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AIDS 2012: KEY LESSONS FROM A DECADE OF ACTION ON GLOBAL AIDS, AND THE WAY FORWARD

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P R O C E E D I N G S

MR. UNGER: Thank you everyone for joining us. Welcome to Brookings. I am Noam Unger. I'm a fellow with our Development Assistance and Governance Initiative here.

Brookings is very pleased and honored to welcome Ambassador Eric Goosby, the U.S. Global AIDS Coordinator, today for our discussion, "Key Lessons from a Decade of Action on Global AIDS, and the Way Forward."

In the interest of time, I will forego the truly detailed recitation of Ambassador Goosby's very impressive biography. But I will note that despite the emphasis of today's event on the lessons from the past decade, Ambassador Goosby's experience in the fight against AIDS makes him a pioneer in the matter. Since his involvement dates back more than 30 years, to when he had not yet completed his residency, but was already becoming a specialist in the then-unidentified disease that would come to define his career.

In the 1990s he helped lead domestic federal efforts to respond to the disease, including setting up the Ryan White CARE Act that unlocked federal support in response to AIDS. And then a decade ago he turned his focus to the global pandemic, establishing the Pangea Global AIDS Foundation to build better capacity for response in resource-poor

environments.

Now he has brought all those experiences to bear in his role as U.S. Global AIDS Coordinator at the State Department. His office has the authority and the responsibility for coordinating, overseeing, and managing all aspects of the President's Emergency Plan for AIDS Relief, which accounts for the overwhelming majority of global health assistance funding from the U.S. And that in turn constitutes more than a quarter of U.S. assistance resources globally -- just to put it in context.

He also oversees U.S. government engagement with the multi-lateral Global Fund to Fight AIDS, Tuberculosis, and Malaria.

His visit to Brookings today is particularly well timed in the lead-up to the large international AIDS conference that will take place here in Washington, D.C., in a month's time. And after the Ambassador's remarks, I'm sure we'll have time for what will be a very interesting set of questions from all of you.

So let's get to it, and please join me in welcoming Ambassador Eric Goosby.

AMBASSADOR GOOSBY: Well than you very much, Noam. I appreciate the kind introduction.

It's really an honor to be with you today. I think that the Brookings Institute has really gone way out of its way to make me feel

welcome, but also to kind of scramble this to make it a meaningful and rich contribution from both people in the audience and those on video.

The AIDS 2012 Conference is now just one month away, as we heard, thanks to the Obama Administration. For the first time in more than 20 years, this meeting is taking place in the United States. As Americans, this should make us proud. What should also inspire pride is that the conference comes to the nation's capital at a pivotal moment in our fight against AIDS.

Seven months ago, many of you in this room heard Secretary Clinton declare the historical "Creating an AIDS Free Generation." Less than a month later the President stated that we not only can win this fight, that we will win this fight. These words from the President and the Secretary were based on a series of scientific discoveries primarily funded by the United States, which has become game changers over the course of the past year.

And because of the science, the world will come together at AIDS 2012 to say that we're turning the tide. That's the theme of the conference. A tide that once overwhelmed the world is now a tide that is uniting the world. Hope is truly taking the place of despair.

But we are not going to be wholly successful in our fight against AIDS, or improving global health overall, if we don't take on three

specific areas of improvement.

First, let me offer a bit of history. I have been involved in this fight against AIDS for a very long time. In the 1980s -- in 1981 -- I was working as a clinician in San Francisco and experienced the grief and loss that came with seeing so many people succumb to the disease because we had nothing to stop the progression of the disease in them. That all changed in the mid-1990s when antiretroviral treatment literally brought people back from the brink of death with highly active antiretroviral therapy in the form of the protease inhibitors. In the United States having access to this treatment has transformed HIV/AIDS into a long-term chronic condition, cared for largely in an outpatient setting. It has saved many, many lives.

But this access to treatment was not universal. About ten, thirteen years ago I turned my attention to the global pandemic, and I will never forget what those early years showed us. AIDS was wiping out a generation and reversing health gains in Africa. Hospitals were completely overwhelmed by the massive volume of dying patients -- people. These were routinely multiple people in a bed, people on the floor. They weren't getting the antiretroviral therapy that was available here in the United States and Europe, so HIV infection was truly a death sentence.

