

**The Second Wave of the HIV/AIDS Pandemic:
China, Ethiopia, India, Nigeria, Russia:
U.S. Strategy Toward Second Wave States
June 7, 2005**

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MALE SPEAKER: Repeat all the specifics other than to say that we are thrilled that she is in the job she is in and that we can cooperate. Vic I have known for many years since the early '90s when he served in Ethiopia as a senior health officer in the ASAIID mission. That period he went on to spend 5 years in India. So, he has a total of almost 10 years in 2 of the 5 countries we are talking about here today. He also served for several years in the regional office in Kenya, prior in Nairobi, prior to serving in Ethiopia. That involved extensive work across east and southern Africa at a critical period, early immergence of the HIV/AIDS epidemic. He is now chief of implementation support division at USAID, which means he is rather integral, rather pivotal on the USAID side in the implementation of the President's emergency plan. He holds a PhD in pathobiology from John's Hopkins University and I will leave it at that. One of the big questions that is on the table here, in addition to the question of how do the folks, like Michele and Vic, see these countries and how do they see their programs emerging and their interactions, their engagement emerging, is the bigger question of what kind of strategy should we have for second-wave countries. Particularly, we have a mixed group here, 2 of which are primary FR focus countries and 3 of which are outside. Do we

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want a grand strategy, a la PepFar for the Russia/India/China states or do we want something that is more disaggregated and anhook [misspelling?]? It is something that we have not really debated out yet and I think that what we do see though is that in some ways the line is eroding between PepFar and non-PepFar countries because you are seeing higher levels of diplomatic engagement. Randall Tobias is in China today. Mark Gible [misspelling?] has been to Russia and to India in the 6 weeks. The funding levels into many of these countries are approximating levels or exceeding levels for some of the PepFar focus countries. There are incremental decisions being made that are eroding the barrier or the line and are beginning to define strategy. I think much of what we will hear from Michele and Vic amounts to a sort of early outline of what our engagement is. These are a form of testing, what makes sense in testing, what is possible, and seeing if there is a payoff to this. There is an enormous high value to diplomacy in all of these states. These are highly sensitive bilateral relationships, highly complicated ones. Several of these bilateral relationships are quite unstable. There is a question of insulating the engagement on health, managing the relationship, and bumping up the global health issue and to mention the bilateral relationship into a higher status one. There are problems of dealing with suspicion and skepticism

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around the sustainability of U.S. engagement. There is the fact that China and India are rising global powers. That they are going to be generating intellectual capital, manufacturing capacity, and exerting their will in multiple spheres, including in manufacturing of medications and other things. That holds potential for greater tension. It holds potential for alliances to form in which new forms of decision power can be made. All of these countries are very sensitive to shocks. If you look at the impact of SARS, the potential impact of the avian flu, Marburg, and Ebola, the impact of 9/11 upon American thinking with respect to global health is perhaps the most profound. Our health diplomacy as a country in the United States is high health diplomacy versus coming at it in the low profile at hock. Our high diplomacy in terms of health is at a very, very early point. Tommy Thompson has talked about this retrospectively about some of the big take-aways from his experience. I think that we really have not thought about what it means to have a health diplomacy that is grand and sustained and has true capacity. What we have done is we have episodic and erratic and fragmented approaches, which may be okay, they may be fitting of the times up until now. I will leave it to that and ask Michelle to lead off. Thank you.

MICHELE MOLONEY-KITTS: Thank you very much and I am quite cognizant of how long everybody sat today, so what I will

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try to do is keep my remarks very brief and I actually think some of the best interaction will be through questions and answers. I must admit as the day has progressed, I started off the morning thinking that I was really struggling with why these 5 countries are grouped together, because I see them as so very different. And as was pointed out, 2 of the countries are indeed PepFar focus countries, whereas the other 3 countries are countries where we have important bilateral programs, but they are not focus countries. Then, after I sat and listened to people through the day and I read through a lot of the documents, I realized in fact that the similarities between these countries were enormous and the potential for lessons learned and some of the issues that people were struggling with in fact are indeed very shared. But, now at the end of the day, I have kind of flipped back again and I really do think again that maybe we should think about them a little bit differently because of some of the infrastructure and human capacity issues and the different roles that donors play in these countries to some extent. Basically, what I was going to do is just quickly summarize some of the key things that emerged from the day that I think are very obvious to everyone here, as to major themes that we have heard over and over again and then perhaps talk a little bit about how the U.S. government sees our response in the face of these. The

