National HIV Strategies: High Level Political Leadership
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NILS DAULAIRE: Good afternoon. I know that many people are still enjoying their lunches. This is a full packed program, but I'm delighted to be here this afternoon. My name is Dr. Nils Daulaire. I'm the director of global affairs at the U.S. Department of Health and Human Services.

We're here today to have a conversation about national HIV strategies, how we've built them, what they mean, what their central points are, and we have, as our panelists today, Minister Benedict Xaba. The minister was elected to Parliament and became the minister of health in the same year in 2008 from Swaziland.

Before his election he was very actively involved with Civil Society. He was the founder and director of an NGO called NATICC that's focusing on HIV counseling and testing in rural areas in Swaziland. He's been deeply engaged in the HIV/AIDS movement and in particular with Civil Society over the years.

Immediately to his right we have Dr. Thomas Frieden. Tom is director of the United States Centers for Disease Control and Prevention. Prior to this time he was the health commissioner for the city of New York where he led very innovative programs dealing with non-communicable diseases, particularly tobacco control in New York City, which has taken

some of the most aggressive steps to reduce the scourge of tobacco.

He, himself, has international experience having worked for five years in India running a TB program in conjunction with the Indian minister of Ministry of Health.

And, finally, on my far right, although he prefers to consider it the far left from your vantage point, is Dr. Dirceu Greco who is the director of the Department of STD AIDS and Viral Hepatitis of the Brazilian Ministry of Health. As many of you know Brazil was the very first country to come out with a national treatment program back in the 1990s, and Dr. Greco, who's both an M.D. and has a Ph.D., has been actively involved in the HIV/AIDS movement, both in his current job in the Ministry of Health where he's been for the past two years and before that as a tenured professor of internal medicine and infectious diseases at the University of Belo Horizonte.

We're delighted to have the three of them here to talk about the development of health strategies of HIV/AIDS strategies. Now, we know that an HIV infection is an individual concern that the disease of HIV and AIDS is a community concern and that the epidemic of AIDS is a national and a global concern.

What we're going to be focusing on in this conversation today is how these three nations have approached a comprehensive strategy from their varying vantage points to

address AIDS, to deal with its major issues and drivers, and we will try to tease out some of the things that could be useful for those of you who are returning to your own countries to work on your own AIDS programs and strategies and also to illuminate some of the real challenges that still face us in the arena of AIDS. So with that, let me start with Minister Benedict Xaba.

BENEDICT XABA: Thank you very much, chair, also to my fellow panelists here I'm with, also distinguished delegates. First the kingdom of Swaziland, it's a landlocked country with a population of about 1.2 million. So as a country we have a high burden of HIV/AIDS, and also the challenge of the prevalence, currently we have a prevalence of about 26-percent to the age group of 15 to 49 years, which is very high for our country.

So what happened in 1999 his majesty the king declared the HIV as a national disaster. So after the declaration we felt that HIV is no longer a health issue but is a multi-sectoral issue, so we started a strategy if we choose multi-sectoral in 2001 whereby we launched through the act of parliament a national emergency response council on HIV.

When it was launched, then we came up with the strategic frame work, which is multi-sectoral, which is guided by three principles, mainly one coordinating board, which is NERCHA, the National Emergency Response Council.

Then also we have got one national strategy frame work and also one monitoring and evaluation frame work. So that was the beginning of our strategic frame work which really had high political commitment from the head of states down to the community level. So I can [inaudible]. Then I'll go into the details very quick.

NILS DAULAIRE: Okay.

BENEDICT XABA: Thank you.

NILS DAULAIRE: Thank you very much. Dr. Greco, Brazil has been known as a leader in this arena. I would very much appreciate your thoughts about how you've gotten there and where you're going.

DIRCEU BARTOLOMEU GRECO: Well, first of all, thanks for the invitation to have Brazil participate in this such important venue. What I can tell you all is that the Brazilian decision to treat people as they deserve started in 1985, just after the dictatorship was overrun and we had a new constitution. In 1986 the Brazilian AIDS program was established, and it was established based on one thing that I think can be used in many countries, including the United States, is that we have a unified public health system that every has access to it.

It was decided in the very beginning it was public, was universal, was integral, comprehensive, and based on the participation of the Civil Society. That's very interesting

because after these years all the policies that drive our response health wise, it's decided in the National Health Council that it's priority commission in the Civil Society participation, that they're elected to participate in that, and the Brazilian program had the, of course, also since its inception at least three decisions, first of all that health is a right to everyone and should be, like the constitution says, a state's responsibility.

