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Strategic Use of Resources: Doing the Right Things With the Right Money Mix
Kaiser Family Foundation
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ALVARO BERMEJO: — going on at mid day and lots of other things to be at, so we really appreciate you having chosen to be with us today. I think we're going to have a really interesting debate and the one thing I do promise is that there'll be time for questions and answers at the end. So I will be quite tough on the panelists to make sure that those of you who have chosen to be here rather than on the street at least a chance to express yourselves and for us to try and answer your questions.

In order to achieve that I want to be very, very short with my introduction, we're here to discuss strategic use of resources in an era that some have defined as an era of austerity and doing the right things with the right money mix. We've got a fantastic collection of panelists, I'll just introduce them as I give them the floor.

The first one is going to be Mariangela Simao who's currently working UNAIDS in Geneva but comes from Brazil from the Ministry of Health were she's had a senior position since 2006, really shaping, directing the AIDS response in Brazil. So we'll really be talking from this that she brings, this combination of country experience, country response and now at UNAIDS sort of trying to bring that experience onto the global states and help us all move ahead. So Mariangela if you could start by introducing the investment framework in the topic.

MARIANGELA SIMAO: Thank you Alvaro and thank you for all of you who are not going to the march but I suppose some of you

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are still leaving when it gets closer to the time. Alvaro already mentioned by background, I used to work for the Brazilian Government, I was the AIDS Director until 2010 when I moved to Geneva.

What we are discussing today is how to make smart decisions to ends AIDS and many that I'm going to touch I'm sure you've heard before in different formats. The AIDS response is very much about reinventing and rethinking our strategies in order to get the best impact for what we invest in it.

Let me just go quickly through the 10 targets, these are the 10 commitments that all countries signed with a political declaration in 2011. I use this to say that we cannot reach one by one, we can only reach them if we tackle them in an integrated manner. There's no way we can reach universal access of 15 million in treatment by 2015 if you don't address for example, the underlying issues of men who have sex with men and other key populations in access.

This is bringing very quickly to you some of the new slides that came out of the report in 2012. You can see here where we are going with the estimation of people in therapy 2015, we are on our way and how deaths are decreasing. We are having good progress towards elimination of new infections in children but we are not there yet and we are not on track to achieve the goal of reducing adult HIV infections by half by 2015.

So we do need to think differently and we do need to reassess our strategies in order to get there. Some of you have

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now seen the plenary where Bernard Schottlander presented on a whole set of new discussions on the global and country aspects of the AIDS response in financing. Just bringing to you here how we've been saying that we have a flat line of resources, you see the green line in international assistance, the blue line you see that domestic funding is increasing. That's a fact.

But another fact is that we still have a seven billion gap by 2015, so we have to make this come from different sources. You can look at this both ways, we can say that this evolved in I wouldn't say flat lining resource context anymore, I would say that this evolving because we've been seeing a change in domestic. We can see this as a threat or we can see this as an opportunity. When we are talking about investment framework I think some of you may already have the redolency paper or other papers that were published afterwards, the alliance paper and it's really about doing the right things the right way in that scale.

In a way you see elements here and I hear – because we've been speaking about investment framework and investment approach in several different places and I hear this is a combination prevention type of approach. It is, but it has some differences, I would say we are involving from concepts and models to a more politically charged discussion.

For example when we place what we can in the combination prevention structure interventions we place them as critical enablers. We are say that without the critical enablers the

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basic program activities won't reach the fullest impact which is stopping infections, keeping people alive.

And it's also about working out what the synergies are, what is HIV specific on our response and our funding, what's real HIV specific that is money that's not coming from any other place and money that comes from other areas? So what are the HIV sensitive aspects of our response? And you see here that we left the critical enablers and developing synergies kind of mixing up at a point because we are talking about AIDS response based on a rights approach. That has seen to be seen at all levels and all programs without gender biased so we cannot simply ignore that.

But at times there will be critical enablers and then at times let's say gender based violence, most of the gender based violence activities are related to are HIV sensitive not HIV specific.

When we're talking about investment thinking, we are thinking about four steps. Understanding the pandemic, know your epidemic, know your approach, designed or rethink your investment portfolio to solve the problem you have diagnosed. Apply these investment portfolios at scale and generate efficiency so we are talking about focusing on increased efficiency. I have heard people say no this an efficiency type of framework, it doesn't take into account human rights and I'm saying we all want more efficiency but we have to take into account that everything we do in the AIDS response has to have a human rights approach.

And sustain, so deliver sustained. In here, this slide

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was used in the plenary and I have to use it because it mentions Brazil, but it's basically saying that Brazil and Russia spent similar amounts on the AIDS response, but you have a different mix of interventions that are used to address the epidemic.

They are both concentrated epidemics, Brazil doesn't have drug users as much as Russia has but Brazil is an epidemic with sex workers and MSM but you can see the difference in the new infections. So how do we put this in a way that we do the right things with the money that we have? And this is an example from Morocco where you see here this is people acquire HIV from 2009 and in grey it the spending on HIV prevention in 2008 and now how the program is managing to shift the spending so that it can better reflect the epidemic profile.

Many countries now are applying investment approach, many countries were applying an investment approach before this investment framework came but these are some of the countries where – and we have some here at the table today who are looking for better efficiency for better results with the money that's being applied.

There are several entry points and methods for the country application that go from the reprogramming of global fund grants or program reviews or national strategies or review of the current strategies but it's really a mix of analysis that focus on strategy. You know very well that information alone doesn't move policies, we need to have very influenced decision making.

This is to show you – it's a complex slide, I'm sorry

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it's very polluted, when you take the programs, this is the proposed spending of the investment framework. Blue are the basic program activities, this is how we could benchmark that they are used because ARTs are more expensive and we could use another benchmark that's related to unit costs.

What are the emerging lessons and observations we have? That it's not just another donor imposed approach - I'm finishing Alvaro. Some key players say that we need more studies before we can take decisions. Let's say we need to move, we know enough and we can fix whatever needs to be fixed as we move along.

Let's just think about what the entry points are, this is in a way for the panel, what are the entry points for new dialogue around efficiency and investment? Always keeping in mind gender based [inaudible], rights based approach. Are there obvious mismatches between the epidemic and the response? Which are the factors that make it difficult to scale up basic program activities and then the critical enablers come into place. How can partners help in the application of investment framework at the country level? I'll leave you with these questions, thank you very much [applause].

ALVARO BERMEJO: Thank you Mariangela. Leaves me with two big ideas and a number of questions very nicely; one, if we're talking about strategic use of resources, a big part of it is investing in the right things, using the money right and you've given us some tools that have been produced to help us do that and asked us a lot of questions, which I hope people are

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taking notes and they will contribute to the debate.