AIDS threatened the very foundations of society. It wiped out people in the prime of their lives when they should have been caring for their

families. It created millions of orphans unable to attend school without the support provided by their parents.

And the disease stalled economic development, leaving countries stuck in the cycle of poverty. That in turn created societal instability, leading the U.N. Security Council to identify AIDS as a security issue in 2001.

It's because of this emergency that resources were mobilized to address AIDS. We weren't looking around for a global health issue to spend money. In truth, this crisis found us. Today, AIDS is no longer a certain death sentence in sub-Saharan Africa. A decade ago almost no one in Africa was receiving treatment. Now 6.6 million men, women, and children are on antiretroviral therapy in developing countries, with the vast majority of them being in sub-Saharan Africa.

It's almost impossible to overstate America's contribution. Through PEPFAR as of last year the United States supports nearly four million people on treatment. That's up from 1.7 million in 2008, showing continued rapid expansion even during these tight budget times. In 2011, PEPFAR's program supported drugs to prevent mother-to-child transmission in 2011 alone to 660,000 HIV-positive women. Thanks to this effort an estimated 202,000 infants were born HIV-negative. We also supported HIV testing and counseling for more than 40 million people, again in 2011 alone.

Truly an incredible achievement.

These results aren't just numbers; they are lives saved, each of them. Each individual is part of a larger family and community that has been and will continue to be our best test of success. For PEPFAR it's all about results. By adopting a targeted approach to address one of the most complex diseases and global health issues in modern history, and then taking it to scale with urgency and commitment in resource-challenged settings, the United States has challenged the conventional wisdom on really what is possible.

Our response to the global AIDS crisis has also transformed the health sector. We are seeing more and more after the initial investment in infrastructure. While focusing on HIV, PEPFAR's investments have strengthened national health systems so they can more effectively deliver essential services for all the needs of their people, including the non-HIV needs of HIV-positive people.

Clinics and hospitals that were overwhelmed with dealing with AIDS now have the capacity to address other health issues that our people face. Beyond that, we have rebuilt hospitals and clinics, increased quality and numbers of trained healthcare workers, put in patient information systems, put in quality control laboratories, and strengthened our commodity procurement and distribution systems.

Our focused investments have enabled access to basic healthcare, often where little or none existed before. In countries with substantial PEPFAR investments, we've seen reductions in maternal/child TB-related mortalities, increased use of ante-natal care, wider availability of safe blood -- just to mention a few.

All of this helps explain why PEPFAR remains a true example of bipartisanship. People sometimes say that AIDS exceptionalism has distracted us from other problems, but that's simply not true. Our response to the HIV/AIDS crisis has increased the size of the pie for global health and bolstered systems that can now respond to a variety of health issues that confront the population.

In reality, PEPFAR has proved that we can take a situation with little hope and turn it around. It challenges all of us to raise the bar for what our global programs are expected to achieve because they must.

And this brings me to the first issue that I want and need to bring to you to consider, and that is to stop treating PEPFAR as one-off health program and start looking at it as the foundation of what we can do with our global health challenge. We need to stop claiming that AIDS has taken away attention from other diseases and look at what we can be when we build upon our substantial AIDS investment and response.

We need a global health vision that is additive to our global

AIDS response and allows us to capitalize on the investments already made. When you think about this, if PEPFAR has built a clinic; trained a doctor, a nurse, a lab tech; put a laboratory in place that wasn't there that is reliable and can give the provider of care diagnostic information to make diagnoses, change diagnoses, or monitor care -- to add a maternal health capacity or a child health clinic, immunization capability, nutrition, etcetera -- over time we should be able to add the treatments for the chronic diseases that are also increasing again in our HIV-positive population as well as our HIV-negative population, such as hypertension, diabetes, and coronary-artery disease.

This doesn't mean -- and I emphasize this -- that we stop our work on AIDS. What it means is that we need to make sure that health systems are not only prepared to deal with HIV, but with the other health challenges faced in the same person and communities affected by AIDS. We are at a point where we can turn to expand the service portfolio at the already-established AIDS sites.

