is supposed to be a discussion, so you will not be seeing any power point presentations, anything fancy like that. It is supposed to be just a discussion, but just my experience with UNGASS, I participated in the UNGASS 2006 in the Political Declaration. Well, I thought it was promising in 2006, but the last one that I have just attended in 2008 for me, I felt it was waste of time and I am trying to provoke the panelists to prove me wrong. If they think, no, I am not optimistic on UNGASS; actually we are achieving UNGASS promises; if we are, please convince me. Why should I participate in the next UNGASS process?

Without wasting time, I am going to introduce our panelists in the order in which they are going to speak. The first panelist is going to be Michel Sidibe from the UNAIDS. Michel is an Assistant General Secretary and the Deputy Executive Director of programs in the UNAIDS. Also his career in Global Health and Development started more than 27 years ago. In his early professional life, he headed the international NGO in his home country in Mali, and that started from 1987 to 2001. He also represented UNICEF in several countries in Africa. He is also mostly passionate about HIV and in achieving most things, for example, like prevention of

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mother-to-child transmission of HIV. He also negotiated the price reduction of ARV [misspelled?] in Africa.

So I am going to do that before each presenter speaks so that I do not waste time and each presenter has seven minutes so that we can allow the audience to engage with presenters. And after Michel has finished, I would allow questions, two questions or three questions, so that we can keep the discussion live and we do not lose what each presenter has presented on. Thank you. Over to you, Michel.

MICHEL SIDIBE: Thank you very much, Madam Chair. Could you hear me? Yes, okay. No? That is better. Thank you very much, Madam Chair. Let me just start up by saying that it is very important for us to remind each other that just two years ago, we made an extraordinary promise that we will scale up towards universal access for HIV prevention, treatment, care and support. It is clear that we cannot lose the momentum, mainly now that we are seeing some results from our collective efforts. The progress report towards UNGASS targets reveal that 130 countries review their national strategy, try to identify obstacles towards universal access, define the road map, 105 countries set national target on universal access which resulted in more focus and accountable response.

Like you heard also yesterday, we have the reduction in the new infection, a reduction in the number of death, and the coverage of services are also increasing. We have 3 million people on treatment, PMTCT programs in just two years increased

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from 14% to 33%, delay in sexual debut in young people, and also, we are seeing that people most at risk in places where we have a conducive policies and legislation are being more and more reached.

By adopting the concept of universal access, the member state we are seeing in 2006, Madam Chair, because you were with us, that the current status quo is no longer acceptable, that there is no reason to have 2 million death per years from HIV/AIDS. That is not acceptable to have 2 million when 7 new infection every year, that is not acceptable to have a 15 million orphans. Why they were saying that? They were saying that because the means exist today to make universal access both available and affordable to the people. However, the reality is that we are not being able to quicken the pace of action as requested by those member state. If we continue with the same rate of implementation like we are doing today, we will have by 2010 only, I said only 4.6 million people on treatment, instead 8.6 million people. We will have a gap of 4 million people who will not be reached if we continue with the same pace of implementation. We will have only 21 million positive pregnant women who will be reached with measure to protect their child instead of reaching 78 million women who will be in need of those services. We will have only 24 million people who will be tested instead of 61 million people who will be in need.

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Each of us, member of parliament, implementers, private citizen, must now work to ensure that we move towards universal access, to make sure that resources which are out there could work to produce results. We need to build an appropriate partnership between governments, civil society, private sector, all the constituency to help to deliver on universal access because if we fail to do that one, I am convinced that we will not be able to deliver on 2015 Millennium Development Goals.

Again, I want to say that the timing is there, the resource are coming, the capacity are being built, the demand for making a difference is seen everywhere where we are working. It is time for us to deliver. It is time for us for universal access. Let us make it a reality. Thank you. [Applause]

VUYISEKA DUBULA: Thank you, Michel, but I would like to pose a question to you. If you are saying that 2.7 million people will get infected by HIV and 4 million people will not access to treatment, then why should we invest in UNGASS? Because why should we invest in the UNGASS process? Do you think it is helping? Should we continue investing in UNGASS? Are the promises that are made in UNGASS, do you think they make sense?

MICHEL SIDIBE: I personally feel that it will be a crime to not just hold the member state accountable. UNGASS is a forum for taking a decision, but is also space for creating public accountability. Up to us to really foster this public

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dialogue in all the different city to make sure that those goals are reached by 2010. So UNGASS for me is the best framework we could have and we should use it to really foster public accountability.

VUYISEKA DUBULA: Thank you. Any questions? I have one there, two. Okay, that is all for Michel. Do we have the mics? There is a mic there, the person who has raised a hand. Can you also move towards the mic? And Michel, if it is possible, if you can note the questions so that we do not take too much time for Kieran?

MICHEL SIDIBE: Yes.

VUYISEKA DUBULA: And I would like to ask people who are going to ask questions to be very brief and ask only one question, not three.

FEMALE SPEAKER 1: My question is directed at Michel. You have talked of women, you have also talked of pregnant women, you have talked of all the other groups, but I did not hear you address the disability group which constitutes 10-percent of the world population, if you could possibly address that. Thank you.

VUYISEKA DUBULA: Thank you.

ANGELIQUE: I am Angelique [misspelled?] from Rwanda and a student in Boston. I have a question on the goals because the UNGASS goals define strategies to allocate resources even to define needs in terms of resources. As we are talking in this conference, I feel a little bit confused on

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what is universal. I know that the goals we are setting a certain coverage of services, let us say for certain services universal was 80%, but the move in this conference is like making every single person in need reached. So what is universal access and what are those goals set? Are they changing now with the current strength and because that is determined automatically, how much money countries should plan to get in ideal situation? Thank you.

VUYISEKA DUBULA: Thanks. Michel, just note them. You will come back because I do not want to take time from us.

