

**CENTER FOR  
STRATEGIC AND INTERNATIONAL STUDIES (CSIS)**

**LAUNCH OF THE REPORT OF THE  
CSIS COMMISSION ON SMART GLOBAL HEALTH POLICY:  
A HEALTHIER, SAFER AND MORE PROSPEROUS WORLD**

**WELCOME:**

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SENIOR VICE PRESIDENT AND DIRECTOR,  
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**MODERATORS:**

**DR. HELENE GAYLE,  
PRESIDENT AND CEO,  
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**ADM. (RET.) WILLIAM J. FALLON,  
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**KEYNOTE SPEAKERS:**

**JACOB LEW,  
DEPUTY SECRETARY FOR MANAGEMENT AND RESOURCES,  
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J. STEPHEN MORRISON: Welcome, today, to the launch of the final report of the CSIS Commission on Smart Global Health Policy, a call for a healthier, safer and more prosperous world. And thank you all for joining us here on this beautiful spring day. And that includes several hundred people who are joining us online through the live Web stream. I'd also like to ask everyone to please turn off your cell phones or put them on mute.

I'm Steve Morrison and together with my colleague Lisa Carty we provided the secretariat for this effort over the last year. John Hamre, my boss, the president and CEO of CSIS, would normally be welcoming you here today. He is also a commissioner and has been a strong advocate of this effort. He's also head of the president's Defense Policy Board, which Secretary Gates has called together today and tomorrow. And John, as chairman of that effort, must be there, and sends his regrets.

I also want to convey the regrets of Congresswoman Kay Granger, another very active member of this commission, who because of an appropriations subcommittee hearing that begins in about 10 minutes is unable to be with us this afternoon, and she asked that we convey her regrets.

We were very ably aided in this enterprise by several very talented and dedicated individuals at CSIS. Suzanne Brundage became overnight the nerve center coordinating the commission's work and was indefatigable and quite indispensable. Daniel Porter, Emily Poster – (audio interference) – Liz Morehouse all made very substantial contributions over the past year and I want to thank them as well.

We have a packed house today. We have a packed agenda and a very tight schedule. And we're going to have to manage our program carefully and keep to our schedule and still enjoy ourselves. We regret that there is not time in the schedule to field questions and comments from the audience over the course of the afternoon. I apologize for that.

We did take a preliminary step of reaching out online to our audience on [smartglobalhealth.org](http://smartglobalhealth.org) and solicit questions and comments for input here today. We received 200 or more of those, which have been compressed and will figure in the panel discussions and some of the other comments.

We also wanted to use this as the occasion, really, to have our commissioners interact on the key themes through the panels and to share their thinking in that way. And so we've structured the day with that in mind. We also welcome your comments online and directly to us from today and beyond, and we'll do our best to respond and we will certainly appreciate them.

In this room today are many, many individuals in many organizations to which we are very grateful for their input and perspective during the commission's work. We go into some detail in the acknowledgement section of our report in trying to be fair and acknowledge those

many, many people who gave us so much time and so much insight. We're especially indebted to the U.S. agencies that helped us – the State Department, the U.S. Agency for International Development, the FDA, CDC, NIH and others who were so supportive and generous.

After today, we'll carry forward with several streams of work that grow directly from the commission. And please stay tuned as we unfold those streams. We will continue to be focused on security and preparedness, on maternal and child health and gender issues, and HIV/AIDS, and we will remain very reliant on you, our friends, in carrying this work forward. And we are intending that we will be tracking progress periodically as we go forward and we will be doing an aggressive outreach process with the administration and with Congress to try and move this agenda forward.

I want now to turn the floor over to our co-chairs to kick this session off. Adm. Bill Fallon, a career naval officer, former head of the U.S. Pacific and Central Commands, will open up and be followed by co-chair Helene Gayle, president and CEO of CARE. So I would like to ask Bill to please come forward and open things up. Please join me in welcoming him. (Applause.)