Our path to creating an AIDS-free generation requires us all to work smarter and better together, which brings me the second thing I need to put before you to really successfully achieve an AIDS-free generation. And that is country ownership. This is the starting point for everything we do. This challenge was stated clearly in Oslo earlier this month by Secretary Clinton, and I'm pleased to announce today that we are going to hear more

from the Secretary on her dedicate to creating an AIDS-free generation at the AIDS 2012 meeting. In Oslo the Secretary said, and I quote, “Country ownership in health is the end state, where a nation’s efforts are led, implemented, and eventually paid for by its government, communities, civil society, and the private sector. To get there, a country’s political leaders must set priorities and develop national plans to accomplish them in concert with their citizens, which means including women as well as men in the planning process. And these plans must be effectively carried out primarily by the country's own institutions.

Unfortunately, country ownership is sometimes misunderstood to signal a complete absence of external support for a country's response. Let me be very clear that this is not what we mean. What we do mean is that the overall leadership role belongs to the country, not to external partners. The United States cannot be the ministry of health for the countries in which we work.

In terms of health this leadership means planning and overseeing its national health sector. And it means that we need to address head on the difficult barriers to country ownership; donors failing to coordinate or allow coordination and making unreasonable demands on partners, governments that are devoting too little money to health and not investing in their people, not being held accountable and I underline this

one, not being held accountable for their results.

There's no time to play the blame game for these obstacles. There's no yield on that. We've all been part of them. It's time for us to pivot and explicitly insert lines of accountability so our management and oversight can grow and learn from lessons that allow us to improve and change the output of these programs to match the changing needs of the populations we serve.

As external partners we must acknowledge that we have a long history of playing the leadership roles often creating an unhealthy relationship of dependence. Over time this diminishes the capacity of the country to ensure that services persist and most importantly remain at high quality. So we need to commit ourselves to support a health system organized around the needs of the country's populations, rather than around our needs as donors. We must choose to step back and support country leadership rather than reserving that role for ourselves. We have a responsibility to build capacity through technical support as countries assume more and more managerial and financial oversight and responsibility.

As for governments, they have a responsibility to their citizens to orchestrate this continuum of services. They must identify their country's unmet needs, prioritize the needs, make the allocation decisions

against those unmet needs using diverse funded lines, such as the Global Fund, PEPFAR, and other bilateral programs. So they are additive and complimentary. Governments must include the people in the decision making process who use the services, including civil society representation, civil society organizations, the faith community and of course, the people living with HIV.

Let me address the issue of financing by countries. It is only one dimension of country ownership, but it is an important one in this era of constrained global resources. At the Abuja summit in 2001 African nations agreed that they would devote at least 15 percent of their national budgets to health. To date, few have. As Secretary Clinton has said, this needs to change.

But we're also seeing progress as countries begin to step up and take over services from external partners. In South Africa the government has more than doubled its commitment to HIV over the last two years to over $1.3 billion per year. A special two-year commitment by PEPFAR to provide antiretroviral drugs in South Africa with aggressively negotiated generic drug pricing as part of the agreement. Help the government launch its own increased purchases with new low prices allowing a shift from a trigger to initiate antiretroviral therapy at 200 CD4 cells to the 350.

Other countries have also increased their investments and are making this a point of emphasis in our diplomatic discussions. In addition to financing, discussions of country ownership must address the political and cultural barriers of an effective response. In the HIV/AIDS dimension this often involves marginalized populations that are often at most risk for HIV, including men who have sex with men, people who inject drugs, and those who have experienced sexual violence. We all know that countries are at different points in terms of recognizing these realities and the need for public health responses to incorporate human rights remains critical. PEPFAR's job is to bring science to the table and pursue dialogue toward responses that are both country-owned, science-based and human rights-sensitive.

Another barrier to progress at the country level is failure to fully include women and girls. Given its disproportionate impact on women and girls, HIV is not only a health issue, it remains and has been a woman's issue. PEPFAR and all HIV programs must be part of the broader effort to support countries in meeting the needs -- the health needs of women and girls, including those living with HIV. As external partners we are in a position to engage countries in dialogue around and strongly support country owned plans that will improve the overall health of women and girls.