MICHEL SIDIBE: Thank you very much. [Interposing]

VUYISEKA DUBULA: Okay, the next speaker is Kieran Daly. He is the Director of Policy and Communication at ICASO. He has academic background in development and economics. After working in West Africa for government and trade unions, Kieran has worked for the last decade in the International and National AIDS Policy with a focus on advocating and directly supporting community sector involvement in AIDS policy, also coordinating and governance. Over the past 10 years, he has been involved in the UNAIDS and the global fund boards in UNGASS. Most recently, he was the Co-Chair of the PGA Civil Society Task Force for the High Level Meeting in June. Kieran is also involved in ICASO in supporting national and regional communities in evaluating processes in the OCs and African [inaudible] implementation and was the lead in developing

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guidelines for community sector involvement in the National AIDS Coordination.

So Kieran, we have heard from Michel that it is possible to reach the targets set by UNGASS. Do you think that is true from the civil society perspective? Are we going to be able to reach the targets? Is the process really helpful from civil society's perspective?

KIERAN DALY: I think the short answers are I do not think we are there and is the process helpful, I think it probably is as a mechanism for accountability and maybe I will extend on that, but I think they are my essential answers to it.

I think in terms of just what I will say will be based on the last sort of eight years of work that ICASO has been supporting in terms of community research and evaluations in relation to the UNGASS commitments and implementation and there are more recent reports, my colleague said in the back of the room, in terms of what that means to communities and I will just touch on a few things. But I think one of the related things is there has been greater civil society involvement in monitoring the UNGASS commitments in their implementation and that has improved, but the big question is it enough? So I will run through three quick areas. One is around the community perspectives and feedback from their evaluations with the main emphasis there on the lack of and the failure to maintain human rights protections within the sort of framework

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of how governments are delivering on the UNGASS commitments. The second is around that level of community sector involvement and the impact it has partly to try and answer these questions and lastly really around the need for new accountability mechanism as it stands not really working in the way that I think community needs it to.

But in terms of the reviews by the community sector, as I said, there had been lots of different reviews including the ones that we support and, in fact, Rico was involved in the ones for Indonesia. But as I mentioned, human rights and legal protections are still failing to be addressed and we are seeing in the UNGASS reports that come out from the countries, the lack of reporting on indicators around legislation and policy that would create an environment in which human rights could be protected and this is maybe the most fundamental issue that comes out of the failures to date and communities have consistently reported this lack of attention particularly for key populations and we have, the key populations that we talk about are particularly sex workers, men who have sex with men, people who use drugs, et cetera, and the key thing here is the reporting by governments is that they are not reporting on some of the data here and even, for example, I think China was one in which we reviewed and they have a 45-page report for the UNGASS, the most recent one. They have three lines of mainly quantitative data related to needle distribution, but nothing on access. And we see the figures from the International Harm

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Reduction Association estimating only about 7-percent of people who use drugs have access to needle distribution.

So these gaps in the data of the reporting that we really need to address. The other one and we have heard a number of times in the conference and even the opening, men who have sex with men in Africa are largely absent from the report, yet an example is Senegal with a very recently low prevalence rate of I think 0.7-percent, but amongst the population of men who have sex with men, it is 21-percent, yet they are not showing up in these reports. And it is really a critical need. If we are going to use the UNGASS process in the reporting process to actually allow us to understand where we are, we need to disaggregate this data because UNAIDS reported recently in their global epidemic update or report the increase of prevention services available for some of these key populations, but we do not really know whether the right people are getting it. Yes, increase in number of services, but is it going to the right people and critical to this and that is what we are getting back from the community reviews of UNGASS reports is the continued criminalization of these key populations and the resulting inequity of access for them.

The other related thing is the consequent lack of knowledge of the epidemic and UNAIDS is very prominent in saying know your epidemic particularly in terms of prevention, but we are not getting that knowledge. It does not seem to be available both in terms of what data is available, but also the

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way in which the countries are implementing their programs. And this was actually seen in the target-setting process that was done in 2006 or 2007, 2006 where they became both unambitious [misspelled?] and the question from the floor about what do we mean by universal access, many of the countries do not seem to see it as every person in need should be reached and that is what universal access means. And that sort of relates to lack of knowledge of what your epidemic is and not really looking at pushing the services to those in need.

I am going to skip because I am aware that you want a conversation, so I think just in terms of the key points around the community sector involvement in the reporting process, we did see through the reporting and the reviews by communities that where they were involved, you had better data and you had better reporting, but this involvement is still pretty tokenistic and I can give examples later if that is helpful. But I just wanted to end and I think on this new accountability mechanism that I referred to and, as Co-Chair of the Civil Society Task Force for the High Level Meeting, which is largely looking at how we ensure civil society involved in that June meeting in New York, yes, we had I think pretty good involvement and we had some great representation of some of these key populations we are talking about, but if you look at what happened there, it was yet again another way in which governments came to the UN, did a series of presentations, no

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real dialogue around whether what they were saying was true, whether their reports were actually reflecting their epidemic.

So we have another talking shop, another series of speeches and what I think, in answer to the question of whether is this UNGASS framework is helpful, yes it is if we then have some better accountability of their reporting on implementation and I would like us to have some discussion about what that accountability mechanism can be and maybe learning from the Human Rights Council a way in which they bring different countries and then there is a real dialogue and questions from NGOs, questions from other governments. So I think I would like to see that and then maybe we actually could have a better accountability in 2011 when we look to see whether they are meeting and reaching universal access by 2010.

VUYISEKA DUBULA: Thank you, Kieran. I am also posing another question. Naming and shaming is not the language for the UN and especially in UNGASS. Do you not think that is letting government get away with murder if we are not going to name China as China not respecting human rights? South Africa if the case if it is the South African government which is not doing the same? Do you not think that is on its own is encouraging poor reporting on key issues which are related to the targets, but that is a question you can answer later. I am taking questions. Two, okay. I am taking two for now. We will have more discussion. I just want to allow all the presenters to at least give you a preview. I have one here,

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one at the back, three, four. Can you come closer to the mics? Kieran, you do the same. You just note them and then we will have further discussions.

