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**CONFRONTING THE TOUGH CHALLENGES IN HIV PREVENTION**

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STEVE MORRISON: Good morning, and welcome to CSIS. Happy new year. I'm Steve Morrison from CSIS, from the Global Health Policy Center, and we're thrilled today to be able to welcome Eric Goosby and our other guests for the roundtable here.

Before we launch into introductory remarks, I want to make one announcement. Since April of last year we've had, here at CSIS, a Commission on Smart Global Health Policy; 25 eminent individuals who joined us in this effort. We'll be releasing the report and recommendations from that commission on February 10<sup>th</sup> at 10:00 a.m. at the Mayflower Hotel. Many of you will have received a save-the-date notice for that, but please but that in your calendar. It will run from 10:00 a.m. to noon on February 10<sup>th</sup> at the Mayflower Hotel. Please join us for that.

In putting this event together, a number of people have put an enormous amount of effort in getting us organized, and I just want to acknowledge them: Emily Poster, Daniel Porter, Lisa Carty, Elizabeth Morehouse, Seth Gannon, Russ Oates from here at CSIS. From OGAC, Anne Gavagan (sp), welcome, and thank you so much for being with us, and Tom Walsh.

A special thanks to my colleague, Andrew Schwartz, from CSIS, head of our External Affairs. This is a partnership that he has engineered over the last six months with the University of Miami Knight School of Communications. We're very proud of that and very proud to be working here with the University of Miami. And we're joined today by Sonjia Kenya, who will be introduced momentarily by our moderator, who has some up from Miami.

I want to add that Donna Shalala, former HHS secretary and president of the University of Miami, has been a very active member of our Commission on Smart Global Health Policy, for which we're very grateful.

Thanks to Mariam Atashi Nawabi, anchor of America Abroad Media, for agreeing to be here today and moderating. And very much thanks to my colleague at CSIS, Phil Nieburg, who Mariam will introduce in a moment.

We're very excited here today to hear from Eric Goosby, the U.S. Global AIDS coordinator, to hear really about current thinking on U.S. prevention approaches on HIV. Early on, during his confirmation, as he entered his office in August, as he launched the new five-year strategy, Eric has made very clear that prevention occupies a new higher-priority place in U.S. policy approaches, and for many of us, this is a very welcome change, and many of us are eager to hear his thinking and more details on the strategy and approaches looking forward.

We know that prevention is innately a very difficult and complex issue. We also know a great deal about what works and what does not work. We at CSIS have, for a long time, given priority to prevention. We had – for six years had an active working group on HIV prevention as part of our CSIS Task Force on HIV/AIDS.

And over the past year, with the leadership of Lisa Carty and Phil Nieburg, we assembled, in the summer, an expert group to examine U.S. approaches on prevention. We've issued a report. I hope you've had a chance to get it. It's been distributed here today.

There are a couple of big themes that come out of that work. One is making full use of U.S. leadership at the national and global levels and engaging other political leadership of partner governments as well as international bodies to take up prevention in a new and different way, to leverage our future commitments. And that gets us into a difficult terrain of conditionality, and I'm sure we'll hear more about that.

What do you do as resources get tighter and as prevention becomes a higher priority? What do you do when you run into obstacles in terms of mal-governance or resistant governance in taking on the challenge of reducing stigma and improving access by men who have sex with men, injection drug users, commercial sex workers, when you have repressive legal environment that is not being reformed?

We've put a big focus in our work on concentrating resources where most needed – focusing prevention efforts and knowing the epidemic, and lastly, in investing in greater metrics, better evidence base and research. And perhaps we should consider – this may come up in the course of the discussion today – expanding the advisory network to bring in, more systematically, advice from nonofficial experts on prevention into this.

This morning, what we're going to do is I'm going to, in just one moment, introduce Eric. Eric is going to come and do a presentation. Upon completion of that, our other guests, Mariam, Sonji and Phil, will come forward here and we'll move into a roundtable portion of our morning. And that will be an interactive conversation for 20 or 30 minutes, followed by opening for the last portion of our program – opening to the audience for questions and comments from you. Please just come forward to the microphones here.

So it's my honor to introduce Eric Goosby. He's known to many if not all of you for his work over the years. Since August he has been the U.S. Global AIDS Coordinator, responsible for overseeing the President's Emergency Plan for AIDS Relief, and the U.S. engagement in support of the Global Fund. Obviously, also he is playing a pivotal role in this next phase in the launch of the president's Global Health Initiative.

Eric is a friend to many of us. He's a leader. He's compassionate and committed and somebody who has been committed to HIV. His commitment stretches back to the early '80s in San Francisco when he began treating patients at San Francisco Gen. Hospital when AIDS first emerged and came to our attention.

In the Clinton era he served as deputy director of the White House National AIDS Policy Office, and director of the Office of HIV/AIDS policy at Health and Human Services. These were pivotal moments in both of those offices with respect to domestic policy and later with respect to international.

From 2001 to 2009, he served as the CEO and chief medical officer at the Pangaia Global AIDS Foundation in San Francisco, a highly innovative group that has put down, in this last phase, new programs on treatment and care and prevention in South Africa, Rwanda, China, Ukraine, among others.

He has vast experience with international treatment guidelines, development of local models of care, and prevention strategies for high-risk populations, and we're very honored to have him here and thrilled that he's taken on this duty in service of this administration. So please join me in welcoming Eric Goosby. (Applause.)

DR. ERIC GOOSBY: It's a real honor to have an opportunity to address you today, and I'm going to be relatively brief with an overview of our prevention thinking. I wanted to thank CSIS for convening this discussion. It's an important one. It's an opportunity for us to increase our ability to clearly have a dialogue and focus at the beginning of what will be an ongoing relationship over the course of – as PEPFAR moves into its new phase.

I think that our ability to think through this, what has been a painful problem for, really, everybody on the planet in terms of prevention response that's effective and sustainable, is a big part of the challenge, and we welcome and embrace, really, all thoughts on it.

I wanted to kind of place this in context of the 33.4 million people who are living on the planet with HIV and the 2.7 million new infections that are guesstimated to occur annually. We still are predominantly looking at a burden of disease that falls in Sub-Saharan Africa, as you can see, and the figure that is repeatedly – excuse me – sorry; I hope you could hear me before that – that for every two people on ARVs, there are five that become newly infected.

My problem with this juxtaposition is they're not related to each other but people look at that as some kind of a balancing. It's not an equation; it's just two separate facts there that I think we should think about, have real implications for how we think about it, but cause and effect is not there.