And the other one – those slides you showed around also the gap that remains but how countries are scaling up to sort of meet the challenge but there still remains a gap. Hopefully again we'll hear during the debate, ideas as to how that can be closed. My next speaker is Dr. Fatma Mrisho, she's done in a way, the reverse transition from Mariangela. Mariangela moved from the Ministry of Health from the country level to the U.N., Fatma has done recent – well not that recently, but has done in the past the opposite move, moved from UNFPA where she was working in East Africa to now is the Executive Chairman of Tanzanian AIDS Commission, TACAIDS.

So I guess Fatma what we'd want to hear from you is all this introduction, the tools we've heard, the big ideas, what do they actually mean at country level and what's the experience of Tanzania in using resources more strategically?

FATMA HAFIDH MRISHO: Good morning. I'm making this presentation on behalf of my colleague as well who put up most of the slides, I only have the honor of presenting them.

For background, Tanzania has an HIV prevalence of 5.7, this was in 2007/2008, we are currently analyzing the third zero behavioral survey, we are not quite sure what the picture will be like. Hopefully looking better than before. We have a generalized epidemic estimated new infection of about 1-percent and we are among the 30 plus countries in the world that have managed to reduce incidents by more than 25-percent. The needs

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nationally are amounting to about 1 billion U.S. dollars for HIV and AIDS and this is across the board. This is for prevention, for treatment, enabling environment, for mitigation, you name it HIV/AIDS across the board.

Current spending is a little above half of that so we have about a 50-percent funding gap and this gap was developed after developing the national multi-sexual strategic framework 2008 through 2012 in costing. And thereafter decide what was available and what was not available and that is how we came up with the gap of 50-percent.

As indicated in most of the discussions since we started, Tanzania is no different we are very donor dependant for HIV and AIDS to a level of about 95-percent. The biggest donors are PEPFAR, Global Fund, a pooled fund between the Danish Government and Canadian Government that supports all district HIV/AIDS activities and then several other donors supporting predominantly civil society or other identified groups.

This is the graph that shows the trend in funding in Tanzania, we clock to the highest financial resources around 2009/2010 and there has been a decline since. Partly because of the financial environment globally which has affected pretty much everybody, our won government as well. So both development partners as well as our government have reduced financial support to HIV and AIDS.

What are some of that challenges that are being faced? Estimation was initially done using the strategic framework and

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what one immediately realizes is that it was more population based, the requirements out there were done using a formula which was almost this is the ideal situation if one can put it that way. Therefore, issues like the investment framework which are now upcoming, they would really be a good strategy for us to move away from having blanket strategies for every Tanzanian to prioritizing to specific areas of needs in specific groups of people of higher needs.

The other challenge is having parallel programs and they tend to have higher costs as well as higher setup financial costs as well as human resource costs and one of the ways of moving away from less rational use of resources would be to try and reduce the number of parallel programs and integrate what can logically be integrated. For example, family planning, HIV and AIDS, maternal health and HIV and AIDS and many other sexual reproductive health activities, and you can see my bias towards that from my previous life with UNFPA.

The other challenge is failure to identify what works best and I think we've had a number of examples of doing so and our country was no different. We are currently undertaking a number of studies to be able to know what works best but also what other priorities of the priorities. The last one is not really the last, but the last on this slide is difficulty in improving on coordination and harmonization within and between implementers.

The strategy that we are now putting up is a strategy

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2013 to 2017 and it will be based on Tanzania drivers of the epidemic, we've already started with the exercise and it is ongoing. Hopefully the strategy will be with us towards the end of this year.

Interventions which have higher returns in combating HIV and AIDS will be the priority focus and strategize on areas that can improve efficiency and effectiveness and the investment framework capacity building has already started as we speak. Right now we have consultants who are supporting the team of national and international consultants who are developing the HIV/AIDS strategy to know better about the investment framework so that they can use it in the development in the new strategy.

I think we can pass that, we've already said that, but second bullet; supporting more rational resource allocation based on country epidemiology and context. We are currently for the first time actually, doing specific studies. For example, we have one on men having sex with men but we also have another one which is anal sex in general because you notice particularly meetings like these ones, we talk about men who have sex with men and we forget that women also have anal sex and the risks are the same if not more.

So we've opted to both and hopefully the information will also inform the strategy. It was also help us have more effective programmatic activities as highlighted by the previous speaker, particularly the six core areas and increase efficiency, I think we've already said that.

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What are we doing about increasing domestic funding? Tanzania plans to establish an AIDS Trust Fund and the source of funding will be taxation, it has already gone through various government and civil society mechanization towards making it happen. It's expected to reduce the funding by about 40-percent if it happens and if it happens in time. I think the rest is the gains that we hope we'll realize by so doing. What is required is more advocacy and more efficiency but also improved governance so that the government and its partners are more inclined to see that this is a real need and it should happen and it should happen like yesterday. Thank you [applause].

ALVARO BERMEJO: Thank you Fatma. Amazing I think, the presentation really helps us understand why Mariangela said Tanzania's one the countries that are investing strategically and there's a strong correlation between I think, between what Mariangela was presenting and what we see happening in the country.

It also shows us that the gap in resources that Mariangela was mentioning, it's not just some accounting gap that exists at the global level but is really reflecting at the national level in declining resources available and the type of strategies that Tanzania is using to try and close the gap and use the existing money more strategically moving from you said I think, blanket strategies for every Tanzanian to a more segmented, targeted approach that really focuses on high impact interventions for those that need it the most.

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So let's see if we can continue with that level of really togetherness in the presentations. My next presenter is Deborah von Zinkernagel, she is the Deputy Global AIDS Coordinator in OGAC here leading the implementation of the President's Emergency Plan for AIDS Relief. Deborah thanks for being with us today.

DEBORAH VON ZINKERNAGEL: Good morning, I'm pleased to join this discussion, I think it's been a rich one so far with the country examples of where do we put our resources to have the greatest impact. We're in a time I think where we look at is as a time of enormous opportunity. The science is clearer, we have better data on our programs and we have partnerships with countries that really are putting us in a conversation around these investments in a very new way.

Yet there are lots of questions that I think that also are coming up with these. Where do we put our resources for the greatest impact? We do have to deal with perceived trade offs and I would say perceived between investing in particular services, treatment, prevention or health systems strengthening because in effect investing in those services is indeed strengthening the health system. So I want to put that out there as a point for discussion with the room.

We look at how do policy makers make decisions among choices, how do we put our money forward, how do we measure the value of our investments? And looking at sort of allocative efficiencies, you have to make these choices as you all do every

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day. So I'm pleased to share with you a little about how PEPFAR is looking these questions and how we're looking at it with our programs.

So as the PEPFAR program has moved from an emergency response to one more focused on capacity building for sustainability we've dedicated a good deal of our attention to sort of evaluating the effectiveness of our programs and moving to sort of evidence based programming as our charge. PEPFAR investments are very much geared to sort of being sure what we're doing has a positive health impact. We're looking for evidence based that use the science and demonstrate the most cost effective way also. So not only effectiveness but also cost effectiveness.