MALE SPEAKER 2: Kieran, given your comments on China and with the Olympic games opening in a few days, should we not use this conference as an opportunity to put pressure on the Chinese government around its abuse of human rights, on HIV and its imprisonment of AIDS activists? [Applause]

ARWIN FONDU: I will introduce. I am Arwin Fondu [misspelled?] from National Institute of Medical Statistics, Indian Council of Medical Research, New Delhi, India. I have a basic question to Kieran and earlier speaker as well. Should we say that in UNGASS evaluation and estimation is more for the generalized epidemic, less applicable or less strategic for the concentrated [inaudible] particularly in lieu of medicine and the coverage? Who are covered? I must say that there is a gap between the governments and socio-cultural [inaudible] of the population. Stigma is very high, is it hidden population? And we know that one-fifth of the population is tested among those who are positive. If you have this knowledge, how far our UNGASS estimate and strategic planning —

VUYISEKA DUBULA: Okay.

ARWIN FONDU: — would we assert to be recommended by the right kind of program implementation?

VUYISEKA DUBULA: Thank you. Can we keep our comments very, very short.

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BONFIS CARANDA: Thank you. My name is Bonfis Caranda [misspelled?], I am from Malawi, [inaudible]. I do not have a question, but I would like to comment. In this conference, I am presenting a poster, the title is The Implementation of Regional and International HIV and AIDS Conventions and Declarations. The study was done in Malawi, Mozambique and Lesotho. My comment is that my findings are that there is normally no independent evaluations of Conventions and Declarations. The UNGASS is better, but [inaudible] evaluation at all. It is reporting on the UNGASS, so in general they are not independent evaluations, so I would like to recommend that we should be doing independent evaluations of Conventions and Declarations. Secondly and lastly, when you look at all the Conventions and Declarations, they are made up sort of at the international level, but there is no guidance to governments to say what is it that you need in terms of resources, in terms of [inaudible] of frameworks, in terms of anything you need to achieve them. They are made up in the air. There is no guidance on how to achieve what is set in the International Conventions and Declarations. Thank you.

VUYISEKA DUBULA: Thanks. The last one.

FEMALE SPEAKER 3: I am also from Malawi. [Laughter] For me, I want to focus on the accountability and I am saying access for all, for me it means that child in the village, in the rural village in Malawi, being able to go to the Health Center and accessing treatment, but unfortunately our qualified

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staff are all trekking to the developed countries where they are waiting there as medical staff and leaving our communities with no nurses, nothing. So as much as we talk about monitoring and I think we are also looking at people at all levels being able to access this. How do we start moving towards that direction because they have been, they talk about human resource, but I do not think we are yet there because the nurses and they are all trekking to the West.

VUYISEKA DUBULA: Okay, thank you. I am hoping that, Kieran, you got all the questions. Then our third panelist is Dr. Mphu Ramatlapeng. She is the Minister of Health and Social Welfare in Lesotho. She was appointed member of the Senate after 2007 General Elections. Until 1984, Dr. Ramatlapeng served as a medical doctor for the Ministry of Health and Social Welfare. Prior to this, she practiced in a private practice. Between 2005 and 2007, she was involved in a number of projects within the Clinton Foundation. She was also a member of several organizations and served on the Board of Directors of Commerce which is an advisory board to the AU [misspelled?]. She also holds a medical degree from Kharkov Medical Institution and proceeded to Johns Hopkins School of Hygiene and Public Health [inaudible].

My question to Dr. Ramatlapeng, from the perspective of Lesotho, do you think the UNGASS promises and targets are feasible for Lesotho? Or what do you think are the obstacles in achieving the UNGASS targets for your country?

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MPHU RAMATLAPENG, M.D., M.P.H.: Thank you, Chairperson. I certainly feel that the UNGASS targets are achievable, but this is based on whether everything is in place to be able to deliver.

You earlier asked me whether why is it that Lesotho is not on the same platform with Botswana and why Lesotho has not reached the same level of delivery that Botswana has reached. I do not think we have ever been under any illusion that we will be able to reach these targets unassisted. I think African governments have made it very clear that HIV/AIDS delivery of care and treatment will not be achieved from your normal budgetary lines. We need some assistance to be able to reach these very impressive targets. Personally, I like targets. I like the fact that we are working towards a particular target. We had 3 by 5. Clearly, we were not able to reach it at the time when we expected to, but [inaudible] countries did reach it, but it was two years, three years after the set target. The question is people remain focused, we are focused on a particular target that hopefully we will be able to reach by 2010, 2011.

To give you a preamble, Lesotho would not have even rolled out ARVs in the public sector if it were not because of the actions of a few people, some of them are on this table. Mr. Stephen Lewis played a major role in making sure that a few African countries that he assisted were able to attract assistance from the developed countries and he became a very

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good spokesperson and ambassador for HIV and AIDS and was able to, for instance in Lesotho, assist us to roll out ARVS in the public sector working closely with the Ontario group of doctors, that was the first group, and then with Clinton Foundation and then Partners in Health. We are very proud that three years down the line, it is not even a complete three years, I will give you a few examples.

A number of pregnant women receiving a full course of ARVs or PMTCT. For PMTCT, the set target is 80-percent, but last year we reached 31-percent and percentage of population tested for HIV/AIDS is 80-percent, the target that we expect to reach, but we were able to reach 25-percent.

Talking about this, Lesotho set out to test every single adult and children over the age of 12 years in what we called the Know Your Status Campaign. I know we set very impressive targets that in three years we would have tested every person, but that initiative largely went unfunded, but even with the 25-percent, the Know Your Status Campaign has remained a very strong brand, the stigma is almost not present in Lesotho. Every person is able to access care and treatment of the 156 health care centers. We are offering ARVs in 122 to date and we are offering them at primary health care level. It is a largely nest-driven model. All the hospitals clearly are also receiving ARVs. We are mindful of the question that was asked earlier by a person from Malawi about the universal access. Mindful of that, the government of Lesotho removed all

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user fees at primary health care level and that means every single person can now access care and treatment of any kind from the primary health care center and harmonized user fees in all hospitals that belong both to the Christian Health Association of Lesotho and the government of Lesotho. So, in this manner, this was also working towards that.