Second is that everything that was decided by the Brazilians were doing—we did not have any financial support from the outside, and many people tell me that's very easy because Brazil is a fifth economic power now, but at that time, 1996 when we decided that everyone should have access to all medication, we were running through very difficult economic times.

The inflation was rampant. I don't remember the numbers, but it was above 300-percent per year. So it was at that time a decision was taken with the main pillars of Civil Society, the participation of government, with academic backup within the prisons and the hospitals dealing with that.

So from 1996, when we decided to have drugs available to everyone, to today in 2012 we distribute 20 different drugs, ten of them produced in Brazil. One of them, after compulsory license that was a [inaudible] that belonged to America at the time, and tenofovir we decided they did not—they issued for a

patent, and we did not issue it. So it's produced in Brazil, too.

So in summary that was how we acted. Of course, think about prevention, and I forgot just one more thing that was part of this background is infrastructure. It was that since the beginning was everything was completely based on a human rights approach, respecting diversity, respecting homosexuals, prostitution, drug users, telling that by law they would have access to everything as everybody should have everywhere in the world.

NILS DAULAIRE: Thank you so much. Tom Frieden, you've dealt with this at the city level and at the national level over the last three and a half years. Tell us about your experience and where the U.S. strategy is going.

THOMAS FRIEDEN: Thanks, Nils. Thanks to you for this session and also, of course, to the leadership of the U.S., President Obama, Secretary Clinton, for their commitment to an AIDS free generation, and most of all really want to give credit and thanks to the community activism, which for the last three decades has really brought us to where we are today in HIV.

Much of the progress that's been made not only with access to medications, not only with an inclusive planning process, and not only in HIV but really it's changed the way we do clinical trials, the way we plan programs for the better.

So a lot of credit to a lot of hard work over many years by many people.

The first requirement we found was to get good information so that we could identify the extent of the epidemic so that we could identify the groups most effected and so we could track whether the programs we were putting in place were working. So our first requirement, we feel, has been good information openly derived and openly shared so that we can have a shared understanding of where we are in the epidemic and where it's moving and which programs are working and which are not working so that we can hold ourselves accountable.

Stemming from that was a recognition that, although we all know that HIV is a very different epidemic in different countries, even within countries and even within states and even within cities there are micro epidemics, and in order to confront them, you need to confront and enlist the strengths of each community that's most affected.

So we've seen, in this country, tremendous declines in injection drug use associated HIV down 80-percent, but we're seeing real challenges with younger men who have sex with men, people who did not grow up seeing their friends die from AIDS.

So that first concept of information leads to the second, which his community specific solutions which draw on the strengths of different communities, and I think the third

area has to do with accountability of the health system, not merely the healthcare system but the broader health system.

We know, in this country now, that although about 18-percent of all people living with HIV don't know they have it, a much larger proportion was tested for HIV and is not currently in care. We need to increase the accountability of the health system for ensuring that people receive the care that is optimal for their own sake and also to protect their partners.

NILS DAULAIRE: Thank you, Tom. Dirceu, when Brazil started its program in the 1980s, it was at the very early stages of the global HIV/AIDS pandemic. You were pioneers. Can you reflect on Tom's comment about the micro epidemics? What do you know about what some populations are in particular harm's way, and what is your program doing about those high risk populations?

DIRCEU BARTOLOMEU GRECO: Yeah, that was a very good point because when you think about Brazil, that looks a lot like the United States, size wise. We have many small Brazils throughout the country and many small states within each state. So we have different ways of seeing, of treating, of getting to people.

What we have been doing since the inception of the program was, of course, with inclusive participation of the Civil Society in all respects with the NGOs and people in many

areas we're trying to working together to get people that are in conditions of much more vulnerability

What we still need today, and that's interesting to tell historically because in 1996 when we decided to start treatment, there was a lot of contrary acting from international community including the World Bank saying that a country that was so dispersed, so complex and so big should not start treatment because it better just to make prevention because treatment is so complex, and we're going to get people not taking medications, and then we are going to go have a lot of resistance.

Well, we proved them wrong. We started it at that time. They were expecting at that time that by year 2000 we would have about 1.2 million people infected, and our best estimates today is that we have roughly 600,000. That's almost half of United States' estimates.

We have probably 250,000 people that do not know they're infected, so that's one point. That's one of our focus, but the other focus that I have been very critical about this discussion about treating people not infected is that we have a much more need now to find people that are infected and do not know about it, and they come to us when they have less than 200 CD4.

It's the same throughout the world. I think the United States is about 25-percent or 28. We have about 30-percent of

people getting to treatment after all problems that they could face. So we're going through different respects, getting to where the most at risk population are, and we have been naming that everywhere. We have been fighting for that internationally.

