CENTER FOR GLOBAL DEVELOPMENT

FIGHTING AIDS, TB, AND MALARIA:
INNOVATIONS AND CHALLENGES

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P R O C E E D I N G S

MR. RADELET: Good afternoon. My name's Steve Radelet. I'm with the Center for Global Development. I just want to thank everyone for being here today and having such a nice turnout. We're waiting for Richard Feachem, who will be here in a few minutes. He's on his way, we'll get started, and he will join us in just a few minutes.

You all know about the terrible tragedy of the HIV/AIDS virus and the TB and malaria epidemics that are scourging around the world but particularly through Africa, and I don't need to remind anyone here of the terrible toll that that is taking on everyone's lives.

The word was very slow to respond to the crisis. Five years ago, none of the three institutions or initiatives that are represented here today even existed. The World Bank had not started its MAP program, which it did start in 2000, and of course the U.S. had not started its Global AIDS Initiative and the Global Fund did not exist.

So the fact that the three are up and running is a sign that finally, the international community is responding, albeit too slowly and perhaps still not as strongly as it should.

The United States has a very strong interest in all three of these organizations. Obviously, in the president's emergency plan for AIDS relief, the global AIDS initiative, where the president will promise to ramp up from 5 billion of spending that was in the pipeline over five years to 15 billion. That is underway and making good progress.

With The Global Fund, the United States is the largest contributor, contributing one-third of all of the funds to The Global

Fund so far. In fact, through that one-third contribution in The Global Fund's programs around the world, The Global Fund is the main vehicle for the United States operating in at least some countries around the world, and of course in The World Bank, the United States is the largest contributor and shareholder of the Bank.

So, as Americans, we have a great interest in all three of these programs.

A striking thing is that all three, while working on the HIV/AIDS pandemic, and The Global Fund, in particular, also working on TB and malaria, is that they actually take quite different approaches in how they support programs on the ground, and these different approaches I think reflect a broader debate about foreign aid and how the international community can best support poverty reduction and economic growth programs around the world.

And these differences across these three programs I think provide the possibilities for complementarities. They also provide, unfortunately, the opportunity for some overlap and perhaps some coordination issues, and I think those are some of the things we want to talk about today.

The truth is with these different approaches, we don't know, actually, the best way for the international community to support HIV/AIDS, TV and malaria programs. We don't know.

We know that the problem is huge, the problem is bigger than we can grab at the moment, and it actually makes sense, I think, to try different approaches and see what we can learn about what kind of approach works best, not as a competition but as an opportunity to

try to learn from each other and hope these things will evolve, over time.

We, at the Center for Global Development, are launching, actually, this would be our first event, a program over the next three years, where we will be conducting comparative analyses on the three organizations and looking at issues around program design, procurement, disbursement speeds, monitoring evaluation approaches, and other kinds of issues that are common across the three but where there are different approaches, with the idea of trying to hopefully encourage greater debate and discussion and make all three programs more effective in what they do.

So in some ways, this event is really the kickoff for our initiative.

I'm really glad to see such a great turnout. We're happy that our founder, Ed Scott, is with us here today, and I want to recognize Jack Valenti who's also here, as a great supporter of the friends for the global fight, and others that are here as well, and with that, let me turn it over to my boss, our president, Nancy Birdsall, who will moderate today's discussion. Thank you.

MS. BIRDSALL: Thank you very much, Steve, and I do want to start by thanking Steve for taking the initiative to put together this event, and my other colleagues at the Center who've done such a nice job of bringing us all together. I think we're very fortunate to have our three panel members. Steve took away some of my thunder, introducing to you Ed Scott--where did Ed go?--who is the chairman of our board, and Jack Valenti, whom we're very pleased to have here.

We have two other bird members here, if they'd stand up quickly. Adam Waldman [ph] and Dick Sabit [ph]. And we also have here at least one member of our advisory group, David De Feranti [ph], whom I saw, and perhaps others. So that gives us an excellent, already influential audience with which to start.

What we're going to do is have each of our speakers--and I hope that Richard Feachem will be here momentarily.

MR. : He's here.

MS. BIRDSALL: Oh. Richard, are you here? He's on his way; not here yet. Almost here.

Each of them I'm going to ask to speak for, say, ten minutes, and then I know it's too short, but it will be followed by some questions, discussion perhaps among ourselves, and then we'll turn to all of you for your comments and questions. Richard, a warm welcome. We did get started but you haven't missed any of the substance, really, except for Steve's introduction, who explained that the Center is starting a project with this event to look at the delivery policies and practices, delivering modes, implementation issues of these three programs represented here today.

So we start with Mark Dybul. You have his bio. It's clear from looking at it, that this is a gentleman and a scholar as well as a doctor.

He is the assistant U.S. Global AIDS Coordinator and chief medical officer in the Office of the U.S. Global AIDS Coordinator. He's on detail from HHS and he has himself contributed on such critical

programs as the mother-to-child transmission of HIV in Africa and the Caribbean.

I think I'll introduce them one at a time. So Mark, Dr. Dybul, the floor is yours.

DR. DYBUL: Thank you very much. It's a pleasure to be here and thank you very much for inviting me. I'm delighted that my biography indicates that I'm a gentleman, up front, because it's--it's a pleasure to represent Ambassador Tobias, the U.S. Global AIDS coordinator who couldn't be here this afternoon, and in a larger sense, to represent President Bush's emergency plan.

I always think, as someone who's been in public health for about 20 years, of the fact that this is the largest international public health initiative in history dedicated to a single disease, which is an extraordinary achievement, I think. As you all know, it's a five year, $15 billion initiative, as Steve mentioned.

As Steve also mentioned, it's misunderstood. Sometimes people talk about the PEPFAR countries or the focus countries as if that's the emergency plan.

The emergency plan actually covers all HIV activities that take place under the U.S. Government, which includes bilateral programs in over a 100 countries, fifteen of which are targeted for a very specific focus which we'll talk about in a moment, and also includes our multilateral efforts, as Steve mentioned, in particular, The Global Fund, which we recognize, clearly, the administration clearly recognizes that the global fight against HIV cannot succeed without a successful, vigorous, global fund, and we're delighted to be partnered

with them to the level Steve mentioned, providing a third of the resources currently available.

We also partner with other groups through the initiative. UNAIDS. WHO's Three by Five. Many international partners, including the Clinton Foundation, Mark Gates, many other foundations that are out there. It's necessary that anyone who can contribute to this effort be a part of the effort.

And I also put a stake in the ground from what Steve said. Our view is that these organizations, The Global Fund, The World Bank, the United States, are in fact complementary, and that we do need this mix of different partners and different players with comparative advantages, and that's really the vision of the emergency plan. That one strategy alone will never be enough. They need all the partners together.

And as Steve mentioned, the emergency plan is doing exactly what the president said it would, and in January of 2003, when he announced it. His budget in 2004 was $2.4 billion, in 2005 was $2.8 billion, and in 2006 will be $3.2 billion. So we see a steady increase, scale-up, which is necessary, and I think we'll talk a lot about that as we move forward with HIV/AIDS.

But success is not measured in dollars committed. Success is measured in services provided and lives saved and that's at the heart of the emergency plan.

The focus of 2, 7, and 10, that we talk about all the time, support antiretrovial therapy for 2 million, support programs that will prevent 7 million infections, and support care for 10 million people,

including orphans and vulnerable children, and all of the dollars need to be targeted on goals such as those--prevention, care and treatment.