There's no doubt that the move toward country ownership and PEPFAR is a work in progress, but it is well underway. During PEPFAR's reauthorization in 2008 Congress provided us with the authority to establish partnership frameworks to make this transition. The frameworks are designed as joint strategic roadmaps on AIDS, agreed to and signed by the United States and partner governments promoting mutual accountability and sustainability over a five-year time period. PEPFAR has signed 22 partnership frameworks since 2009 launching really a new era of collaborative planning with our partner governments. I leave tonight to sign the partnership framework in Haiti.

Most importantly, the discussions are creating a new level of trust and transparency among those involved as partners reveal vulnerabilities and limitations in a shared effort to prevent gaps and services. I believe we need to reach that same point of partnership in all of our health global work. For example, African countries face health workforce issues handicapping all their health efforts. Through the medical and nursing education partnership initiatives, the MEPI/NEPI, PEPFAR is supporting countries and developing sustainable local capacity to produce skilled doctors, nurses and midwives for generations to come.

Of particular note, we make grants directly to the African Educational Institution, the medical school or the nursing school. They are

the principal investigator in these grants. They are the senior partners in these relationships, identifying a U.S. counterpart in the process. In some as partners, we must challenge ourselves to apply our human and financial resources in ways that strengthen national leadership to expand the country's capacity to make the programs more sustainable with the sole purpose of saving more lives. But country ownership alone will not solve the AIDS crisis, let alone our broader global health challenges.

We must also challenge the world to accept that global health remains a shared responsibility. It is not the purview of governments alone, but also the private sector, civil society, faith-based organizations, and communities who together contribute financially and otherwise to the fabric that is needed to establish a responsive and sustainable health care delivery system.

A crucial part of this shared response is the multilateral mechanisms. And this is the third thing that we need to achieve in AIDS free generation. That is a robust multilateral response, particularly targeted toward the needs at the country level. The Global Fund to fight AIDS, tuberculosis, and malaria really is an indispensable tool and remains a single conduit through which other countries that will never have a bilateral program can funnel resources to those countries in need. It provides that large scale mechanism for combating these diseases,

particularly for those donor countries without the bilateral programs.

By law the United States cannot provide more than 33 percent of fund contributions, so the money we provide leverages resources from other donors multiplying impact beyond what our dollars could do alone. In recent months since the United States demonstrated its increased commitment to the Fund, both new and old donors including Saudi Arabia, Japan, Germany and the Gates Foundation has stepped up their contributions. We know that other donors are also looking to do the same.

Part of our shared responsibility is to ensure that all resources are used as efficiently and effectively as possible. With our support and encouragement the Global Fund has taken a number of actions in recent months to recommit itself to this goal. The Fund's new General Manager Gabriel Jaramillo has dramatically reoriented the Fund to assume a role as an active investor. I'm very optimistic about the impact of the Fund moving forward and that heightened impact in turn will strengthen its ability to generate additional new resources.

To support country owned programs PEPFAR and the Global Fund are increasingly engaging in joint planning and now co-finance many components of country responses. For example, the Global Fund resources covering the expense incurred by buying antiretroviral

drugs, while PEPFAR focuses on targeted technical assistance, monitoring and evaluation systems, patient information systems, voluntary counseling and testing, et cetera. Weaving a series of resources together that at the individual site create a responsive medical delivery capability.

The reality is that we need both the PEPFAR and the Global Fund resources to be successful, but they need to be convened by the country. All country, Global Fund, PEPFAR, bilateral foundations, et cetera, resources, all are central to any vision of a sustainable future for Global Health and it is through that responsible orchestration by the partner country that this will be realized.

Another important multilateral dimension is that of the technical agencies the United Nation's family, including UN Aids and the WHO. The need for their technical contributions at the country level is great. These organizations have done a tremendous job in marshaling global support for health issues, but now we need to figure out how to best maximize their impact at the country level. And this is a dialogue I look forward to having with my colleagues globally. Multilateral activities in country must be assessed through the same lens of accountability as those of PEPFAR or our partner country governments, asking whether they are making a contribution that is truly additive. If not, it's incumbent on the country government to address that and on all of us to support

them in doing so.