We have to recognize that we have homosexuals throughout the world. We have sex workers everywhere. We have drug users in any country in this world, and we have to respect them, and by respecting them it's going to be easier for them to get to the health system, and that's a problem everywhere because people are afraid of getting there and then being well accepted, and we bet that we will be able to, if we diagnose them.

We have found out, and that was really confirmed now, but people are being treated. There are many reasons that they're going to be better. They're going to have better quality of life. They're going to survive, and they're not going to spread the epidemic. Even not only because they don't want to but, we all know that by decreasing the viral load people are much less infected. So that's the way we have been preceding in the last few years.

NILS DAULAIRE: And, Benedict, your country, Swaziland, is known for having a generalized epidemic whereas in both Brazil and the United States it's more of a sub population epidemic. How has that affected your targeting of groups that

most at risk, and how is your strategy approaching, addressing that particular set of challenges?

BENEDICT XABA: Thank you very much. Like I mention our strategy is really very intrusive. When we developed it, we had to involve a lot of players in this strategy. For example, we have got traditional leaders. Besides traditional leaders we've got traditional healers. Where most people, when they get infected first, they're in denial, they'll start consulting also the traditional healers for treatment. So it's critical that we involve everybody.

Also the issue of HIV counseling and testing, we had to find people also to immobilize people to test first so that we have many people who know their HIV status. Then involve the people living with HIV in our strategic frame work. So what we are approaching now using the strategy, we have involved a lot of people living with HIV in our programs.

More especially in our clinic we have got expert [inaudible]. Then we continue into the community to mobilize people in our community, but because it's so generalized and we have discovered throughout surveillance that we have got a number of people that are infected with more specialty ages of 35 years to 40.

Then you look at more specialty men in that age category. Then you go down for the young people that is the out of school youth that is more from the age of 20 to 25.

Then you can see that the relationship between the older men and the younger ladies is very, very common. So we need to have some messages targeted to those groups and mobilize the out of youth school for HIV counseling and testing.

Also we needed some specific interventions targeting men only. Hence we started the campaign on male circumcision, which is really going very, very well on male circumcision. Though it was not part of our culture, so we have to start off fresh and not to deal with culture is not something very easy, so we have to do a lot of effort. So we have some targeted intervention, one especially targeting men. Then we have the interventions that are targeting women.

For example, our prevention of mother to child transmission is one of the best programs now in the country whereby we have about 96-percent of our children born HIV negative from the HIV positive mothers. So it's working very well, but we can't wait.

We have to start introducing antiretroviral therapy, which also is a program that is continuing, but I might say that when we do the surveillance, we can see that it is stabilizing but at the higher level mainly because of our HIV program or antiretroviral program so it's stabilizing at a higher level. For example, the natal care is at 40.1-percent, but the original population is still at 26-percent. So that's the approach.

NILS DAULAIRE: Thank you. So you're talking about ways of engaging with your community. Tom, the CDC is famous for its epidemiologists, for its disease control activities, not always so famous for its community engagement, and I wonder if you could talk about some of the ways that you and the broader U.S. government effort are really working to engage those most at risk and Civil Society in addressing HIV and AIDS.

THOMAS FRIEDEN: Well, starting with the planning process, the National HIV/AIDS Strategy was built through a series of community engagements across the U.S., with individuals, with organizations, with providers, with groups that had special interest and commitment and experience addressing HIV, and all of that fed into the National Strategy.

In addition CDC provides prevention grants both to states and large cities as well as directly to organizations both on a national level and locally for programs that will be able, not only to do a great deal of good in those communities, but will be rigorously evaluated and serve as models that can be used throughout the country. This is fundamental to our commitment to working with communities to address the epidemic.

In addition we've been able to look at different models of reaching different communities, understanding that there needs to be specificity within the U.S. What we've done most recently is, based on the data, to dramatically shift how and

for what we provide resources. As someone said in this room early in this conference, we've never been where we are now before. We've never known quite so well how we can make the most difference in caring for people and reducing disparities and decreasing incidence of HIV.

So what we've done with the CDC dollars is to begin providing them to jurisdictions based on where the need is greatest and within jurisdictions for the people at highest risk and within that population for the programs that work best. So it's a partnership with the community to say we will work together toward a common aim of driving incidences down by at least 25-percent over these five years, and for that we know that mutual accountability and creativity is going to be essential.