The investments that we make need to be additive not duplicative of other donors, not replacing country funding, domestic or diverting existing resources. We're looking to expand the pot and how we approach it and they need to be catalytic for country leadership establishing and maintaining and managing sustainable programs. We also are looking to position these to leverage other resource streams be it the Global Fund, other donors, other partners as well. So with those things in mind it's beginning to put the package together.

This graph shows you sort of quickly the impact that PEPFAR has had in the broader health context. We can now demonstrate that all cause mortality in the original 15 PEPFAR focus countries dropped precipitously during those first five

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years of the intensive HIV investments. And while we look forward to more evidence based programs, we also want to consider as I mentioned before sort of the cost effectiveness. For example, new evidence on treatment as prevention has eliminated some of the perceived dichotomy treatment or prevention because in both ways treatment is also shown to be a very smart investment.

So we've contributed to a special issue of the health affairs which I hope that you can have available and access to which describes some of the benefits as we look at both individual and community level impacts of treatment and I think there's some interesting pieces in there.

We can also take advantage I think, of another tool to achieve long-term goals towards ending this epidemic through the reduction of the vertical transmission. PMTCT was an early priority for PEPFAR and we're proud to be a part of supporting the global plan for elimination of mother-to-child transmission. We're encouraged by the accelerating progress that we're seeing in countries, but you can see here how far we still have to go and how fast we need to get there.

So this slide shows sort of the reductions in new infections but we're I think, accelerating now, I think there's a new energy and a lot more partners in this effort and it's going to increase the rate at which we can take these down.

So let me talk a little bit about expenditure analysis and how we're looking at this. Now as we're sort of compiling

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much better data on PERFAR investments we've got a better understanding of how we're spending our money. This sounds like it should have been a no-brainer but actually it's pretty complicated in a program where you have multiple layers of partners and sub-recipients and all the way down to the ground that we are able to track and be accountable for sort of the resources and how they move.

We also need to look at how epidemics are changing in countries, it changes each year, as we look at our portfolio. What's the right thing to be doing now with our resources and with others that are on the plate? PEPFAR is using economic and financial data now sort of at multiple levels and the most important of these is our expenditure analysis tracking initiative. We had pilots in seven countries in 2010 and PEPFAR is now linking that at routine tracking link to program achievements and we're moving towards them in all of our countries.

The roll-out will start in November of 2012 and will include nine countries which will account for 76-percent of PEPFAR's total annual budget for countries. So this expenditure analysis will give us data that links spending with our results and can demonstrate not only what we've achieved but also what we invested to get to these achievements.

This is a slide looking at sort of the experience that we had in Mozambique which is one country where we actually have longitudinal PEPFAR expenditure data. The expenditure analysis

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was pioneered in 2009 as a means to sort of rapidly assess PEPFAR cost in country and it was repeated in 2011. The results from the longitudinal study show that even with the doubling of the number on treatment, the average PEPFAR expenditure per patient year declined by 45-percnet. Moreover, the variation of the unit expenditure among the same five implementing partner also narrowed.

We're able to look at the average and also the range of expenditures per output across all of our partnerships and identify the outliers. The extreme outliers are on the high side, require further discussion around either the cost model or other factors that may be impacting why their costs are so much higher than others. We also look at those on the very low end to sort of say are there lessons that could be learned, are they particularly efficient ways of doing things? But as we look at the delivery of services, the economy's a scale and program maturity, there are lots of reasons that kind of come in and impact what the final costing is.

Having these types of tools really helps I think, talk both to country, helps our program managers be much more efficient in how we look at things.

The PEPFAR expenditure data for us is critical for managing PEPFAR but it's important to say obviously we don't exist in a vacuum when we're bringing resources into a country. In many countries it's not either a PEPFAR or a non-PEFAR program or country, it's multiple partners contributing country

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resources, global fund resources, private sectors involved and there's a comingling of these resources so it actually becomes quite challenging to try and then link what's your input as it relates to a cost output.

In South Africa for example, I think we have quite a large program but in actuality it's only 15-percent of the total budget that is invested in HIV/AIDS there and each year we're increasingly integrated into a broader primary healthcare response. So we are more moving away from direct service provision there into one of a technical assistance model and for that reason it becomes even more challenging sometimes to link it to a particular outcome.

But I think partnerships are critical in this one. Looking at how do we get to common methodologies of assessing costs and reporting on them requires a lot of coordination among the stake holders.

This is another slide that sort of talks a little bit about our framework of partnerships. We are in a new model of having partnership framework agreements with countries, we have 21. Countries have signed these with us now and we're not moving towards partnership framework implementation plants which is an example what you're seeing here is one of those which lays out sort of responsibilities and measureable outcomes.

This one is coming from Tanzania, you can see at the bottom we look we at expected contributions, other contributions and our contributions and how those come together. But I think

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it begins to track who does what and it's important in that regard.

So quickly I just want to look through a little bit about how this comes together for country ownership. In South Africa as I've noted, we have a large investment but then you look at other investments as well, the country has these tools at their hand to see who's doing what, what the percentages are. We need to be much more transparent and are working to do that and sort of what our investment categories are and how do they related to the national strategic plan of South Africa which is at the end of the day, what we need to be supporting.

I think to summarize for you I would just say that again, our investments need to additive, they shouldn't be diverting or changing the course of what other investments would be coming from the country. They need to be hopefully a catalyst for other external investments as well, we're asking partner countries to invest their own, we need to figure how best we define common indicators, our costing elements at various levels of service delivery. And working to move forward and be very, very clear but hopefully continue to learn as we go, as we do this in more and more countries and have this available as a programmatic tool. Thank you [applause].

ALVARO BERMEJO: Thank you Deborah. There's one slide that Deborah showed that I want us to sort of keep in mind. A lot of the criticism that at least I get working at the International HIV/AIDS Alliance when we talk about strategic use

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of resources is that in the end you're moving resources into HIV and that mortality's just being replaced by other parts that are getting weakened.

And I think the slide that Deborah showed and that is based on a number of studies, shows very clearly the decline in all course mortality in PEPFAR supported countries and that really the effects of the AIDS investment are felt on all course mortality, not just on HIV related mortality. I think it's important that we take that as well and very much also remember as Deborah said at the end, use the science, look at cost effectiveness and remember that the PEPFAR money can't replace country responsibility either. I think those are a few things to keep with us.

My next speaker is Mr. Raymond Yekeye who's the Program Director for the National AIDS Counsel of Zimbabwe. If you remember that slide from Mariangela, another one of those countries that were listed as investing strategically and with an interesting experience of also try to mobilize national resources to contribute to the AIDS response, Raymond.

RAYMOND YEKEYE: Thank you very much for the introduction. My presentation is basically to look at our own experience in using the investment framework. I wouldn't say we have gone very far in using the investment framework but we are at the beginning and we have actually looked at the priorities that we want to do and how we can apply the investment framework at country level.