When you look at the three issues we've addressed today, recognizing PEPFAR as the foundation for other global health successes, promoting country ownership and fostering a shared responsibility, the thread that unites them together is that we are truly putting countries in a stronger position to ensure we can reach the goal we are all committed to. Achieving an AIDS free generation and creating a stronger and more secure world. So as we draw closer to AIDS 2012, the meeting, let me end where I began and that's with a message of hope. We know what most of know and have learned over the years, we know what must be done to end this epidemic. And I have great hope that we can do it and get it done. Hope that we see in the science that guides our efforts. Hope that we see as the world unites to turn the tide against this devastating disease. Hope that has taken the place of despair, hope that keeps everyone in this room pushing forward, getting up, and doing it again. It's an honor to be part of this effort. It's an honor to be with you all as we move forward, as we begin to see the light at the end of the tunnel, and I want to thank you for this opportunity to address you this morning. Thank you.

MR. UNGER: Thank you. Sorry. Is it on? Thank you, Ambassador Goosby for those remarks. From a development

effectiveness perspective, it is wonderful to hear from a leader of an assistance program about an approach that is results oriented, that is evidence based, and with an increasing emphasis on country ownership. So thank you very much for that. You spoke about strengthening broader health systems and also about others stepping up to advance multilateral support, and I'm sure we'll get questions on those topics and some I suspect, on different ways of pursuing and prioritizing prevention and treatment.

But before I turn it over to the audience for questions, I'd like to ask a question of my own about the transitions to greater country ownership, which are clearly essential. This administration has had a heightened focus on sustainability, and some of the program components that you mentioned that focus on building capacity, some of them have been in place for quite some time. Others are newer, widely recognized innovations that are just coming online like these partnership frameworks.

Do you envision significant shifts within PEPFAR's overall budget? I mean, if I'm sitting in Congress and looking at the overall program and the big picture, do you envision significant shifts that clearly demonstrate an even greater focus on building capacity? And if so, what do those shifts look like and what are the tradeoffs? You've talked about the tradeoffs of not building capacity in country, but if there's a big shift

now within the program to build greater capacity, are there tradeoffs in the other direction? And especially in light of a possibly flat or even decreasing budget.

AMBASSADOR GOOSBY: Sure. Well, I think that if we aren't serious about shifting our emphasis to country ownership, we will not achieve the sustainability that you refer to. We need to take the leap to partner with our partner countries in a dialog that allows them to gain and trust so they reveal their vulnerabilities to us and their ability to manage, oversee, monitor, and evaluate these programs. Once we can develop a technical assistance kind of, strategy or curriculum for each country for each ministry, at provincial levels as well as federal, we will then be in a better position over time to expand their capacity to truly manage and oversee these programs.

The management and oversight is critically dependant on a monitoring and evaluation system that gives -- and is close to real time feedback, to policy decision makers, allocation decision makers, where and what they're doing, what they're not doing, what they need to continue to do, and what adjustments are needed in the program to achieve that. I believe that although this is a slower trajectory, to get a capability in place, it is the only means through which a sustainable service portfolio can be realized in these countries.

It's a long haul, it's a long-term commitment, but the United States remains committed to that sustained portfolio of services, and not just a transient expansion of services with a retraction on the ending of the program. In terms of the shifts that we expect, the vision here is to take an existing platform that is strong with trained doctors, nurses, laboratories, as well as patient information systems, procurement distribution systems, all of which could be used for any service needed be it HIV/AIDS, TB, Malaria, maternal and child health services, children services, nutrition, etcetera.

Those types of expansions need to be added onto that platform to allow the services to increase, that are available not just to the HIV positive person already using the site, but also for those who are HIV negative who now can start using the site. I don't envision shifting resources from AIDS to hypertension, diabetes, and coronary artery disease. Acceptance so far is they need a lab to support diagnosis and treatment of those other disease.

They need doctors, they need nurses, they need a procurement distribution system. All of those need to be taken advantage of and used for the same purpose. Other resources need to come on and be additive to that already existing platform. And we need to be open to using our AIDS specific resources to expand them and stretch them as far

as we can to support that expansion.

MR. UNGER: Well, thank you. I'll now turn it to the audience because I know people have been waiting patiently with questions. If you have a question, please raise your hand, wait for the microphone, and identify yourself. And please make sure it is an actual question. I'll start here in the third row, up front with you sir. Please wait for the microphone.

