

Design Considerations for Evaluating the Impact of PEPFAR

Institute of Medicine

April 30, 2007

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FEMALE SPEAKER 1: So first let's just ask if anybody who hasn't gotten a chance to speak or ask questions yet has any questions for some of the presenters from last session, on implementers, in country perspectives? Okay. Panelists, any questions for each other? Oh my gosh, okay.

AGNES BINAGWAHO, M.D.: I can make some comments maybe on using churches. I think this is really crucial because they have a lot of power at country level. I think also it's not only the churches will have to be strength, communities themselves without religion because we can create [inaudible] that access to care is related with religion. We have to be careful, so strength of the church and because they really leaders at the community level, yes. But strength with communities, even out of churches is also something not forgot.

Also to make such a research like the one we are here for, it is very important that American taxpayers know that the Senate and Chambers take decision out of this evidence based. That's true. But also people who are doing research, because I have here a list of good research plan for countries, never forgot to involve countries in your research. Research is not for Washington. Research is for people who are suffering of the disease. And don't bypass countries to plan for such research to be sure that you go through what is purity for the country.

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And the other thing is for countries ownership is still - I'm going to talk - and for me is the key word because people are complaining that for PEPFAR indicators what you have done in run down we have now one unique format for pontification and Global Fund, World Bank, PEPFAR have to align to our formats. And this format is designed for the district level so that we have 30 districts. The 30 districts do their aggregate all the plan of the stakeholders at district level and have the plan of the district. And they send it to the central level. We aggregate it and we have plan of the country with indicators. I took us time, almost one year and a half, to align the 27 plan to our own indicators. But we managed to do so that in the end of the day with one reports is indicators. People are happy here. But we are happy in the country. So this is also something important for the country to do. And maybe a response like PEPFAR funds has activities for angeos [misspelled?] who are in the field. It will be a great thing to help to capitalize the sort of things in the other countries. And from what I hear about STIMNE type of medicine to treat STI and sometime not the good one, this is also something relying to countries. Low and rules how to trace, protocols to trace belong to the country because if not somebody comes from Belgium, come and apply what they do in Belgium, others what they do in Scandinavia, others what they do in China. I think all those things have to be decided at

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country level. Protocols belong to countries. And in one day you're not allowed to treat malaria like you want. You have the first line drug, the second line, same thing for STI. Jessica is there, she can tell you and same thing for IEVs [misspelled?]. You have the first plan. And to do so, we go to rules signed by cabinets. Enough of these are now to go out. And if somebody comes with a new idea say, oh we have discovered this and it's better. So we call our [inaudible] and we have them to decide. And we [inaudible]. So those are comment I want to say that the key word is always ownership and take responsibility of the mission. People are because don't forget that in all the majority of countries, people who are there are elected and have responsibilities. Thank you.

MALE SPEAKER 1: Maybe just to add on a few things that my colleague has said. And we mentioned about the church leaders. And we say yes, it's important. And to really recognize this structures that have been there for a long time and how powerful they can be, or should be, or they are and make that a good point to enter the healthcare system. Now I said the church leaders are important. Sorry, I'm not being defensive about it. I'm just trying to explain it a bit because in north there's a lot of training and the impact sort of assessment is on output not on outcome. Because for example when you talk about involvement of let's say community health workers in HIV care, most communities in [inaudible] if you if

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you broadcast it and say we want to do training for community health workers, there's a lot of people who will show up. But the true sense and what we've seen to be very sustainable is the actual training of the patients themselves as community health workers for them to offer this service to their other colleagues because most of them are either subsistent from us or are not involved in work that involves them being at work the whole day. So when they plant a crop they don't sit there and wait for it to grow. They have other activities that do. And one of the things can be to visit another colleague who's just started AEDVs [misspelled?] or started care and they can share some experiences. They can see if they are taking their drugs well and everything. This will have an impact on adherence, this will have an impact on how you're able to measure the outcomes, or how undetectable rates and things like that. So I completely agree. We need to rethink no the mechanisms that are existent on the ground like I said again and I'll say it again. The wheels are there on this ground it's just how well we can prepare them, how well we can make use of them such that they continue moving forward.