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first thing that we heard was that multi-sexed foralism [misspelling?] is incredibly important, that this is not a question of just one part of government engaging the ministry of health, but that you need have national commitment at the very highest level of society as well as at the community. I think that this is something that we have learned across the world as we have worked to implement these programs. I think we are starting to learn indeed a great deal of how to move forward with this. I think we saw in both China and Nigeria some really stunning examples of what leadership could do. We heard a plea from Russia to help with that leadership. I think we have learned not only today, but as we are implementing programs that obviously prevention is incredibly important in these countries; that there are far more people that are uninfected than are infected; that the youth population is incredibly important and we need to protect them. One of the questions that was not addressed today though that I want to put on the table, which I think is very important, is the question of the orphans and vulnerable children. In fact, what we are learning as we look at more data is that the OVC population is not young children as we think of, but in fact the larger cohort are kids that are just entering their sexual years. Therefore, again, I think when we look at this continuum of prevention, care, and treatment, we have to look

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at saving the lives of parents as well as what is the role of Orphans for Prevention. In deed in the prevention area, I think the whole question of how do we deal with stigma and discrimination across these countries is still a huge issue. How do we reach marginalized populations and how do we get them the services that they need? Gender issues are hugely important. I totally applaud Helene. I think that we need to not only think about women and how we are going to address women and girls, but again how we are going to really change social norms around male behavior so that in fact we are really intervening on the epidemic on that level. Again, it gets us back to the age old story that everybody in this room has discussed at nausea about what is the role of D in the ADC formula. Also, I would say that there is a case to be made for prevention of IDUs. We talk a lot about how we can prevent IDUs from contracting AIDS, but we do not talk a great deal about how we can prevent children from becoming IDUs in the first place, which in fact is an important conversation to have. There is a lot of discussion about data and surveillance and the need for higher quality data so that we can actually make sure that our interventions are much more efficient and targeted to really addressing exactly what the problems are. I think we have learned today that these 5 countries are enormous, huge, diverse, and complex. AIDS is not everywhere.

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How can we make sure that our resources are really used as effectively as possible? We cannot do that if do not have an understanding of where the epidemic is and where it is going. We heard also today a lot about expanded partnerships, the important role of government, of the non-governmental sector of faith based organizations, of the business sector, of the corporate sector, and I think again that is something that we think is incredibly important, as well as poor public health infrastructure and how that can be strengthened along the way. Taking the 5 minute overview of at large what are some of the issues, I think very important is what is the U.S. government's response in the face of that. First of all I wanted something clear. There has been an illusion to what is a PepFar country; what is not a PepFar country; what do we care about in terms of these, or those, or the others. If you look at the legislation, what you see is that in fact all of the countries where the U.S. government has a bilateral presence are really PepFar countries and indeed we work very closely with the global fund that receives a substantial amount of funding as well from the U.S. government. There is however a very important difference between focus countries and our other bilateral programs and I think it is something that is indeed evolving. But, one of the basic premises in the focus countries is that the U.S. government resources in those

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countries bilaterally will be of sufficient magnitude to help really try to bring programs to scale using our own resources. Whereas in the other bilateral programs, we will never have enough resources to bring programs to scale. What we need to do is to look at models, success stories, help bring people together, find the appropriate targets and gaps where we can make the most difference, and really work with others to make sure that the programs are brought to scale that need to be. A couple of very important things are that regardless of the country, the U.S. government is supporting host-country strategies and plans. We are firmly committed to the 3-1s. We think that it is the only way that programs will be sustainable for the long term and we really view ourselves as working in partnership with our host country governments to help implement their strategies and plans and to really make sure that in fact that this is not a vertical stand alone program. Likewise, in terms of sustainability, that is one of the reasons why we think engagement of all sectors of society is so important because that again is not only do you affect change over time, but how you make sure that the change is sustained. The last point I want to make quickly is I think we have heard a lot about integration of prevention, care, and treatment and that is very central to the emergency plan strategy and something that again the U.S. government does not have to support

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directly. But, I think as we saw, for example the example from China where people are working on prevention, care, treatment, policy, financing, and budget, every aspect of the epidemic is being looked at in one way or another, it is that kind of connection that we think is really going to make success in the end of the day. My final point is, and I think probably for me the biggest thing that I have taken home after today, is how quickly the environment changes. Not only is it changing in terms of, for example where Nigeria was 2 years ago compared where they are today in their success, but also we are learning so much as we go along and we have to maintain the flexibility that is needed to change as well. One area that I would like to highlight with that has to do with prevention. One thing that we got a brief reference to and I missed part of the day so maybe I missed this, but I think that right now, whereas in some of these countries, we are in a position where in fact the epidemic is still very much in high risk groups and we have seen that it is starting to spill over. This is one of the reasons why people are very concerned. In many of the countries we work now, your number one risk factor is in fact an infected partner and being in a relatively stable relationship because of discordant couples. So, the whole approach to how we are going to really work with testing, do prevention for positives, incorporate prevention for negatives,