The National Intelligence Council estimated that by 2025 there could be as many as 50 million, 25 to 30 million of whom would require treatment at any given time. Our prevention efforts, if scaled up, could dampen that trajectory, but we still are looking at a large number of patients, expanding from both those who are engaged in the treatment end of it, both for opportunistic infections and the initiation of antiretrovirals, adding to the total number living, in addition to the influx of the 2.7 million annually.

PEPFAR's goals over the five-year strategy have been outlined for you. It's on our Web site, and the annexes really have the detail of where and what we intend to engage with. We are, in addition to the transition from emergency to sustainable, engaging our partner countries in a dialogue where an increasing level of responsibility and oversight management is the focus, to truly focus on that, and then to expand prevention care and treatment, both in concentrated and generalized epidemics. The integration and investment in research and innovation become critical complements to this core focus.

The attack into the biomedical, behavioral and structural interventions are the biomedical, behavior and structural, as defined here. We also have strategic opportunities to so-called combine our prevention opportunities on given specific populations to overlap and synergize with the impact. This is an idea that we hope we can, in the course of our PEPFAR programs, better understand and demonstrate improved or added efficacy in a combination approach.

So PEPFAR prevention will support countries and mapping, focusing on the demographics and moving from the demographics backward to see how these populations do or do not interface with the prevention effort on a kind of geo-mapping level; to use the data that we have from other studies, as well as the opportunities that are presented to us in country to converge our strategies to converge on populations, as we were saying, so we get combination prevention approaches; to be able, within any given country, to compare the convergence of a specific menu of prevention interventions compared to another menu; to look at some different combinations with populations and to really be positioned so we can better understand the relative impact of this approach; and then to continue to link treatment and care programs in that to ignore a strategy that does not emphasize those who are already HIV-positive as a central target would be a missed opportunity.

The recalibration, as an example, in South Africa, where an attempt was made over the last year – a little less than a year, six months or so – to re-engage the demographics and look at where the new seroconversions are mostly assumed to occur in a geo-mapping exercise and then trying to map our programs and see if we are indeed well or not well-interfaced with where the new seroconversions are occurring, it has resulted in a shift of funding from the 23 million down to the 32.5 and, more importantly, has better – has allowed us to better interface our prevention programs with where we think the virus is expanding through the population.

So challenges to successful prevention programs is the lack of country data for planning and thinking about where the prevention effort should concentrate. A blanketing approach to the whole population that does not take that into – does not take that into – factor that into the thinking has dominated too much and we're trying to flip that where more of our planning, again, is based in what our understanding is of how the virus is moving.

The fact of the matter that – incorporating the fact that it's not just one epidemic for South Africa; it's multiple epidemics, indeed, geographically, but if you take any one of those dots for any given village, town or city, you have multiple epidemics within that city. To not have a strategy that approaches your prevention effort in that way, again is to miss that opportunity. So understanding that better, more intimately and tailoring our programs to accommodate that becomes the exercise.

The ability to match what we do know works with how we emphasize our allocation decisions and what we financially support is another factor, becoming more rigorous around our abstinence and be-faithful populations, moving into and adding a capability to refer, for those that are unwilling or unable, to a condom family planning strategy, which is the complementary piece for those who cannot remain abstinent in their personal relationships. For multiple concurrent couple populations, this also becomes important to converge those two capabilities.

Our understanding needs to expand. We need to document, at least for sampling – sentinel sampling of these projects, if not all of them – an ability to show that we indeed have connected and have conveyed information that has resulted in a behavior change. Measuring that, identifying that, understanding that has been a real challenge to everybody on the planet to come up with process and programmatic outcomes, to demonstrate impact is really our goal.

And we seen this as a central piece, both of our research – monitoring evaluation/research activities in PEPFAR that needs to, in real time, inform our projects as to what and where and who we are impacting. That will be increased.

The ability to address stigma and discrimination is inherent in all our prevention activities as well as our treatment activities. Emphasizing that, taking advantage of that, engaging with discussion with political leadership, policymakers, not episodically but in an ongoing way, both from our PEPFAR leadership but as well as our diplomatic relationship in country through the State Department, has been part of our strategy – an expansion of our strategy with the PEPFAR issues and the issues in Uganda and Rwanda in particular.

The structural conditions are pair and parcel with that, looking at having less of an impact on this, except indirectly, but looking at how laws and institutions favor or diminish your ability to identify, enter and retain patients in care becomes a central piece of that discussion; understanding the relationship to what would be laws or practices that push behavior more underground being the thing we're trying to avoid. And we want to be nimble enough in our understanding of what we're doing within any given community to identify efficacy and move the machine to preferentially going down that pathway when we see something that indeed does impact.

Examples of challenges, as you look at this – prevention strategies, increasing our ability here. These are all the standards that we have seen everywhere: cervical barriers, HSV-2, suppressive therapy, going on up to your PMTCT condom, male circumcision strategies, looking at this as an attempt to move through a variety of different menus that would be able to converge on any given population to increase our ability to prevent infection.

We still need to move, as I've alluded to, to better understandings, effectiveness at the population level is something that we need to be able to talk about better, to be able to understand better, to be able to document better. The combination prevention efforts, does it work? Is combination better than single? There's evidence to think that it should be. We are in a position as we move these programs not to pilot but to scale, to answer that more definitively, at least with the populations we're in front of, and our hope to increase our ability to reduce incidents, at least below the prenatal numbers that we're seeing throughout these countries is the kind of surrogate goal that we're putting as the marker for each of our attempts.

And then, as something not to decide but to inform decision-making, we are going to be looking at cost effectiveness of different projects in relation to prevention of infection as we move forward. I've never really had a cost-effective analysis that wasn't used to argue against a program, but it certainly is a critical piece to understand your program and your program's

ability to sustain itself. And we need to increase our cost-effective understanding of most of our programs.

So the idea is to work with our multilateral partners to ensure that the interventions provided converge and are created occur in an environment that does not increase barriers to entering and retaining patients and care. We want to work actively against that on all fronts. We want to expand access to high-quality interventions that converge on populations, and hopefully we'll reduce the number of new seroconversions and the burden of HIV on the medical delivery system in country.

Access to services based on principles that are equitable and non-discriminatory become a critical foundation of that discussion. Supporting prevention efforts for women, integrated family planning, reproductive health linkages, and treatment programs becomes the overall kind of 30,000-foot level of orchestration, and scaling up programs that really aggressively take advantage of what is a low-hanging-fruit opportunity that we identify to find and target our most at-risk populations, many of whom are marginalized and, again, move further and further away from entry and retention into care.