From this year, we are also paying 4,500 community health care workers who are our soldiers, our foot soldiers, who have been working since 1976. These are the people who are able to identify sick people. These are the people who are able to refer people for care and treatment and also these are the people who have told us that because Lesotho has got such a difficult terrain, it is probably easier not to use horses, because that is what we use, but buy motorcycles. Now hopefully all of them will be able to use motorcycles to be able to communicate with the villages and the primary health care centers. We, therefore, feel that the UNGASS targets, while they are very ambitious, we are going to be able to reach them.

Another issue is the issue of partners. I do not think people should shy away from Lesotho now that [inaudible] is free. I think people should continue seeing Lesotho in the same light as a liberation country and assist Lesotho.

The fact that the Melinda Gates Foundation was able to assist Botswana in a manner that they did, Botswana has reached all the UNGASS targets to date in a very, very short time and

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that is concerted effort from both the government of Botswana, political will, and the donors. We are not in short supply of the political will. Lesotho is doing very well on the political will side. Lesotho has got the Archbishop testing very openly in front of everybody. The Prime Minister has tested openly. Almost everybody of good standing in Lesotho has been able to demonstrate that this thing is not a scourge. You can live beyond that.

Also, we have rolled out a DNA-PCR because we realized that our young children are dying very, very soon between the ages 0 and 18 months. We were losing more than 50-percent of the children. So we have rolled out DNA-PCR and shortly actually we will be addressing the public on it. We therefore feel that because we have embraced every available measure to make sure that we move forward, we are on track. I think we will be able to achieve that. Thank you. [Applause]

VUYISEKA DUBULA: I will reserve my questions for you for later. For me, I am encouraged to see Health Minister being positive and saying we will reach targets and we are determined to reach targets. Well, I am taking a lesson. Questions, please. I did not say where I am from. [Laughter] Okay, can you go closer to the mic? I have another question there. Okay, two questions. Yeah? Start. Okay.

MNUNGUS KUMAL: Mnungus Kumal [misspelled?] Chairperson of the Treatment Action Campaign in South Africa. Thank you very much to the three presenters so far who think good update.

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Sorry, Chairperson, I will ask three questions and I will be very short. [Laughter] Dr. Ramatapleng like Vuyiseka said it is very encouraging to see a Minister of Health being very excitable about Millennium Development Goals and the progress made in your particular country. I come from a very different country, South Africa, and I can promise you the report that you have on how far we are meeting our targets is a report that does not really begin to show the extent of the problem and how less we are responding and I think the ineffectiveness of our monitoring process in ensuring that we meet the development goals. So my question is Dr. Ramatlapeng, what is it that we are missing in the African region, specifically in meeting the development goals that at this point in time we are still reporting reaching 27-percent of people that have to test when we set our targets for 80-percent? What are the resources that had they that we are not using because I do not think everything that we need to meet the development goals rest on financial resources. So in your own opinion as the Minister of Health in an African region, what do you think is missing? And I will tell you what my [laughter] views are, but I am not going to tell you now. To Michel —

VUYISEKA DUBULA: No, one more minute.

MNUNGUS KUMAL: Michel, I want to understand when would we get to a point where UNGASS has the balls as they would say to face up to the challenge and face the reality that we are actually not doing enough as countries and as people who run

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these processes to come back and say we are not doing it and we are not doing it enough, so when are we expecting to see that before 2010?

VUYISEKA DUBULA: Alright.

PIWEY SHOPETRON: Thank you Madam Chair. Piwey Shopetron [misspelled?], Swaziland. I would like to have some questions to ask my honorable Minister in Lesotho. I am very much happy the way she has presented herself on the issues of achievements of the goal and the ambition she has that she hopes they achieve the goals. And then I have one question. She talked about the political commitment. How far have they gone towards reaching the 15-percent allocation on the Abuja Declaration? That is my question and the resources allocated to us by HIV and AIDS programs in her country. And then my second question is on the issue of WHO monitoring for those that are on ARV. How are their monitoring systems in place and then how are they chasing their defaulters and what is the package within the monitoring so that she can say, yes, we have achieved our goals? Thank you.

VUYISEKA DUBULA: Thank you. Minister Ramatlapeng, you just note the questions and then after we have done all presentations.

And my next panelist is Rico Gustav. He started to work in the NGO sector in 1999 initially on issues around drug addiction and then he moved in the area of AIDS when he realized that Indonesia was entering a phase of HIV epidemic.

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From 1999 to 2003, he worked in various community organizations and faith-based organizations in Indonesia. In 2004 to 2007, he worked in the UNAIDS country office in Indonesia and community unit as a Liaison and Partnership Assistant. He conducted several qualitative studies on access to ARVs in Indonesia and promoting greater involvement of people living with HIV. Since 2005, he also started community monitoring in Indonesia, especially in monitoring country progress towards UNGASS targets. And in 2007, he participated in Gestos Project in monitoring sexual and reproductive health and rights and currently, he has been involved in the community follow-up to Commission on AIDS in Asia report based in Bangkok, Thailand.

My question for you, Rico, do you think the UN meetings have paid enough attention to the challenges of the most affected countries, for example, Asia, Africa, Latin America? Do you think the UNGASS process has actually paid attention to the high burden countries?

RICO GUSTAV: Okay. I personally think that, I will give you an example. Right now there are discussions in Asia regarding the terms generalized and concentrated epidemic because we in Asia, some of us feels that it is not properly used in Asia terms. You can actually read the Commission on AIDS in Asia's report on that, but this has not been reflected in the UNGASS, so what I think is UNGASS should accommodate these differences between these regions because every regions have different characteristic of epidemic, have different

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characteristic of populations and sub-population and things like that. So in terms of that, I think UNGASS should also accommodate that and also I would like to add some points on how UNGASS should link, UNGASS and HIV should link with other commitments also. I think it is very important for us to recognize the UNGASS on drugs because right now, the UNGASS on drugs and UNGASS on HIV is like separately moving. However, these two issues is very close and I think it is really important for UNGASS to also accommodate this and be somehow in the documents also.