And we think we've moved fairly well, both in moving the dollars and achieving success. The Global Fund together with the U.S. Government, WHO, UNAIDS, were pleased to announce in Davos, a couple of weeks ago now, the fact that the world has come together to fight this epidemic, and we were there, announcing not our own success but the success of the countries in which we work. We just happened to be the organizations that support some of those efforts, but it's really the national governments and it's the national programs that are getting us where we need to be.

And we're also making great progress in care and prevention. Our annual report will be out, we hope in two weeks, it's a little late, and that will delineate what we're doing in prevention and care, because we believe you can never separate treatment from prevention and care.

The three must always go together in integrated approaches and I think that's one of the very important pieces of the emergency plan.

As I just mentioned, what we're really doing, all of us together, is supporting national strategies. We have to do that. The heart and soul of President Bush's emergency plan, despite everyone's desire not to believe this, is to support national strategies, to build local capacity, so that it is the people on the ground doing the work, not any of us here.

We are there to serve, we are there to support, but we are not there to run things. Stand-alone service sites supported by individual donors are neither desirable nor sustainable, and it is the goal of the emergency plan to build that capacity for sustainability, and that's why there's a difference in how things operate and that's why we have 15 focus countries.

The United States Government has been on the ground, with people, doing HIV/AIDS work for up to 20 years in some of the focus countries. We are building on that expertise to work shoulder to shoulder, in country, with people, to help build the capacity, with people who've been on the ground doing the work.

We did not go to countries where we didn't already have strong bilateral programs to build a new infrastructure. That's why we have The Global Fund. That's why we have The World Bank. That's why we have many other organizations. What we can do is where we already had capacity, help scale up, fully scale up national prevention, care and treatment programs, and that's the focus of the emergency plan, that's the focus of those 15 countries, to scale up for success, to begin the process to build that capacity with people already on the ground.

And let's just take one example, antiretrovial therapy, because we've already talked about it. Antiretrovial therapy does not exist in pills. Antiretrovial therapy exists in expanding the capacity for antiretrovial therapy, building the infrastructure that's necessary, building the physical infrastructure, the laboratories, the clinics,

supporting the human infrastructure, the people that need to be there to provide the services, all of whom should be local personnel.

The logistical systems, the monitoring evaluation systems, the supply chain management systems. All of that is part of antiretrovial therapy. Antiretrovial drugs are but a piece. The same is true in prevention and care. While we need all to do together is to build an infrastructure so that we can move things forward and the donors must coordinate their efforts, so that we are supporting the national strategies to expand those systems for sustainability.

I'd just like to highlight a couple of areas where we're looking at, that are critical areas, as donors, and as the countries we need to look at, and that's human resources, and I'll just say three things about human resources. Train them keep them, and get them to where they need to be, out in the rural areas because everyone's sitting in the cities right now, and if we can do that over the next couple of years together--train them, keep them, and get them to where they need to be, we'll have gone a long way to build infrastructure, at least the human capacity infrastructure. We then need to build the other infrastructure.

And then we need to report on it, we need to know that we're actually accomplishing something with what we're doing. And that's the key.

And I would say that's really the scale-up for success. Build capacity. That's how you go from 200,000 in our case to 2 million in five years. That's how we'll go from where we are with care to 10 million in five years, by building that capacity, and it's only

together, with all of the partners up here supporting the national strategies, that that will be achieved.

So, once again, thank you very much, I'm delighted to represent the emergency plan, to be up here with such distinguished colleagues, and I look forward to the conversation.

MS. BIRDSALL: Thank you very much, Mark. You said some things that are music to the ears of development specialists.

Let's turn to Jean-Louis Sarbib. He is a French national, senior vice president--he has the most important job in The World Bank, in my opinion, which is senior vice president of the Human Development Network.

Prior to that, I know that he was a vice president for the Middle East and North Africa, and you see here on his bio how many other good things he's done. I think one of the interesting ones, maybe we'll hear a little bit about this from him, is that he represents the Bank on the GAVI, the Global Alliance for Vaccines and Immunization. I suppose on the GAVI board.

So Jean-Louis, welcome. I hope that you can do as well as Mark on the timing.

MR. SARBIB: I will try. Thank you very much. Let me first say that it's a real pleasure to be here and I'm very happy that you've launched this effort, because I think trying to understand how the various actors on the battle against HIV and AIDS need to work together and helping us learn from each other and work together I think is a very good initiative.

I will say a few words on the role of the Bank and what I see as the major challenges, going forward.

I think that the Bank has been interested in AIDS for a while. I think the first project was in 1986. But it took a while for the leadership of the countries to actually respond to the many entities of the Bank, and I remember very well one of my former bosses in Africa coming back and telling us how hard it was for him to get some of the presidents, even talking about the disease, and while Africa and African leadership seems to have taken on the challenge, we don't see it in the same way, for example, in these days, in the Eastern Europe or Russia. India is also still somewhat resistant to making the sorts of efforts, and these are places where, if not controlled now, it is still possible, the epidemic can make the fastest and biggest inroads.

Just imagine a 4 or 5 percent prevalence rate applied to the population of India and I think our numbers would look small by comparison.

So trying to get attention from the leadership is extremely important and is increasingly part of our overall economic and development dialogue with the countries.

The policy reduction strategy papers which guide most of the work in the poorest countries pay increasing attention to HIV and AIDS, not only in the diagnosis but also in the measurement of results and outputs. It's far from being perfect yet but I think there is a greater attention being paid to it.

And increasingly, we're also focusing on the longer-term dimension of the epidemic, because the more successful we are, the

more people stay in treatment, the more HIV becomes a chronic disease. So that you not only have to worry about the emergency part of it, but if people stay on ARV for 20 years, 25 years, then the focus shifts to the capacity and the sustainability of the health systems to be able to continue to deliver this.

We obviously are providing some funding. So far as have 1.8 billion that are committed and 610 million that are disbursed as of the end of last month, and we have new instruments, we have the multi-country AIDS program that Steve mentioned, but we also are trying to do more innovative things, if I can say, by having regional programs, because as the essential communicable disease, AIDS knows no boundaries. So we have a couple of programs.

We have a program of the Abidjan/Lagos corridor, which covers the routes of the truckers, and we're also working on the program for the Great Lakes.

So those are the sorts of things that we are trying to do as well as increasingly working in a way that involves the communities. That none of the MAP programs is designed with that, a strong input from the grassroots and without the ability for people at the grassroots level to know how much is made available, there is periodical publication of what the projects are making available in newspapers, so everybody knows how to get it, and 50 percent of the 1.8 billion of the MAP are earmarked for community work and so far we have between 25,000 and 30,000 communities in Africa that are involved in treatment, care, and prevention.

So I think that if you look at the financing part of it, we have gone from 300 million ten years ago, to about 6 billion disbursed, if my memory serves, last year. Twenty fold increase.

The question is, has there been a twenty fold increase in results? And to my mind, while the financing remains a very important part and we must continue to mobilize resources, we must make sure that The Global Fund and others have the resources that they need, the real challenge today is implementation.

We have gone, in a way, if you will, to be a bit provocative from a financing gap to an implementation gap, and we don't see the results going fast enough, and this implementation gap, let me talk about it in three ways.