The second thing around ownership again, I think it's important to understand and underlie the importance of contextualizing [misspelled?] the entry point because a lot of the issue around ownership is because of how things are perceived. Because various countries, particularly in Africa,

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we are very high context culture. We are very oral and we talk to each other. We don't write a lot of these things down. But we talk to each other. So how I view Rwanda being treated and how Ghana is treated or how another country is treated is going to be absolutely important when it comes to my being approved to the same agencies of the same program. So the characteristics of countries and contextualizing it is absolutely key to how programs are implemented and what kind of ownership is going to come about that. And like I said, Rwanda would a good place to learn on how this approach has worked. But also be careful of how we approach that to other countries because Rwanda is very unique and had an incident in which really has brought a lot of [inaudible] in Corzan [misspelled?] the people but most of all other countries, for example you don't have one drug supply chain network. You have one that is the private sector. You have a mission sector. And you have the government that is providing. How this is approached and how the ownership around the interventions is going to be approached is going to be key to what the other countries are going to look out to.

Again, even interventions, things like OVC care or [inaudible]. The cultural dynamics of such an interventions are also key because in Africa, we don't only care for one child we care for many children. And we are children of the community. We're not children of someone. So how are

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interventions, which are going to come, and how are they really culturally contextualized? And I'm really, really watching to see how the issue of circumcision will be approached because in our context in the west we had read the studies in Wadon [misspelled?] was in the Western part of Kenya where they don't practice a lot of circumcision. In the eastern, the middle, and the central part of Kenya where this is a common practice and the religious expect those who are not circumcised how this is going to be informed is going to be key to whether it's going to be taken as a cure or as a thing of saying if you are circumcised then you can continue your risky behavior and nothing will happen to you. So contextualizing is key. And I really don't want to belabor that any farther than I have.

FEMALE SPEAKER 1: Any other comments from the panelists?

MALE SPEAKER 2: We've talked a lot about achieving indicators with respect to impact. And one of the things that occurred to me and partly because Ruth is sitting down there and she's a very interdisciplinary kind of person, HIV, reproductive health, etcetera, is thinking about the positive and negative synergies that potentially occur. So there's been a fair amount of press on the committee's recommendation that the earmarks are binding and unhelpful. And most of that attention has come around the fact that it forces people to program in ways that are sub-optimal for a country. But

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actually for me, the more striking impact was not so much that the countries had to put more or less area into one area or the other, it was that it forced pipeline programming. So that if you have AB money and you have C money, it means at country level there are AB contractors and C contractors. And even if nobody is against the idea of doing integrated ABC in a particular place it doesn't happen because you have different channels of money being accounted for in different ways, which ends up translating into programs on the ground, which were not intended.

So that and I really enjoyed Sara's presentation. But I have to say that when you went through your litany of what is and isn't being considered in mother to child transmission prevention, it struck me that there've been a couple of studies not published suggested that far and away the most cost effective way of preventing mother to child transmission is to make sure that women who are HIV positive, who know her status, and who does not want to become pregnant has access to appropriate family planning. Now you didn't mention that one. But not because I don't think maybe you don't agree with or whatever but just because it's a different chimney. And one of the most obvious places to look for positive and or negative synergies is with reproductive health programming. And I think that as we talk about these impact evaluations I'm just as guilty as anyone else because I focus on particular indicators

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and how you measure them rigorously. We do also have to ask the question about positive and negative synergies. And that started to come out in things like system wide effects of the fund and PEPFAR itself has started to look at it. But I think especially when they're as close as reproductive health and changing sexual behavior for prevention of transmission of infections, we have to explicitly look at that much more.

FEMALE SPEAKER 1: I see a lot of nodding. Anybody who disagree with that?

FEMALE SPEAKER 2: No.