NILS DAULAIRE: Dirceu, the issue of disparities is one that I think occupies every country, but I know in particular that in Brazil you have some real challenges because of your underserved indigenous population in the Amazon Basin. Perhaps you could talk a bit about how you are reaching the least served, and tell us a bit about the ways that you've engaged with your indigenous populations in other parts of the AIDS strategy. Tell us about the green bull here.

DIRCEU BARTOLOMEU GRECO: [Laughter]. Okay. Well, I think it's a good point when we talk about disparity, and the word is very desperate. If you see the countries where we say

that there's no money, many times the money is there, and it's the distribution that's very bad, and I can say at least by in relation to Brazil we haven't always been a very rich country with a lot of disparity.

There was change since President Lula decided to help that, and with just by cash transfer he was able to take almost 16 million people out of extreme poverty. So that's part of the focus of this, what we're going to do.

Of course, we also have the indigenous population that number wise is small compared to the size of the country, but the importance is the same. So we have been having a lot of work dedicated and especially in the frontier of the Amazon with many of our neighbors from Latin America, in conjunction with the local government, with UNAIDS and with other agencies to help them get to the health that they need, and that brings us another subject. That's where very much interested in controlling the epidemic of [inaudible] that's hepatitis.

So hepatitis is a point. It's a point of intersection, and with indigenous populations who may know. We have hepatitis delta in the Amazon that can be wiped out with vaccination that we have also. So these things are going together, but with involvement of the Civil Society, as mentioned before, the Brazilian government has a lot of their participation in all aspects.

I mentioned the National Health Council's, but in the department of HIV/AIDS we have the main council that help us with the policy. It's a 36-member council with 12 coming from the Civil Society, elected by them, different. They choose. They elect, and the participate with us.

When the spreading, I mentioned that we produced drugs, too. We produce also other things. We produce rapid tests. This year alone we distributed almost eight million tests throughout the country, and we produce condoms, and I have mentioning to my friends that every time I put my hands in my pocket, at least three condoms from the Amazon come to my mind, not my mind, my hand. My mind's all the time, but come to my hand [laughter] and I brought some to you here.

NILS DAULAIRE: This is a new way to think green. Is that right? [Laughter].

DIRCEU BARTOLOMEU GRECO: Yeah, also. It's made from rubber plants from the Amazon. It's made by indigenous people that live there, and we produce 100 million of those. Brazil distributes about 700 million altogether per year, but 100 million is made there.

We're trying to boost production, and the green effect is very interesting because we need to emphasize condom using, and that may be a way of doing it, too, telling people to be happy to have condoms every time they have relation with

someone else. That would be the best prevention method that we can still have.

NILS DAULAIRE: So we have a means here of bringing together the Rio+20 Conference and the International AIDS Conference. We can say save the rainforest. Use Brazilian condoms.

DIRCEU BARTOLOMEU GRECO: Very good. I'm going to write this down. [Laughter]. I'm going to use it next time, yes.

NILS DAULAIRE: You've talked a lot about human rights as the basis for health and healthcare in Brazil.

DIRCEU BARTOLOMEU GRECO: Yes.

NILS DAULAIRE: Benedict, I wonder if I could turn to you and ask about some of the challenges that you face from the human rights standpoint. How does Swaziland address the issues of men having sex with men? How do you address the issues of women's empowerment in a traditional society?

BENEDICT XABA: Thank you very much. The issue of human rights is we really forecast as a country, more especially starting in the involvement of people living with HIV and also the respect of their rights. So the issue of having the MSM, it has just come up in Swaziland. We have just done a study recently. Most of the time there is an issue of stigma and discrimination. So most people will not come up or disclose that they are MSM.

So it has been a huge challenge in trying to find out where they are and what they are doing. So I think it's one of the areas which as a country we still need to strengthen because at the moment we still don't know where are these people who are MSM and so on. So I think we need to do a lot of mobilization in that area.

NILS DAULAIRE: And if I can just ask are there legal constraints in Swaziland relating to homosexuality, or is it closer to South Africa where it's embodied in national law and constitution?

BENEDICT XABA: I would say probably even culturally, we've got a culture which is very strong in the country. So I think it's very difficult for people to come up and say I'm MSM or I'm a lesbian. So it's very difficult. I think though it is not in the constitution, but I think culturally we take things that are [inaudible] as low. So I think it's very difficult for most people to come up and disclose even their status regarding that area.

So I think that is a huge challenge. So we need to do quite a lot of awareness, but there's no way where these people are condemned publicly or politically, but it's just happened as an individual. So people are not opened up to say I'm a gay or a lesbian.

So they don't come up. So but with the study that we have done recently we're able to have some people coming up,

but it was very difficult even to come and publicize and open and say this is what our findings are. So I think that is still a challenge, but we are seeing quite a number of people coming up.