I think Mark has already mentioned the health systems. I think it's extremely important. The human resources dimension, I will subscribe entirely to what he has said. But I think we also need to look at other diseases that are not getting the attention of HIV. I'm thinking of malaria.

If you look at malaria today, 47 percent of hospital admissions in Zambia are due to malaria. So if we begin to reduce that load on the health system because we take care of malaria patients, which I know The Global Fund is doing and The World Bank is refocusing on doing it, then we're going to have that much more capacity to deal and handle the HIV.

The other thing is really coordination. I'm delighted, and I fully subscribe again to what Mark said about the leadership of the national authorities in other countries.

Unfortunately, if I want to be honest, this is still more often the theory than the reality, and Peter Piot and our friends at UNAIDS are having a hard time making the three ones. One AIDS strategy, one national authority and one monitoring and evaluation system to make the three ones stick on the ground.

It is really something on which we need to work, and next week I'll be going to a high-level meeting at the OECD where we are actually going to look at not only the improvement of coordination but also the challenge of having vertical programs have a horizontal impact in the sense of not really privileging one particular disease at the expense of the strengthening of the systems.

And I think it's extremely important that the three big players learn how to share information much more systematically, and in a way that actually harvests the synergies, because I agree that they exist and they need to be harvested, but again to speak the truth, sometimes the synergies are more competition than they are synergies, and it has sometimes an issue in terms of confusing the countries.

So it's wonderful to have as a philosophy that the countries are leading but the behavior of the donors, including the Bank, have to align with that philosophy, because otherwise we are not helping as much as we should be helping.

And there are examples of things that work well. We have the example of Kenya, where there is an annual program review by all donors together. We have the experience of Rwanda, where there is a common implementation framework that has been put in place.

We have Malawi, where funds have been pooled together to allow the government to actually control things. But we still have sometimes a difference between when our money comes and what the budget cycle of the country is, and that is not helpful.

I think we have to have the discipline to respect, really, truly the leadership of the countries. And then there are, as we look to the overall situation, issues that are going beyond one country and on which I think The World Bank may have a comparative advantage, and that is all the trade-related issues having to do with the availability and affordability of antiretrovial drugs.

I think it's wonderful to see that we are today including through our relationship with the Clinton Foundation, we can procure drugs at 130 or $150 a year per patient, but in countries where the majority of the population lives on one dollar a day, this is still too high and it still requires a different sort of thinking on which we need to get our heads together.

Let me finish by saying a few things about the delivery systems and the fact that it is increasingly obvious to us that we need to build as many alliances as possible. I spoke of the role of communities but I also want to speak of a very important ally with whom we have begun to do work in the treatment acceleration program in Mozambique, and that is the role of faith-based organizations.

In Africa, for example, where you have 14 million orphans, it is increasingly obvious that home care, home-based care is very much the responsibility of church-based organizations, and I attended

a meeting, recently, with faith leaders, in which the willingness to try and work together with international bodies to harvest the capacity of the faith-based organizations to actually reach out very down into the communities and to mobilize, and also to remove what remains of the stigma that still prevents people from entering into treatment or into testing, I think this is a very big potential that needs to be leveraged, needs to be used, if we really need to make the kind of progress that we need to make.

Finally, last point, it's monitoring and evaluation. I think increasingly, we are in a world that demands results, and we need to create monitoring and evaluation capacities in the countries that allow the governments, that allow the national authorities to know whether the resources, the methodology, the way in which they address the epidemic in their country is actually giving results.

So The World Bank is housing the Global Action for Monitoring and Evaluation team, and we're very happy to do this, but it has to have, as its objective, the strengthening of monitoring and evaluation systems in the countries, because, increasingly, the money will come if the results are there, and in order to know that we have results, we really have to have monitoring and evaluation systems that do make a difference.

There's a lot more that I want to say but I'm trying to stay within the ten minutes which I probably already over killed. So thank you very much, Nancy.

MS. BIRDSALL: Not by very much. Thank you, Jean-Louis. Thank you very much.

Now we're very lucky to give the floor, finally, to Richard Feachem. Many of you will know him. He is the first executive director of The Global Fund to Fight AIDS, TB and Malaria, and has been doing that since April 2002. Among other things, in the past I know he was the dean of the London School of Hygiene and Tropical Medicine.

He was the director for health, nutrition and population at The World Bank. So he would have been working for Jean-Louis, if we could collapse time in some interesting ways. He is a doctor of medicine and he has a PhD in environmental health and you can read more about him in the bio. Let's go to what he has to say.

Richard.

DR. FEACHEM: Well, thank you very much, Nancy, and good afternoon, ladies and gentlemen. It's a great privilege and honor to be here with Jean-Louis and Mark and Nancy, and such a distinguished audience, and I'm looking forward to the discussion time.

I thought the most efficient way to give you a quick update on The Global Fund and its partnership with PEPFAR and with The World Bank, was to show a few slides. So I hope these are visible from the back of the room.

The first slide is the chronology of The Global Fund and, really, it's to remind you that our third birthday was about three weeks ago.

So The Global Fund was conceived at the G8 in Okinawa, in the summer of 2000, it was born in Genoa in the summer of 2001 at

that G8 meeting, it came into being in Geneva in January 2002, and its three years old.

It's been a rapid growth process, so that today our portfolio is one of 300 programs in 130 countries and our two-year commitment to that portfolio is $3.1 billion, and our five-year commitment to that portfolio is $8 billion.

We have a very focused mission, which I summarize with this little mantra that I repeat constantly. Raise it, spend it, prove it. The pressures on us to drift into other people's business are relentless and we resist them relentlessly. We are a financing instrument, we are not a development agency, we are not a technical assistance agency.

We have a sole purpose to raise large amounts of money, to spend it effectively, and to prove that we are doing that, and not to stray into other areas of work.

And in designing the model for The Global Fund, which is, as many of you will know, an innovation in the business of development finance, there was a need to balance three important criteria which sometimes are in conflict with each other.

First, sustainability and ownership, things which everyone in this room would fully subscribe to.

Secondly, speed. We deal here with an emergency. HIV is an emergency. Malaria is an emergency. TB is an emergency. When we delay, when we stumble, when we do things slowly, people die who need not die, and therefore a sense of speed and urgency is critical. And lastly, accountability.

We do raise large amounts of money, mainly from the taxpayers of the wealthy nations of the world, and we have a duty to ensure that that money is spent for the intended purposes and that there is full accounting and transparency.

We hold these three principles very dear, they sometimes conflict with each other, in which case judgments have to be made.

Our HIV investments today, it continues to grow as we launch new rounds--but our HIV investments today are in the countries colored on this map, and as you see, we are investing in the heartland in Southern Africa, in the rest of Africa where AIDS continues to grow steadily in most countries, and in Asia and Latin America, and I would particularly draw your attention to our investments in the three time bomb countries for the pandemic--Russia, China and India, and I'm sure we'll say more about those countries at the discussion period.

Our investments in tuberculosis in another group of countries, partly overlapping, partly different. Of course the TB pandemic rides on the back of the HIV pandemic, and the two pandemics need to be dealt with together, and our investments, wherever possible, deal with both diseases in parallel.

We are covering, in our current investments, as you see, many, but not all of the high-burden countries and a number of other countries besides.