VUYISEKA DUBULA: Okay.

RICO GUSTAV: And I would like to also speak, I would like to comment on UNGASS progress in my country, actually repeating what Kieran is saying that just I will tell you what is happening in Indonesia. Yes since UNGASS, there are some progress in Indonesia. Since UNGASS, we actually are providing free ARVs for PLHIV. What they did not mention in the UNGASS country report is that this free access to ARVs for the last four years, there are some major issues with the chain supply management and what happened is that every three month or every four month, some PLHIV have to stop their ARV treatment and this is a major issues and it is not reflected in the UNGASS report, so I agree and you can see it in this ICASO's report because I have been involved in it and it is reflected there. So I do agree that UNGASS should accommodate more qualitative indicators or somehow to show this qualitative aspect of the

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picture because if we do not show that aspect, then it is totally useless. Yes the service coverage is scaling up, but still the quality, how about the quality? In other sessions I was also mentioning about how VCT services is Indonesia scaled up, had major scale up for the last two years, but also at the same times when we did some qualitative study, we also found that the quality of the service is not that good. We actually found a group of VCT counselors who are actually beside doing counseling, she also offering the client for multi-level marketing and things like that. And this drive the clients off and there are some questions about the quality of services. I think UNGASS should ask more about these kind of issues along with the quantitative issues. Thank you.

VUYISEKA DUBULA: Thanks, Rico. I am going to take questions; one, only one.

ALESSANDRA: Yes. Okay. I think that UNGASS is mainly important because it has helped us to keep our government accountable at the national level and it is also very important because it highlight the fact that the national response is not only government response, this is also a civil society response. For the last review meeting, we from civil society had the high expectations about the number of information we sent to UNAIDS regarding the national realities in our countries, so groups likes ICASO, IACIT [misspelled?] in Indonesia just as in Brazil, youth coalitions, we did strong work provide informations to UNAIDS and, in the line that Rico

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was commenting in terms of providing information with qualitative that could be aggregated to quantitative information that UNAIDS to use when doing their report, but in the last recent launched AIDS Global report, we did not find any information that we provided.

So what is the meaning of civil society to provide information to UNAIDS if this information is not used when UNAIDS released their documents? This is one question to Michel and the second question is about we went to UNGASS in the last review meeting and when we left UNGASS it was supposed that in two weeks we will have the summary from the President of Assembly and it was a very negotiated process not having another Declaration or Commitment. The summary is not ready yet so perhaps, what happened because I did not see this summary yet.

And the last question is about the process. We know that UNGASS is not like a convention that governments are obliged to fill, so we saw that no goal were achieved up to now and we know and you need to talk about that that no goal will be achieved until 2010, and now what is going on? And just to finish, I think that the question that Kieran is bringing that some of us are trying to raise in all meetings we are is the question of accountability and we need this mechanism that could be not only to civil society participate, but also to see how could be possible to have a much stronger bodies, international bodies, to point the fingers to the governments

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in a clear way because I am from Brazil. In Brazil, UNAIDS have a very good relationship with the government because the governments are performing well. But UNAIDS cannot say anything in countries when they are not performing, so how could we change in this moment that UNAIDS is also revising your format and going through and UN General are revising the way they are going to work? So to me those are — [interposing]

VUYISEKA DUBULA: [Interposing] Thank you. Thank you.

ALESSANDRA: **—** the important questions. Thank you. [Interposing]

VUYISEKA DUBULA: [Interposing] Thank you. That was a very long comment and I am hoping that you have noted. The last speaker and please be patient, for those who have asked questions, there will be time to engage with your questions and I am actually trying to reserve some time towards the end of the discussion so that we can have an interactive discussion and anyone can ask any question.

So the last speaker, Mariangela, she is a pediatrician and a hygienist. She is mastering in Maternal and Infantile Health for the Institute of Child Health of the University of London, currently known as the University College. She acts in the field of public health since 1983, initially as a pediatrician in basic units of health and later as a director of the Department of Health Attendance of Curitiba — is that correct? — of the Department of Surveillance and Research of the State General Office of Health — there are so many of, of

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in your bio, sorry, — in Brazil and of the Information Center and Planning of Health of Curitiba. She acted in the Brazilian STD and AIDS Program as the Health Head of the External Cooperation Unit from January 2004 to 2005 November and since then she is a director.

My question to you, Mariangela, we have heard from some of the countries that are not doing not so good in achieving the targets, but we have heard that Brazil is doing good, so is that true, because we have heard that you are doing some good work in Brazil, because we do not want to leave here depressed? [Laughter]

MARIANGELA SIMAO, M.D.: That is why you left me for last. [Laughter]

VUYISEKA DUBULA: Yes.

MARIANGELA SIMAO, M.D.: Can you pronounce your name because you pronounced my name very well.

VUYISEKA DUBULA: Oh, Vuyiseka.

MARIANGELA SIMAO, M.D.: Yuseka.

VUYISEKA DUBULA: Vuyiseka.

MARIANGELA SIMAO, M.D.: Vuyiseka, it is difficult, but — [Laughter]. Actually, Vuyiseka, I think in Brazil, we did have some progress. We still have major challenges and I am going to speak about it a bit, but I am going to take the opportunity of being last and try to respond to some of the issues that were raised here and first issue that was raised was your comment that it was very, the 2008 UNGASS left much to

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desire and is it useful or not. And actually, I think Kieran responded to that when he said about commitments and accountability.

But I would like to say Michel, on these international agreements, we end up with too many words and we end up on going around words and around words and sometimes the targets or the goals are not easy to understand. And I would like to make a call for simpler targets because the simpler the targets, the better and the more accountable, the easier to be accountable and that is for all of us who work on as activists, where we are always trying to put out our view and our agenda on these commitments and then they end up endless and we sometimes lose focus, just a provocation.