ADM. (RET.) WILLIAM J. FALLON: Well, thanks, Steve, and good afternoon. I'd like to thank each and every one of you for coming, and those that are tuned in on the Web today as we launch this report of the work of the Commission on Smart Global Healthy Policy. And I am happy to see that we're blizzard-free. For those that are not in Washington, it is a beautiful, glorious, sunny day and a heck of a lot more promising than back in February, when we had this event originally scheduled.

I just intend to speak for a minutes, quickly explain how we went about our work, outline the commission's goal, the overall spirit and logic of the approach. And I think this background is important in understanding the product that you have in your hands. Time is tight; you all have the full report. It's available online at [smartglobalhealth.org](http://smartglobalhealth.org), and you can follow along if you haven't already consumed this thing.

Later in the program, during several round-table discussions that we have scheduled to hear from other commissioners about three key things of the report – maternal and child care, measurement and accountability, and U.S. leadership and partnership with friends and allies. I want to first express my special admiration and gratitude to my co-chair, Helene Gayle, a person of boundless commitment, insight, generosity and leadership in these areas of development and health. She's been a patient guide and always in good humor, and become a good friend in the process. I learned an enormous amount from her that I'll carry with me in the future. Thank you very much, Helene.

I want to thank my fellow commissioners who devoted significant time and energy to our deliberations. And I see that many have gathered here. I'd like to highlight Donna Shalala – Secretary, thanks for your strong contributions - Rhona Applebaum, Mike Merson, Pat Mitchell, Joe Rospars, I see, and Rex Tillerson, I see, who's come in, and Rajeev Venkayya.

And I know we're going to have a few others that are going to drift in over the next couple of minutes, and as we spot them, we'll highlight them for you if you don't already know who they are. There are some commissioners that couldn't make it today. They all remain active and vital contributors. They're listed in the front page, the signatory page, of the document.

I want to thank members of the Obama administration who kindly provided their input to our deliberations on many points: Secretary Jack Lew, deputy secretary of state; and Gayle Smith, senior director at the National Security Council and special assistant to the president, both of whom are going to join us today and we certainly appreciate the tremendous amount of time and effort that they devoted. I'd also like to single out thanks to Zeke Emanuel, Eric Goosby, Dana Heide (sp) and Jennifer Klein for their contributions.

Now, the 25 commissioners who began this work almost a year ago are all seasoned opinion-leaders, accomplished in their respective spheres, who think strategically, care deeply for our country and for the good that we can do in the world. We began with many ideas from our diverse backgrounds and concluded collaboratively and optimistically that the United States can better the lives of the world's citizens and advance our own national interest by investing strategically in global health. And this is a smart choice in our best national interest.

The remarkable achievements of the past decade inspire us to recommend doing more in the future. We already have many of the tools to lift and save the lives of millions. We have partner governments that are serious and ready to do more. And there are very able multinational organizations willing to partner with the U.S. government. These partnerships are crucial to improving the health of the world's people.

Our perception of health and its impact in the world has changed. Health matters in new and different ways. It is today a very visible, essential ingredient of economic productivity, the viability of families and the stability and security of communities and nations. Our understanding of global security has changed fundamentally. We now understand the vital importance that health plays in the personal security of families, be they women, children, husbands, who live in tenuous circumstances, and the links between a safer, healthier and more prosperous world population to our U.S. global/national interest.

A goal from the outset was to answer a core question: Can the United States achieve a smart long-term approach to U.S. health that harnesses all of America's assets and expertise in better and fuller partnerships with our friends and allies? I think we've come up with some good answers. Not perfect solutions, but a coherent, compelling plan of action that people of different political outlooks from diverse walks of life can rally behind.

From the outset, our approach was a deliberate experiment. We insisted that at least a third of the commissioners be seasoned professionals and recognized opinion-leaders in global health. They were to ground us quickly in the quickly-evolving realities of global health and make sense of this world for the rest of us. And they were patient.