And I hope that we will be able to add to our understanding of both the difficulties and successes that we identify as we move these programs to scale and aggressively identify efficiencies, redundancies, eliminate parallel systems of care that really are not contributing to our ability to contain the infection.

A much more detailed description in the annexes of our Web site goes into a lot of the strategies that we have teased out that we'll be implementing over the next two to three years, and I would encourage you to take a look at those for more detail.

So Steve, I'll stop it there and move to the discussion. (Applause.)

(Pause.)

MARIAM NAWABI: Thank you very much, Dr. Goosby, for providing an overview of what the new PEPFAR strategy is with the Obama administration. I think it's very helpful, and some of the questions and dialogue we have will pick up on what you discussed.

I first want to introduce our other two panelists that we have here. On my left is Dr. Sonjia Kenya. She is a manager for health disparities at the Jay Weiss Center for Social Medicine and Health Equity at the University of Miami.

As was stated earlier in this program, the Global Challenges Program is a partnership with the University of Miami's Knight Center for Media, and we try at each session to have someone from the university come and speak with us.

She graduated with a degree in African-American studies from UCLA. She has two master's degrees and a Ph.D. from Columbia University in health education. She was a health

disparities fellow at NIH from 2002 to 2006, and from 2007 she's been at the university of Miami.

On my right is Dr. Phillip Nieburg. He is a pediatrician but he has many years of public health experience. From 1997 to 2003, he was at the Center for Disease Control, and since then he has been at the Center for Strategic and International Studies, working on the Global Health Policy Center. He has his degrees from the Case Western University, his M.D. and a master's of public health from Johns Hopkins University.

So I want to welcome both of our panelists in addition to Dr. Goosby. I also want to acknowledge Sanjeev Chatterjee from the University of Miami's Knight Center for International Media – he is the vice dean there – for supporting this program. We want to have this dialogue between a university and a research center and to get this information out actually to students. We do have each session that's taped so that others can benefit from the information that's shared.

Dr. Goosby, I want to first start on the issue of funding. As we all know, programs can't do much unless they have money to back them up. And although the funding for PEPFAR has increased, it wasn't what the Obama administration had initially wanted it to be. Do you think that there is enough funding to actually put into place all the programs that you mentioned?

DR. GOOSBY: Well, I think that the funding has increased and that has given us the ability not to stop our expansion strategy because we are still looking not at – not a decrease in activity but actually a steep increase in prevention activity.

The constellation of programs that are in many of our larger countries are such that there are many efficiencies that can be identified really with not real digging going on, looking for situations where programs have been funded – where multiple entities have been funded for the same population, so there's more than an overlap of target population.

Their catchment areas are really the same, looking for an efficiency to scale of number of those types of programs. Matching it with the demographics will kind of do that – in a very clear way will match the populations up with the programs and the access points.

We also expect to be able to incur a lot of resource savings from a diminution in the cost of care and treatment. As we move into now the sixth year of PEPFAR, we are getting better at identifying, entering, retaining patients and care, in all aspects of the disease, both treatment, care, as well as prevention. And that economy of scale is significant.

The third big resource saving exercise is, as we – and this is what I would say is the smaller of the three and will come in over the next two to three years – is as we move to a more country ownership program, there will be – and as our NGO community moves more toward mentoring and technical assistance, there will be savings that will be identified there as well.

MS. NAWABI: Dr. Nieburg, I want to bring you into this discussion. There is not a controversy but varying viewpoints from advocacy groups that, you know, who is to value a life,

that, okay, it is cheaper to put money into prevention and some other treatments that actually can treat other diseases. You know, the antiretroviral medicine is expensive, but if somebody needs it and we have it available, then why shouldn't we fund that as well?

DR. PHILLIP NIEBURG: Well, it's certainly true that providing antiretroviral treatment to people who are infected with HIV and who have AIDS is a very dramatic way of extending lives. And on the other hand, keeping people who are currently uninfected from becoming infected is also a way of saving a life.

So it's clearly a delicate balance. I mean, people who are currently on treatment obviously need to stay on treatment, but I think we have yet to confront the issue of how decisions are made about allocating any resources that are extra. And the same is true about other interventions that save lives in situations that are beyond HIV, for diarrhea and vaccine-preventable diseases. It's a very difficult situation to confront.

MS. NAWABI: So this issue is out there. These dollars are limited and they have to be allocated in a certain way. And there is this shift then from the prior PEPFAR that was more treatment-oriented to more prevention and other integrated care.

Dr. Kenya, in terms of integrated care and how that can improve treatment, you mentioned earlier to me that you can go to Cuba and you saw where this can work. Can you explain how this can actually work where a country manages a program and it does have positive impacts?

MS. KENYA: I think we've seen that in other countries as well. Thailand has a wonderfully renowned program, the 100-percent condom program. And, really, what both Cuba and Thailand did was they paid attention to the social norms and the behaviors that increased transmission in those countries, and what they did is they created social interventions that were effective in, one, changing what is behaviorally considered acceptable, specifically in homosexual behaviors, and they also went and intervened at the places where they knew the most – the highest rates of transmission were occurring, regardless of their legal status.

So in Thailand they introduced condoms into essentially sex workers and they put laws in place and policies in place that really enforced the use of condoms with every sexual interaction. They have some work to do since they had those great declines in their initial HIV transmission rates.

However, what is particularly concerning about PEPFAR is I think that we are providing treatment and we're allocating a lot of resources to the places that need it most, but perhaps we're not paying enough attention to the social and the environmental conditions and the behaviors that are going on where we really have the opportunity to intervene in a meaningful way.

And what I've seen in my own work locally in Miami is when you do pay attention to those social norms and you intervene with modes and methods that are relevant to the population

that you're targeting, you can see very significant clinical outcomes, and it has nothing – we know the medicine works.

It's not about the medicine. It's about the education and the access and all of the other sort of environmental barriers that prevent people, one, from knowing what their status is, knowing how they can either maintain their negative status or reduce the progression if they are currently positive. And I think that's an area where we have a lot of opportunity to grow with PEPFAR.

MS. NAWABI: You mentioned these social norms. You know, of course treatment of AIDS is an issue that's bipartisan – both parties want to address it – but there are some interesting shifts that are taking place with respect to party lines. In the prior PEPFAR there was this element of not providing as much funding for those programs that dealt, you know, with family planning and that provided care for sex workers and homosexuals.