MR. COLLINS: Well, thank you. This is Chris Collins with amfAR. Thank you, Ambassador Goosby for your tremendous leadership at OGAC. And it's truly incredible what this program's accomplished. You know, in November of last year, Secretary Clinton gave a wonderful speech, and in that speech said it was a policy priority to achieve an AIDS free generation. And she called out three interventions that were a core to accomplishing that, and she did acknowledge of course that, you can't deliver those in isolation. But she called out three core interventions.

I'd like to get an update on where we are with going to scale with those interventions that the secretary called out. They were treatment, voluntary medical male circumcision, PMTCT. For example, where are we in terms of the country operational plan review and bringing to scale those three core pieces? As we know, the allocations to treatment had been falling overall in PEPFAR. I'm wondering if that's

changing.

AMBASSADOR GOOSBY: Thank you, Chris. Those are all good questions. We have reviewed our country operating plans for 2012 and have tallied up, kind of, where we are in our pursuit of, kind of, World AIDS Day targets. Those include the treatment targets as well as the male circumcision, the expansion of PMTCT services, as well. We believe that we, in light of the COP review, are on track to achieve all of those. We, since 2009, have continued to expand all of our portfolio areas of care, prevention, and treatment significantly -- really during this kind of, resource constrained budget period.

And we are quite confident that we will achieve the goals that were articulated by President Obama and Secretary Clinton. In terms of the male circumcision scale, it is a slower process. We've learned this by direct experience. Having the political buy-in is difficult to get and critical to have before you can move to implementing the program. Trying to put the other first doesn't work. We have kind of pulled back in that expectation, putting the cart before the horse, and are now shoring up the political buy-in and the, kind of, targeted community awareness that needs to come with that for both the male as well as the partner, and have given -- and gotten a lot better at doing that.

It is going to be -- of the three, the most challenging to

achieve, but we are positioned to achieve it and are budgeted to achieve that, as well. In terms of the PMTCT, we have been in a strengthening exercise, really since 2009. We over the last year, have partnered with UNAIDS, UNICEF, WHO, other both private and public sector partners, to bring the resources together to aggressively move to scale our PMTCT effort. We have targeted -- out of the 390,000 children who are born HIV positive on the planet, we have looked at where countries -- what countries are contributing to that. They boil down to about 30 countries, 22 of whom are in sub-Saharan Africa. We have developed specific plans to look at what their current effort is, and looked at the holes in drop-off from testing to staging to initiation of antiretroviral therapy for pregnant positive women. We've also looked at where and when they're identified and on antiretroviral therapy for both the woman and the baby, that they have a seamless line into follow-up care for their continued antiretroviral therapy. We've also funneled the HIV positive into that treatment line, but have not forgotten the HIV negative at high risk and the HIV negative prevention, kind of, messaging that should go along with that and try to address that, as well.

I am confident that with our current plan in our current portfolio in each of the countries, that we will move aggressively towards the AIDS free generation, achieve the goals that were articulated last year

by the president and secretary, and I believe we have engaged in the other dialogs needed to make sure that this effort can be sustained; multilateral dialog, as well as dialogs with our other colleagues in bilateral relationships.

MR. UNGER: Great. Towards the back on the aisle, please. Yeah. Alex?

SPEAKER: Thank you. And thank you, Mister Ambassador, that was a very positive, wonderful presentation. In light of your emphasis upon health systems -- the importance of health systems, your stress on partnership, and your emphasis on multilateral programs and relationships with multilateral institutions, I thought it interesting that there was not a single reference to the World Bank, and I wonder if you'd care to comment on that, particularly given the resources and the other kinds of emphases that you've talked about? Thank you.

AMBASSADOR GOOSBY: I would absolutely include the World Bank in that multilateral community. I think that all of our multilateral efforts need to understand their current contribution to the AIDS effort and to global health in general. They need to explicitly understand what their resources are doing in each country that they're in over a given time with a specific eye to, does this intervention have a high probability of sustaining or is this going to be a transient contribution or

can we change it?