And our malaria investments look like this, which is roughly the map of endemic malaria in the world. So our malaria investments follow malaria geography. Malaria is the quick win for all

of us. It's the utterly preventable, utterly unnecessary child holocaust. Malaria is probably killing 3 million people a year, not 1 million people a year, as often stated. They're mainly children and they're mainly in Africa, and none of this is necessary, and if we only do the right things for malaria on a big scale, we see a very dramatic, rapid impact, and we have with us in the audience Dr. Brian Sharp, who leads the fantastic program in Swaziland, Mozambique, in South Africa, which has had such a big impact on infection and death from malaria in such a short period of time, and if it can be done in those three countries, it can be done in other countries, and Brian and his colleagues are showing the way in terms of what can be achieved in Africa with technologies that we have available today.

Where is Global Fund money going? Let me show you four distributions. Firstly, geographical. It's 60 percent to Africa and 40 percent to the rest of the world.

Secondly, by disease. It's 56 percent to AIDS, 31 percent to malaria, and 13 percent to tuberculosis. The TB proportion is likely to rise as a result of round five which is just being launched.

Thirdly, by recipient. Half to government programs and government recipients, and the other half to many different kinds of nongovernmental program and nongovernmental recipient.

And lastly, what is the money actually being used to buy? Half for drugs and commodities and consumables, and the other half for the strengthening of capacity of many kinds--buildings management, IT, and human resources, human resources, human resources, and I want to echo what both Mark and Jean-Louis have

said about the criticalness of human resources in some of the poorest and most effective countries.

Now those four distributions are very interesting because we have policies on none of them. We have no policy on geography of investment, we have no policy on the division between the four diseases, we have no policy on the split between public and private recipients, and we have no policy on the content of the distribution that you see in front of you.

These are completely demand-driven. These are the results of successful applications that have been made to The Global Fund, and The Global Fund plays no role in who applies or what they apply for.

And it may be Adam Smith's invisible hand, or somebody else's invisible hand, but, clearly, demand-driven economics is working spectacularly well in the context of The Global Fund, because a completely policy-free environment has led to a distribution of investments, which is roughly what a panel of experts would recommend, if this was driven by a panel of experts.

I'm delighted to say it is not driven by a panel of experts. It's driven by the wisdom of people in Malawi, South Africa, Nepal, the Philippines, and Nicaragua, who decide for themselves what they wish to apply for The Global Fund to do.

In the current portfolio are some, are built-in, the financing of some significant progress but still well short of what we need.

For example, 1.6 million people will be put on antiretrovial therapy in the current portfolio, if all plans are executed as intended.

In TB, let me take the second bullet, 12 million new treatments for multidrug-resistant TB. In malaria, The Global Fund has quickly become the major financier of the shift in 40 countries and in the future, more countries, from the old malaria drugs that don't work to the new malaria drugs that do work.

So these are some of the things built into the current funding decisions. It's a modest start alongside PEPFAR, The World Bank and others, but it is a significant start, I think.

Grant agreements get signed on a weekly basis and disbursements increase. I mentioned that on a two-year basis we've committed 3.1 billion, and as of today we've disbursed about 900 million and those numbers continue to rise.

Very briefly, challenges, let me mention three, and I hope more come up at the discussion time.

Firstly, the functionality of the CCMs. One of The Global Fund's innovations is the country-coordinating mechanism, a multistakeholder committee with whom we have our relationship.

CCMs have, in some ways, been a great success and are applauded, and in other ways have created problems and issues to be resolved.

So CCMs are ongoing work and we're not, by any means, comfortable with where we've so far got to with CCMs, and I'm sure more about that may emerge during the discussion period.

One of the challenges with CCMs is in the field of donor harmonization, to find ways to collapse CCMs with other national coordinating bodies, so that we don't proliferate national coordinating bodies.

Secondly, small secretariat. The Global Fund is a multibillion dollar fund run by 140 people living in a small office near Geneva airport. We employ nobody outside that building near Geneva airport. There is no other multibillion dollar fund in the world run by 140 people, nor is there any other development finance mechanism that does not employ people in the countries to which the money is going.

So there is a real challenge to do the work at this scale with such a small and lean team, and we only meet this challenge by leaning very heavily on our partners, The World Bank, PEPFAR, the World Health Organization, UNAIDS, some of the major NGOs, and others. Without their support, we couldn't possibly do what we do.

And finally, technical assistance. Things go wrong with our programs just as things go wrong with World Bank programs and things go wrong with PEPFAR programs.

Unlike The World Bank and PEPFAR, we're not in a position to mount technical assistance. We don't employ technical experts. We don't send people out on planes to help fix things when things need fixing.

So, again, we're highly dependant on our partners for the identification of problems early, for the diagnosis of those problems, and for mobilizing the inputs that would solve the particular problem in

the particular country, and this again is work in progress. We're not where we would like to be in those relationships, or the effectiveness of the mobilization of technical assistance.

Thank you very much indeed.

MS. BIRDSALL: Thank you very much, Richard. It's a lot to get into ten minutes.

Let me try to get some discussion going up here amongst our presenters. Let me start with a question for Mark.

It was interesting to me how much you did stress this concept of ownership and the need for partnership. The fact is that to many people, PEPFAR is not seen as representing necessarily those objectives. Perhaps PEPFAR suffers from this overall sense of a unilateral approach in the long history of aid programs by the U.S.

So could you say a little bit more about what you really mean, perhaps by addressing a particular issue, which is transparency. I think it was Jean-Louis who said that if all the programs were as transparent as possible about the proposals that they are looking at, the way money is spent, where it's spent, how it's spent, that that would be a first step in making coordination easier.

Perhaps you could say a little bit more about what's really happening, what the problems really are in being coordinated, in not being unilateral and not being Washington-driven, and perhaps in the context of what information is made available to the public and civil society groups.

DR. DYBUL: That's a very good question. I think we've had to overcome a lot of misperceptions in the last two years and I

think we have overcome a lot of misperceptions as things have moved along.

You know, any time a president announces something in a State of the Union, the first someone's going to think of as unilateral, but that's actually not how the implementation has occurred.

Let me just give you a concrete example. Botswana. Before the emergency plan began, Botswana had a very robust, very vigorous and aggressive program for prevention, care, and treatment, particularly around treatment, and it was supported by Merck and Gates but really led by the Botswana. Now in a unilateral approach, we would have entered in and said, well, we have these prevention, care and treatment goals. We're just going to open our clinics and start our treatment. It's not what we do.

We go in, work with the government, bring in all the consultative partners under the national strategy, and so what we do to support treatment, for example, is support national training, support national laboratories, support national logistical systems, and that's our contribution to treatment. It's not going in and starting clinics. And that's the way we work in all the countries.

It takes a little more work in some than others, and I think there are great examples of coordination between us here. In Rwanda, The World Bank and the emergency plan actually are tied very closely together under the national strategy again, where The World Bank started moving out their MAP programs, we're doing the wrap-around for those programs, initially, and then we're helping with the systems after that.

The Global Fund and the emergency plan are very tightly connected in numerous countries, whether it be Haiti, Mozambique, Ethiopia, Namibia, where the national strategies actually say basically what piece should the emergency plan be doing, what piece should The Global Fund be doing.

The Global Fund will provide--for example, The Global Fund will provide drugs in the clinics. We will provide the training, the laboratory, the other infrastructure, in a certain country, or another way around. That's how it actually works on the ground and that's how it needs to work.