In terms of the guidelines, Dr. Goosby, I was reading that, you know, some of them are written into law so it may take some congressional changes, but some are policy, and some of them may be policies that you could actually impact. And I'm just wondering, in terms of the new guidelines and how this money can be spent – we have this pot of money but then it's how can it be spent.

There is this whole issue of opting out, that some of the faith-based organizations were able to opt out of those requirements, but that if these requirements are in place, that this will cause faith-based organizations to reduce their programs. What are the guidelines that you think will be implemented in terms of how the money can be spent and what restrictions there may be?

DR. GOOSBY: Well, we are aggressively focused at looking at our guidelines and matching it up with new perspectives around appropriateness, need. We are committed to positioning the provider so they can respond to the needs of the patient that's in front of them, not have an ideological belief system interface or get between that provider's ability to respond to those needs.

And that is requiring a dialogue, both internally and externally, with our implementing partners around the ability to identify; once these needs have been identified, to acknowledge a need to move that patient in front of someone; then, if they are unwilling or unable, to address that need.

So these referral consultative relationships which we do all over the world – in the United States, right here in Washington, D.C. – can accommodate a different philosophical, ideological, religious belief system as a barrier to that, but we are keen on making sure that that patient's needs are met.

MS. NAWABI: Will the guidelines require – let's say a faith-based organization who doesn't agree with distributing condoms, will it require them, if they accept the funding, to provide that service or can they opt out?

DR. GOOSBY: Well, we will have to have a way for that patient to get the service. They may not deliver it, and we accept that, but the ability for that person to be referred to someone who can address that need is a basic medical, ethical requirement that we are in plain discussion now to try to address.

I also want to say that our faith-based organizations are very effective at what they do. They are some of our better implementers – indeed, are in settings that are not only are they better implementers but they also are in settings where there is no one else. We need them to blanket the population needs in every country we're in. They are frequently not in urban settings but they're in the rural setting.

So a way and a desire to find a way to keep them working for us and with us for the patient populations that they have been responding to for many years before PEPFAR and hopefully many years after is the goal, and I'm confident we'll be able to figure this out.

MS. NAWABI: And, related to that, there's issues of countries who have various laws that might discriminate against certain patient groups, and that has been an issue with respect to getting the funding to the patients who need it.

I want to ask, in terms of that restriction, you know, the CSIS reports on this topic made recommendations that these country partnerships should be resourced more, that they will provide for more sustainability, but what recommendations are made for a country that may have those restrictions and not reach those populations?

DR. GOOSBY: Well, that's a yet-to-be-addressed as well. I mean, in the introduction, Steve Morrison mentioned the issues of conditionality, and I think that's an issue that the U.S. government in general is going to increasingly have to confront.

So you know, since resources are scarce and since there are lots of populations that need help, it makes sense to allocate resources to places that use them most effectively and efficiently and to – and to not – to think about putting human resources in places where HIV risk behaviors are criminalized or where forced detoxification, for example, goes on in prisons.

So there are a number of issues, and there are also ethical issues in the way that Dr. Goosby is mentioning that have yet to be confronted but are coming closer and closer. And so –

MS. NAWABI: So obviously there are complications.

DR. GOOSBY: Right.

MS. NAWABI: There's the science of it and what can be done to help a patient, but we deal with restrictions and guidelines based on ideological issues here that you mentioned, Dr. Goosby, as well as country laws that may also come into play.

With respect to the country partnership, Dr. Kenya, you mentioned you've seen examples where having the country manage the program has worked well. You mentioned Thailand and

Cuba. But some advocates would also argue that there are some countries that have problems with corruption whose health ministries do not perform well, so if we allocate more money through those ministries, do we think that the money will then reach the patient? Has CSIS and your report looked into this issue?

DR. GOOSBY: Well, I think that's – we didn't deal with it directly in that report, but it's part of the same conditionality issue. For example, it's the kind of principles that the Millennium Challenge Corporation has used or is using to allocate resources.

And, ultimately, because resources are limited, I think it's the same concern, that the resources should go to places where the lives can be extended the most or where most people could be kept uninfected from HIV. And so to the extent that issues like corruption become a drag on the system, that has to be taken into account.

MS. NAWABI: And, Dr. Goosby, following up on that, you know, part of the new strategy is to shift these programs from a lot of these NGOs. It's been multi-tiered with different kinds of organizations providing the service and receiving the funding, from this pot of U.S. money. There's obviously other sources for multilaterals.

Would you say that capacity building for the public health ministries is going to be part of that effort to ensure that the money will be spent wisely?

DR. GOOSBY: Yes, it will be a central part of it. No one is talking about moving the effort just to the public sector. We're talking about engaging the public sector in a dialogue around increasing their current role, around management, definition of unmet need, especially the prioritization of the unmet need, and then the allocation decisions.

None of that necessarily means movement of money to public systems. That will not happen until we are sure that transparency also moves with it. It's not rocket science. We'll be able to figure that out and know if those resources are being used or not being used. There will be transgressions, for sure, and we'll respond to them, but not to remove the entire pool of resources because of one transgression, but to find the bad guys and get them, stop the transgression, and redirect those resources back to program.

I'm confident that we can do that. In doing that, we will create a cadre of capability in the country that will serve our programs and the entire country's constellation of programs and needs for the future, and indeed as a central piece of the contribution we want to make.

MS. NAWABI: So this will be a phased strategy. It might be different for one country. There's 15 countries –

DR. GOOSBY: Yes.

MS. NAWABI: – in PEPFAR versus another one, but that is one option that is being sought for sustainability reasons?

DR. GOOSBY: That's right.

MS. NAWABI: And, Dr. Kenya, I want to ask you, you've analyzed the new PEPFAR strategy; you've been involved in this issue for over 15 years. If you could make one recommendation to Dr. Goosby and the Obama administration of, you know, what are some areas that should require more attention or could be more helpful? What would you recommend?

MS. KENYA: An abstinence-only strategy has never worked. It's never done anything – and I may be very ignorant – it's never done anything but increase the rates of disease and unwanted sexual consequences.

So I think when we talk about encouraging abstinence and even giving our resources to organizations that will only promote abstinence, I think it's a huge mistake and I think it really ignores our current science. And I think that we have many examples of this in our own country when we promote these types of policies with our programs and not providing accurate sex education to populations in need of it. We see the dire consequences. We've seen it here.