NILS DAULAIRE: And what about women's rights?

BENEDICT XABA: Women's rights, they are respected again in the country. There's a lot of empowerment on issues of gender in the country, and women are able to go for probably testing are not forced in other aspects.

So there's quite a lot of empowerment, and we do have a strong Civil Society that is raising these issues, but it still I think with our culture it's still taking long because the issues of respect, separating women's rights in respect is usually a challenge, but through the Civil Society I think we are taking the right direction to ensure that women's rights are respected, and also the constitution, since we have been having a country without a constitution.

Since we have a constitution, so the bill of rights is enshrined to the constitution that gives women freedom. Like before we had a widow inheritance. That means when you are with your wife, then you pass away, then your brother can inherit your wife. So it has been very common in Swaziland, and it has been a challenge of the spread of HIV.

So in the past you would be forced like I inherit you because my brother is gone, and I will take care of your

children. So women, they didn't have a say in that aspect, but since now we have a new constitution, so women have a right to say no, and it will stand for their rights, and the widows really they can even go to court and address the issue of human rights, but there's a lot of empowerment that is still needed because it has been cultural, so to change a culture of a society is not something you can change overnight. It takes some time to change culture.

NILS DAULAIRE: And, Dirceu, I see you had something you wanted to add?

DIRCEU BARTOLOMEU GRECO: I want to add to that because when you look at what our constitution, I'm talking about the Brazil constitution, says about rights that everybody is equal, I think that's a minimum that we can everywhere. I think we have to fight in all countries to respect prostitution, not avoid them, to enter the country like happens in many places, but that's not in all of course. We are, as you know, Brazil's a very liberal country, but we have a lot of violence against women, violence against homosexuality.

So there's a thing that every day we have to do something about that, and what to do about it? One is to take them to the churches, but that's not enough, and what we have been doing for some time now is trying to get, and we are accomplishing that, to have health and education at schools at the same time, and we're talking about violence.

We're talking about sexuality. We're talking about condoms and see if we can change the way that the children see the country, and others ask many people think that they can be violent against different ways of facing life. So it's very hard work, but we have to be together in that.

First of all, get into the constitution so that everybody has the same rights. That may be the first step, far much more difficult to impede that violence can increase vulnerability as we have seen in HIV/AIDS, but we see it everywhere.

NILS DAULAIRE: Tom, here in the United States, marginalized and criminalized groups are at particularly high risk of HIV infection. How does the CDC approach address those groups that are particularly hard to reach?

THOMAS FRIEDEN: On the one hand I think we can reach out to specific groups through specific programs. For example, in jails we now have rapid testing programs, but it's also crucial that we work with organizations that are embedded in the community that are emanating from the community.

Our biggest challenge in this country now really is the increase in risky behavior in young men who have sex with men. Most of our infections are in younger men who have sex with men, more than 60-percent, and we know that to serve this population we're going to need to go where they're going, and it's challenging because even programs that have been very

successful previously at reaching people now with the internet are facing the possibility of very rapid and fluid sexual encounters that are difficult to try to get condoms involved, that involve both consensual and sometimes non-consensual sex that involved drugs and alcohol in ways that people may regret in the morning or days following.

So these are real challenges, and working with communities to ensure that we're systematically identifying strengths, identifying leaders, offering services, offering prevention, and making condoms universally available, ensuring that testing is universally available, increasing treatment to drive down both the burden of illness as well as the risk of infection, these are all crucially important areas.

I think we're seeing some real signs of hope in different parts of the U.S. where we are seeing big decreases in new infections the more effectively we can reach people and get them on treatment, but we have much, much further to go.

NILS DAULAIRE: Benedict, Tom just mentioned the internet. I recognize that Swaziland is a traditional society, but I also recognize that technology is changing the face of Africa today with mobile phones and internet. Can you tell me whether your programs have started to make use of these new technologies, social networking, mobile technology, the internet for prevention and care programs?

BENEDICT XABA: Thank you very much. Yes, the issue of internet is also taking a wave in Africa, also in Swaziland. So the issue of social marketing and issues of Facebook is very, very common in Swaziland, but for now our programs, we are using the internet or mobile phones mainly on the care and treatment program. So we haven't started really using the social network for prevention.

So what we have now in our ad program is the phone appliance whereby after taking treatment we are able to send an SMS just to remind them to their phone app and also for attendance program to check why people they are not coming back. So it has helped us to know the people who have stopped treatment more especially because, first, maybe the person is dead, or the person has decided not to take treatment. So it has helped us to make a phone app.