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and really find successful strategies I think are some of the challenges that we face as we move forward. I think if we look across the board at every single intervention and we see where we were 2 years ago, when we were not thinking about things like ARV resistance or is there going to be sufficient world-wide supply of drugs for us to be able to address the need, one of the things that I am taking away from today is this flexibility and the need that we continue to evolve as we look at these big issues so we can adapt and change as necessary. With that, I think I will leave it and then pass to Vic and then we can take some questions.

VICTOR K. BARBIERO: Thanks Michele. I guess I am in the unenviable position of having, as I am looking at my notes here, every point that I decided to raise being raised before a number of times, so bare with me as I just move forward on a few discussion points if you will. I came to Washington a little bit more than year and a half ago and we were thrown right into the PepFar activity. It has been quite an experience in terms of the curve of effort and the curve of response that we have had. It has really been a consured [misspelling?] effort. One of the most impressive things that I have seen so far is from USG standpoint, what Ambassador Tobias calls "leaving your uniforms at the door", where we try to really get together as our U.S. government agencies and try

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to define in those focus countries the best niches that each one of us can fill. That has been very difficult at times, but also a very rewarding exercise. The progress that we have made to date has been extremely impressive to me. I tried to think a little bit about the characteristics of the second-wave countries that we are talking about here today and again this has been mentioned frequently, but all of those countries have significant epidemic potentials. The opportunity for HIV to increase, explode, expand in those countries is very real and very important. It is very important that we stem the tide as best as we can. Each has large populations, however, each also has a strong political commitment, all be it one that needs to be expanded and certainly maintained in the future. There are different epidemics between the countries, but also different epidemics within the countries, as we saw for example India in the northeast where we have an IDU-driven epidemic and in the south you have more of a sexual-driven epidemic. Those kinds of epidemiological issues are very important when we talk about addressing the epidemic as time goes by prevention, care, and treatment wise. Modes of transmission are different, as well as cultural and social norms. Each of these countries has complex issues within them and internal issues that need to be resolved politically, epidemiologically, structurally, and administratively. We all will have to curb the trends, lower

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that slope of transmission if you can, level it in the near term, and decrease it in the longer term. Each has a window of opportunity, but as we all know, windows do close. I think it is important that that urgency that was talked about today not be lost. Complacency is the worst thing we can have, even in the optic of success because we have had success across the board. But, we cannot be complacent. I think those countries also share all of those things. In terms of characteristic from our USG strategic response, I noted a couple of things that again have been reinforced today: collaboration at the host government level is essential. That has been said time and time again from Michelle, from the Ambassador, from everybody that I know at the office of the global AIDS coordinator that collaboration among U.S. agencies, but also among bilateral and multilateral agencies as well, in the field, at headquarters, across the board day-to-day activities: what do we need to do together to achieve the global goals of HIV/AIDS prevention and control. The objectives for the USG are prevention, care, and treatment. I say that with that order because I have heard time and time again in meetings that we have had that prevention is the anchor. We have all talked about that today and that is a clear priority. We have to be able to prevent in order to keep the infection at bay. It is intuitive. Even though treatment is at the forefront in many

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cases, prevention is always there behind it. It is not a matter of resources necessarily; it is a matter of effort and a matter of priority. Clearly there is a prevention priority, at least from my understanding in the USG strategy. Adherence to the principles of the 3-1s across the board: how do we implement them and how do we work as real partners in the field to do that? It is going to be a struggle. It was not easy in India. It was not easy in Ethiopia. They are competing issues among the donors, among government, among states in countries. But, try to really move forward on the 3-1s principles. It is something that we are all moving forward towards. Another thing that I have learned and we have experienced here is evidence-based decision making and the option for course correction. We have to look at the data. We have to value those data and we have to correct our decisions as we go forward. We do not know all of the answers now. Mistakes will be made. Hopefully they will not be catastrophic mistakes. But, looking at data, epidemiological, social, and behavioral data and correcting as we go along are key in terms of strategic priorities. I struggle with monitoring evaluation in at least the projects that I help manage and the activities that we pursue in PepFar. We want to try and promote sound monitoring and evaluation, but not overwhelming monitoring and evaluation. There is a line between it because we can get