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My presentation basically is going to look at the background of Zimbabwe and HIV and our experience with the investment framework and what are our priorities in terms of operationalizing the investment framework.

In terms of our trends in HIV, this is coming from a demographical survey 2010/2011, where we're looking at our HIV prevalence being 15-percent. The last THS was 18-percent so we are seeing a decline but of course there's a slight difference between men and women and this I think, something that everyone has been talking about over the years. In terms of HIV within our age groups, I think this a standard graph for HIV, I think everyone who has been in this business for some time will agree with me that there isn't a big difference in terms of what is happening in Zimbabwe and what is happening elsewhere, especially in Sub-Saharan Africa.

This is a slide looking at discordance, the percentage distribution of couples living in the same household both of whom were tested for HIV and you'll see that we do have a significant number of discordance of couples when you look at men and women. That's about close to 13-percent.

I'm supposed to talk about the investment framework and I don't know what has happened to my graph there but I decided just to focus on the ART Program. We have seen an upward trend in terms of the numbers of people on treatment and at the end of May we added on 480,000 people who were on treatment. I think that's the graph. This is as you can see, a rapid scale up of our

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treatment program from 2004 to 2010. I think we have seen a huge increase particularly for 2010 and 2011.

Some colleagues have already eluded to this, and I used just treatment I didn't look at the other areas around prevention, creating an enabling environment and so on and so forth and you'll see that our treatment program is still heavily supported by partners. Although the AIDS levy at the end of May was supporting around 23-percent of the patients on treatment. However, we're looking at that number going up as we go towards the end of the year and we're looking at probably between 150 and 200,000 patients being supported from the AIDS levy by the end of the year.

The levy, I think yesterday there was a more detailed presentation on the levy. We have seen an increase of the levy from 2009 we had a zero balance at the end of 2008 because we changed our currency but we have seen a gradual increase of the levy from 5.7 million on 2009 to 26 million at the end of 2011 and our projections are that the levy will go up to about 35 million by the end on 2012.

How we have been having the levy in terms of collections, I think most of the levy that we have collected I think has been used because 50-percent of it is supposed to go to treatment. It's a statutory requirement from government that we need to use 50-percent of it for treatment.

More specifically now to our case and the investment framework, I think the positive side is that Zimbabwe's one of

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the high impact countries with a significant pattern of HIV, I think that I've already highlighted. We also have sustained political commitment and will to curb the HIV epidemic, I think the levy is one such example of commitment.

I think very few politicians would like to test their voters but our government has taken that bold decision to ensure that we have a home grown solution to fighting HIV. The HIV response is an integral part of the national development plan and also it's part of the health other sector development strategies.

Significant successes have been recorded in the HIV response in Zimbabwe, we were one of the very fist countries to record a decline in HIV prevalence. You saw our increase in the numbers of people that are accessing treatment over the years. We have a current national strategy plan which 2011 to 2015 and this has been highly prioritized around the three zeros and the high level meeting targets. We have a pool of donors operating in Zimbabwe who are very committed and aligned their support strategies with the national priorities and plans and then of course, the increase in the levy.

However, what we have noted in looking at the investment framework and how we can apply it at country level, we have seen that the country is too largely dependant on external resources. I've already said that the levy at the end of May was supporting around 23-percnet of the patients who were in treatment and we are looking at the remainder of those being supported by partners.

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The mechanisms for tracking domestic and donor resource allocation and spending require strengthening. We do have partners who are supporting the program but the challenge is how much is it that they are bringing into the country? Some of it includes not just the commodities; some of it includes technical assistance. How much technical assistance is coming into the country and how much of that do we really require as a country?

Then opportunities for domestic investment have not been exhaustively explored and attempted and we do have opportunities to further increase our domestic investment in HIV. Systematic effectiveness, efficient analysis have not been undertaken yet and opportunities for adjusting the costs of the response have been explored but only sporadically.

Our priorities for operationalizing the investment framework at country level; what we decided by operationalizing the investment framework at country level is ensure sustainable resourcing of the HIV response and other priority health and development programs and initiatives. We also want to increase domestic and sustained donor funding for the HIV response, what we are saying is that even though we want to increase domestic funding we still need to work with our donors in terms of making sure there is sustainable financing for the national response.

Then we also want to analyze and increase effectiveness and efficiency of the responses implemented both by public sector and the civil society and communities. I think we have already done a bit for communities, I think we did something with the

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World Bank looking at how the communities are contributing to the response. We also want to reduce the costs of the response through a set of appropriate measures. That's the end of my presentation, thank you very much [applause].

ALVARO BERMEJO: Thank you Raymond for your presentation and sticking to the time. Take a couple of things maybe for discussion later. I think you highlighted something Mariangela also mentioned around how can partners help in the alignment and you were talking about saying there is quite a lot of donor alignment behind country plans but maybe you can tell us afterwards a little bit more around how that has been achieved and where that leadership comes from.

The other important point maybe to pick up as well later around resource tracking, and you said we need to improve the ways in which we track not just national resources but donors resources coming into the country as well. I think an important point also for the debate. Thank you.

My final speaker is Marieke van Schaik who's the Managing Director of the Dutch Postcode Lottery and I'll say a little bit more for those of you that don't know the Dutch Postcode Lottery. It is the largest charity lottery and private fund raiser in the Netherlands but also one of the biggest foundations funding health in the whole world. She's going to talk a little bit about what they call the dream fund and what innovation in funding can add to the mix.

MARIEKE VAN SCHAIK: Thank you Alvaro and good morning

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everybody. I will talk about our dream fund but let me start by telling a little bit about our lottery model and funding vision. We are a charity lottery as Alvaro said, our mission to raise funds for good causes and raise awareness about the work of the organizations that we support and we've done that now for almost 22 years and 50-percent of every ticket we sell goes to good causes.

We have 2.5 million households playing in the Netherlands with more than four million tickets every month and your ticket number is your postcode so when you win you share with your neighbors living in the same postcode that is, if they all have a ticket of course.

So the lottery's very much about sharing, sharing with your neighbors and sharing with good causes because if you don't win someone else does win. You see some pictures of people receiving checks here of parties that we organize for our participants but also I think it's in this picture UNHCR receiving a donation.

Since the start 22 years ago, we have raised $3.5 billion Euros for good causes and in 2012 that was an amount of $284 million Euros that we could divide, we now fund 85 organizations with a structural annual donation. You can see a selection of these organizations here.

We work in the Netherlands and abroad in the fields of nature conservation, health, poverty eradication, human rights and climate change. These 85 NGO's that we fund structurally

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receive an annual contribution, it's un-earmarked funding, we want to be a reliable donor so we screen an organization before they become beneficiary. We have a thorough screening and once you are a beneficiary we give you an annual donation and we don't interfere with where you want to spend the money. We do have a yearly checkup and a five yearly thorough evaluation but we really want to have this relationship based on trust.