We also needed leaders from other walks of life: business, foreign policy, Congress, security, media foundations. We needed their independent outlook, their fresh ideas, their critical perspectives. We hope to leverage their collective wisdom, strategic views, influence and shared faith in the United States to achieve positive health outcomes outside our borders.

Throughout the commission's work, we also confirmed a very powerful point: that the United States' contribution to global health has been and remains a bipartisan enterprise. But that significant progress is dependent upon high-level leadership. These factors remain the key to future success.

Global health is an enterprise that has the exceptional ability to unite U.S. citizens in collective action. We wanted to demonstrate that reality through the very composition of the commission. We work cooperatively. In our two sessions, in countless calls and one-on-one conversations, in our travels to Kenya in August, and Geneva in November, these interactions cemented friendships, enriched our appreciation of the remarkable achievements of those who work in the laboratories, hospitals and field sites to make this world of ours a healthier place.

It also made profoundly clear to me that we are building on a foundation of remarkable achievement in recent decades in science, in research and in public health. This is a good moment to recognize how much our nation has achieved in global health and to examine how we can best focus our efforts in the coming years to get the best outcomes.

We can do so much more if we set our minds to it. We don't want to coast or, certainly, slide backwards. And we need reinvigorated leadership to transcend increasing fragmentation we've seen in the past couple of years within the global health community. We filled our proposals around five core elements for achieving success over the coming years.

These are, first, to stay the course in ongoing initiatives to address the HIV/AIDS, tuberculosis and malaria challenges. These are the bedrock of U.S. achievements in the recent past and we ought to use them as a springboard as we go forward. Second, this is the moment to move ahead with speed, determination and a long-term strategy to improve the lives of mothers and children, so critical to health, stability and security throughout the world.

Third, we have to operate at a higher level in disease prevention and global preparedness to meet emerging threats. Fourth, let's make certain that we're better organized for success to achieve these goals that we've set for ourselves. And finally, and certainly not least, let's put in place a robust multilateral diplomacy that will be effective in strengthening our partnerships with other nations, international organizations and NGOs. I'd like to turn at this point and ask Helene to speak in more detail about some of these recommendations and how we can best achieve them. Helene, can you please join me up here?

DR. HELENE GAYLE: Thank you. It's wonderful to look out and see this incredible audience that has gathered for this and to see so many colleagues and friends who I know have been committing so much of their lives to this effort. I also just wanted to thank Bill for the kind introduction.

It's also been really invaluable for me to work alongside of Bill Fallon over the last year as we've worked on this. He's an incredible individual with a lot of compassion and insight. And probably most important, he's an optimist and he believes profoundly in America's role in the world and its ability to do good. He's a man of great honor and commitment to his country.

And so for me, it's really been an incredible opportunity to have this partnership of working together. And as he said, we have become good friends, we've enjoyed working together and I think having worked together for the last year, we've decided we're going to continue to do that. And our next act is a reality TV show called "The Admiral and a Doctor." (Laughter.) So thanks Bill.

I also just want to echo Bill's thanks to our fellow commissioners for all the work that they put into this process. You take people who have incredibly busy lives and ask them to even make a greater contribution over their time, but it's really been incredibly rewarding. So let me just, as Bill said, touch for a few minutes and elaborate on the five core elements we identified for achieving success over the next 15 years.

The first one: the imperative to sustain the progress in HIV, TB and malaria. And we all know that it's very easy oftentimes to go from one issue to the other and feel like, you know, that was yesterday's issue and now we're going to move on and do something new. But we have to recognize that this in fact; the U.S. effort to control these three infectious diseases is the foundation of U.S. achievement in global health.

We can do more and we must. We can reach the goal of supporting 4 million living with HIV with life-sustaining therapy. We can achieve higher efficiencies. We can continue to make progress on these areas that we've already laid an incredible foundation. What's most vital is to preserve a continued trajectory forward and forward movement even in a period of constrained resources and the addition of vital new goals. So that's number one.