So I think it's just a new evolution that is happening in the country, but for prevention we still don't have a strong program. I think there we need to strengthen the program, more especially for the youth which is out of school and that most people that uses the internet.

So I think in that aspect we can still learn from the other countries what we can do for the youth and more especially the after school youth, which is affected by HIV due to the transitional sex. So I think that is very, very critical.

NILS DAULAIRE: And, Dirceu, and, Tom, both of you, how do you see using these new technologies? What opportunities do they offer for your programs that are just emerging?

DIRCEU BARTOLOMEU GRECO: Yeah, we have been using and thinking of increasing the use of everything that we can to reach people, but it's interesting because if you do a survey and see how much people know about HIV/AIDS and how to get protected, of course 95-percent in everywhere you go, they know what to do.

One thing that maybe we can use that much more extensively is to tell people that HIV/AIDS is still here cuz the same is happening in the United States. I just read this in the paper this morning. People have not asked what happened 20 years ago. They just think that AIDS is alright, especially when they listen to us saying that the time is here, we're going to have an AIDS free generation.

How are we going to accomplish that? I think one thing that we can do and have been trying to do that is trying to get at least three different situations. With the Civil Society, as I mentioned before, we have been having them together and even opening bids of grants.

This year the Brazilian government opened a $7 million grant for the NGOs to work within these different areas. It's almost four times what Hillary Clinton mentioned the other day

that was about two million that the United States was going to put this year for the NGOs.

Getting to our colleagues, the medical doctors, and telling them, look, when you get someone in your office, instead of just asking for cholesterol triglycerides and telling them to get slimmer, give them a test. Invite them to be tested for HIV, for syphilis, for hepatitis. That may help because people are going to start thinking that, but the last thing that I think is the most important is that we see them.

If we know that, we have to ask our providers to ask for the tests. That's why I think that we're saying Brazil is different from the United States. We don't believe in empowerment because I've never seen anywhere people giving power to someone else. We're talking about emancipation and people knowing that they have the rights, and with the rights in their hands they can ask for what they really deserve.

So we have been doing that in this many pronged ways of confronting a very difficult situation that we still face, and I cannot forget to remember again three days from today is the world international day against hepatitis. It's going to be our next international meeting probably.

NILS DAULAIRE: Thank you. Tom, in terms of using the new media and the not quite so new media?

THOMAS FRIEDEN: Right, I think we have some opportunities that some of which have been explored. So, for

example, treatment reminders through cell phone, very useful, helpful technology.

At the same time in many places the websites that facilitate encounters present the new challenge, and anonymous sex presents a new challenge in terms of partner notification, in terms of safe sex, and I think there's really a role here for trying to figure out what works in a way that's respectful of people and takes advantage of the new technologies.

For example, what do we do? To give you a very specific example, somebody says they test positive, and they say, yes, I have a partner. I had this casual partner. All I know is their email address. Should someone send that person an email saying please come to this place to be tested? Should someone say you are at risk? Is there a duty to warn? Is there a right to warn? Is there a risk to that individual?

These are issues that we dealt with in the non-virtual world, but now that we have the exponential increase in, frankly, efficiency of contacts through internet, we need to deal with it, and I will say that this is a challenge for us in the U.S. because I would say that what people are doing to connect with each other in unsafe ways and safe ways is much quicker than what in public health and prevention services we've been able to do on internet, Facebook, instant messaging and other technologies. So I think this is an area where we

need to be very focused, very realistic, and to learn as much as we can.

NILS DAULAIRE: So, Dirceu, I saw a facial expression there, and I know that again from the standpoint of human rights many of these issues come into play. I'd be interested in your reactions.

DIRCEU BARTOLOMEU GRECO: Yeah, that's a very difficult situation cuz when you think that you should—you're not saying that, but if you have a way of telling people that they were at risk because they had a risky situation, where particular rise in things that should be for all. I mean, when I say that HIV/AIDS is just passed one to another, if the other wants to do it unless it's not consensual sex, I think our role is to make sure that everyone knows that by having sex without protection they are risk, and by doing so we have to open up a way of bringing them to us so then we can counsel them. So that's a way of doing the same thing in different ways. So that's a point.

I don't know if you were going to mention it, if I'm going to try to change the subject a little cuz when you say—we did not talk about, but I think I'm going to ask about sustainability.

NILS DAULAIRE: Yes.

DIRCEU BARTOLOMEU GRECO: Okay, so I'll wait to you to ask for it.