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bogged down. I know that in terms of some of the projects that we are managing where loading down our new grantees with monitoring and evaluation criteria and if we are not careful, they will be spending a lot of time doing the M & E and not doing the program service implementation. So, that kind of balance of sound monitoring and evaluation, yet keeping our eye on the ball in terms service delivery, is key. Everybody has talked about this and again from my experience with our strategies, capacity building, capacity development, system strengthening, and local network expansion are also priorities. It is a medium and long-term endeavor, but it remains a priority and I think it is really going to be the key to success because it is the key to sustainability. Counseling and testing, not just for target achievement, but for knowing one's status and tracking the epidemic, are also very, very important elements. And, last but not least, do no harm because there is in the serene of the real opportunity to do some serious harm and we have to be careful what we do, how we do it, when we do it in order to make sure that we stem the tide of the epidemic and make sure that we do not cause any real problems in terms of implementation of our programs. I want to share with you something. Can everybody see me? Vasser Tobias [misspelling?] does this great histrionics. He talks about this: he says this is development; this is health;

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this is AIDS; this is PepFar. He has told us this a number of times in order to try to have us focus our efforts to really make sure we do the right things, to sharpen our strategies, to sharpen our interventions, to sharpen our outcomes. A lot of us have a lot of trouble with this, especially when we think about if we are going to deliver services, we have to have a system there that can deliver those services. Although this kind of approach is something that we need to really appreciate, we also have to figure out how do we achieve the objectives of PepFar within the context of a focused, streamlined, and efficient approach. That is not easy, strategically or operationally. We have to try to figure out how we can do that in the best way. I wanted to share that with you because I think it is a great optic to do. We have all talked a lot about prevention. I know there are major issues with ABC, but ABC is something that I think works. We have to figure out how we balance those interventions, relative to the epidemiological situations that we are in. That is a pretty easy way to approach what I think is a complex problem, but it is something that I rationalize in my own mind, say ABC has elements of a sound prevention strategy, but what is the balance and what does it take? Youth. If you want to talk about waves, youth is the wave of the future. How do we really focus on youth and use the prevention side and other service side to address the

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issues that are here now and are coming in the future for youth. I am glad to hear again Helene talk about gender, the male side of the equation because gender is not only about women. The issue of gender in HIV/AIDS prevention goes both ways in terms of men and women and how we deal with the male side of the equation, in terms of transmission is key. Last but not least, in terms of prevention, we talk about changing norms. That is an easy thing to say a very difficult thing to do. But, it is worth the effort. Over time, this is not a 2-year, 3-year, 5-year approach. Changing norms takes a much longer time of that, at all different levels from the political down to the operational side of the equation and down to the village level if you will. I think it is key that we keep our eye on the ball in terms of those norms as well. I had a slide that I wanted to show you, but I will just explain to you. As a student of the natural history of infectious diseases, we were talking in the office a month ago in terms of the curve of transmissibility, if you will, of HIV. The bottom line from what this graph looks like is that in the first 3-4 weeks of infection, the viral load goes way up and the infectiveness, the transmissibility, the transmission potential of that individual is extremely high in those 3-4 weeks of time and then drops down, very, very low, so your viral load is low and the person is less infected, if you will. The problem is that

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you cannot diagnose in that early period of time. How do we then approach prevention? To me, that is an issue that is so at the center of our prevention of HIV/AIDS that the theory and the practice of HIV/AIDS prevention, care, and treatment is mind boggling. How we get to those kinds of questions? That is just an illustration of our evidence-based decision making and I think it is very, very critical. They are not easy problems, but we must address them if we are going to succeed. Orphans, as Michele mentioned, is key. 2 years ago, the estimated Orphans were 25 million by 2010. Probably based on prevalence rates that have been readjusted, it is going to be 18 million by 2010. It is still a mind boggling number that has tremendous issues relative to family structure, urban issues in terms of street kids, education, etc. How we deal with the OVC problem in the future is going to be key. Success. What do we need for success? We need collaboration across the board. Human capacity development, institutional capacity development which was alluded to earlier, gender inequity issues are at the center, home-based care: we need to figure out how we are going to do home-based care in the future because that is really going to be where a large part of this battle is going to be fought. How do we manage costs and quality of service? How do we engage PLWAs more? Drug quality, the availability, the access to drugs, and last but