We also feel that the organizations that we support are the experts so we are not setting up our departments with experts in every level, it would be a hard task dividing this much money anyhow. But there are many organizations that are experts in their field and we feel that we want to have this relationship of trust.

As I said we have a large audience in the Netherlands and we organize many events and produce many T.V. show to involve the public to sell our tickets of course, but also to give shape to the second part of our mission which is raising awareness on the causes that we support.

This a famous hostess in the Netherlands and in her quiz show, which is a quiz show for lottery participants, we always talk about our causes that we support. There will be questions about it, we will be referring to the work of the charities that we support and we also do this with any email or any direct mailing that we send to the public. We always talk about our work in the charity sector. This is also important because this way many NGO's can reach an audience that they might not

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otherwise reach so easily.

We are also an international fund raiser now know at the United Postcode Lotteries, the Dutch Lottery is by far the biggest and the oldest with 22 years but since 2008 there's the Swedish Postcode Lottery and the People's Postcode Lottery. Together, last year we found out we are the world's third largest private donor so we are very proud of that.

This is our lottery and then our Dream Fund. I just told you about our funding vision, we want to be a reliable, structural, long-term donor but when we started financing these organizations our money was an extra. These organizations could do new things with this and extra things with this but after a number of years this money becomes part of a general budget and that's very natural and logical. But we felt that this money that we have is money from our participants, it's not government money, you can take risks with it, you can be more entrepreneurial and we really wanted to encourage that in NGO's.

So we introduced the Dream Fund and we did that by taking 10-percent of the contribution to our beneficiaries, all of those receiving a million a year or more, we took 10-percent of that and put it into a Dream Fund. The organizations can apply for funding from this Dream Fund and these are big projects that are high risk but with a potentially very high impact and gain changing. One of the first projects that we selected was the Max Art Project in Swaziland.

Swaziland is a kingdom and it's a lower middle income

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country and it has a population of about a million inhabitants and an HIV prevalence of almost 30-percetn. The project aims in the short-term to ensure that at least 90-percent of those in need of treatment based on current guidelines are on treatment by the end of 2014.

And in the long-term it is to ensure long-term access to treatment and care for HIV positive patients in need of treatment. To provide proof of concept of the benefits of treatment centered prevention thereby catalyzing the widespread adoption of a new form of HIV prevention in South Africa and beyond. And finally, to reduce the number of HIV infections in Swaziland by half by 2020.

Now this is a risky project and a project that hadn't been undertaken on this scale and I feel that we could only do this and give this nine millions Euros to Stop AIDS Now because Stop AIDS Now is a trusted and long-term partner of ours. We have seen more projects that they've done, we've seen their work, we know they are a well organized and well connected organization.

And on top of that they selected very important and reliable and strong partners among which the Clinton Health Access Initiative, Surf AIDS, GMP Plus and also working very closely with the universities from South Africa and the Netherlands for the scientific component of the project and last but not least, also working in very close conjunction with the Swazi Ministry of Health.

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Here we have all the pieces of the puzzle of this ambitious program and all these parts support the government of Swaziland and Swazi civil society in this integrated approach. We were a donor looking for a daring and offerative projects and this was just Stop AIDS Now and CHAI were looking for and together we invested in this project and we were working on this project and we really hope that by just doing this we can set a model and show that this works.

Of course not everything will work but we can also show what doesn't work. We will be a flexible donor and we hope that this can be a blueprint for future generations not only for Swaziland but for Africa and beyond.

Let me close by saying that it is of course the participants of the lottery that made this possible by actually pursuing their own dream of winning a lot of money. But if they don't, everyone who plays the lottery is very aware that this money then goes to good causes and this way we can hopefully let this dream come true in Swaziland. Thank you very much [applause].

ALVARO BERMEJO: Thank you Marieke for reminding us that the right money mix, which was in the title, especially when dealing with an epidemic that changes as quickly as HIV/AIDS also needs some venture capital to try new things that can really be game changers to use your words and thanks for helping make that dream come true. So now it's time to hand over to you, the demonstration is starting outside one of the fingers is actually

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on financing the AIDS response and calling for a financial transactions tax. So when you line up to speak behind the microphones here in the middle we'll add you towards the number in the demonstration as well and then you don't need to go out. Thanks, so please line up at the microphones. We'll start here and then move to others.

TRACY ELLIOTT: Good morning, thank you for this insightful information. My name is Tracy Elliott [misspelled?], I'm from Atlanta, Georgia the United States and as you know the United States is neo-fied in terms of dealing with the national AIDS strategy. The ink is barely dry on ours and some of you have been working with national AIDS strategies for much longer than that.

So I'm wondering if I can take this down to a micro level for just a moment and ask you to help us who are on the local and regional level figure out how to coordinate working with a national AIDS strategy and smart investment techniques? And pulling this down to the local and regional level in terms of how we at that level can work with you on a national scale effectively and efficiently using our dollars on a local level in the same effective ways that you're using them on a national level.

ALVARO BERMEJO: Thank you. I'm going to take one more question and then see who wants to respond to that.

PATRICIA BARTLETT: Hi, thank you very much for great presentations. My name is Patricia Bartlett and I'm a social

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worker at Duke University where we also have a long standing collaboration with Kilimanjaro Christian Medical Center in Moshi Tanzania and I wanted to just speak for a moment to the issue of medical education and the PEPFAR grants for the MEPI's the Medical Education Partnership Initiative for which we have one at KCMC.

I think it reflects the HIV sensitive part of the equation of this national strategy which looks at trying to stop the brain train from low middle income countries within the medical staff in those countries. I know that our MEPI is looking at novel way for shoring up the medical training for doctors, nurses and lower levels and I just wondered if you might speak to how you can see that as part of the national strategy in improving the medical education? Thank you.

ALVARO BERMEJO: Okay I'm going to ask the panel to respond to those questions and then come to you and other people who line up. So we have two questions; one around the links of local, national, regional planning and implementation. What are the tricks and what tips could we give to colleagues here in the U.S.? The other around medical education and its integration in the national programs. Anybody wanting to start?

FATMA HAFIDH MRISHO: Thank you. Our way of doing it is you develop the strategy together with those levels that you want to implement with. It shouldn't be done post development, it should start early enough so that they internalize it and they feel that it is part of their process. The epidemiology may be

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changing and I think it's a lot more complex in the states because every state is like a separate government the way I understand it.

And therefore even if there is a unified national strategy, each region in our case, each state in your case, needs to domesticate it and adopt it to the environment available.

It's sometimes up to the level of a district. And I don't know the counterpart of our district. Either states may be a county, I'm not quite sure. In the opening statements we were informed that even in Washington DC you do have pockets of high prevalence. And one may wish to tone down to the level of a district.

Regarding the training, human resources for health it's one of the biggest constraints we have in Tanzania of operating at a level of about probably half of the health – health human resource needs that we are required to have. So it is a big issue for us.