Can we do better? Absolutely. But that's the process, that's what everyone is trying to get to, and I think if you go into countries today and ask people, that's what they'll tell you is happening. That's where things are going.

Now transparency's another issue. How do you get that message out? Well, we certainly have spent most of our time in the last year trying to get things up and going.

We have not focused so much on communicating and talking outside of the country where we're really trying to get the programs going. One of the problems is our Web site. The Global Fund has an outstanding Web site, one that we aspire to greatly. We have just actually now gotten approval, all the approvals, bureaucratic approvals we needed to open a Web site. So we are going to have a Web site, which is modeled on The Global Fund, with some peculiarities about things we do that The Global Fund does not do, to try to get that information out.

We have country strategies in each of the countries which we're cleaning up now, they just submitted them, we're making all the changes that were made, and those will be available to the public.

There are country operations plans in each country. There's a lot of procurement-sensitive information in those, so we can't give those out until the procurement sensitive stuff is done. But those will then become available.

So as we've gotten done with getting things out, we're moving towards letting people know everything that's happening, but in the countries they do know, and that's where it matters.

MS. BIRDSALL: Okay; great.

Jean-Louis and Richard may want to follow up on this but let me first ask Jean-Louis to comment on the problem that many of us have with The World Bank activities, which is that they're slow, and as is the case with the perception that the U.S. is unilateral, some of this may be a worldwide perception based on history. Maybe it's different with the AIDS program.

You mentioned there's a new instrument, or different sort of instrument that's represented by the MAP program at the Bank.

Could you say a little bit about what are the incentives in the Bank, which are reflected, hopefully, in this new instrument, or reinforced by this new instrument, that could get things moving faster, and what's been the experience with that? What is the difference with this instrument that you have invented?

MR. SARBIB: I think first of all, the idea of the Multi-Country AIDS Program, MAP, was to have a kind of a blanket approval

by our board, so that when the dialogue with a country got to the point where they were ready, where the country was ready to go ahead, then there was the possibility of drawing on this pre-approved system with a lot of discussions already premade and there was two phases in the MAP.

The first one was when it was still an IDA credit, and when it was a credit, sometimes the countries were very far down the line, and saying we're going to do this, and then there was the promise of a grant, and that sort of stopped things for a while until we really got the dialogue to get back on track.

Since IDA 13, the availability of grants for AIDS, I think that the approvals have been much faster. But the real challenge came in the fact that the rules that apply to World Bank projects had to be adapted to the specific conditions and to the technical difficulty of procuring drugs, so that what we did is we have somewhere here--and I don't know that I have it here. This is a commercial for this document which is a technical--

[Start side 1B.]

MR. SABIB: [continuing] ARV is not an easy thing to do. And then what we have as well is to look at the procedures of the Bank for disbursement, for procurement, and we have this little thing which is called Turning Bureaucrats Into Warriors, which is essentially--

MS. BIRDSALL: This is The World Bank "little thing."

[Laughter.]

MR. SABIB: No, but what it is, when you go to a country and you want to find out a guide, right? you look at what it is that you

want to see. It's like when you have a hotel list, it's thick because there's lots of hotels. And this one is thick because people have a lot of questions.

So what you do, you don't have to read the whole thing; it's a catalog. You have a question, you go for it, you look for an answer, and if you're technologically-minded, you even have a CD-ROM that you can carry with you, you can do on your visits. This has become a best-seller among the--we don't sell it but it's a best-seller just the same--among the people who are in the implementation of programs, because instead of everyone having to reinvent the solution that somebody else has found, we have this and we're trying to keep it up to date.

So the simplification of our procedures, specifically adjusted for what we find on the ground is what I meant when I say that we are beginning to develop these new instruments, and it's having a very good impact and spill-over effect on other simplification procedures in the Bank. What I had most in mind is that, you know, in the Bank we have a problem, that we can only lend to a country or have an operation with a country when it is a lending instrument.

With the grants, we've been able to do multicountry operations, and that is very important because for HIV and AIDS you don't stop at the border. So that the two projects that I mention is among the first projects that the Bank has done on a multicountry basis.

The other thing that we're doing, that we didn't do in the past, is to make sure that in our infrastructure projects we have

components to take care of HIV and AIDS. So that in the Chad, Cameroon project, for example, we had a whole specific set of activities to make sure that on the work sites, that there was what was needed to prevent another source of spreading of the epidemic to take place. So those are the kinds of things that I meant when I said--now the Bank has been slow in the beginning, and I told you the first project was '86, MAP was 2000. It had a lot to do with the fact that we cannot do projects if the countries don't want them.

So that the work that the Bank had to do to actually put this on the map as a development issue is something that it took a while, because there was the stigma, there was the resistance in society to talk about anything having to do with sex. We find the same resistance today in Eastern Europe of having, dealing with the drug injectors. Drug injection is not talked about, even in countries that have done well with HIV.

In Thailand, for example, you still have a problem of dealing with HIV that comes from drug injection.

So I think this long period had to do with getting this issue surfaced as a real development issue and not simply something that health ministers were worried about.

I think that the disbursements are increasing now. The rate of disbursements on the map is higher than the average rate of disbursements for the Bank. Maybe it's not saying very much but it's saying something.

MS. BIRDSALL: Very quickly, did the board approve something that is in this preapproval state, so that once a country is ready and the project officer says okay, the money can start?

MR. SARBIB: Yes.

MS. BIRDSALL: It did?

MR. SARBIB: Yes; it did.

MS. BIRDSALL: And that was a couple of years ago.

MR. SARBIB: That was in 2000 for the MAP I, and I forget--no, 2000, and I--

MS. BIRDSALL: And do you believe that that has made a difference?

MR. SARBIB: It's sped things up and also it has allowed the--we don't have to discuss every single AIDS operation when it comes to the board.

MS. BIRDSALL: Okay. Let me go to Richard.

Richard, the issue with The Global Fund that comes up in the air, you know, and I'm putting things on the table that are in the air, is the issue of the country coordinating mechanism.

Does it create conflicts within a country? How do you see it working? Do you see it changing? Does it create too much of a burden in some recipient countries to have to go through this process? In general, could you give us, be as frank as you can be at this stage about how you see that process evolving. Is it going in the right direction, and you're going to get "the bugs," you know, fixed? Or does it require some rethinking?

DR. FEACHEM: Well, thanks for that question, Nancy, and I flagged CCMs as one of the challenges in my brief introduction.

CCMs were dreamt up during the preparatory phase of The Global Fund, in the autumn of 2001, and then were begun to be implemented in 2002. When they were originally conceived of in the early Global Fund architecture, I was not connected with The Global Fund. I can attribute these decisions to Paul Amer [ph] who's sitting in the audience today.

I was sitting in San Francisco having the luxury of being a disengaged observer who could take shots from the sidelines, something I can no longer do, and I didn't believe in CCMs. I thought this was a misguided idea.

I have become a huge fan of CCMs, and I'll tell you the good news and the bad news, as I see it, about CCMS today.

I think CCMs have brought together a multistakeholder ownership group to drive the national work against AIDS, TB and malaria, in a way that nothing else has done, and you can talk to communities living with HIV, you can talk to churches, you can talk to NGOs in country after country, and they will tell you we may still have problems but, gosh, we've got a seat at the table we never had before and we've got a voice we never had before, and we can see changes in terms of multistakeholder ownership and involvement, that we never saw before.