Number two, improving the lives of women and children. I think this really is the moment. The stars are aligned, there's momentum and support from multiple directions to tackle these complex challenges. We see it in the White House, we see it in Congress, we see it in foundations, in other bilateral partners, other governments; most notably, perhaps the U.K. and the role that they've taken. We've seen the commitment in the U.N.

For too long, mothers and children have been neglected, and I think it's totally unacceptable for us to look at the number of lives – a woman dying every minute of every day in childbirth, children dying needlessly of preventable diseases. So we have a historic opportunity to correct us. Let's seize the moment and really put together the tangible solutions that are within our reach, whether it's improved infant nutrition, vaccines for childhood disease, expanding prenatal care and access to family planning, better emergency obstetrics.

We know the things that can make a big difference. We know that these solutions are possible. But they do require an effective, integrated maternal-and-child-health program effort and it does require looking at having a functioning health system. But we know that success cannot be achieved rapidly but it is doable.

Third, the third one is the imperative to make prevention and preparedness strategic goals. Prevention is still the most cost-effective way to reduce disease burden and poor health outcomes. Whether it's through changing behavior, changes in norms, attitudes, policies, legal environments and making sure that the right prevention tools are available, prevention is the key to reducing the incidents of HIV and ultimately changing the course of the HIV epidemic. It's the key to lowering tobacco and alcohol use, curbing obesity and dealing with the alarming rise of chronic diseases and premature death and disability that they cause.

Preparedness also has risen to the top ranks. H1N1 was a dry run – a mild test, fortunately – that reminds us yet that we inhabit an interconnected world that faces a multitude of emerging threats. We've made considerable progress in recent years but we cannot wait passively for the next major threat. We need to act now to build capacities to detect, respond and protect populations and build a more transparent, equitable and predictable global system that shares information, specimens and narrows the present gross disparities in the divide between the wealthy and the poor.

Fourth, the imperative to better organize ourselves and ensure adequate resources over the long term. And let me talk a little bit about the long-term resources. We need a global health plan that reaches further out in time. We can't keep thinking in terms of short-range objectives. We have to set a goal of 15 years at least to 2025. We need to assure the predictability of adequate resources. We think our case is solid for that.

If we make the changes we propose, build better and more integrated measurements, focus strategically in the target areas that we've identified, success will build upon itself. Over time, we can imagine our commitments rising to about \$25 billion by 2025. Investments in global health clearly remain without a doubt a best buy. They account for a mere 0.2 percent of the overall federal budget but have delivered dramatic concrete results over the past decade. PEPFAR and the President's Malaria Initiative have been the nation's most effective public-sector investments in global health, and have showcased the American spirit of generosity.

The commission is united in the belief that we should fulfill the administration's goal of committing \$65 billion to global health by 2014. It makes sense to begin slowly, ramping up new programs incrementally, and build momentum and credibility. If we follow this path, I think we can be successful. It's equally essential that we better organize ourselves. We propose the establishment of a deputy advisor in the NSC charged with leading the policy and oversight of global health programs and a truly comprehensive senior-level interagency global health council to lead on that implementation.

The State Department and USAID have huge equities in our approach to global health and have to remain in the center. We've noted that the progress of the State Department has made in advancing the Global Health Initiative and call for that to continue. We also acknowledge that Health and Human Services, which has had a longstanding role in global health, has grown rapidly in its global health commitments through the agencies like NIH, CDC, FDA and HRSA.

Treasury is essential both with respect to the World Bank and other multilaterals, and in making certain that we take our seats at international deliberations and on innovative financing options. The Defense Department is building ties with other militaries and has strong surveillance and emergency response capability. Our intelligence community has the special ability to provide over-the-horizon estimates. So it's clear that this has to be a multi-departmental process that is integrated and coordinated if we're going to have the impact that we want to as a whole of government.

We also emphasize that Congress can do more in bridging its committee jurisdictions. We call for a new congressional consultative group for the next three years comprised of the key party and committee leadership. This is an area where I think Congress can show its ability to transcend divisions creatively to support the global health initiative. We detail how we can do better in measuring results, incorporating business competencies in our approach and communicating and building support for global health efforts with the American public. We think all of these things are essential to really building our successes in the future.