AGNES BINAGWAHO, M.D.: I don't understand negative synergies.

MALE SPEAKER 2: It's been rather than for example -

AGNES BINAGWAHO, M.D.: I understand little synergy that's been program as a fighting.

MALE SPEAKER 2: Anything that causes harm to the other program rather than benefit. So if you have a VCP program, which for whatever reason makes it more difficult for appropriate family planning to occur rather than less difficult, then you could have negative impact on reproductive health program rather than a positive one. So it can [interposing] -

AGNES BINAGWAHO, M.D.: Yes, a negative - I can see an example of that. The nutrition puts some [inaudible] of a

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family, HIV positive to produce baby to have food. This is a negative synergy.

MALE SPEAKER 2: Exactly.

FEMALE SPEAKER 2: I just returned from Bricina Faso [misspelled?] where we were looking at the work that Peace Corps volunteers were doing around HIV/AIDS and went into some villages. And it's not anything new to me and it's not anything new to this group but the almost total lack of power and control that women and girls have over their lives. But it seems to me that is something that is very much at the core of dealing with AIDS and that we deal with it peripherally. And it's too bad the ethicist left because I'm really sort of curious from an ethical point of view and a traditional point of view from the two of you from Rwanda sort of how far can we go in that area. That's what the tradition is, is that women are oppressed. They're controlled by men. Maybe you would argue with oppressed but some people would say oppressed. They don't have much control over who they marry, when they marry, when they have children, and when they have sex, or who they have sex with, or whether or not condoms are used, or all of those sorts of things. What in your view and other's views are - how far can we go in changing those traditions in ways that are both ethical and I don't know how you even say it, but don't violate your traditions. What are good traditions and what are traditions that should change?

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AGNES BINAGWAHO, M.D.: I'm going to say all tradition of oppressed women should be removed. My goodness, 50 years from now in this country, women were oppressed. Did you agree? You went in the road and you fight it. So why should we say that good culture or good tradition were oppressed women? Never. So this is part to the success. But the change will come again from the country. It will not come from outside. And in my country is not the same because there is this positive discrimination for women just to create the gender balance. That mean if I am a woman, I compete with the man. We have the same mark. I have to be chose. We have the highest number of women congresswomen, almost 50-percent of the Parliament. And it's in the constitution that if an election doesn't put 30-percent of women in power, the election is cancelled per se. So we go elect again. And to change that they would need us. We will never change that. We change that for more, not for less. So that means countries are not the same. And we cannot say it's not for that that every problem is solved in Rwanda. No. Because you can have change in urban area or in educated portion of the population to really go to the grass root and to a poor woman and to make them known that it's their rights and their responsibility. Maybe it takes on generation. You see what I mean? Now we know the part of Africa there are some place where men are oppressed. It

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happens. We never say that. And I don't know. So I cannot talk for others. I'm going to -

MALE SPEAKER 1: I think that's an interesting perspective that we could talk some more about that [laughter]. I just need to clarify. I'm not from Rwanda [laughter]. I'm from Kenya. It is next door. But our cultures are completely different. And as you can see, and you hear from [inaudible] that we are very, very different because if you look at for example some of the interventions that are targeted to address some of the cultural things in Africa, actually western interventions trying to address an African cultural perspective. Now some of the cultural things are very good but they have been abused. So for example, if you have a women empowerment program or something that you want to bring about women empowerment in a country like Kenya where we have 42 tribes, which means almost 42 different cultures within subcultures within that culture, then if you target women, you sort of will walk against what has been happening for the last X number of years. And that way what you will get is a role conflict that will not help the situation. But if you target the men and sensitize them, then the women will be respected. But again, the approach to these who is coming to speak about these things, how is it being approached. Is it a young man like me or is it an elder in the society has very different implications. And if you're coming from the west to come and