And also when Kieran said know your epidemic and then I am going to draw on the Brazilian response to talk about it when you are saying why Brazil is doing good or has some successes. When Kieran said that know your epidemic should drive the response, actually, it is not enough to know the epidemic. Because whether you call key population, most at risk groups, vulnerable groups, we did not see. I have been here since the beginning of last week in different meetings and even Michel from the perspective of 2006 UNGASS, there are several issues that are so called a cultural [misspelled?] when you talk about key population or vulnerable groups. For example, in 2006 we have a lady from a Muslim country who was defending that we should not have written down commercial

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sexual exploitation. The Muslim countries wanted us to only mention sexual exploitation. That means that sexual exploitation is right as long as it is not commercial. Or this year I went to the world health assembly and I was sitting beside another country where a lady came up and defended female circumcision.

So what I am trying to say is that it is not only governments that have to move towards an agenda defending human rights. Societies have to move as well and we cannot agree because these issues have a very strong cultural background that they are right, because it is a human right violation anywhere. When you are talking about sexual orientation or laws that criminalize gay men or sex workers, we are talking about human rights violation. It is not acceptable anymore to say that that is culture and I heard that in the past few days. And in Brazil I would like to say that one of the reasons we have been moving forward with the prevention agenda is because we named the populations and we worked with them and sex work in Brazil is not criminalized. It has a lot of stigma and discrimination, but the government and many civil society organizations are working towards bringing visibility, positive visibility to sex workers. The same thing with homophobia, it is going to be a crime in Brazil. So it has to move. What I am saying that it is not only governments that are accountable, but societies are accountable as well. So we all need to be more proactive towards these human rights violations; if we do

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not, because these human rights violations jeopardize access to prevention and to treatment and to everything.

And finally, when we talk about access to treatment, Brazil is a country that has free universal access. I think our colleague here asked a very good question. What is universal access when we are talking about universal access? We are talking about free universal access and, is it achievable or not? And we proved in Brazil, it is a developing country, with many inequalities, many problems, health problems included and we are managing to have a sustainable response. And I think we do have two major challenges for the future. Like we have been hearing and Michel knows it, I am sure Kieran as well, there is a lot of talk internationally on should we focus money on disease-oriented approaches? Or should we work with strengthening health systems. There is a lot of discussion and this is a very strategic issue right now because when they are saying increasing access because we have already given people in treatment, but it is only 30-percent, but to increase access we do have to have points of delivery in health services. This is not such a big problem in Latin America and the Caribbean, but it is a big problem in Africa.

What is a big problem in our region is access to good medicine, good quality at lower prices. It is unacceptable now that some countries in Latin America, there is a huge gap in what we pay for second line drugs in Brazil which is much more competitive, in some other countries like Mexico Bay and the

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Mexican government is taking some strong measures regarding that.

So I think we do have this two big challenges regarding achieving universal access by 2010. We have to bring together people who work towards strengthening health systems and the people who work fighting AIDS and we have to lower down prices and increase availability of cheaper generic pre-qualified [misspelled?] drugs. Thank you. [Applause]

VUYISEKA DUBULA: Thank you. Alright, questions? There is one here. Okay, after that question, I am going to start with you, Michel, if you can respond and the floor is open for discussion after each presenter has responded and I am hoping you can maybe some kind word towards your conclusion because we are getting closer to the time to close.

FEMALE SPEAKER 4: The question I want to ask to Mariangela, as Vuyiseka has asked before that you achieved or you did so well in Brazil. My question would be, you spoke about challenges or obstacles that you came across, my question would be what are those challenges and how did you manage to overcome them in order for you to achieve what you have achieved today? Thank you.

VUYISEKA DUBULA: Alright, over to you, Michel.

MICHEL SIDIBE: Thank you very much, Madam. Hello? Thank you very much, Madam Chair. I am having trouble because a series of questions here, but I will start with disability one. I was just lucky to be in the press conference on the

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disability, so I am happy to have this question. Winston Zulu [misspelled?] was one of the panelists there was sharing with a lot of emotion the fact that he was an activist for almost 20 years, traveling all over the world, talking about how much it is difficult to be HIV positive, and to live also with TB, but during this 20 years of activism, no one asked him about his disability. He was not even able to come to this podium because nothing was planned to make those people who could not come like us to just jump those steps to reach this podium. So I personally feel that we have been completely missing that 10-percent of the total population in the world today who are living with some kind of disability and that we have no program focused for them, no strategic information are really mobilized to make sure that we could end understand what is happening between disability and HIV infection and no systematic research is going on. So I personally feel that Mexico probably is giving us opportunity to also explore these areas.

The second question is about global report. Thank you very much for raising this question. I thank our colleague from Brazil. I am very happy because it is the first time to be honest with you that we have a real, I can say, comprehensive report which was able to include not just the data coming from the government, but the data collected from civil society, data coming from Oswald [misspelled?] survey, from foundation, from even scientific research group. We managed even for the first time to have 700 individual focal

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points, maybe you were one of them, selected from different part of the world to give us their qualitative feedback on the report which were proposed to use. Of course, it is very difficult for us when we are receiving 130 report coming from different groups to reflect all the information, but if you are going to the report, you will find tables where we are trying to take into account what you are trying to say by classifying countries in function of where they are, by saying that those 20 countries managed to just achieve 25-percent of their targets set since 2006. Those countries moved towards others [misspelled?]. So I think your question is pertinent.

We need to improve that. We need to work more closely to make sure that the report will already integrate. Your summary report from the High Level, I am also frustrated, but like Mariangela was saying our jargon and others, that is a member state jargons. Unfortunately, sorry, you were there when we were negotiating this Declaration. We were there until 2 a.m., 4 a.m. the last day and we were not even sure that we could have a Declaration because we are just fighting if we have to put towards universal access or as close as possible to universal access.