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certainly not least, adherence are going to be key for our success. With HIV/AIDS, we have to do almost a paradigm shift to chronic disease management. I know in my experience, I have been dealing with infectious disease management for 25 years, this is a different bug. How we move forward on the chronic disease side and the management of infection and the management of prevention is going to be a critical issue and represents for at least a lot of the international agencies a paradigm shift. Last but not least, public/private sector partnerships: we have talked about it today and they are going to be key. Governments cannot do it alone. Private sectors cannot do it alone. NGOs cannot do it alone. Corporate sectors cannot do it alone. It has got to be a real partnership. Where the challenge is: capacity building, adherence, the emergence of resistance. It will come. What do we do when it does? Counseling and testing getting is much out and as many out as you can in terms of knowing status. Medical barriers to service delivery: they are there. Who can deliver drugs? Who can diagnose? Who can counsel? How we deal with that at the lower levels of the system I feel are going to be very important. Developing, strengthening local networks and sustaining them are going to key and as I mentioned, home-based care. The eligibility of patients and patient tracking, looking at CD4s over time for 100s of 1000s of patients is a

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huge, logistical and scientific issue. How can we deal with OVC? As I mentioned, the care and support continuum. Keeping targets in perspective: if we do not reach our targets, 3 by 5 for example, that is okay. Let's move the systems forward so we can put programs and policies in place for over the long term because this is a long term effort. Over the long term, address these critical issues. Second to last challenge: ownership and sustainability at the country level. It has to be local ownership. If you are going to get sustainability, you have to have ownership. Last but not least, stigma and discrimination.

To wrap up, a long term optic is required. I think the United States government is committed to prevention, care, and treatment. I think local systems and local networks are going to be key to sustainability. We have to ensure that we have drug quality and drug adherence. HIV/AIDS can be stopped. It is a matter of time. It is a matter of science. It is a matter of commitment. It is a matter of communication. It is a matter of partnership. It is a matter of compassion. Thanks.

MALE SPEAKER: Thank you very much. [Applause] Why don't we take several comments and questions here and we will bundle up several and then we will come back to our speakers.

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Princeton, Sir, I am sorry that I have forgotten your name. Tezy [misspelling?], Mark, Richard, we will do a cluster on this and then we will move over there. Princeton Lyman.

PRINCETON LYMAN: I thank you very much. Princeton Lyman, Council on Foreign Relations. In trying to segment this problem down a little bit and you talked within health, Victor, PepFar etc., but if you just take the health area and the recognition that is growing to stophede [misspelling?] an HIV area of health delivery when countries are facing needs in a broad set of health and their are scarce resources, the need for building a very broad health infrastructure becomes essential. PepFar may be only a part of that, but where does the coordination come in on building that broader structure. The question is: should that be allocated to one of the several major donors? You say to the World Bank, "Look, you are in charge of developing the systems, the programs in each country and we will part of that". And, then on some other aspects, you look to someone else. Thank you.

MALE SPEAKER: Let's get a couple of questions out for comments.

MALE SPEAKER: Every time we come up with some other things that need to be done, it is always framed in the perspective; can we afford to do all of this? I asked the question the [inaudible] on; can we afford to not do this? The

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question I have is: why are we so focused on what we can give the rest of the world in the United States? The rest of the world can also have something to give to us. There are innovations that are available other places. Historically, let's look at tuberculosis for example. The global strategy for tuberculosis was developed in India. I think that one of the areas that I have not heard much about is that kind of a collaborative developmental effort that the USG can really catalyze and really help everybody get underway. The sharing of information about what happens, I will tell you from my own, personal perspective sitting in Chicago, and I know more of what is going on in India than Indians do.

MALE SPEAKER: Tezy, Mark, and Richard and then we will come back to you. We will load you up.

TEZY: I wanted to pursue a bit this question of the diversity of strategies that PepFar is supporting, PepFar and more generally the U.S. and to ask if you could give us a little bit of a sense of what some of the differences are in national strategies that the U.S. government has been willing to support. Also, how close you believe we are to the 3-1s? My starting point there is the study, the CSIS paper on measuring prevention, which has a rather arresting table at the back of it with a long list of measurement criteria. It seems to me that just about every box is checked under the U.S., but

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that the other donors seem to be going with a much smaller list. Am I misreading this or does that mean we still have a lot of work to do?

MALE SPEAKER: Mark.

MARK: Thank you both. This relates to the question that you rose at the outset Michele about the need for multisectoral approach and Vic in terms of expanding the reach of the prevention programs beyond the health sector. We skirted around it, but there has not been a mention, I do not think, all day about the schools and the education and to what degree we really have reached the range of the upper primary grades through high school with effective prevention programs that obviously have to go across the full range of ABC and insure that particularly the girls have the information to available to them to at least begin to protect themselves. It is one of the few areas where you have girls in a setting where you can provide a collective message if you will. Yet, I have not heard that and I am wondering whether PepFar views that as somebody else's problem in terms of the level of resources or in the countries' strategies, is that a requirement, whoever funds it, that this is an area that will be covered.