So there's a lot of good news out there with CCMs. The CCMS today, and there are 130 of them, range from the very good to the absolutely terrible, and everything in between.

We've recently broken off relations with North Korea, but until we did North Korea had a CCM. That's now going to appear in the Oxford English dictionary as the definition of an oxymoron, the North Korean CCM. That's got to be an archetypal oxymoron. And so we've got CCMs both in countries where you would expect them not to work but also in countries where you would not expect them not to work, like South Africa, that are not working well. The CCM in South Africa is not working well.

So we've got a range of CCMs. Are the good ones good? Yes. Are the middle ones giving power to NGOs, faith-based communities, people living with HIV? Yes.

Are the lousy ones lousy? Yes. Is there direction? Yes, there is direction. CCMs are changing. They're reforming themselves and some of those--and it's always in the right direction. I don't know of any CCM that's moving backwards. I know of quite a number that are moving forwards.

Let me give you a striking example. The Indian CCM has recently appointed an HIV-positive NGO vice chair, something inconceivable in the Indian context two or three years ago, and that CCM has decided that we should have an NGO principal recipient, that our money should flow to India not only through the central government but also through an umbrella NGO. That's a CCM decision, in conceivable two or three years ago.

So a number of CCMs are reforming themselves in a positive direction.

In November, The Global Fund board moved from guidelines to requirements for CCMs. So we now not only have our guideline document, which we urge on CCMs about good practice, but we also have a short list of requirements, which if not that met by the middle of 2005, would cause The Global Fund to severe relationships with that particular country. So there are now some teeth, there are some absolute requirements set by the board of The Global Fund to move The Global Fund CCMs in the right direction.

Is there a problem with the CCMs in relation to donor harmonization? Yes; there certainly is. We have CCMs. We have national AIDS committees of various kinds, and we are encouraging the collapsing of these different organizations, which poses a number of interesting challenges but is being done in some countries.

Let me mention two of the challenges. Firstly, TB and malaria. If you collapse the CCMs into an AIDS organization, what happens to TB and malaria? Obvious question; needs to be solved.

Secondly, the role of civil society. Some of the suggestions for collapsing CCMs into other bodies would have the effect of reestablishing government control and pushing civil society to the margin of a debate. We do not want that to happen. We want the collapsing to maintain the strong voice of civil society, the corporate sector, et cetera, on the CCMS. But all these problems can be resolved, capital by capital. In some cases they are being. We've got distance to travel.

Overall, my judgment of the CCM experiment would be six out of ten and getting better, and in some countries having remarkable impact.

MS. BIRDSALL: Let me push you on that just a little because you described a process, and I think in the development world there's a sort of breathlessness, you know, about civil society and participation.

How can we, as a community, assess over the next several years the extent to which that process makes a difference in terms of effectiveness?

You know, I often think what would happen in the District of Columbia if The World Bank told the mayor, or the Federal Government told--well, maybe the Federal Government does is a bad example. But what would happen if the budget of a city were a function, somehow, of civil society groups getting together and arguing? How is it affecting sustainability to, in effect, bypass the institutions that Mark emphasized are being built with PEPFAR resources?

DR. FEACHEM: Well, let me take the last point first and then come to your earlier point, Nancy, and these are very good questions.

The capacity that is being built with PEPFAR and Global Fund and World Bank is not only the capacity of the public sector. It is also the capacity of the nongovernmental sectors.

And for HIV/AIDS, dramatically, but also for TB and malaria, governments alone cannot solve this problem. Is it not within

the power of governments to do all that needs to be done in the field of HIV, either prevention or testing or treatment or orphans.

Look at orphans in Africa today. Who has picked up the burden, to the degree that it has been picked up? It is the faith-based organizations.

How much significant action on orphans goes on in Africa today, run by governments and instigated by governments? Very, very little. So the capacity that we're talking about is multisectoral capacity, with important emphasis outside governments.

The CCMs allow that to happen more effectively than previous structures did, I would argue. The World Bank also emphasizes civil society as does PEPFAR.

MS. BIRDSALL: How do we assess--

DR. FEACHEM: Okay. On the question of assessment--

MS. BIRDSALL: --a link to effectiveness?

DR. FEACHEM: Two things to mention. Firstly, in the process--I showed the diagram saying raise it, spend it, prove it. Prove it is always challenging in the development business.

We're setting up, at the moment, a number of indicators and yardsticks by which to measure the business of The Global Fund and its relation to other partners.

Among that list of measures will be measures of CCM performance, impact, so there is going to be a measurement tool--I think there already is, actually--a measurement tool for CCMs and these things will be regularly reported.

In addition, we've just commissioned a very large study from a Washington-based organization of CCMs, and that will be a completely independent study of what they're doing right, what they're doing wrong, what the problems are, and whether there is a movement in the right direction in some cases.

So this will be independent assessment of where we are with CCMs. So people should shine alight, people should be critical. My judgment is the glass is half full and it'll get fuller as we make incremental changes, and as the CCMs themselves instigate reforms, which is happening.

MS. BIRDSALL: We have until 4:30; right? Right. So I do want to have Mark and Jean-Louis think about, at least in your closing remarks, saying something about what you really mean by evaluation and monitoring. What are the incentives you're creating in your organizations, or through independent assessment?

Richard just referred to an independent assessment of a Global Fund mechanism. So I want you to at least go to that later, because all of you emphasized the centrality of monitoring and evaluation, but we don't get a sense of how you plan to do that.

So think about that but let's turn to all of you for some questions and comments and please tell us who you are, introduce yourself, and if you want to direct your question to one of the three here, please go ahead and do that.

MR. DAVIS: Hi. My name is Paul Davis from HealthGap. I have two questions, one for Mr. Dybul and one for, the second for Mr. Feachem.

For **Dr. Dybul**, what role do IMF limits on sectoral spending play in perhaps slowing progress towards meeting some of the ambitious three by five goals and the PEPFAR goals for treatment scale-up? And should I go ahead and ask a separate question now or--

MS. BIRDSALL: If it's a quick one.

MR. DAVIS: Perhaps the other gentleman can discuss, there's been a lot of talk and there's a lot of very exciting talk about health care workers and health care capacity, health systems scale. How can you guys incentivize this in the work of the MAP program and The Global Fund, maybe for the next round?

MS. BIRDSALL: What I think I'll do is take three questions at a time, give you a chance to think about them. Dick Sabit and then Ed Scott. I'm going to give our board members the microphone next. Dick, go ahead.

MR. SABIT: We've heard much that's admirable from the three of you about how your organizations complement each other and how you cooperate.

I'd like you to comment a little bit on ways in which you think you're in competition with each other, and as an economist, I'm not suggesting, certainly, the competition is bad. There's beneficial competition but there can also be destructive competition and I'd like you to comment on how much of that you think is going on and how to minimize it.

MS. BIRDSALL: Okay; thank you very much.

Ed. While Ed's going to the mike, I wanted to remind Jean-Louis, he mentioned the problem The World Bank had when it worked to develop programs within a country and then someone came along with grant money. That sounded to me like an unhealthy sort of competition.

So maybe you could explain that. Ed.

MR. SCOTT: I had two questions. The first was, you know, you have The Global Fund that's a grant-making organization, which Richard emphasized does not give technical support, does not give, you know, operational oversight. Yet PEPFAR, which actually delivers services, but only in 15 countries and in some very restricted contexts. Then you have The World Bank that's doing a little of this and a little of that around the world.