I think more attention to that needs to be part of the thinking on day one for any of the multinational, multilateral programs that are existing. I think that World Bank has a special role, and there's great hope with Jim Kim coming into the position, that the World Bank will look at its portfolio of services, its loan programs, the resources that move from north to south, and better understand how to maximize the ability to truly have a demonstrable impact on capacity expansion for the countries.

Examples of World Bank creating an ability to work with countries such as Angola, Nigeria, that have a significant mineral reservoir of resources that those, kind of, extractive industries be tied to the treasury of these countries so they are immediately -- before that resource is up for grabs, investing in health and education for their people. When you put money in the treasury of a country, it quickly becomes subject to a lot of competing needs and figuring out how the Point 7 countries, Norway in particular, positioned itself to make sure that those resources were capped -- Botswana, another example -- that those types of strategies be part of what our World Bank colleagues bring into the portfolio of services and resources.

MR. UNGER: Let me take two questions and I'll lump them together. So in the back, I'll go to the back row, just back there, and then

we'll come up front on this side.

MS. PEARSON: I'm Carol Pearson, I'm with the Voice of America. Ambassador Goosby, could you talk a little bit more about this partnership agreement with Haiti and what it looks like, what you're going to be doing tonight?

MR. UNGER: And then let's take –- let's combine that with one question up front, and then, Ambassador, if you could answer the two together.

MS. SLUTSKER: Hi, my name is Mandy Slutsker and I'm with Results Educational Fund, but I also volunteer with the local D.C. organization, HIPS, and my question is, with the upcoming AIDS conference, it seems like there's going to be one population noticeably missing, and that is sex workers. And the State Department Travel Band and PEPFAR's anti-prostitution pledge seem to have made it difficult for sex workers to engage in this conversation about ending HIV and have had some unintended consequences. And given that you said PEPFAR is evidence based and human rights focused, I'm wondering if PEPFAR is looking at reviewing and possibly reversing these policies so that sex workers can better engage in the fight against HIV?

MR. GOOSBY: Well, let me take the Haiti question first. This is the result of really work that began in October of '09, to work with

the Haitian government to define what their specific continuum of services for HIV positive, HIV TB positive people are in Haiti, what services the government wants to make available to each of these individuals over time, so the continuum of services that they're supporting.

Those services basically -- what we agreed to in the partnership framework that's being signed is setting up a referral capability from primary care clinic systems. There are about 137 PEPFAR sites that are already up and running in Haiti. Those have ARV capability. Those sites, matched with primary care sites, will raise the primary care services in that same region, referring to secondary and tertiary facilities.

There's only one tertiary facility in Haiti. It fell down with the earthquake. The United States is rebuilding that tertiary hospital in Port-au-Prince, and it's rebuilding three secondary hospitals that are out in the states, in the, you know, that are secondary hospitals that refer from the primary care sites. So a referral system is really what's being put up. It will have an ability to also put maternal and child health referral in place, immunizations in place, and a small list of the central services that basically allow for screening for hypertension, diabetes, and cholesterol, coronary artery disease.

And that all is at the kind of mid point in being implemented. It's already started. It's about a year into being implemented. But over the

next year and a half, will run to completion. The building of the tertiary hospital in Port-au-Prince, the Huey Hospital, will take about a year and a half to complete.

In terms of sex workers, the ban that was put in place really focused on individuals who had to report a disease such as HIV. That was taken off of the list as something that would block entry for a visa. Any other activity really wasn't related to the removal of that waiver for the visa, but the customs and immigration services have a lot of laws that are still in place that, indeed, did focus on the sex workers and their ability, and that is a past history of felonies.

So I hear what you're saying. We've been in continuous dialogue with them. We won't be able to change the law, but sensitivity around that issue in blocking an individual who, indeed, wants and has something to say and do with the conference is actually in dialogue for kind of exceptions to be made, but it has been a difficult thing to overcome. I appreciate your questions.

MR. UNGER: I'll jump in with a question of my own which is a bit of a different angle, but it relates to your point about the broader global health investments and the additive ways to build onto the PEPFAR program. Within the Quadrennial Diplomacy and Development Review, there was a commitment to look towards a target of the end of fiscal year

2012, so September of this year for transition of the leadership of the President's Global Health Initiative to USAID, in an effort to build USAID to be the lead agency for development initiatives across the government.