So let us be realistic, that is certainly also part of the whole member state and diplomatic wording debate, but we have just received the report from the President of the General Assembly and it will be shared with you because it is a process

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which is managed by the General Assembly President. So it is the summary report of the President of the General Assembly.

The goal setting, you raised a pertinent question many of you have already addressing that. It was serious debate when I was leading this all universal access process in more than 130 countries, seven region. The debate was [inaudible], we were talking about global coverage, global access, what means really universal access. Let us not make it complicated. I was just saying that we will have, if we continue with the same rate of implementation, only 4.6 million people on treatment in 2010 and with people in need of treatment will be around 8.6 million people. What we are talking about how we will reach those 4.6 million [misspelled?] people who are in need of treatment and each country has been able — three minutes more? Thank you.

VUYISEKA DUBULA: [Inaudible].

MICHEL SIDIBE: Just I finish. Yes, I will not come back. So I think it is important, but it is important to also mention that each country set their own target which is very important to hold countries accountable. Namibia were having 1-percent in 2003 coverage in treatment. Today, we are talking about 88-percent, which is a big increase, but still need to continue to maintain that and we have our Minister just right now telling us in Lesotho, we will manage to have it.

But what is the most important is also the Round 8 Global Fund just came out, 6.4 billion request from the

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countries and is due to what? Is due to the fact that we have been supporting with civil society groups, countries to reinforce their capacity to come out with more demand for resources in order to scale up their program towards universal access, 6.4 billion requests is doubling what was requested for the Round 7 and it is important because during this whole process with civil society, we managed to set a target for making sure that the success rate which is just 40-percent for global fund countries were accessing to global fund money for AIDS to say let us go to 70% which is the type of process which help to create inclusiveness and other things.

Accountability? We all agree, that is what I said. Let us foster public accountability. I personally feel that we need continental review, we need regional, sub-regional review with SADC, with others. We were just in Lisbon last week where we had a review coming from Lisbon countries trying to see where they are and how they can improve, how we can have [inaudible] cooperation to make that happening. We need also certainly to have independent bodies with a clear mechanism which can help also to come out with a better assessment of where we are.

I will stop there, but I think those are few elements I just wanted to touch upon.

VUYISEKA DUBULA: Okay, thank you. Now you have three minutes, three, three, three minutes to respond. Kieran.

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KIERAN DALY: Okay. I will be very brief. The first point I just want to really touch on the obvious question which I think was more of a statement around China and whether we should use this as an opportunity to challenge the Chinese government around the detention of AIDS activists, etc. I have actually lived in North America for long enough to say we have set a no brainer [misspelled?], but I think obviously I think some of us are cynical about conferences, but without that, it is a place we really need to raise some of these issues that we cannot do at the country level and I think it is a call for us to do something, trying to be one country, but may others as well.

One of the lucky things is the number of questions that came to me actually were answering the questions as they all came together, so I think your question about naming and shaming, is this the answer, the question about or the statement around needing independent evaluations, the example of South Africa from the Chair have talked about [misspelled?] their report not reflecting the reality of the challenges, the comments around the need for qualitative data and information, I think all of these are statements and reasons why we need the shadow reports from civil society and I think it is an interesting one. There was a portion and in fact my own organization did push to try and get civil society involved in the official processes rather than investing too much time on shadow reporting, but Alessandra [misspelled?] mentioned there

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were some shadow reports that were really critical to highlighting the differences between official reporting and unofficial reporting, so they in part conclusion it is essential that we continue to support the shadow reporting alongside the official reporting as another element of checking whether we are delivering on the targets.

My last note, very quick, one point, I very, very rarely publicly disagree with Mariangela, but I think the idea of having simpler targets or even simpler indicators and the complexity of it, I think in part we actually need to get that complexity because of the points around needing disaggregated data and the existing reporting and the existing indicators do not necessarily give us the information we need to know whether the services are going to the right people.

And lastly, is mainly my point is through all of this I think it has become very clear that we do need to improve, as Alessandra said, the accountability mechanisms and we are not doing it in this discussion, but I think it is a call to everyone to start that discussion about how we make it better because the present summary was not meant to be a negotiated [misspelled?] test. So to not have been done within the two weeks it was promised is concerning because it highlights again maybe the lack of accountability and somebody, somewhere, some government is obviously not happy with the text that none of us have seen, so it does highlight the need for a new mechanism. That was probably more than a minute. [Interposing]

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VUYISEKA DUBULA: Thank you. Right on time.

MICHEL SIDIBE: I want just to add one thing, just one, one. It is very important that because if you look at this shadow report or whatever you call that, I will not call it shadow report, but report made by civil society, just today I think [inaudible] launched a report which was clearly demonstrating that most 128 countries were reporting to us, 90 countries, 90-percent of those countries [inaudible] report on MSN. So those are the type of parallel reports which are very useful for us to really create pressure on the member state to try to look at also which type of question we need to raise to address those vulnerable or sensitive issues.

VUYISEKA DUBULA: Thank you. I will not allow you again. Please.

MPHU RAMATLAPENG, M.D., M.P.H.: Is the microphone on?

VUYISEKA DUBULA: I think it is on.

MPHU RAMATLAPENG, M.D., M.P.H.: Thank you. I will start with the question from the lady from South Africa from treatment, action [inaudible] campaign [misspelled?], she wanted to know why our reach is so low, why we are only reaching 27-percent. I am not going to have excuses for Africa even though I am an African, but we must remember, this disease has been in existence now for 25 years. Africa got assistance when? When did Africa get assistance? Less than 5 years ago. It is very important for us to be sincere and say Africa is not doing a good job. None of the African countries have been able

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to produce ARVs or generic ARVs. It is only after the efforts of such an organizations and I will mention Clinton Foundation who were able to negotiate the prices down that majority of the African countries were able them to be able to get these ARVs. That is one thing, but other issues are too many to enumerate.