We've seen men on the down low and how that's contributed to HIV disparities, racial disparities in the United States. And we see where these racial – these ideologies contribute to very, very disturbing outcomes all over the world. And we should be a leader in advocating that science-based programs that have proven outcomes. That's what we support. We don't support ideological – I mean, we have a problem with that in our own country, and I think the last – you know, that was a very, very motivating question about why we changed the administration.

MS. NAWABI: I'll let Dr. Goosby respond to that. Isn't the Obama administration actually opening it up more to not focus on more of an abstinence strategy, as the prior administration did?

DR. GOOSBY: Yes, much of our attention is looking at a way to expand the service constellation for the providers that had been just in an abstinence-based dialogue, to include condom and referral into family planning and other health services.

That response is a critical piece of what is needed and we hope that working, again, with the entire community that's already engaged in this work to look at the services that we are able to put in front of patients as the primary goal.

MS. NAWABI: Dr. Nieburg, I have the CSIS report that I read on this topic. It's very helpful. It provides succinct recommendations. Now that the new PEPFAR strategy just came out last month, in analyzing that, what would you say could be done more that was in the CSIS recommendations but maybe perhaps not included in the new strategy?

DR. NIEBURG: Well, I actually think the new strategy does a good job of hitting the same kinds of issues that we were focused on in terms of – certainly the appendices, or annexes I guess they're called, have covered in detail most of the issues.

I think one thing that might be interesting to think about or might be useful to think about is having indicators that are more population based than individual patient based. So for example, the President's Malaria Initiative has an explicit goal of reducing malaria infection – malaria deaths in the population by 50 percent.

The PEPFAR goals up to now have been focused on the population, the medical model, people who come into the programs rather than a population-based. You know, I think that's one of the reasons – I mean, there are obviously large differences between controlling malaria and controlling HIV/AIDS, but it might be easier to help target resources if they were population-based goals like that.

MS. NAWABI: And picking up on that, one of the shifts with the new strategy, as I understand it, is to integrate the treatment of HIV/AIDS with malaria and TB. And in your prior role at CBC, you actually led a department that did all three.

DR. NIEBURG: Right.

MS. NAWABI: So you're well-versed with this. Do you think that that is possible with the limited resources that are available, that if it has to be allocated in certain areas, do we have enough money to do that?

DR. NIEBURG: Well, for tuberculosis, which is probably the bigger problem of those other two, I think it is possible, and that's because, in general, TB programs are already well-resourced in most places. The issue is really integrating the program so that people – HIV-infected people can have their TB detected and treated and reversed, making sure that new or current TB patients have their HIV infections detected.

So I think that integration, which took a long time to get started, is now moving along pretty well, and I think that will go pretty well. Malaria may be a little tougher. We're not very far down that road yet but we'll see.

MS. NAWABI: Picking up on that prevention versus treatment, America Abroad Media actually just recently did a whole one-hour radio piece on this topic, having gone to different countries to assess this, and the findings were, again, that the treatment has been effective for those patients who received it, but that the problem just keeps outgrowing the solution.

As you said earlier, there is just more patients who keep getting HIV than are being treated. As part of the new PEPFAR strategy, you mentioned some of the numbers that are being targeted. How much more money will it take to actually achieve those goals, given this problem that's multiplying more than the solution we have?

DR. GOOSBY: So that's a difficult one to respond to because it kind of depends on how you cut the pie up, but if you look at the number of patients on antiretrovirals now, look at the 200 to 350 change the WHO recommendation change has created. You know, you're still looking at 33.4 million people who eventually, at some point in time, sooner or later are going to need antiretroviral therapy.

Matching as aggressive a response as was mounted for treatment with prevention is the goal here, and we need to turn the volume up on every aspect of that and take advantage of every component of that, but at the same time not ignore those already infected. To abandon them stops the motor that puts people in queue to get tested for a reason, and to not understand the disease to be the kiss of death, which is really how it is largely perceived and is a huge motor for stigma.

So I've never seen a destigmatization program work without a robust treatment capability, both within the health profession, as doctors and nurses where there's a huge amount of stigma in many of these instances, as well as in the larger civil society. Without that in place, you are not positioned to effectively diminish the stigma.

I think that what needs to change is who we call to the table. We will not, through a bilateral effort, successfully treat the burden of disease that we already know is out there. We need to aggressively change the discussion to include a call of responsibility to the larger global community to look at what is the need that you are capable of responding to or contributing to the response – activities such as the Global Fund, other bilateral unity aid-type efforts; there are a number of emerging strategies around kind of basketing of resources.

All of these need to be looked at, probably convened by multilaterals but then thought through and made real through a country-based-led discussion where these multiple divergent resources are then looked at and added up at the country level to address their desire to move to universal coverage, and address that large unmet need. We will not be able to do it alone. We need to admit that and engage with our colleagues on the planet to converge resources.

MS. NAWABI: Picking up on that, obviously this is a multilateral effort and it's a global problem. The U.S. historically has been the largest donor of these programs.

DR. GOOSBY: Still remains.

MS. NAWABI: Still remains, in addition to many other programs, and with the economy here, you know, being a challenge, it will be difficult, as you said, to fund this. What do you think needs to happen for other countries to get on board and to provide more funding to these programs? Does the administration plan on convening any international conferences or summits on this issue to kind of call other countries to action?

DR. GOOSBY: Well, I have been charged with starting this conversation, and it is well along the road of beginning discussion at both the U.N.-WHO levels, Global Fund as well. We need to prime the pump with that discussion. We need to engage bilaterals who are capable of identifying resources that can go toward this to do it. That will be in some convening discussions and also kind of private discussions as well.

All of that has started. The U.N. and WHO are planning to convene, at the country level, a robust discussion on the 200 to 350 challenge for universal coverage. We will participate and support that actively.

But I think that this will require leadership on the president and the secretary's level to challenge our colleagues in countries at the G-8 level in particular to look at this differently and to commit differently to it. Countries that can need to be challenged: Why not? That discussion needs to happen. I think that both the secretary and the president are in a position to actually put that challenge out.

MS. NAWABI: You know, what's interesting is obviously the global challenges theory that we have focuses on these Millennium Development goals, and the prevention and treatment of HIV/AIDS is one of those eight segments of that program.

Dr. Kenya, have you seen, in the countries that you have visited and worked with, a greater, kind of, cooperation with the multilaterals in addressing this issue, or do they want to focus on their own problem and get the assistance to their ministries?