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teach about this and it has another whole myriad of interventions. In Africa when you are speaking to men and you mention women and children that is an emotive point because once they see that their women are being taken advantage of is a sign of weakness for us men. So if you tell me right now my wife is in problems or my wife is being taken advantage of on this I become really emotional. And I could do some things, which don't look very pleasant. So how that is targeted how it is packaged to the communities is absolutely key. It's not what the outcome you want and the western intervention that is there because as a Ugandan provon [misspelled?] and I can speak for Ugandans because my wife is, that if you see a turtle is on a tree, somebody put it there because it has no mechanism of holding the tree to get up there. So if you see some of these cultural practices, for example in Western Kenya this condition study was done in a whole issue of life inheritance. Yes, that is bringing a lot of issues in the transmission of HIV. My wife inheritance was not a bad thing. It's just been abused. The whole concept and cultural perspective of wife inheritance 100 years ago was to ensure the widow and the children are taken care of by the family because they belong to the family. But what has happened now is inheritance has been for sexual favors, for financial favors. And so the system is abused. Now if you come to speak about wife inheritance to that culture and you come and say it's wrong. It's a woman's right not to

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be inherited the response you will get from men is not going to be very good. But if you target it to men again, through their elders who have all these high context environment, who are very oral and say, in our days the issue of wife inheritance was not so that you could have this but it's so that you can take care of the orphans and the children and then bring a support system around that. Then the intervention will be successful. So I think most of the western interventions have not really caught on well in Africa because you assume we don't know much.

FEMALE SPEAKER: [Inaudible]

MALE SPEAKER 1: I think the impact mapping right from the program design perspective is key. And how well involved the implementers, not at the country level, at the ground are involved in this process will create ownership that will ensure there is continuous monitoring and there's continuous ownership of the data that is ongoing and it's being used in programs to make decisions. As long as it's not that involvement right from program design and you bring it on after, it will be looked at as a western thing. So the results that you're looking at, the indicators that you are looking at are not to benefit my operations, but to benefit your funding, to benefit your positions, and things like that, and not necessarily to benefit position. I gave an example in the morning and it's only in the program that I work for. It's only last month that

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we had a strategic information office to be there. There was data being entered here. But a lot of data by the interpretation of that data and how it's important for me as a director to make decisions about finances, I didn't see it before. Three and a half, four years later, that's when we're seeing it. And again I thank Constella Futures [misspelled?] because if you work with the futures group, as part of AIDS relief there. And that happens. So how that is mapped and then calculated right at the program design and how it is that ownership and the importance is highlighted right from the onset will enable me, who's dealing with communities every day to make informed decisions and maximize the resources that are being supplied, whether from PEPFAR, from Global Fund, from the church, from wherever it comes from. But as long as that is not going to be there, we are always going to look at it as western thing.

AGNES BINAGWAHO, M.D.: If I can add on that, the inheritance of women is typical. Like he says, in the traditional society it was a good thing. It was to avoid the children from the first marriage to be left out of the second marriage. So now if you put men in your side and create a win-win situation between men and women. Say our objective because of society change, now it's not the same value. We have accidental way. We have money. We don't have any more cows, etcetera, etcetera. And if convince the local leaders and the

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society like it has been done in Rwanda, that for men it is good that their wife inherits to save the children have together, they would go for women every time. Now because the situation has changed and what was traditionally was the fact that women can not inherit has been lost. We just keep that. So there is many way to change the situation that never leaves out the people, never leaves out the community leaders.

FEMALE SPEAKER 1: Let's take one final question over there and then we're going to pick up some questions from earlier.

JESSICA PRICE: Okay, thank you very much and good afternoon everyone. My name is Jessica Price and I work for Family Health International in Rwanda. So the perspective that I bring is really a perspective of a technical assistance partner. And I'd like to bring it back to the gentleman who introduced the concept of negative synergies. What that did when I was listening to his example about family planning is it triggered a thought of something that may not be part of an impact evaluation of PEPFAR but something that I think needs to be examined is the ambiguity of some of PEPFAR's policies. And let me just give a quick example. When I first went out to Rwanda close to three years ago, I remember participating in the first COP planning session, which was difficult. But one of the things that I learned during that session was for those who were receiving AB money, we couldn't educate youth on

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sexually transmitted infections. That was one interpretation of PEPFAR policy. So I think that my suggestion is though although implicitly I think things are getting very much better in terms of understanding PEPFAR policy, explicitly they aren't. So for each PEPFAR country there's a different interpretation of PEPFAR policy including can you use PEPFAR money for family planning? I just think that there are many areas that are still up for interpretation. And at the level of the implementers or technical assistance partners it's a problem. Thank you.