Fifth, and again by no means last, we can be smarter about how we nurture our essential partnerships with friends and allies. Whether it's WHO, the Global Fund, GAVI Alliance, the World Bank, UNICEF, all of these are vital partners to our work in global health. They're not perfect but our success relies on building and improving these partnerships. Over time, these institutions can and should carry a greater share of the responsibility.

We can also do more to accelerate new, innovative financing options and mechanisms that could lead to more sustainable sources of funding over the long run. So I think we need to be and we focus on how it's important that the U.S. is more engaged in some of these discussions, pushing to see what we can do that works in this area of new methods of financing.

And we also detail how a stronger, multilateral engagement can better coordinate efforts, reduce inefficiency and put a strategic focus on solving some of the most vexing global problems, whether it's health workforce deficits, tobacco control, the prices of commodities. Those are just some of the examples.

Finally, one closing appeal: We need to take the high road, take the long view and remain committed, be united across party lines and other things that often divide us to make sure that U.S. leadership on global health remains strong. We all know that this is a tough moment in our history. We confront a grave fiscal crisis and painful, slow economic recovery and dangerous fraying of bipartisan ties.

We also have many competing priorities in an ever more complicated world. The commission wrestled with these realities throughout our deliberations, as well as the fundamental issues of how we can afford to do more for the rest of world when our own citizens are struggling with their mounting needs being placed front and center.

But at the end of the day, we remain more convinced than ever that a strategic investment in helping build a healthier, safer, more prosperous world – our smart-power approach – is essential to promote our own national interest and to save and enhance the lives of millions

around the world. So that's where we are. Those are the areas that we wanted to focus on.

And now, it's my delight that we have with us this morning the deputy secretary of state, Jack Lew. He needs little introduction in this audience. He has an illustrious career. He served as the director of the Office of Management and Budget in the Clinton administration. After that, he had a successful stint at the right time on Wall Street. And across those years, he retained a keen interest in development and finding the means to get better results for every dollar that was spent.

He is now the deputy secretary of state for management and resources, taking the lead on the State Department's efforts to assure that foreign assistance is strategic and well-resourced. He's been a driving force behind the global health initiative and he's also been extraordinarily generous in his sharing of insights and wisdom with the commission throughout its work. And for that, we are immensely grateful, Jack. (Applause.)

JACOB LEW: It's a pleasure to be here this afternoon with so many friends, colleagues and partners on an issue that's of critical importance to all of us in the nation and the world: global health. I want to thank Helene for that generous introduction and for her leadership, her work at the CDC, the Gates Foundation and CARE, as co-chair of this commission. She's played an integral role in shaping our nation's approach to improving health care here at home and around the world.

I also want to thank Adm. Fallon. After a distinguished military career, he has turned his attention to the very real national and global security threats posed by the inadequate health systems of the world. The world is coming to realize something that Adm. Fallon figured out a long time ago: that when people's lives and livelihoods are at risk, their communities are not secure, and that insecurity can spread across borders and oceans, and affect all of us.

I also want to thank everyone who served here at CSIS on the Commission on Smart Global Health Policy. The commission represents a broad range of expertise and viewpoints, including my good friend Donna Shalala, my friend, Bob Rubin, Sen. Bill Frist, who recently returned himself from doing heroic work caring for victims of the earthquake in Haiti; and to the outstanding team here at CSIS, John Hamre, Lisa Carty, Steve Morrison.

As a group, these commissioners remind us that saving lives and preventing disease are shared goals that transcend political differences and draw on the deepest of American values. This report reflects their broad knowledge, experience and dedication. It's full of innovative thinking and persuasive arguments for how our country can get better results from our work to improve health worldwide. And I join you in looking forward to seeing these ideas take root in policies and programs.