And as we develop the multi-sectored strategic plan, the health sector carves its strategic piece to develop health sector strategic plan related to HIV and AIDS and human resources for health, both laboratory, clinical in terms of medical officers or different carters [misspelled?] as well as other that we refer to as paramedicals, they all are part of that strategy.

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And KCMCs actually, as I'm sure you are aware of the many units in Tanzania for quite a number of carters.

ALVARO BERMEJO: Thank you Fatima. Raymond You want to go on that as well? You can use this one.

RAYMOND YEKEYE: Thank you very much. I think my colleague from Tanzania has really touched on some of the issues. I've already indicated that for us our strategies are linked to the global, regional and then our own national commitments. So for example you are talking about the eyelevel meeting targets. You're talking about having new infections by 2015. And our company is a signatory. Our government is a signatory to those kind of targets.

And then what you then do is domesticate, I think that's the way my colleague used to ensure that your strategies within the region are talking to each other and they're complimenting each other. In terms of medical education, I think it's looked at in the broader sense of the human resources for health. And one of the things that we have done is to come up with an HRA strategy for the for the country.

As I indicated in my presentation, our NSP for HIV and AIDS has to talk to the broader health strategy and then all the other strategies that you find within the health sector. So the ministry has a health strategy, they have an investment case for health. They have an HRH strategy and our NSP is to

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be linked to those strategies and other development strategies that are within the country.

So what we are looking at is not HIV as independent from both development and the health sector strategies.

ALVARO BERMEJO: Thank you Raymond. Deborah can we hear from PAPFAR as well.

DEBORAH VON ZINKERNAGEL: I don't think I could be more eloquent than my colleagues from the countries in terms of the necessity of that investment. I would just add that we need to – in how we are supporting that initiative we need to look at how it is sort of designed. You need to retain the benefit of that investment in the country. So part of Mepy I think is very much looking at how do you recruit and retain once you've invested in educating physicians. What kind of system do they, where do they come from. Do they go back to where they practice where they what part of the country they've come from. What kind of support do you need for faculty. Often research and research opportunities is a driver to keep people in countries and satisfied in working.

So it's a broader initiative. It fits within larger plans. The benefit extends beyond HIV but it needs to be a thoughtful program in order to retain that investment benefit. Thank you.

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ALVARO BERMEJO: Thank you I'll take two questions from this mic over here.

HEIDI SCHLUKER: Hello my name is Heidi Schluker [misspelled?] I'm a research fellow at the London School of Hygiene. Is it working now?

ALVARO BERMEJO: You need to get closer.

HEIDI SCHLUKER: Okay. Hello my name is Heidi Schluker I'm a researcher at the London School of Hygiene Tropical Medicine. I was really pleased in the opening ceremony and the plenary and even now in this talk to hear that gender equality and gender based violence is important. It was addressed in I think every speech I heard. Still in the investment framework it is put down as a development synergy. And I was very pleased now to hear that it could be a critical enabler as well.

I was wondering though that, you know, given the importance that it's based on, gender inequality shouldn't it be a proper critical enabler given how crucial it seems to be from whatever everyone mentioned? Because, and as our we heard from Zimbabwe, the countries are looking at this investment framework to see where it should focus on et cetera.

So the question is, shouldn't it be have a higher importance in the frame work. Thank you.

ALVARO BERMEJO: Thank you.

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NANCY RECULMAN: I'm Nancy Reculman [misspelled?] from Washington University in United States in St. Louis. My question was around this statement about investment in AIDS services in the strengthening of overall health service and wondering what data is available to support that claim or understanding that overall health services are improving directly relate to the AIDS investment. And then specifically about PEPFAR, whether PEPFAR has indicators to monitor this. That their AIDS investment is supporting the overall development of health services, thank you.

ALVARO BERMEJO: Thank you. I'll ask the panel to respond and then go over to the mic over there. Or Angela do you want to start with the question on the investment framework?

MARIANGELA SIMAO: Yes. I think it's very important to clarify that investment framework is not a strait jacket. And it's a tool. And it has to be applied intelligently. And then you have to consider the local context. We can have, like I said, you can have situations where critical – specific programs are critical enabler and in that context will be a synergy.

So it depends a lot on how the context of the epidemic. On the other hand it's very important that we don't use this to hide behind. Like many times we hear, for example, that same

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sex orientation is an invention of the West, right? Of rich countries and developed countries. We can't use investment framework and in saying that we are applying the local context in the culture and get behind that and not recognize, for example, that there is an underlying epidemic among MSM in Africa, for example.

So that's why I'm always pushing that we cannot take it as it is and say it's going to be applied in Brazil and Batswana, in Tanzania, in Zimbabwe the same way. But the principle has to be there. So human rights based, apply a gender [inaudible] to it.

And the other thing is just going back to say, and I think our colleague is here in this panel we're very, very good at showing that. That she feel we need to focus more. But we don't only need to focus, if you focus and do small parts, don't scale up we won't get anywhere so we need to focus scale up and increase efficiency. I hope I clear.

ALVARO BERMEJO: Thanks Mariangela. Do you want to pick, Deborah, the second question? And maybe others add?

DEBORAH VON ZINKERNAGEL: Sure, I think that's sort of two parts in your question. One is looking at the investment of a particular service and how that relates to sort of the health system strengthening broader over all. And I would take an example of antiretroviral treatment. Where you need, in

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order to deliver the antiretroviral treatment, you need to have a procurement and distribution system to bring drugs to the clinic, to give to the patients so they can get treatment.

If you're doing a procurement and distribution system and strengthening that capacity within a country, you're contributing to what can be a procurement and distribution things for many things. For many commodities and drugs so it's an example where you may be a particular service, but you're certainly strengthening a broader system or capacity the same is true for a healthcare worker who needs to be trained in order to deliver the antiretroviral drugs.

If you're looking at quality and quantity of health workers you're actually contributing to a larger health system outcome. There are studies that reflect some of those broader benefits so as a sort of trickle down health systems benefits. Increased use of antenatal care, where you have PEPFAR programs operating. There is a provider, there is a clinic, there is somewhere to go there is a service to receive, so you'll look at something, you'll see a decrease in TB mortality. Obviously also linked with HIV.

But they're broader, there is sort of a range of those and we're happy to provide you some of that data if you're interested in it. But it's — that's why I let off by saying it's not an either or. It's a both and it's sort of capturing

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those impacts. I think is part of that work that we need to be doing.

ALVARO BERMEJO: Thanks would Fatima or Raymond want add to that last one?

RAYMOND YEKEYE: Maybe the bit one on gender within the investment framework. What we have realized is that we have to apply the tool at program level and within the national response. And what I talked about was applying the tool at the national response level. And I didn't talk about applying it at program level. But if you're going to apply it at program level, we have applied it in the development of a combination prevention strategy.