FEMALE SPEAKER 1: Comments back on that or no? I'll probably defer to Tom other than to give a plug for the implementer's meeting. I think this issue of continually clarifying and also updating for technical guidance is critical both from people coming in and out and just programs evolving over time. So for each country there will be a combination of some of the country USG officers and select partners who implement in that country who can go back and also represent to the rest of the partners on twelve different technical areas where it will be during a pre-meeting where the purpose is really to clarify some of the guidance, figure out where the misinterpretations are, figure out what things could be maximized better. So I don't think that will be a perfect solution. But it is a recognition that is an issue. Tom might have more.

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TOM KENYON, M.D.: Yes, thanks. Having been through four COPs, I can reply to some of that. And I agreed there was not so much un-clarity in the guidance but lack of information on a lot of things like you just mentioned. And I think with the guidance it was often an over interpretation of what we couldn't do. Oh because it's not there that means we can't do it. And in fact we saw I think countries even going the other extreme, especially with other prevention and support condoms. And in fact with this past year's guidance to the field, it was changed to being condoms and other preventions because we felt there was a retreat by countries from heavily programming using condoms and other prevention modalities. So I think there was some misinterpretation, over-interpretation, and at points, it depended on who you asked. But I think each year those issues are taken into consideration to update the technical considerations that now accompany the country Operational Plan Guidance.

And specifically on family planning, I had an experience just before I left as we were seeing many women on therapy now becoming pregnant we went back to check the list and said, oh my gosh has anyone looked at the family planning guidance in this country. And we actually realized that the family planning guidance was from 1995. Here we were in 2006. Nobody, including agencies working in family planning had bothered to look at see, shouldn't these be updated taking HIV

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into account. So one of the things we managed to do was leverage resources with another partner, because updating guidelines is time consuming and costly, that we'll ensure that there's content in here relative to HIV. And others can update the guidance with respect to other aspect of family planning. So it was a way in which to leverage but still to get out of the pipe so to speak and to take this very important public health consideration into account and to react to it. But the family planning commodities - no we don't purchase those under PEPFAR. That's where we do wrap-arounds with other programs that do have support to do that. And that allows us to conserve our resources for HIV interventions and support.

AGNES BINAGWAHO, M.D.: I'm going to add something. HIV is still a new disease. And HIV for all programs out of PEPFAR, out of Global Fund, and the World Bank even if they are finishing now is still a learning process. That means we do things and we find something. We learn about it. We try to correct after. That's the reason why couple four, couple five, couple six, couple seven are so different. And the same for Global Fund we're on one, two, three, four, seven. When you go to Geneva and you remember in 2000 you tell us to do - so they say, never, never, never. You just bring the paper. And so it's a learning process for countries as well as for all paths. And I think that couple eight, couple nine will be with new

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rules because we are going to learn how to do better and how to bring in the COP new things identified by the country.

FEMALE SPEAKER 1: Thank you very much. Just I'll take a couple of quick comments and then we're going to -

MALE SPEAKER 3: Let me just come back to you Tom on your comment just now about the family planning focusing your resources on the AIDS things because we just heard Steph [misspelled?] say family planning is in fact an AIDS intervention. The context here is one in which HIV programming, just from the U.S. side alone has gone from 121 million dollars a year back in the mid 90's to 5.3 billion dollars. Family planning in the same period has reduced 14-percent. And the number of women of child bearing age in the developing world is increased 30-percent in that same time period. So is it really not appropriate for PEPFAR to engage more actively in terms of procuring commodities and contraceptives as an appropriate part of HIV/AIDS prevention and control?