I also bring the congratulations of the secretary of state, who is in Moscow today representing the United States at a meeting with Russia, the EU and the U.N., and making progress, we hope, on resolving the Middle East conflict. She sends her thanks to all of you for the work you are doing here to foster peace through health.

Let me begin today by asking you to imagine two women who live not far from each other on the other side of the world. Both have just given birth. Like most women worldwide, they did not deliver their babies in a hospital but at home with the help of family members and perhaps a midwife. And they both experienced a not uncommon consequence of childbirth: postpartum hemorrhage. The first woman lives in a village with a small health clinic that has a trained nurse and is stocked with oxytocin, an inexpensive drug that can stop the bleeding. The second woman does not. The first woman lives; the second woman dies, and her children lose their mother and their provider.

It's clear how the absence of a simple intervention devastated this one woman's family. What may be less clear is why her life and her family's health matters to us. That's what I'd like to discuss today: how the health of people on the other side of the planet affect the lives of people everywhere, including the United States. And how, as a result, the Obama administration is working to improve global health in a new way with a new commitment.

When people think of global health threats, they often think of pandemics. And it is true that the diseases in one country can quickly spread to another, which we saw earlier at the end of last year with H1N1, which swept the globe in a matter of weeks. But the impact of poor health care goes beyond the spread of disease. Poor health prolongs poverty. When people are sick, injured or underfed, their ability to work or attend school declines. Health crises foster political instability, as we've seen in countries ravaged by AIDS when millions of adults disappear and states shut down or fall apart.

Disease fuels famine. When farmers grow too sick to work, their crops die and widespread hunger can result. And that sparks violence. There've been food riots in more than 60 countries since 2007 because people who can't feed themselves or their children find themselves in situations where sometimes all they can do to express themselves is riot. And disease and undernutrition sustain the social and economic divides that prevent billions of people from participating in the life of their communities, contributing to broader progress and pursuing their own dreams and aspirations.

In other words, health crisis is more than a health crisis. It's a political crisis, an economic crisis, a social crisis and a security crisis. In our interconnected world, crises that start in other countries rarely stay there. But this is only half of the story. Just as poor health has a broad impact, promoting better health can have broad impact. When health improves, economies grow, opportunities rise, trust in government increases, societies flourish and life becomes more stable and secure.

Furthermore, as the story of the two women illustrates, life-saving interventions are often inexpensive and easy to administer. A dose of nevirapine costs less than \$5. A shot of the measles vaccine costs less than a quarter. And a dose of oral rehydration therapy costs about a dime. Yet every year, more than 400,000 babies are infected with HIV, about 3 million people die from vaccine-preventable diseases and 1.5 million children die from diarrheal disease.

For these reasons, a strong connection between health and broader progress and the potential for investments in health to have a significant impact across many lives, the Obama

administration has made global health a central priority of U.S. foreign policy. We're investing in health to save lives and alleviate needless human suffering. We're also doing it as a means of protecting our citizens, supporting our partners and making headway across a range of issues. Improving global health accords with both our values and our interests. It is an urgent national and global need that we cannot underestimate or overlook.

Last May, as Gayle and Adm. Fallon noticed, President Obama announced the launch of the global health initiative, a \$63 billion commitment over six years to improve health outcomes, with a particular focus on improving the health of women, newborns and children. This initiative continues a strong tradition of U.S. support for global health.

The United States is the world's leading contributor to the Global Fund to Fight AIDS, Tuberculosis and Malaria; we're the largest donor country to the GAVI Alliance; and we've had great success in fighting AIDS through PEPFAR. Since President Bush launched PEPFAR in 2003, it has delivered life-saving antiretroviral medicine to more than 2.4 million people, provided care to nearly 11 million and prevented almost 350,000 cases of mother-to-child transmission of the virus.

And now PEPFAR will be a cornerstone of the global health initiative. Our budget request for 2011 represents the largest commitment the United States has ever made towards fighting AIDS. So with the global health initiative, we're building on years of experience and commitment, much of it done with the support of many here today.