And others have said things like gender, you realize they're more important and you need to give them the prominence that they deserve within the combination prevention strategy. So it's about applying the tool in each of the programs. In financing and so on and so forth. Thank you very much.

ALVARO BERMEJO: Thank you. There are a lot of people standing up so I'm going to take three questions next and then I'll come back to you. Those two in the middle and the one at the back.

FEMALE SPEAKER: Thank you so much for all the representations you made. My question goes to anyone of you. When you read through the investment framework you find that

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they are global resource needs or estimates. And if a country, a specific country was actually implementing maybe the six basic activities and other interventions like the social program enablers with a [inaudible].

We're wondering are there specific measures that a country can measure itself with and be able to tell whether they're implementing the investment framework. Where or is it just a guideline.

BOB ANTIGIONI: Hello I'm Bob Antigioni [misspelled?] I work up at the Institute of [inaudible] at Baltimore. My question is somewhat related to hers but it's a bit different. So we've spoken since the week about how we are moving from an emergency response to targeted access to a more sustained one that potentially targets eliminating AIDS and preventing any infections.

So under this new partner we need to focus more on not just access iniquity but the effectiveness of interventions preferably at a patient level but at least at population levels. So I'm wondering in terms of all the tools used by UNDP, UNA or PEPFAR shown before, how integrated our matrix to undercut out comes and how much of this goes into the discretion with each country in determining their investment mix. I am showing that it is actually the most effective interventions that get continued funding going forward.

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ALVARO BERMEJO: Finally at the back.

BOB FARRIS: Thank you very much, my name is Bob Farris [misspelled?]with USAID and I had a question regarding the post code lotteries and wondered if you had ever partnered with countries to help them develop similar financial schemes so that they could help self-finance some of their health sector programs. Obviously it wouldn't be at the scale of post code lotteries but would also be a way of country ownership and they could continue into the future to finance important things within the health sector, thank you.

ALVARO BERMEJO: Thanks. Mariangela I'm not sure I understood the first question 100 percent but as I understood it is the investment framework just a tool or does it also have benchmarks that go with it so that a country can really measure its investments against others in similar situations and help it guide. I'm not sure if I'm 100 percent understood it but maybe we could start there?

MARIANGELA SIMAO: Thank you. You know I'm 56 years old and I think I'm losing my hearing. It's true it's not less. But as the investment framework is a global framework where it works on estimates, right? So if we break it we can take them each of this countries because it was based on an estimate for several countries. But we can can't take this data from the countries and apply them and say this is the

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reality. Because you know the reality, I said many times the modulars, they are not very much into reality. They work with [inaudible]. So actually when we say let's apply a thinking, a smart and strategic thinking around investment, in user framework that has basically put together the basic program activities where we have studies showing they are very effective.

With exception of behavior change where there are still some study that show that some behavior change interventions are very effective and some are not. But it's mostly about this — but then it's showing because if we go back and let's say let's prove that laws that criminalize same sex behavior, let's have a randomized controlled trial that these laws are impeding access, we can't do that.

No, we have to work with the evidence that is available and also because it's the right thing to do. It's the right approach to it. So the investment thinking, investment approach provides elements to — like you mentioned very well, to think about the programmatic response but also how do we leverage advocacy towards a better national response, fully funded that addresses the needs of the country, the real needs.

ALVARO BERMEJO: Thank you. Deborah I think the second question is for you.

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DEBORAH VON ZINKERNAGEL: I think it's an excellent question because in order to have any sign of that kind of comparability there has to be some common language that we all speak in terms of both our investments and sort of outputs around them. So I can tell you a little bit about where PEPFAR is working. We're working with the global fund particularly now, to sort of look at harmonizing our expenditure categories. It's important when we begin to report data together that we're all talking about sort of the same elements.

With you and AIDS we're looking at expanding the investment framework for improving sort of allocation impact better data and better harmonization of data I think is going to help all of us to actually I think that we're measuring and reporting on the same thing and we're evaluating things properly and with the world bank we're developing expenditure minimum data sets. So here are you all familiar with the MASA's which can be very long and very cumbersome and difficult.

Multi-year processes and they're almost by the time it's done it's no longer always representing reality. So I think at that level sort at that macro level we need to be sure that in order to make assessments that are on target, we need to be talking about the same things. So across those three

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large partners we're trying to look at our PEPFAR program and how do we look at the same things together.

ALVARO BERMEJO: Thanks Deborah and Mareke the third one I think was for you. When will we have an Indonesian post code [inaudible]?

MARIEKE VAN SCHAIK: Well if you want to start one we can talk about that. we have not done that yet. Financed any big project on financing of health systems. We do work with — if we would do that we would always do that through an NGO because I think we would finance an NGO who would take that as a goal.

We do, do that in the field of sustainability and in view of climate change we have some NGOs that we support that specifically work towards advising governments, local governments, regional governments and national governments on how to implement these strategies and also financing of these strategies. So I think it's a very interesting concept and we're open to that.

ALVARO BERMEJO: Can I give you my card right now? Thank you. I'm going to take one, two three.

FEMALE SPEAKER: Thank you. My question is directed to the two presenters from Africa. First I want to know how have your governments ensured that they protect the domestic budgets allocated to HIV and AIDS so that they don't get redirected to

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other areas of – high priority areas simply because we do get or HIV and AIDS gets extra funding. That's the first part. And the second question is to find out what is the allocation of your countries budget on HIV and AIDS in comparison to what the external donors are giving. Thank you.

ALVARO BERMEJO: Thank you.

MAURY TONSMAN: Yes hello Maury Tonsman [misspelled?] from the Harris-Grey School of Social Sciences. If we're talking about – my question is to our two Africa colleagues and maybe from the person from PEPFAR, if we're talking about getting the right mix, having worked quite a big on HIV prevention policies there are two points that come to my mind, one of them is two maybe blind spots.

One of them is if we – we know that the demographic in the health surveys in Mozambique show that 30 percent of children below 11, who are HIV positive, have HIV negative mothers. That's 22 percent is the percentage in Swaziland. Now if we're heading towards elimination of children born with HIV or getting HIV, these children didn't get HIV from their mothers so maybe we should look in to the available evidence of unsafe medical care that still is happening in a lot subs that are in Africa.

A second question is concerning the issues of non-behavioral drivers of HIV transmission efficiency. We know

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that [inaudible] for example, increases HIV transmission risk by three or four fold. We know that 120 million people in Sub-Saharan Africa live with [inaudible].

Similar evidence is available for soil transmitted [inaudible]. And I was wondering these nonbehavioral drivers of the epidemics don't seem to be found anywhere, except for maybe blood transfusion. I know PEPFAR is doing a lot on that in the national strategies, thank you.

ALVARO BERMEJO: Thank you.