DR. KENYA: I've seen definite cooperation amongst all sectors of the communities in the countries that I've been to visit, as well as – my research replicates that of Paul Farmer's in Haiti. And that – the mode that we really work on, it's called the community health worker model, and this is not rocket science. You take people from the community – laypersons – you train them, and then you send them out to the community to provide support services, education, and increase access to care, and I see that model as being a viable opportunity for us to really encourage the countries that we work with to take ownership of their programs.

The money that we save on additional – you know, the additional transmissions that might be prevented can be used to pay salaries and encourage employment in those countries. And also, that's very, very effective in changing what social norms are and what's socially acceptable; to have peers on the street, coming to your home, telling you about what HIV is, how to take your medicines, how to access treatment, why you might want to get tested, and why you need to adhere to your medications.

In doing that, you have community representatives educating people and changing what is considered acceptable, saying, "hey, I'm gay," or, "my brother is a man who had sex with another man, and he's still a human being." And I have never seen those types of changes occur in a society, and I'm going – I'm very young, and my observations of what happens in society – but I've never seen those changes occur from the top up.

MS. NAWABI: You know your work is focused on urban communities in Miami, and you've said before that there are a lot of similarities between what those populations experiences and what someone in an impoverished country would.

DR. KENYA: Absolutely.

MS. NAWABI: What kind of lessons learned can domestic U.S. AIDS policy learn from the international experience?

DR. KENYA: Oh, my goodness, that's a loaded question. We can learn that our resources need to be comprehensive. For example, when I went into Overtown – and I was recruited to the University of Miami to do this – we had no HIV testing. So obviously, you're not going to have any impact on HIV prevalence if there is no HIV testing. So – and also using that, our local community partners, I think that our communities are urban, inner-city communities, and ideally, I mean – and it's ideal this conversation is happening in Washington, D.C., where our HIV rates do mirror that in many parts of many of the worst areas of the world –

I haven't seen any community health workers since I've been here in Washington, D.C., telling me about HIV education, and I look like the target population, and that's what I think we need to see more of. I haven't seen any billboards, but what I do see is every time I walk down a street in D.C., and I see more than one minority, I try to estimate in my head how many are HIV-positive, and it's scary as an American, in our American society, in our capital, that that's what I'm thinking about.

So the lessons that I've taken from Haiti and from Cuba and from Thailand are really, pay attention to the behaviors that are increasing transmission. Throw your morality out the door. If you're going to sit here and judge people, then you're going to increase poor outcomes and more racial and class disparities in HIV.

MS. NAWABI: Thank you very much. We'd like to have a good time for a discussion. I know there's a lot of policy folks in the audience, so if you could raise your hand and then come up to the mike closest to you and just say your name and your organization and keep it to a question, for one of the panelists. Sir?

Q: Dr. Goosby, congratulations.

DR. GOOSBY: It's good to see you.

Q: You're doing a great job, and I'm working in Russia, as you may know. Two questions –

MS. NAWABI: I'm sorry – your name, and your organization?

Q: Harvey Sloane, the Eurasian Medical Education Program.

MS. NAWABI: Thank you.

Q: Two questions. We know that the need is far outstripping our ability to deal with this epidemic, particularly from a medical standpoint. My first question is, what kind of money is PEPFAR, the Global Fund, the CDC, all the organizations that can help, put on finding evidence-based information about how to protect people and prevent the spread of HIV – first question? Second question – I'm glad you are using social network and marketing, but I was surprised you didn't mention texting. Haiti today is being – people are getting around by texting –

DR. GOOSBY: Oh, texting.

Q: Not taxi, texting. (Laughter.)

DR. GOOSBY: It's a generational thing, right? (Laughter.)

Q: I get it. I have in my travels abroad, I almost feel that the best thing we could do would be distribute a cell phone to everybody, so they can get that information. You don't, Dr. Kenya, you don't go through the missionary hospital; you don't go through the mores of that society. You directly hit that person who wants to get information about that particular way of treating disease, or not getting it. So thank you very much.

DR. GOOSBY: Yes, well, it's good to see you, Harvey. I think that the way that we are looking at our prevention shift – this is the way I'd say that – is in each country. We're not looking – I mean, it doesn't matter what the total PEPFAR pot kind of does prevention treatment care unless you translate that into how it translates into program.

We are trying to basically put each country that we're in, certainly the 17 focus countries but even as you move up into our 30-country level, there are prevention opportunities that present themselves, especially in Eastern Europe, Russia, the 'Stans, all of those need to be addressed as prevention opportunities, where the prevention pot's going to be bigger than the treatment pot. So I mean, it's that kind of a shift. We want to be in a position where our prevention effort has engaged on every front we think affords an opportunity.

In terms of taxis – (laughter) – I think that we, you know, I've been in this work long enough to have that kind of be something that I didn't see as an opportunity initially. I said, whatever people want to do with that, great. But I have come 180 degrees, anyway – not full circle – but 180 degrees to wanting to test it.

I want to take it to scale in one or two countries – we're already engaged in choosing the countries, we already have the resources to do it – to show whether or not an aggressive, kind of infomatic approach, e-med, e-health-type approach to prevention and treatment from high-risk populations targeted for high-risk messaging, recurrent kind of case-management opportunities so we don't lose people, to adherence and lots of follow-up strategies, especially where there's no addresses on the majority of the patients we're seeing – to use that as a means through which we can identify, enter, and retain patients in care.

We are going to take that to scale probably in Rwanda, although not finally decided, because they're almost – they are very eager to do it and have put a lot of things in place to do it, and then in a country that's not ready to do it, that will need a lot more infrastructure support. But I'm right there with you to really try to understand if this is indeed the tool that we think it might be.

MS. NAWABI: Thank you. This gentleman here had his hand –

Q: Thank you. David Shear, Strategic Partnerships. We're working with the Friends of the Global Fund, through the UN Foundation, both in Africa, Asia, and in Europe. As we pursue

our work, clearly the refunding of the Global Fund coming up this year obviously is a centerpiece. One, we wonder if you would let us know the strategy of PEPFAR at this point in time in terms of supporting that effort.

Secondly, as we work on the implementation side of this in Africa, we see increasingly the importance of sustainability. And that means obviously linking with USAID, the Bank, and other international organizations with respect to the development side. And if you could talk to that a little bit too I think that would be very interesting for us.

DR. GOOSBY: Sure.

Q: Thank you.