TOM KENYON, M.D.: Well I think we make contributions to family planning in other ways. One way in which is the whole counseling and testing process. We have women actually getting more attention and dialog during at least in pregnancy than they probably ever received before. Again, where I was based we were adding 500 lay counselors to the health system to allow in this case pregnant women, but also women with HIV who

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are not pregnant to have additional time with in this case a lay health worker, but someone conversant with these issues. The problem is when we start diverting resources to purchase those commodities, than there are other things HIV related that we can't do. But we can use the infrastructure that we can help build through HIV supported programs to benefit other services, in this case family planning. But I think the diversion of resources, specifically to purchase family planning commodities would have its toll on other aspects of what we can offer for HIV specifically. But we have other programs and we're not the only donor in this regard. But it would have idolatrous affect on what we can do in the HIV arena.

FEMALE SPEAKER 1: There were a couple of questions that were passed in on the index cards earlier, maybe about a half dozen. And most of them, maybe half of them, were answered. One question was about the Rwanda study that was referenced by Ellen Moore [misspelled?] and we have a presentation on that tomorrow. So we're just going to hold off talking about that right now. But then there were just a couple of questions that basically should be addressed to the OGAC, so Tom and Shannon, I'm going to leave it to you to sort out how to respond. Let me just pose them.

SHANNON HADER, M.D.: Did you notice they separated us so we couldn't compare notes before we answered [laughter].

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FEMALE SPEAKER 1: Yes, it's a test. So a few sort of factual questions, one was how were the 2-7-10 goals established at the outset of PEPFAR? Second is whether you could clarify if BCT is being counted toward the goal of providing care for 10 million people? That was raised by David Goodnick [misspelled?] and is apparently somebody that's not completely clear. And then Shannon, I think this is probably for you, is and I'm just going to read what was written. How can a top down model for research used in the new PEPFAR public health evaluations help to generate quality research that's relevant to program planners and implementers? So if you could sort of split those up somehow and take one [laughter].

SHANNON HADER, M.D.: You can start with the 2-7-10 and the BCT.

TOM KENYON, M.D.: I'll try the 2-7-10 and I obviously wasn't there. I was one of the jubilant crowd in the field when the announcement came that we had this incredible investment. And instead of nibbling at the edges around the epidemic we could actually jump in and do something substantive. But my understanding is using - and we have much better data in 2007 than we would have had in 2003. But what we knew about prevalence and thereby modeling of incidence - these two, seven, and ten represented approximately 50-percent of those who would be eligible for treatment in the country at that time, approximately 50-percent of those in need of care

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and also the new infections. And interestingly in the country I was in, we had just finished an exercise of establishing national treatment targets. And our targets matched 100-percent. Again, we had assumed that through the government program we could reach approximately half of those in need of treatment because of limited capacity. Some would also go to the private sector and get their treatment through that modality. And others unfortunately would never get into the service and would succumb unfortunately. So I think it was the best information we had at the time. And I think it was very helpful to have those targets as a rallying point in the country. And it was very helpful to have them set out because then instead of deliberating endlessly about what we're going to do, we could be more creative in deciding how we are going to reach these targets. Because I think it's very helpful, especially with the massive influx of resources we have was to have a lot of those decisions or projections made. And we could move with it as one USG team. Had we not had that and we had to go through some laborious exercise of making these estimations, it could have been six months to a year before we ever got things off the ground.

The second question was on counseling and testing and is that counted towards the 10 million for care. And I don't believe so. Is it?

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FEMALE SPEAKER 1: [Inaudible] would you know the answer to that?

TOM KENYON, M.D.: It's not because if that's the case we've already exceeded it because I think we pointed out we've already provided testing and counseling and testing services to 18.7 million people. And that's counseling and testing is of course an avenue for accessing those services. And in some countries too we encourage them - if it's counseling and testing for TB to assign that to your TB support. If it's counseling and for pregnant mothers to attribute that to PMDCT services, not to counseling and testing per se.