KAREN BLYTHE: Yes, my name is Karen Blythe [misspelled?] I'm with Interhealth International based in North Carolina overseeing our East Africa programs. And I first wanted to say I was very humbled to hear Fatma mention that Tanzania was 95 percent dependent on donor funding. I think that — you know I want to just applaud you for saying that.

Because I think it shows also how much we need to do to help different countries with this important shift of limited resources. But my question is more around I wanted to hear more about the vision of donors as well as national leaders as to your thoughts on how these strategic investments should be leveraged in the future to build local leadership and ownership as we move in the future.

ALVARO BERMEJO: Thank you. Three very good question. Who wants to start? Raymond.

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RAYMOND YEKEYE: Thank you very much. How have governments — how are we protecting the funding for HIV. I would say that for the fight for our governments in Africa to increase allocations to the Abuja levels I think continues. And I'm glad that our government continues to try despite limited resources to ensure that they do provide some resources for HIV and AIDS despite the fact that there is a levy.

So the levy is managed outside the main stream budget of government or central government so this levy does not go into the coffers of central government but it is managed outside that. But government over and above also does provide to the best of its ability, by the way, some funding for HIV and AIDS.

And in terms of percentages I would say that I don't have the exact figures in terms of what is the percentage, but I can say that progressively since 2009, government has provided some resources for HIV and AIDS within the central government allocation.

In addition, to the AIDS levy, which is a separate funding altogether. And then maybe the issue around the local leadership ends on it. I think in my presentation what I tried to indicate was that we still need the relationship with the donors in terms of the national response.

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But we also need to show that we are committed by putting something on the table by providing leadership in terms of giving the priorities that we want as a country. But I said in one of the slides that we also need to look at the costs and the contributions. There is usually the undervaluing of what governments are doing for the national responses.

For example we never caused the infrastructure that the governments are maintaining. So we do get our donors bringing the ARVs but we do have all infrastructure that is there, that is maintained. No donor is going to pay for electricity and water and so and so forth. And what is the cost of that contribution by governments.

We are probably not doing that. Yeah? How much is our civil society contributing we need to look at that and cost it as well. How much our community is contributing and how much our donor is contributing. That way we didn't as governments we are providing the leadership and the direction in terms of where the response should be going, who is bringing what. I was talking about [inaudible] who is bringing what. How much is the private sector contributing to the response.

These are the kind of things that we need to cost appropriate, trick appropriately and share these with our partners so that we are able to provide the leadership that is required.

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FATMA HAFIDH MRISHO: Thank you very much. We would like to see it as a national contribution rather than government contribution necessarily. Government contribution is important but increasingly we are seeing the private sector, which is growing, private sector also contributing to HIV and AIDS in terms of supporting their own workers, but also contributing directly to what the government is doing and also putting in the some money to civil society. How do we protect that money? I think it's mainly through advocacy and a little bit of prayers as well.

Because a third world country means many, many high priorities. And sometimes it's very difficult so you demonstrate to the effect, you demonstrate the benefits and that is why investment framework has a potential to do that. What about nonbehavioral transmission? Evidence based, evidence based. We will always have many others, but let us start with about where does the bulk of the infection come from. And if we start from there, resources allowing we can then say tier two is this and tier three is this. And that is about prioritization.

And evidence will also show you that some of the infections start early and they are not transmitted through mother to child and therefore one needs to address adolescent and also childhood. Education, specific to HIV and AIDS quite

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early on. We start at fifth grade. Fifth grade is about 12 years. And it is an uphill task because sometimes you have some organizations, not quite happy with that. But again, evidence helps justify what is being done.

In terms of leadership exactly as my colleague has said. Again, advocacy, evidence based advocacy really helps. In Tanzania our president publically tested with his wife for a young good looking man to do that I'm sure it wasn't easy. But when he did that, we've had like 16 million tests since. It's becoming fashionable, that's what leadership is about.

ALVARO BERMEJO: Thank you. Deborah or Mariangela if you want to add a bit more maybe to the question of our colleague back there on other forms of transmission, particularly atrogenic.

MARIANGELA SIMAO: Very quickly just drawing on the Brazilian lessons and best honor on how to — what made the difference in Brazil. Like when Brazil started treating people was 1996 with the — was already doing it from 1991 but what made the difference. Brazil at the time was a low income country. And there was a lot of activism and pressure. We had the conference, AIDS conference and there was a lot of very focused pressure on the right point and time. Young know it was were the laws for the budgeting were made.

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And then the incidents – the political incidence was then on the – most countries have a yearly cycle for budgeting right? And most countries have laws that say what our directives for what this budget is. And in Brazil the activists in civil societal organizations made pressure to have HIV included forever in the budget, in these directive laws.

So that's the place where – that was in 1996 where it says that Brazil had to provide access to – from then on every year we didn't have to discuss whether the budget was there or not because that was a part of – it's a very [inaudible] target intervention.

Who makes the laws on budgeting? Ministers of finance prepare the laws to parliaments and to congress. Let's have a better incidence – political incidence from that pressure point and make sure that HIV is not neglected when the national laws on the budgeting are being prepared. What was the question on modes of transition sorry?

ALVARO BERMEJO: Well I think our colleague was commenting on health care generated infections among children that are point to HIV positive – HIV negative mothers but then show to be infected sort of after birth and also the contribution of other diseases to increase sensitivity to HIV.

MARIANGELA SIMAO: That's a tough question.

ALVARO BERMEJO: I think maybe Deborah will answer it.

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DEBORAH VON ZINKERNAGEL: I think your point is we really need to be, when we're planning services we need to be looking pretty closely at the epidemic. And what is the epidemiology where the case is, where is the next new infection going to happen and how do we sort of adjust and position our programs to be responsive to it.

You're correct there are many other condition which are predisposed to HIV. We know that malaria, a pregnant woman with malaria is more vulnerable to HIV. You need to not look at HIV in isolation but here is where I think it's critical to be working really closely with the countries ministry of health.

Looking at developing that capacity, strengthening that capacity to track data so that you can then place your programs in a proper place where you're intervening as appropriately as you can. PEPFAR doesn't fund all – doesn't fund everything in terms of other conditions. But we're very, very anxious to be sure that we're optimizing our opportunities of prevention as well.

And I'll comment briefly on your question regarding sort of a strategic capacity building and local ownership. How do we go in that direction? I think we've recognized that we need to spend a lot of thoughtful time around that capacity building and it's often not directly a health service. It's

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sitting down and working through sort of management systems, tracking systems and paying attention to those that have to manage programs as well as those who are delivering direct care services so that the end of the day the planning follows the management follows the delivery system.

It's important and expanding capacity there is a first critical step towards that country ownership of the response.

ALVARO BERMEJO: Thank you I'm afraid we've run out of time so in finalizing I'd like to thank Louise Van Dette [misspelled?] and her colleagues at Stop AIDS Now who I think have put up a fantastic panel and particularly thank all the panelists and all of you for having come today. Thank you.

[END RECORDING]

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