DR. GOOSBY: Two good questions. The Global Fund, kind of, is the future – would be the short version of it. It is a pot of money that everybody contributes to, that goes to country, and then is transformed into program. There are issues with all of that, in terms of taking that pot and efficiently transforming it into programmatic responses.

The presence and use of technical assistance, when technical assistance is introduced, how it relates to the principal recipient, how the community, the country-coordinating committees, the CCMs are convened, how they deal with in kind of inherent conflicts of interest, how you deal with a transgression when an error or corruption is found, how technical assistance should come before a cessation of resources.

All of those things, the Global Fund is acutely aware of. We sit on their board and have engaged in conversation with the leadership and the secretariat that in, that raises my level of comfort and confidence they are indeed moving on all of those fronts. We are having a board meeting at the end of this month that addresses all of those issues and the issue of eligible funders.

How do you compare unmet needs across different countries of different economic capability? But it is probably the means through which rich countries can support resource-poor countries. And we need to look hard at the Global Fund to make it everything it needs to be to be efficient and effective at making that transition.

The – PEPFAR really threw the appropriation; it gives a third of the money to the Global Fund and has really since its beginning. We're around a billion five hundred now – 1.5 billion or so – in the amount of money the U.S. citizens, U.S. Congress allocates to the Global Fund. We see that as a conduit through which these resources can effectively move, and we need to think about who contributes to the Global Fund and support in every way efforts to increase that contribution and the countries contributing. I think there's more room to go with that.

MS. NAWABI: Thank you. The woman in the third row?

Q: Hi. Nandini Ooman from the Center for Global Development; thanks to CSIS and the Knight Center for hosting this event, and of course Ambassador Goosby for sharing time with us

when you have a lot more to do. But I actually wanted to raise the issue – you’ve talked a lot about scale-up and impact and I think all of us in this room are absolutely behind you in the approach that PEPFAR too has taken.

But there is a lot of concern about what is meant by “scale-up,” given that successful prevention often is very much at the community-based level. And so how are you thinking – and I know you are working through these things – but it would be useful for us to know how you are thinking about measures for success that will allow you to report both to Congress as well as to beneficiaries about how money from the U.S. and other countries is being used effectively to actually prevent infection.

So to be succinct, could you walk us through what you mean by “scale-up;” what are some of the measures for success; and how will you incentivize countries to be able to measure those successes and report – as a country, I mean, I think global measures don’t make sense when we’re talking about prevention given the contextual nature. So that – just, maybe a country example, like South Africa, would be useful. Thanks.

DR. GOOSBY: Well, I think that it’s been the million-dollar question, or multimillion-dollar question, to figure out the surrogate markers of successful prevention efforts. What are the outcomes? The number of preventions averted? The number of infections averted is a difficult thing to kind of reliably quantitate (sic). Our thought – and we are actively working on what these markers will be and should be, and we’re also engaged with both UNAIDS and WHO in trying to define these same markers, because the whole planet needs them.

We are going to move forward anyway; and by “scale-up,” I mean taking your demographics, understanding where your virus is moving within those populations, not 20 years ago but in the last year, where your new seroconversions are located, and then backward-position our programs – our prevention programs – so those communities are interfaced with and connected to our prevention effort first; and then go to the general population. So for concentrated epidemics, it makes a lot of sense.

But it also makes a lot of sense to target communities that have generalized in the same way, because there’s really no other way to target them, but to be smart about how we position those prevention interventions, with that generalized epidemic, looking for opportunities where people are convened, where people are receptive, where we don’t have to build it from the ground up. Those types of efficiencies can make a big difference. And then eliminating redundancies or ineffective programs. And we’ve gotten to the point where we need to do that.

I think that our ability to measure this is going to be best reflected in an impact on incidence. And we are hoping – and that’s a big statement, as you know – but we are hoping that we can take surrogate markers of incidence, as you get with your pre-natal numbers, and use that as a ballpark figure to get under. And not exactly sure that that’s the – certainly not the only thing we’ll do, but that is kind of where the thinking is settling out now.

We've got some of our best thinkers in our country and in Europe helping us think through this, and once we get an internal position, we'll take it to the larger community to actually get a reaction. But we, as I said, are moving forward with it aggressively now.

MS. NAWABI: Fourth row?

Q: David Bryden with the Infectious Diseases Society of America. The dedication to research-driven approach – evidence-based approach – is certainly very welcome; we're extremely excited about what we're hearing about that.

Two questions, if I could squeeze them in. One for Dr. Goosby: how do you anticipate pre-exposure prophylaxis if it proves that the case is changing our approaches in the nature of HIV prevention?

And for Dr. Nieburg, I'm wondering – I was a little concerned they didn't – among the specific recommendations in your report, there isn't any recommendation for scaled-up funding. And when it comes to prevention itself, the Futures Institute has shown, with their modeling, \$200 million extra each year over the next 5 years for male circumcision would be an enormous savings over the long term in terms of averted need for treatment.

What we've seen over the past couple weeks, Americans willing to open their wallets for Haiti at an enormous level – \$200 million so far – even with a tremendously difficult economic picture. What we've seen so far, in terms of Americans willing to donate more, does that give you any hope that the U.S. government might actually be willing to keep, or able to keep, its promise to double foreign assistance and scale these programs up in the way that they need to, if a compelling case is made, and even an emotional case is made, that this needs to be done, in the way that obviously Haiti has moved people?

MS. NAWABI: Thank you.

DR. GOOSBY: So let's see, the first question was – you took me right into that second one; I was concentrating on that, sorry. So what was the first issue?

Q: (Off mike.)

DR. GOOSBY: Pre-exposure proph is probably something that has reached the threshold of – we need to plan for its implementation. We are concerned that some of the data and the length of time that it's taken to get this control group straight has been very frustrating. We have taken the step to engage in preliminary planning around what we would need to do to move that to-scale.

If we do get data that shows efficacy, we would move it to-scale as a central piece of our prevention effort. It would probably take the form of high-risk groups, and not be a general-population focus. Injection-drug users, sex workers; some MSM strategies should include it. There are also some situations with women who are disempowered in relationships where that would also make sense.

I think that the ability to look at how that impacts the ARV – total ARV need of a country – is pretty breathtaking, when you kind of do the numbers on it. So we are actively looking at how we would try to move that to-scale.

There are also a number of foundations, not the least of which is an activity convened by the Gates Foundation and Steve Becker up there, who is really trying to tease out the nuances of populations that indeed will benefit more than others with that strategy, and to look at the implications for a movement to-scale.