But this initiative is not simply a continuation of past practices; it represents a new business model – one that emphasizes integration and coordination across the health spectrum rather than addressing single diseases in isolation, one that leverages our existing investments for broader impact and one that is built upon the principle of partnership, so that the countries we work with can in time provide care to their own citizens without relying on us or other donor countries to fill critical gaps.

We are reaffirming our commitment to the core services that have saved countless lives and served as the hallmark of our global health efforts. The United States will continue to deliver drugs and vaccines and bed nets and birthing kits to people worldwide. But we all know this model of aid cannot be sustained indefinitely.

That's why we are working to take our health programs to the next level by helping our partners expand and strengthen their own systems. For example, by establishing better supply chains so local clinics have enough frontline drugs and basic supplies to serve their communities, and by building on existing clinics so a woman gains access to HIV counseling, prenatal care, delivery care and family planning all at one location.

We also hope to help countries provide not only treatment for those who are sick, but preventative care to protect people from getting sick in the first place. It may not be self-evident to place prevention as a top priority when the needs of the sick are so great. But that is when prevention is even more critical to stop the spread of illness and lessen a given disease's long-term impact.

For example, for every two people we put on AIDS treatment today, five more are infected. And we continue to lose ground against this and other epidemics. In many places today, local health workers are too overwhelmed by patients with urgent needs to focus on prevention and wellness. By expanding their capacity, we hope to change that.

We are doing our work with an eye towards innovation. The United States has a strong tradition of funding, developing and implementing health innovations. And that tradition must continue across the board, from the pursuit of new vaccines to the use of new diagnostic technologies to the development of innovative financing mechanisms.

We are calling on our ambassadors to play a new coordinating role. As our chiefs of mission, they are best positioned to bring everyone together around one table and harmonize their efforts, not only in health but in our work on climate change, food security and so many other areas. And we are embracing a new commitment to results. Rather than measuring our success by how many programs we run or how many dollars we spend, we are investing in monitoring and evaluating our work so we can track our progress and learn from both our mistakes and best practices.

There are a few specific health issues we are focusing on immediately, including nutrition, safe water and neglected tropical diseases. But there's one area in particular that I'd like to address today and that's maternal and child health. Because of the central role they play in caring for others, the health of women is critical to the health of children, families and communities.

When mothers are sick, their children suffer; when mothers die, their children are more likely to die. This has broad implications. In fact, one of the most constant predictors for political upheaval is the rate of infant mortality because in places where infant mortality is high, the quality of life is often low.

Despite the importance of women's and children's health to larger progress, unfortunately they're particularly vulnerable to poor health, in part because of entrenched attitudes about whether women and children, particularly girls, should receive care as a matter of high priority. As a result, childbirth continues to be one of the leading causes of death for women in low-income countries and nearly 9 million children under the age of five die every year, mostly from preventable causes. This issue features prominently and persuasively in your report, and is a priority that we share.

Some of the changes to U.S. policy I've discussed today are already underway. Others will be implemented in the months ahead. Virtually all are addressed in this commission's important work, which we're here to celebrate the launch of today. Together, they represent a new approach and new commitment to improving the health of people worldwide.

This work won't be finished in a year but the United States is invested in it for the long term. We are committed to seeing it through and we are committed to tying our programmatic efforts with a renewed emphasis on global health diplomacy to raise health issues not only in the

context of development but also in the context of democracy and security of nations and institutions worldwide.

The people in this room represent our country's top talent in the field of global health. We are counting on each of you and the organizations and institutions that you represent to help. Your experience and dedication will make all the difference in our work worldwide. We need your ideas, we invite your critiques and we ask for your support.

The road ahead is sure to be full of obstacles. There will be times that we try something new and fail. We will grapple with tangled bureaucracies and struggle to maintain momentum. This will not be easy. Indeed, it's one of the most ambitious projects we've ever embarked upon. But we must always remember that the future we're working to achieve is the real goal.