NILS DAULAIRE: So, Benedict, let me come to you in terms of this flow of information, and the flip side of information is, of course, misinformation, and misinformation is rampant. It's both on the internet, as you saw in your neighboring country for many years, the president learned on the internet things that are not true about AIDS and acted on them but also in communities. So how do you deal with misinformation in a society that's just emerging from a very traditional society?

BENEDICT XABA: Yes, the issue of information, it's really a challenge, but as a country we use our structures, more especially coming to the traditional structures where as a program we go down to the communities and sit down around like using the community leaders so that the people can really understand, what especially of grassroots live in. I'll make an example of issues of condom usage or the condom.

We had a challenge one time. Somebody just put a condom in water. Then after putting a condom in water he had to put it on top on the sunny place. Then it started shining and so on. Then started spreading the information that the condom has got the HIV virus. So it was really a difficult information how do we counter that information because people, they believe more to the misinformation so we had to start against some campaigns just to give the right information on issues of condom usage and so on.

What is working well for Swaziland is going down to the people at [inaudible] living and sit around and really discuss the issues. Of course we use the media like the national radio. It's very effective for Swaziland as a country which it's a small country. It's easy to reach. So the national radio is very effective where we've got programs, probably a week.

Then we've got advertising program. That's engaged as well as the print media. So we use it, but what is very, very effective is to engage the society just right away where there's a misinformation, more especially the traditional letters. Most people in Swaziland, when there is a traditional letter, they will believe you. So it is critical that whenever we print some information, even new information, you must start having a workshop for the traditional leaders. Once the traditional leader is able to understand what you're trying to bring, then they're able to pass in the information to their communities.

So I think community work is very, very critical for us as a country in passing information, and in another way we almost know each other. We are like a family in Swaziland. So we talk to each other almost every day. So it's easy to make information from one area to another area.

So I think that's the aspect that is helping us as a country to use our structures, not to change our structures but

to use these structures that people know and they will understand and also use the people they respect like the traditional leaders who are champions in the communities so people will accept that information as correct.

NILS DAULAIRE: Thank you. Well, Tom, Dirceu started to raise the issue of financial sustainability, which I think is one that Ministries of Health these days, with the global economic situation, are increasingly facing, whether they have donor funds or are funded by their own taxpayers.

Secretary Sebelius, just this week, announced that the waiting list for the AIDS Drug Assistance Program are finally being cleared so that all people will have access to drugs whether they have their own resources or not, but how do you see this process evolving, given that we are not reducing at this point the number of HIV positive people? We're still getting a constant inflow.

THOMAS FRIEDEN: There are a few trends that are really important. The first is to work hard in every country to be more efficient because, frankly, healthcare is expensive, and if we can provide the same quality of care to more people for the same money, we can do more good with our resources.

So I think a key priority is to increase efficiency, and I will say that within PEPFAR we've been able to work with countries to drive down unit costs of treatment very substantially, and I think we can make even further progress as

we transition services to local providers. As local providers work we've seen lower costs and maintained quality.

So I think first issue has to do with efficiency. Second is the functioning of the healthcare system. This is really important, and in the U.S. we have the Affordable Care Act, and the Affordable Care Act will now make it possible for people to get a routine test through any insurer without co-pay. It will make it possible for people with HIV to get health insurance without discrimination against them. So it is very important in increasing access and equity and care.

At the same time it's crucial that we ensure that the healthcare system is accountable for outcomes, and this is an area where I think we're eager to learn from other places around the world and from places within the U.S. that are doing a better job because on average only 28-percent of Americans living with HIV are on effective treatment.

And even if you take out from that the people who don't know they're positive and even if you take out for that people who were never recommended to be on treatment, and even if you take out from that the very small number of people who have said I don't want any treatment, that's entirely their right, still most people who by all accounts should be on treatment are not effectively treated, and that's a failure to use existing resources well. That's a failure to hold ourselves and our health system accountable for good outcomes, and the

result of that is going to be hospitalizations that are avoidable, infections that are avoidable, and tragically deaths that are avoidable.

So I think the sustainability challenge and the efficiency accountability challenges are really one challenge, which is to get as much value as we can for the dollars that we have and to ensure that we're using all of the strengths of the community, whether that's the healthcare system or community strengths, to enlist them in the battle against HIV.

NILS DAULAIRE: So, Dirceu, Brazil has a constitution that accords everyone the right to health?

DIRCEU BARTOLOMEU GRECO: Yeah.

NILS DAULAIRE: And healthcare? How can you afford that? How does that work? What lessons could we all learn from that, and where are your challenges?