MALE SPEAKER: Richard. One last question and then we will come back.

RICHARD: Sure, 3 points.

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MALE SPEAKER: No, 1 point Richard. [Laughter]

RICHARD: They are 3 related and they are very quick.

MALE SPEAKER: 1 point. 3 in 1.

RICHARD: 3 in 1. Okay, the first of the 3 in 1:

capacity and sustainability has come up a lot and if we just think of what Professor [inaudible] in terms of what Nigeria is facing in terms of the numbers and so on. You can think of it in terms of all of those donors, operationers, and who are involved in it getting the capacity to get up to this 250, 350, 450. But, when you think of capacity and sustainability in the context of this wider development in terms of the Nigeria, and that question is not even coming up. I cannot go into any more detail because I do not have much time. But, I think that it is a question to start thinking about. The second one is leadership keep mentioning. Dealing with the failure of leadership in this broader sense of behavior change and the responsibilities, I think that is something that in terms of most African countries and most of the leadership structures are not really even being raised. Finally, testing is something that has hardly come up in our discussions today. But, as was pointed out earlier, if in fact you make estimates in terms of the number of people who are infected, but in fact you only know a small number of them. What kinds of strategies in terms of testing might be required?

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MALE SPEAKER: We have got a question around do we go to the World Bank or some other agency and strike a deal on a broader approach? We have a question about building, sharing, and collaboration in the dots case in India. There is a question about how you deal with diversities of different national strategies, a question on schools, and then Richard's last 3 points.

MICHELE MOLONEY-KITTS: Okay. On the stove pipe for HIV question and should different donors break-out different pieces: I think that there has been some historical effort in that direction. But, basically I think what you find is that so much of this is also driven by the countries and what they need and where they are headed. Certainly for us, this is an HIV program. We recognize that there are some serious constraints to that. At the same time, we do believe there is going to be benefits to the public sector and health sector at large as a result of this. There is now way that you can increase the capacity of a national laboratory to do quality assurance for HIV and CD4 counts or deal with the issue of how we are going to address pediatric AIDS without actually strengthening overall pediatric care. So, we do think that some of those things will be off-shoots. I actually feel as though this is an on-going conversation that the donors have. There is no simple answer.

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MALE SPEAKER: There is an opportunity to address this very issue within the context of the 3-1s. If there is a single plan, the donor's government at the country level and define the niches that they can support. If there is agreement, but I think a number of us would probably agree with that you need to have a stronger system if you are going to achieve all of the goals that we want to achieve and you begin to do exactly said and look at which of the donors that can support infrastructure, that can support construction, that can support laboratory, that can support training, that can support drugs and come to a real, single plan. It is easy to write that single plan. I have been in the meetings. It is very difficult to do, but we have the opening, we have the policy agreement world-wide on the 3-1s and that to me is the avenue that should address your question.

MALE SPEAKER: Care to talk about testing a little.

MICHELE MOLONEY-KITTS: Actually, I want to explain something that I think is not clear to everybody in this room. You have to work in this business day in and day out to really get it. But, the reality is that the President's emergency plan is extraordinarily decentralized. I think most people, especially people like us sitting in Washington, do not quite realize that. That has a huge amount to do in terms of some of the questions that we have been asked about diversity of

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strategies, about another kind of and of [inaudible] Tobias' sayings that basically that Washington or headquarters will define the "what" and the field defines the "how". When you look at some of key "what's", there is no question that all 3 things that were mentioned: capacity building, sustainability, leadership, and testing are all very much important "what's". We recognize and I am sorry that you do not feel like testing was addressed enough. For us, it is a huge priority. In fact, I think it is central. The 15 countries have done 5-year country strategies. If you look at Kenya, Uganda, and South Africa, some of the bigger countries, you will see that the central thesis of their 5-year strategy, on which everything depends, is in fact knowledge of status. I think that is important to keep in mind. In terms of programs being different, there is a huge variety of differences and I could just name a few. If we look at the program in Botswana that is very closely tied to a national strategy, I think it is probably one of the places where maybe the 3-1s is quite effective. There is a close collaboration with the Gates Foundation. The government very much directs what happens. If you look at South Africa, where the private sector is very engaged in what is happening, the corporate sector and private sector strategies are extraordinarily important. To Vietnam, where prevention is critical and in fact and it is yet not