That seems to now be on hold or should not be going through. And the idea was that that target would be reached if certain benchmarks were met. What benchmarks have not been met in this process, and is part of the hesitation that if the Global Health Initiative is led from USAID, but PEPFAR is still kept separate from USAID, that the majority of global health investments will be outside of the agency that believe in the effort? Can you explain a little bit of the thinking behind the scenes?

MR. GOOSBY: Well, I think that the Global Health Initiative really did show us the advantages that are realized by coordinating and working together, integrating our planning, decision-making around what services we're putting in place across vertical programming, HIV, AIDS, TB, maternal and child health, family planning, nutrition services, all of those service portfolios which are in most of the countries that PEPFAR is in, as well, those give an opportunity when we integrate our planning, to actually implement it differently so all those services rise in their ability to be available.

Our need to coordinate at the country level is evident. And

we have been also impressed with that coordinating effort for USG programs, that the need to coordinate at the global level across multilaterals, other bilaterals, with country programming is the essential kind of means through which we will achieve a greater capability of services, more services kind of for the same amount of resource.

That ability to integrate is really a diplomatic dialogue. And the Secretary, and through the Global Health Initiative process, has realized that we need to elevate our health diplomacy truly to a diplomatic dialogue and put that expectation on our ambassadors and country to support them in that effort.

The decisions on the benchmarks and how this will evolve is in its final stages of deliberation. It's now with the Secretary to make that final determination, so we'll have to be patient with how that all evolves, but it will be soon.

MR. UNGER: Okay. We have time for one last question, and then we're right up here in the front row. And if you could, in your answer, mention any concluding remarks that you have, as well.

SPEAKER: Thanks very much. Mr. Ambassador, thank you very much for your very positive and hopeful speech. I share the hopefulness in that speech. If you look at the international numbers on development aid for health, what happened in the past 10–15 years is

actually unprecedented. If you look at the Institute for Health Metrics and Evaluation Report from 2011, do you see that external support, financial support for health has increased to 27 billion annually for 2011, which is many times more than 50 years ago? So it's a truly amazing story.

If you read a little bit further in the report, there's actually some disturbing news that for every eight dollars that answers the country for health, the country itself, reduces its own expenditures by 56 cents. That's a big number. The number is in line with previous studies of the same kind of phenomena. You must be fully aware of this. What's your view of this, and what do you think in the next few years can be done to really reduce, if not eliminate, this kind of substitution?

MR. GOOSBY: Well, thank you for that question. It has been an understandable response by many countries to have resources coming in through global funded PEPFAR, and to our colleagues and country that are looking at many unmet needs, they turn their resources toward something else. We have seen this as counterproductive and it really precludes our ability to be added. They need to not only sustain their resources with partner countries, but also, over time, as they are able, increase their resources so they truly are investing in their population.

I found in partnership framework kind of dialogue the most

convincing discussion, but then when I remind our partner country's leadership that I'm in a discussion with our appropriators, every time we try to move resources to your country, that it diminishes my ability to ask my appropriators for more money if you aren't willing to invest in your own population, and they are very aware of that investment or non-investment.

So I have found being honest with them about what my challenges are in trying to agree and sustain more funding, that that's the best way to make it happen.

So I want to thank you for this opportunity to have this dialogue with you and look forward to all of you contributing in your own ways to move this agenda forward. I do think the President and Secretary Clinton feel strongly that we are at this moment in time where if we can converge our resources in a smart way, to converge them at the country level, to have an agenda on day one of capacity expansion so countries can truly manage and oversee these programs, that the resources, which we know for many centuries over time will evolve and become more realistic, that that output will increase our ability to really put a basement of health care services on the planet for those populations most in need. So I want to thank you again for the opportunity to talk to you today.

MR. UNGER: Ambassador Goosby, thank you very much for your leadership. Please join me in thanking Ambassador Goosby.

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CERTIFICATE OF NOTARY PUBLIC

I, Carleton J. Anderson, III do hereby certify that the forgoing electronic file when originally transmitted was reduced to text at my direction; that said transcript is a true record of the proceedings therein referenced; that I am neither counsel for, related to, nor employed by any of the parties to the action in which these proceedings were taken; and, furthermore, that I am neither a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

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