DR. GOOSBY: Yeah, I think the question about scale of a prevention is – I think the answer is relatively simple, which is that, I mean, the intention of that paper was to capture that as the major issue. Most of the people involved in the meeting that led to this paper, including the two of us who ended up writing, are involved with the Global HIV Prevention Working Group. And for those of you who know that, the big “scale-up” is their major issue, so if that didn’t come across in the paper, I’ll need to go back and look at that.

But obviously, the scale-up on the prevention side means increasing competition for resources with the care and treatment pieces, and so that has to be handled very carefully. But scale-up is definitely a high priority – the highest priority – in the prevention area.

MS. NAWABI: The fourth row?

Q: Hi, thank you so much for having this round table. I had a question that specifically deals with young people ages 15 to 24. As we know that this is still the population of some the highest rates of new HIV infections, and I would like to pose this question to all of you about some suggestions about how young people – how your prevention strategy could be more youth-friendly and incorporate young people. And maybe some specific details on how young people will tie into your prevention strategy? And I’m Nickie Imanguli, from Advocates for Youth. Thank you.

DR. GOOSBY: You want me to take the first part of that?

I think that if we allow the demographics of the epidemic to lead how we position our prevention interventions, they will not be ignored. I think that youth have always presented a difficult population to identify, test and enter into care, and keep in care, for a lot of reasons that have to do with just social maturation and self-perception. Those differences need to be incorporated into the strategies.

I think that Harvey’s suggestion that texting and phone, infomatic-type strategies, might make sense – even in very resource-poor settings, for youth populations, makes a lot of sense. And then there’s always the traditional kind of athletic – for general information dissemination – convening around musical stars, pop music, rock music, or whatever, local music.

Having athletic events convene – the upcoming soccer tournaments that are kind of running throughout many of the countries we’re in afford opportunity for that, and we’ve already

partnered with those types of organizations to saturate the World Cup activity with prevention messages that are really looking to hit youth.

MS. NAWABI: Dr. Kenya, since you've worked with a lot of communities, both outside and inside the U.S., and specifically with minority communities –

DR. KENYA: I think it's too bold. I think in order for youth to be involved, we have to empower them, one, with the education so they can be involved, as well as the resources; similar to the Truth Campaign, which is the only thing that had any impact on tobacco and youth. It was youth-led – of course it was funded, and still is funded, by the tobacco companies – (laughter) – but perhaps that could be something that the music companies or the alcohol companies could participate in and provide the resources so the youth could lead with their own messages.

I'm a big proponent of community-based, participatory research. Unless you involve a target community in your program planning, you're not going to be effective. One thing the youth can't do, though, is they're not in the position to dictate what policies provide them with what types of education.

And as we know, the big federal funding joke, whereas if you receive a certain amount of federal funding to provide certain types of health education, you are not allowed to discuss condom use and things – a lot of issues around that that were big in the former administration. I think that we really need to actively address those and we need to look at those very seriously, not as – I think – how do I want to frame this?

This has not been taken seriously in this country, the way that we educate our youth. And they do make up 50 percent of the new infections, and that's the same throughout the world. And in other parts of the world, the youth are even less able to participate in public health efforts. And I think that we need to do more for the population that does present the greatest new risk.

MS. NAWABI: Do you have any thoughts?

DR. NIEBURG: Yeah, just something to follow on the last two comments, plus in addition, to following on something that Dr. Kenya said earlier. I've always been amazed that the “know your epidemic” conversation that UNAIDS and WHO have been discussing for the last, like, five or 6 years, includes – the way it's presented – only recent infections, as opposed to knowing your epidemic in terms of the risk behaviors in the community; looking at behavioral surveillance as well as disease surveillance. And it seems to me that expanding that idea to behaviors is one way of bringing in youth. And the issue with youth, really, is that learning things right the first time is much easier than unlearning bad practices and then relearning the right way.

MS. NAWABI: Because we only have a few minutes, I just want to ask Dr. Goosby if he has any thoughts he'd like to share with this public policy kind of audience about what your next steps will be in terms of carrying the PEPFAR strategy forward both within this administration to get the funding, and globally?

DR. GOOSBY: Well, thank you. You know, PEPFAR has been about saving lives, and that is what it will continue to be about. We are going to increase our ability to be efficient at continuing that effort to save lives but also as efficient and as aggressive in our efforts to try to prevent new infection.

We are going to move in a deliberate and specific way to challenge our program services in-country, to reside and embed themselves in the public sector gradually over time because we feel it is the best way to ensure that these services remain there for the populations that we've already committed to.

The president and the secretary are fully committed to that effort. I would say it is up amongst their highest priorities, and it is with that conviction that I agreed to move forward with this work.

MS. NAWABI: Thank you very much. I want to thank our panelists, Dr. Sonjia Kenya from the University of Miami; Dr. Eric Goosby, also, ambassador for Global AIDS Coordinator for the Obama administration; and Dr. Phillip Nieburg from CSIS for presenting these unique perspectives.

And the good news is that there is a strategy, that this issue does have a lot of attention and priority. Obviously it needs more resources but it's good to see that the administration has a plan. Obviously, this is within the larger global framework that this needs to be implemented and also funded. And this series, the Global Challenges Series, is kind of addressing some of the key challenges within that.

We have these millennium development goals – this is one of the priorities – but how do we move that agenda forward with different countries? Sometimes you'll have laws that unfortunately discriminate against their own citizens, and we have these guidelines on how money can be spent, so it's obviously very challenging but it's good to see progress being made on some challenging issues.

The next session – we have one every month, and if you're on the e-mail list for CSIS, you will receive it. We do have [miamiseries@csis.org](mailto:miamiseries@csis.org) as an e-mail address if you want to send any thoughts. But we would love to see you participate at another session.

And I just wanted to take a moment to reflect on the prior session that we had. We actually had the Haitian ambassador with us at one of our prior sessions speaking about Haiti's goals in meeting the millennium development goals, and he had shared with us that a cruise line was going to be going to Haiti and that this would really help their economy, and they had a really positive outlook.

And it was really devastating to see what happened with the earthquake and how that's going to affect the country's ability to respond to this natural disaster but also meet these goals that they already were struggling to meet. So I just wanted to reflect on that and have everyone give a moment of thought to all the victims in Haiti. I know all of you are probably doing something to help global issues, but Haiti is definitely a country that needs all of us.

So I want to thank you again for your time, for attending, and we hope we see you at another session of the Global Challenges Series. Thank you. (Applause.)

(END)