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really a generalized epidemic yet. So, you will see across the board, we can show you that actually each one of the countries has programs that are quite tailored to their own situation. Some countries, for example Uganda, have made tremendous progress in terms of very innovative approaches to treatment and testing without reach and health care workers that go out on motor bikes to deliver ARV therapy. Whereas a country like Mozambique is still struggling with policy issues about only doctors can deliver ARVs and yet there are only 300 doctors in the whole country. For those of you who follow Mozambique, there has recently been a change in that I am proud to announce. There is a very wide variety. In terms of how we are doing on the 3-1s, I almost want to defer to my colleague who is sitting there quietly in the back. I think the third one on monitoring and evaluation I actually think is probably the one we are the best, farthest along on. There is a very great interagency group called the MERG, which never ceases to amaze me, that is making a lot of progress in terms of defining indicators and working together. I personally do not sit on that, but I think other people in the room do and could probably speak to it in more detail. I think in terms of the first one, there is a lot of commitment to it, but some countries are not there yet, as well as probably some donors are not there. Like everywhere, you do find that at the

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country levels, various things influence what happens. Again, the same thing with the one coordinating authority, I will tell you we recently had a bilateral meeting with UN aides where one of our decisions of one thing that we were going to move forward on was to identify a couple of countries where we really wanted to move forward quite actively in terms of piloting and implementing the 3-1s, all 3 of them at the same time in the same place and figure out how we could work with governments to make that happen. So, it is important for us.

MALE SPEAKER: Why don't we take 2 more.

MALE SPEAKER: Just in terms of the collaboration side of it that you asked Sir, I think there is a great potential. I think overall collaboration at all levels is going to be key in terms of the implementation of this program. There are going to be lessons learned programmatically. For example, what have learned from Dots that might be translated good and bad to HIV/AIDS and ART? We have learned some lessons from Dots programs and how to do treatment. What can we benefit from that? The other thing that I would suggest also in terms of collaboration is certain countries have had success in certain areas. How can you translate that to some of the other countries in various regions? I think people are very much open to that to answer your question.

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MALE SPEAKER: What I would advocate is the U.S. take a leadership program. I think that one of the problems that we have when people give you an example and we try to keep it there, the vast majority of [inaudible] can not afford to go to national conferences. We need to go out there and intervene and talk to them and [inaudible]. We cannot even go to bilateral [inaudible]. In terms of models, for example, our own success is bent on years and years [inaudible]. We think that it is fragmentation of HIV intervention [inaudible]. It needs to be integrated to help the public out.

MICHELE MOLONEY-KITTS: We would agree with that and I think one of the numbers that sticks in my head right now is how very few people are actually benefiting from PMTCT services. I mean, we talk a lot about how difficult it is to do prevention, this, that, and the other, but here is a very tried, easily measurable, absolutely proven technique and if you look in high prevalence countries at the number or percentage of pregnant women that are actually benefiting from PMTCT services, it is abysmally low. We are making some headway. I think we would agree with you.

I want to go back to the question on education, which we did not mean to skip. There are 2 parts to the answer. The first is we absolutely support curricula and training in schools for people who are in schools around life skills and

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all kinds of things like that. In fact, one of the concepts that we are working on that you may have heard of is something we call "wrap around". It has to do with this issue that was raised earlier on the policy front about what is the interface between development and some of the broader, very important development agenda issues and this very focused HIV piece. Education would be a primary one. So, what we are doing is we are trying to look at places where different people can come to the table with their comparative advantage and make one program. We have a great example in Zambia. As some of you may be aware, there is another presidential initiative, which is the President's initiative for education in Africa. There, in fact, in Zambia, the PepFar program and this program are working very closely together. We are cofunding the same groups of people in some places. PepFar is funding work place for teachers where we are doing testing and sensitization and treatment for teachers in the school system. But, the President's education initiative is doing training of teachers because in fact the death rate of teachers is happening so rapidly in Zambia that it is setting everything off kilter. We are supporting a local organization, FaWayZay [misspelling?] that some of you may know, the Federation for African Women educationalists in Zambia to do life skills training and peer support for adolescents in schools. We are also supporting

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secondary school scholarships for girls who are orphans because we feel as though in the prevention zone, if you are an adolescent girl, one of the most dangerous things you can do during your day is go back and forth to school. Often secondary schools are boarding situations. So, there are all kinds of creative things happening in the field to try to put these packages together so that you have a holistic response to a sector that is not the public health sector.