And the question I have is there some sort of requirement here, that the panel sees for some leadership role to be filled by somebody who would say, look, this is truly a war against these three diseases. How are we going to coordinate, direct and lead that war?

And the second question I have is specifically at The World Bank, and that is when I was in Kenya, you know, you hear about 600 doctors being laid off, and you go to the AIDS clinics and there's no doctors or nurses, and you say why not? There's this money being made available to you.

And they say, well, the IMF and World Bank says that our public sector expenditures have to be kept within a certain bracket.

And it seems to me that the left hand and the right hand aren't paying attention to each other and I'd like The World Bank representative to comment on that.

MS. BIRDSALL: Okay. Should we just go--well, why don't we start with you, Mark, and then Richard, and we'll give Jean-Louis time to think about that last question. I think he's probably accustomed to it. That's good; but it was asked for us.

DR. DYBUL: And I hope Jean-Louis and I don't disagree, because Paul's first question was directed at me regarding the IMF, and how these caps can cause problems. It's not just us, it's anyone who's massively increasing resources in the health sector, will caps cause a problem? and I don't think there's any question that if we're not attentive to it, it will cause a problem, particularly as we go down.

But I do think conversation, and I hate--you know, as a researcher, I hate saying, well, we had a meeting, so it's okay. But we had a meeting and the dollar amounts that we're contributing, and I think The Global Fund is doing this as well, to each country, is now available to the country representatives of the IMF and to the central office of the IMF. We're not going to engage directly in changing the macroeconomic policy of the IMF but they know the dollar amounts, they know the targets, they know where we're going, and they are interested in incorporating that into their macroeconomic projection. Obviously, a lot besides the emergency plan or The Global Fund will go into those but we're providing them with the information, which is the first step, and there was a high-level meeting, two or three weeks ago,

just tried to lay out how we would move forward from having that information.

So it's beginning, because everyone recognizes it's a problem.

Do you want us to answer one at a time, or answer each of the three that we were asked?

MS. BIRDSALL: Why don't we go to someone else and we'll come back to you.

Richard.

DR. FEACHEM: Well, I certainly agree that the budget caps and very tight public expenditure rules are posing a problem, and Uganda is a strong example of that, and I think we need to work that out.

On the human resources question from Paul, the approach The Global Fund has taken is to encourage applications for innovative schemes that will be dreamt up in the individual countries to solve and reverse the hemorrhaging of nurses, particularly, but also lab technicians and others, and we've had some applications, we're expecting a lot more in round five. I'm sure they'll be about training but even more important retaining, and what innovative ideas come forward in the field of retention, we wait to see. But we're very happy to finance large-scale, if necessary, ideas, both for training and retaining, because if we don't do this we're not going to deliver the services in the countries which are losing health staff very alarmingly fast.

On the question of competition--I'll just rattle through all three questions if I can, and then hand over.

On the question on competition, I think there were some elements, early on, and I think we all regretted it a lot, and I think that's something in the past now. I think there's close working relationships and the positive aspect of what lies ahead, I think, I would call learning by doing things differently. Learning from each other by some of the inherent differences in our models. And I think that's an important opportunity.

I don't think we should all be the same. I don't think we should all do things in the same way. I don't think we should be utterly coordinated. I think we should run some natural experiments and try things differently. It's a huge task, there's space for that, but the important thing is to capture the lessons, to be very frank, exchange good news and bad news, and converge on what emerges to be good practice.

And lastly on leadership and Ed's point about could we do better in coming together and being more cohesive in our approach, even if not identical? I think yes. I think we're moving in that direction but I think we can certainly do better.

The three major financiers are on the podium right now and I think we could be closer and I think we could be more cohesive, and I think there's a will to move in that direction.

MS. BIRDSALL: Jean-Louis, Richard said about the budget caps, quote, "We need to work that out." Can you help us work it out with the IMF?

MR. SARBIB: Well, first of all, I think that there has been some statements issued by The World Bank and the IMF on the fact that--and I think we have a copy that we're happy to circulate--that the grants, provided that they can be sustainable built into the framework, are not a problem, and I think that the very difficult question is to find the right balance between building the fiscal space that is necessary to reach the millennium development goals and having it in a way that does not get us to the problems of loss of stability, inflation, and all the like.

So that what there is right now, when we're working it out, there is quite a bit of effort that is made as a follow-up to the high-level forums that took place in Abudyah [ph] and in Geneva, to try to think about fiscal space for recurrent expenditures, and that is the work that is ongoing between the Bank, the Fund, and we're going to be talking about it again at the end of next week at the OECD.

Now there have been some problems. I've been in many meetings where health ministers really put the blame on their colleagues in the finance department, which then puts the blame on the Fund and the Bank. That's fair game. But the issue really is to make sure that-- Kenya is becoming a "cause celebre," because everybody goes there and sees what you just reported.

The problem is that we also have a dialogue in Kenya to say that we'll be very happy to let you spend more if we begin by fixing the ghost workers, and there are many more ghost workers, that people that need to be, could be hired. So that the corruption issue is getting straight in the way of being able to make progress, and

I don't think it helps anybody to go and make big statements saying that, you know, I've been there, I've seen it, you can't hire the doctors without having the full background of what is going on and the nature of the dialogue that we're having with the government, because if you put more valid doctors, you're not solving the problem of all the people who are draining resources from the budget without making any contribution.

So I think this is, unfortunately, part of the difficulty of having a comprehensive dialogue with the countries and I'd like to take exception with saying the Bank does a little bit of this and a little bit of that.

What we're trying to do is have a comprehensive approach to development in a way that shows that you cannot be successful in HIV/AIDS unless you have a macroeconomic environment that's going to create the growth that you need, to have the resources to hire more doctors.

So it's not a little bit of this, a little bit of that. It's trying to have a view of development that, unfortunately, we don't have a "magic bullet." We cannot push on this button and get a result at the end.

So I think what we need to do is continue to have a dialogue and I very much agree with Richard that there was competition. The example I had in mind was we were far along the way with a country in Africa, that I shall not name, and that country just dropped us like a hot potato when the funds came in the grant way. But then this country had problems implementing, and so we

decided to put some of the Bank funds to provide the technical assistance that was necessary, so that the grant money, which we think is what is needed.

We didn't have it for that particular country because it's too rich to have grants. But when the funds came and the technical assistance was not there, the Bank spent its own administrative budget to provide the support to make sure that the funds would actually give the results.

So these are complicated issues that cannot be solved simply by slogans. We have to have a continued dialogue and I think we're making progress, because these issues have been surfaced. I think the issue of fiscal space, the issue of what are the incentives that we can then give, not only to hire people but to retain people, not only there is an issue of being able to pay the people properly but there is the issue of stopping the rich countries from going and hiring wholesale graduating classes of nurses.

And you can't get in there without getting into some very touchy human rights issues. If people want to migrate, it's their right to do that. So what is it that we need to do to create the conditions in the countries? And again we need a little bit of this and a little bit of that, in order to make sure that the whole thing works, and that creates an environment where development can take place.

MS. BIRDSALL: Okay. We do have, from the Center, a book coming out on the "brain drain" and "brain gain" issue, so you'll hear about that in the future.