SHANNON HADER, M.D.: So the question was about PHE in a top down model. Those of you who know me, I am just recently returned from the field. I was in Zimbabwe for the last several years. So I can unequivocally say with honesty, this is absolutely not a top down model. And it's our full intention to make sure that PHE never becomes a top down model. I think what we're really trying to do is provide the added glue and the added supports to maximize investments across country, not to limit creativity at the country level, not to limit good projects at the country level but in fact to enhance their quality when need be by giving them technical support. But in particularly enhance the impact of these studies by helping to coordinate them across countries. So for example,

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this year we got from six different countries nine different adherence study proposals. What we have at central level is perspective. We get a chance to say, oh look at it. All these different countries have the same question. And all of them are starting out new. Maybe we can put in the extra time that's really hard to do at country level to connect the groups, see if in fact they're actually asking the same question or different questions, and if they're similar questions or the same questions let's at least try to figure out at a minimum how we measure the outcomes in similar ways, how we define adherence in similar terms, so at the end of these projects we can say more than just in Kenya it's like this. In Uganda it's like this. In this site in Zimbabwe it's like this. And have a larger platform for our answers.

Similarly, through some of this prospective both from what we hear informally and what comes in from the COPs, there are certain questions we here expressed over and over by country level that are clearly difficult to measure as one country alone. A lot of the infant feeding issues and getting to scale on infant feeding interventions, very, very tough for one country alone to look at a country like that both in numbers and timing and get into an answer in a timely way. So we can at this central level, here those statements and say, okay maybe this is something worth investing the extra efforts in a multi-country study.

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And this is also why I think at this point in PHE we're actually not using central budgets to fund discreet projects. Most of our evaluation projects right now are funded through country program dollars. And I sort of like that. And central funds, we're trying to use to put in the added glue, the added tools, the added technical assistance that's going to up the quality of those country funds.

FEMALE SPEAKER 1: Well I suppose as befits a discussion about a program of sort of unprecedented scale and pace of implementation and complexity, what we heard today is sort of discussion of impact evaluations that would be of unprecedented scale and complexity and scope. People voiced kind really very comprehensive wish list of things that would be examined through what people were referring to as impact evaluation. I think in some cases that could be challenged in a narrow definition. But really a range of questions around the effectiveness of treatment, care, prevention, interventions, behavioral and biomedical endpoints, issues to do with everything from unintended consequences on the health system to gender relations. And I'm not doing justice, I'm trying to give a flavor that we've all heard a really remarkable scope of interests. And I think what struck me throughout certainly the afternoon's conversation is how much of the discussion focused around appropriate process and

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linking with the field and particularly with decision makers in country who really do own the programs over the long term.

So I think the one point of commonality that hopefully came through across all was how much impact evaluation can contribute to the long-term sustainability of the PEPFAR ambition, whatever PEPFAR is called in the future perhaps. And how essential it is in our work tomorrow to really focus as much as possible and identify the methodological challenges and opportunities to address at least some of the questions that were raised.

So let me give you a quick preview of the meeting tomorrow again from 9:00 to about 5:45. Three main sessions, the first one trying to tap into quite an extensive base of knowledge and experience from previous large scale evaluations of HIV/AIDS programs and some other types of programs. Then a discussion of methodological challenges and hopefully opportunities and approaches of two different types, one is to look at sort of AIDS specific outcomes and impacts. And the other really focusing on much of what we've heard on that wish list of evaluation topics is focusing on methodological challenges and opportunities to look at outcomes that are broader than those directly related to AIDS, the health system, and social and economic impacts more broadly. So it is a significant agenda tomorrow but we anticipate really by the end of the day really being much more up to speed around the

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specific methodologies that could be used. So thanks very much for those who hung in there all day and we'll see you tomorrow. Thanks to the panel.

[Applause]

[END RECORDING]