MALE SPEAKER: Thank you. Professor Sotema and Michele, whatever order you want.

MALE SPEAKER: Okay. Thank you. First, thank you very much for this presentation and as we approach the end of the day, Steve, thank you very, very much for organizing this most interesting session. You talked, Steve, about health diplomacy and your field that certainly has gained interest with HIV/AIDS and with the recognition of health as being key to development and of health being conceived and looked at as a global public good. In that context and in the context of what [inaudible] told us about the complexity of the second-wave countries where no one can do it alone, of course increasing attention to harmonization, I wonder whether you could briefly speak about the comparative advantages of being bilateral versus multilateral and do you think the U.S. position will evolve on that in the coming years.

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MALE SPEAKER: Professor Sotema [misspelling?].

PROFESSOR SOTEMA: Michele has asked my question. But, I want to underscore the Shoafe [misspelling?] collaboration. Yesterday at dinner I did talk about it and I think that one thing that we would like to, at least I coming from Nigeria, would like to hear from her is that an initiative would be on the way to insure that the momentum that we have created and the experiences that I, in the second wave, are shared by those countries. Yes, I think the U.S. can participate in that, but I think that [inaudible] is more in position to actually [inaudible] the hope for this because you already have relationships with all of the 5 countries and the men actors in those countries. I think that we could go away from here with that sort of commitment.

MALE SPEAKER: On the question of diplomacy, in terms of Michele you are asking with bilateral versus multilateral in terms of observations around U.S. policy? I think it is evolving. I think when PepFar was launched, it was launched in the immediate lead up to the Iraq War. It was a period of high bilateralism. It was a White signature, White House initiative. It shared in many of the tensions. It was shaped and shared by many of the tensions in this period. When you look at the Bangkok conference as sort of a Nader point in terms of diplomacy by not just the U.S., but by many of the

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other actors, subsequent to that time I think there has been a recovery in a mixed strategy of bilateral and multilateral engagement that has shown a great nuance in commitment to the value of diplomacy. I think one of the problems in the U.S.'s approach has been the diminishment of diplomatic capacity over the last couple of years for either bilateral or multilateral purposes. In the midst of this very intense start-up phase, there has been senior staff turnover. Some of the senior diplomats are no longer there. There has been a concentrated focus understandably on operationalizing programs. But, that is not a fixed reality. I think there is a much greater appreciation emerging around the value of diplomacy and what that means. I would guess that would be a higher investment in the future around that because you do not make a commitment to 3-1s, you do not make a commitment to a joint estimation of treatment as was seen at [inaudible], unless you are prepared to make the counterpart commitments in terms of your own diplomatic time and energies. You do not make a commitment to sustain the global fund without, as has been recently the case in terms of U.S. policy, making the requisite commitment. In my observation, there is a growing awareness around the need for a better health diplomacy that is both bilateral and multilateral. Thank you.

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MICHELE MOLONEY-KITTS: Yeah, I mean I can just to underline that I think that there is something about the beginning of this emergency plan that I think is also very important for people to understand, which is that we had to do just incredible things. In 15 countries, HIV/AIDS bilateral budget went from in some cases maybe \$10 million a year to \$70 million. At the same time, we had asked people to do business very differently and for those of you who may not have had experience with U.S. government missions in the field, there were plenty of countries where we were working in where the CDC person did not know the name of the USAID person, let alone sit down and program as one group together. We had 2 incredibly rapid programming cycles because we got our FY04 funding and had to program that. We got it in January; it was programmed by June. Then, we get our FY05 funding, which was programmed in September. We had incredible pressure to produce results. There was definitely a price to pay for that start-up and the price to pay was that in fact our people started acting quite unilaterally just in order to get the work done. I think that it was not the U.S. government's desire to work like that. It was never really our intent. It was just kind the reality of trying to get through the day. I think that it is very clear now, you know the fact that Ambassador Tobias is in China right now with Dr. Piatt [misspelling?] is an example of how

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committed we really are to realizing that this epidemic is not something that a bilateral donor, a foundation, a multilateral organization, a host country government, or a PVO can fight on their own. Our success is going to be totally defined, I think personally, by our ability to partner and our flexibility around those partnerships.

MALE SPEAKER: I am going to call things to a close. I want to thank everyone for their participation and contributions, especially our delegations that have come such a long way, Carol and Michele for making special effort to be here, Helene for making a special effort to be here, and for Estridge, Jessica, and Jennifer for pulling all of this together. Thank you all and we are adjourned. [Applause]

[END RECORDING]