I think we have time, even though it's 4:30, if you'll bear with us, for one more round of questions. If you can make your questions short and brief, and then a quick wrap-up from each of our speakers.

Please.

MS. PEREZ: Hi. My name is Sue Perez with Results. My first question is for Mark. Given that TB is the leading--

MS. BIRDSALL: Pick the best one cause you only get one.

MS. PEREZ: Okay. This is for Mark, then. Given that TB is the leading cause of death for people with HIV/AIDS, I'm hoping that you can speak briefly about how PEPFAR is addressing TB in the context of HIV/AIDS, also as well as a means to reaching PEPFAR goals overall. Thank you.

MS. BIRDSALL: Go ahead, please.

MR. PETERS: My name is Ken Peters. I'm an economist. I wanted to compliment, first off, Jean-Louis Sarbib about his answer because it's not that easy being on the ground, there is a lot of corruption. But a very simple question about the, what the other gentleman mentioned, about the coordination of things that go in the ground. Today, there's millions of dollars being poured into countries in the mother-to-child program, it is very successful, and people laud how successful this program is. But there's no milk for the mothers afterwards. No one is keeping track of the amount of--I want to call it the relapse, the recidivism of HIV that's taking place, and it seems to me, as an economist, that these are millions and millions of

dollars that are going out the door with the simple coordination of where is the milk to let women leave the hospital with?

MS. BIRDSALL: One more.

MS. : My name is Sherri D...[?] with the Center for Health and Gender Equity, and I think one of the messages coming out through this panel is the mutual support of each agency for each other, and I was wondering, what is being done to get that message out to Congress, and, in particular, on our recent issue with Senator Brownback, who is now saying that PEPFAR funds are being used to support abortions through funding [inaudible], sort of what the response will be to that. And as a follow-up, if the administration will continue to stand by its position that the Mexico City policy will not apply to HIV/AIDS funding.

MS. BIRDSALL: Okay. I will give each of you a few minutes to either answer the questions or say something about evaluation, or both, and we'll start with Mark. I think that last question may have been primarily for you.

DR. DYBUL: So I don't have the option to talk about evaluation. Okay.

MS. BIRDSALL: No; you can do both.

DR. DYBUL: Okay. I'll actually answer, since a couple were addressed, I prefer to answer questions and then I'll include the evaluation in the wrap-up comment.

On Mexico City, the president made a decision and I have seen no indication that the president is going to change his decision, and we'll have our discussions with Congress as we always do. We're

all up on the Hill and awful lot and we keep the Congress as informed as we can, collectively, and when we have sessions with them.

On tuberculosis, it's an incredibly important area, and you'll see in our annual report that we spend an awful lot of time addressing this because the connectors between HIV and TB is critical. We support and are supporting, actually, hundreds of thousands of TB patients who are HIV-infected for their TB therapy, and we will continue to do that.

We have said we will pay for tuberculosis therapy for any HIV-infected person. Conversely, TB patients are an extraordinarily important population for accessing people who are HIV-infected, and so we're actually targeting counseling and testing within tuberculosis sites.

You know, one thing we've all been talking about is to get to the treatment numbers we need to get to, we need to test tens of millions of people and we're just not there. So this is an important population.

On MTCT and the milk, you know, this is a country decision. We don't go in and tell people they have to use milk substitutes. There's a lot of cultural issues around this.

What we do is try to teach them that either milk, in which case we do support milk substitutes, for example, in Haiti, or consistent breast feeding, and there are follow-up studies now that show that the rate is reduced and that you actually do maintain the difference between people who are receiving Verapine [ph] and didn't, which is a fascinating research question.

But also the real answer here is we need to get full treatment out, so that we reduce the risk of transmission for the long term.

MS. BIRDSALL: And in case everyone doesn't know the Mexico City, I'm afraid to try to enunciate it, could you just--

Dr. DYBUL: The Mexico City or the president's decision?

MS. BIRDSALL: No. First. what you mean by the Mexico City.

Dr. DYBUL: The Mexico City agreement was that the United States would not fund groups who performed abortion for child survival, reproductive health activities. There was a decision made that that prohibition does not apply to HIV, so while our money cannot be used to fund abortions, we do not preclude groups who perform abortions with other money.

MS. BIRDSALL: Let's go next to Jean-Louis.

MR. SARBIB: Just one quick answer that I wanted to give to the prior set of questions on leadership. Leadership has to be in the country. It's very clear to me, and we have UNAIDS as a way to coordinate the various partners, but leadership has to be definitely in the countries.

On monitoring and evaluation, I think what we're trying to do in our MAP programs is to localize accountability as much as possible. Having the approval of proposals, having local authority over replenishment, and in order to do that we are trying to provide information at the local level. We have regular monitoring of our implementation support missions. We have performance-based

mechanisms by which the next round comes if the first round as achieved the results that were supposedly going to be achieved.

There is a lot of learning by doing with bringing the various managers of the programs periodically together. In Africa, in particular, we have quite a bit of this training.

And then the basis of all of this has led to this booklet which is being updated, so that we learn by doing and we try to improve performance.

Is it working? Well, not yet, but the results that we get from various countries are harvested in the team that is doing the global monitoring and evaluation, that is housed in the Bank on behalf of UNAIDS, and we hope to be able to have some kind of a training program, a booklet that will allow us to build the capacity but the emphasis is really building it at the local level.

MS. BIRDSALL: And Richard.

DR. FEACHEM: Thank you, Nancy. Three quick comments. On the abortion question, which I was really surprised by, I would just echo Mark's reply on that. On evaluation, obviously incredibly important and we're not doing enough and we're not doing it well enough, but let me transit that into operational research, which it seems to me is closely linked to evaluation and the words can describe at the overlap the same activity.

The scale-up of antiretrovial therapy in low-income countries is by far the most challenging thing in international health and public health that we have ever tried to do.

There's no precedent for taking on anything as difficult and as challenging and as laden with risk as this is.

And yet today, the amount of serious operational research that's going on alongside the scale-ups in antiretrovial therapy is minor, it's trivial, and I think it's a challenge for all three of us on this platform to ensure that high quality, well-focused operational research is taking place as these programs scale up, so that we learn quickly the lessons of experience.

If we don't do that, we run the risk of making huge mistakes and knowing about them too late.

We also run the risk of not realizing the value of the good practice when we have in fact adopted good practice. So I think it's something where we should work more closely together and do much more.

My final comment is I now have the title forth next book by the Center on The World Bank and it's called "A Little Bit of This and A Little Bit of That."

MS. BIRDSALL: Well, listen, I think that this was, for me, a great education, very heartening to see the spirit of cooperation amongst, as someone said, the three major funders.

I do think it's the role of the Center to evaluate and assess, among other things, the extent to which each of you truly begins to invest in serious evaluation, not only relying on the countries to invest in monitoring and evaluation of their programs, but that you all somehow begin investing even in the baseline data that will give us the real independent and credible evidence of what is working.

Let me take this chance, briefly, to thank all of you for participating with us. I hope you are also heartened but remain critical and constructive observers and thinkers about what is this huge challenge. I think we can all see that there is a good chance that the silver lining in the cloud that is the AIDS pandemic will be the new ideas, the creativity, the new emphasis on results, the new approach, including evaluation, that these different programs are creating, because the emergency was in a peculiar sense, perhaps ironically, inspiring for the donor community and the development community.

Thank you to all of you and thank you to our participants.

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