DIRCEU BARTOLOMEU GRECO: Yes, it's interesting to hear Dr. Frieden mention that finally the United States had the Affordable Care Act that gets everyone to get tested. Welcome to the club. [Laughter]. I think that's the thing that we have to have, and if you—I'm not an economist so many times I get confused by many things, and one of them is that because it's much more money wiser to forget people to be treated, to be good care, and to receive what they deserve and expect in them that after they get sick, because they didn't have access, they're going to be much more expensive to be treated.

So even economically wise it's very much better. That's what we have been doing now, and the only contradiction of it I see in as much as we, of course, all want to be very effective in what we do, be accountable, what is very interesting that coincidentally we're talking about this exactly now when we're going into a terrible economic crisis that was started because of bank inefficiency.

So they were inefficient, and now they want us to be efficient. So the few things that have to be together to say that we have to sustain what we have, and when you asked about Brazil, that as I mentioned before, it started in 1996 when we had a lot of difficulties, it was a political decision, and when we found out the amount of money that we saved by getting people to be tested, to be treated, to receive medication, getting whatever they need to survive, we found out that there was a lot, a least we save about almost double what we invested.

So I think that's the way we have to keep going, but this sustainability has a lot of problems. One of them that we live in a different world, and I think Brazil has been trying to say that and act like that, saying that we need to do much more recent collaboration. We do that a lot with Africa.

We have been doing it with the help many times with the United States and other countries, but we do it in a way that we all act as equals, and one thing that I mentioned three days

ago Brazil helped Mozambique to start a plant to produce antiretroviral in Maputo without no strings attached. It was no global fund. It was nothing. We were there. We helped them. They went to produce, and I think that's a thing we can do together.

And the one other thing that we did not mention is the price of medication. I mean, we cannot survive paying what we pay for the medication that the drugs companies sell to us. We have to fight it all the time. I think International AIDS Society has to be part of that.

United States, with all the power you have, we have to participate in that because we're thinking, and Swaziland is going to feel what we have been getting now. We start treating in 1996. So we're getting people in third line medication. We're going to get that, too, because people are going to survive. Third line medication the price are obscene, and we cannot buy from any other source than the producers.

So there's one thing that we have to get our hands together, get our part together, to fight for this way of sustaining, and there aren't enough courses if we don't find a way of getting people to know their status. We're going to be treating, but we're not going to stop infection. So that's the sustainability has many different places that we have to work in this respect.

NILS DAULAIRE: Benedict, our hour is almost up, and you have the privilege of the last word here. I wonder if you could take off from what we just heard about the costs of treatment, sustainability. I know that in Swaziland you do get outside support as well as your own domestic resources, but how do you see the next ten to 20 years being able to sustain and manage and afford the AIDS program that you have and the AIDS program that you need?

BENEDICT XABA: Yes, thank you very much. The issue of sustainability is also a challenge, also when you look at the kind of sources, looking at the number of people we have enrolled on that. So I think what is critical as a country is the issue of prevention. So I think we need to be aggressive in prevention.

For example we have a good program on prevention of mother to child transmission. So or this generation that is coming up, which we in course I'll say they're HIV free, but I'm afraid that when they reach the adolescent stage, they'll be contracting the virus again. So it's likely, and it's like also as my friend is mentioning that probably we are afraid more especially [inaudible] AIDS that [inaudible] that we might need the deadline drugs. So there's a question of the price there and the question of the sustainability there.

So I think it is critical as countries that we enter strong collaboration and also we have our partners. For

example, we have PEPFAR. That is our biggest supporter in the country in our HIV program. So there's always that question of sustainability if we are going to help PEPFAR tomorrow, due to the economic crisis, welcome to [inaudible] to have as a country supporting, but the political commitment and the country ownership I think is the backbone of the country.

With antiretroviral drugs as a country about 90-percent we feel they must come from the domestic resources. Then the strengthening of health systems we get support from PEPFAR and other partners.

So I think the ownership of the country, the political will also is important, but also we need the manufacturers to come into play in issues like private/public partnerships. We really need to have private/public partnership and have new ways or innovative health financing ways to see that we address the issue of HIV, and it is no longer a health issue, but it is also an economic development issue.

So it is critical that we forge partnerships, more especially in Africa. The issue of procurement and antiretroviral drug is still not properly managed. We have to go to India, other countries to get antiretroviral drug. So I think procurement can also help us in Africa, and it maybe cut the cost, but our big point of this program, I think, is prevention, prevention, and prevention.

NILS DAULAIRE: Well, thank you, all, for your insights, for an interesting and enlightening conversation. Join me in thanking Dr. Dirceu Greco from Brazil, Dr. Tom Frieden from the United States, and Dr. Benedict Xaba from Swaziland. [Applause].

[END RECORDING]

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