For instance, we have attrition of staff due to death and going to greener pastures. I mentioned the fact that although this disease is old in a sense, but a lot of people who are working in Africa, they were not trained to treat HIV positive people. They did not know anything about ARVs and I am one of them. I did not know anything at all about ARVs. I had to go back and learn again how to treat people with ARVs. And again when it comes to children, children medication was very unfriendly. It was liquids that were very difficult to draw and you know Africa has a lot of people who are not educated, there is a lot of poverty, we have civil strife, we have migration, whether internal or external, you have migrant workers who work. If you look at the region where I come from in Lesotho in South Africa, majority of the Southern African countries will be working in South Africa in the mines and they remain there for long periods of time.

So all these issues plus poverty, and also we must understand all these goals that we are talking about today they are actually targeting women. We are supposed to make changes to [inaudible] of the population that is actually not empowered. So there is too much that we need to do to be able

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to achieve these targets. You need to change the laws. You need to empower the women. You need to maintain your staff. You need to understand that it is not only about ARVs. You need to also cater for MNE as one person asked. Yes, if only you could see what I had written here, in the MNE there is a big question mark because clearly we are not doing as well as we should. Yes, indeed, there are certain targets that we are able to measure very well, but not everything.

For instance, in Lesotho now, I would not be able to give you a figure of people who have been on ARVs. I can only give you a figure of people who have ever been on ARVs. But the ones that remain right now, I would not be able to give you. We have migrant population between Lesotho and South Africa, so that is very tough.

Abuja Declaration, I have to tell you that a lot of governments actually embraced Abuja Declaration and my country was able, the very first year after that, to give 15-percent, but thereafter, we have gone back to 10-percent. Why? Because we were not able to in the public sector to be able to move all that money and use it all, and if you do not use it, it goes back and you will be given only what you have been able to use. Why? Because we do not have staff to do that to be able to move this money. The same applies to the funding from the donors. The donors are very reluctant to fund HR [misspelled?]. I think with those few words that will be it.

VUYISEKA DUBULA: Okay, thanks. Rico?

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RICO GUSTAV: Yeah, I think the question Alessandra was asking was directed to Michel and Michel already answered. But if I may I just want to add some points. Actually, Alessandra asked about the use of the community report. I would also like to drag attention to the use of the government official report because sometimes, and again I am speaking from the country level, the government report is separated from the national strategy planning, so actually they are doing the UNGASS report, but they do not integrate that into program planning, they do not integrate that into national indicators. And I think it is really important for the governments and for the countries to integrate this process so it is not an isolated event in order to achieve the universal access or UNGASS targets. Thank you.

VUYISEKA DUBULA: And then lastly, Mariangela, we have five minutes.

MARIANGELA SIMAO, M.D.: Thank you. The question from you was what are the challenges in Brazil and I think we have many challenges [laughter]. If I am going to list all of them we will be here until tomorrow, but I will focus on three of them.

First, I would like to say that the stigma and discrimination that surround people living with AIDS and vulnerable groups is still a major challenge. I think in every society in the Western world, in the developing world, so it is

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still a major challenge as it increases vulnerability and we should always have a political agenda to address that.

Second, in Brazil specifically, we have started a mobilization again to increase access to early diagnosis because we have like 40-percent of our people who are tested for HIV, 40-percent of them when they do their first CD4 count, they already have severe immuno deficiency lower than 200 cells and so this is a major challenge for us. But I think the most important or the most challenging problem we have ahead of us is attending the needs of people living with AIDS because we have a long-term treatment program and there are special needs and all people who live with AIDS many times need programs to what we call promote social inclusion because they have been excluded or to promote that they are not excluded from society and also Michel has mentioned disability side effects of medicines and also problems that come from the AIDS itself and this is a big problem for people living with AIDS and also I think we have another thing on people living with AIDS is young people with AIDS because we have a whole generation of people who either acquired through vertical transfusion or acquired in early adolescence and now they have needs and they want to have a full life like everybody else and they have sexual rights, they have reproductive rights, and in Brazil, the government has to work very strongly to provide access to all that.'

So I guess I will just finalize by mentioning what the Minister said about 3 by 5 and what Michel talked that we were

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in UNGASS 2006 until 4 or 5 in the morning discussing whether it would be towards universal access or as almost as possible to universal access. And I would say that what we got there was a compromise because we got us [laughter] close as possible towards universal access. What we really wanted was universal access by 2010 and whether that is achievable or not, or like 3 by 5, these are mobilizing goals. I do not know what is the right word in English, but in Portuguese it is very clear, where you move society, you move governments towards a certain goal. It does not mean you are going to get there at the time, but you are moving the direction of it.

VUYISEKA DUBULA: Thanks. Okay, now in closing because we are not going to be able to have more time, for me what has come out clearly from the panelists is that we cannot abandon UNGASS. It is a start for countries to account, but it needs to be improved because from Michel's presentation it is clear that we would not be able to achieve or to have 3 million people on treatment if we did not have any process to start with to make sure that governments are accountable, but it needs to be strengthened further at the country level and the regional level so that that accountability starts at the country when we have to write reports and we write honest reports and state this is what we have done, this is what we have not done. And that political will, because accountability is nothing without making sure that political leaders are accountable to the public and they are actually achieving the

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targets. But also for me, the other thing that came up is that we need to strengthen the link between UNGASS commitments and other commitments especially the Millennium Development Goals because I am coming from a region where women are dying and one of the Millennium Goals is saying that women and children can no longer die of AIDS, but they are still dying and I am not saying that to name and shame my region, but that is reality and with the exception maybe Lesotho started getting support two years ago, but South Africa got support long time ago, because we started support in South Africa from 1997, I mean showing that there are other things that works and we are here to support when we got backlash and exodus of people living with HIV, so nothing against you, Minister, and I am still saying you are a positive example in Africa. And I am hoping that all African leaders will take the positive attitude that you have.

With that, I would like to close officially this session and thank you for attending. Thank you to the panelists. [Applause] Excellent job.

[END RECORDING]

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