It's a future where parents line up outside clinics on vaccination day and there are always enough shots for every child, where mothers receive confident and compassionate care as they bring new life into the world, where pharmacies are stocked with the essentials so no one has to die for want of a simple cure, and where people everywhere have the chance to live safe, healthy and productive lives, no matter where they live or what their income. This is a future we hope to achieve and the foundation of stability, prosperity and peace for our country and for the world. Thank you. (Applause.)

DR. GAYLE: Thanks so much for those comments and again, we really want to – on behalf of the commissioners – really thank you for the time that you and Dana and others on your staff have taken as we've worked through this. Let me just throw out a couple of questions to begin with. You know, this is a town that does a lot of reports – a lot of report writing.

And clearly, as you said, you know, this area is something that the administration has already taken on and made a commitment. Tell us a little bit – why a report like this is or is not helpful – well, it is helpful, hopefully – (laughter) – but tell us, what a report like this does. And then, you know, maybe how should we think about the next stage of this because we don't want this to just be a report that sits on a shelf. You know, how can this continue to be helpful to your work?

MR. LEW: Well, it's already more than just a report that sits on a shelf. When we had our first meeting – the better part of a year ago, we went over what our schedule was for putting together the global health initiative and in fact, we've already had the kinds of conversations where the work leading up to this report has helped us develop our thinking as we've developed the global health initiative.

I think if you look at the content of the global health initiative and the content of this report, there are a lot of similar strains of thought and the basic direction of the objectives. I think as we go forward, there's obviously a challenge in the fiscal climate we're in to maintain the sense of urgency. The funding for the program will be critical to our being able to implement it.

The transition from focusing exclusively or primarily on disease treatment to the broader connection between different aspects of health programs challenges a way of doing business that was pretty well established. We think it's critical. I think reading the report – the report thinks it's critical and the debate continues. So we need both the members of the commission and those who agree with its results to remain engaged in the public debate.

ADM. FALLON: Mr. Secretary, the Department of State, of course, engages with our neighbors and friends in countries around the world. One of the observations that we, as commissioners, came to realize pretty quickly was how essential it is for these partner countries to actually work with us. So it seems we may have great ideas and hopefully, we'll have the funding to support this. Any ideas or thoughts about how we get these other countries to really be true partners with us in this effort?

MR. LEW: You know, I've had bilateral conversations with probably the better part of a dozen countries. I've spoken to the leaders of most of the international health organizations and I think we've made substantial progress in the last year. The issues that we're discussing have resonance in foreign capitals and international organizations.

I think we're at a point where our following through on our piece of it is what we need to do to gain the credibility and have the leverage to take it to the next step. I think there's a growing appreciation amongst donor countries that there's a need for ownership in the countries that we're trying to help.

You see it in the Paris and the Accra accords. You see it in the principles that our president laid out when he was in the field last year. And it's very deeply embedded in our global health initiative and the direction of the report. I think we also have to be sensitive to the fact that we're going into countries that almost by definition, because they're developing countries, don't have the very high level of resource to be dealing separately with 20 or 30 or 40 of us that want to help.

So we owe it to them to coordinate a little bit and make it easier for them. And I think that there is an interest in the world community to do that. We're certainly, through State Department and USAID, investing a lot in the effort of reaching out on a diplomatic and kind of a development-partner basis to make that happen.

ADM. FALLON: Great.

DR. GAYLE: You know, you've got a lot of things on your plate and global health is one of those. And you know, one of the things you're leading on is really looking at the overall picture of how we do our foreign assistance and you know, how we go about doing that, perhaps in a way that's more integrated, more strategic, longer-term vision, et cetera.

Say a little bit about how this area of global health fits into the overall thinking. You touched on it a little bit in your comments, but as you look at the broad picture of our efforts in foreign assistance and foreign development, where does this fit? How does it integrate? And

what's been your thinking about that as you go through some of the studies that are ongoing now?

MR. LEW: Health starts out in a different place than other issues because we have a preexistent set of programs that are so well established, so it's a great benefit in health that we have a rich resource base and the question is, how can we use that research base and the additions to it most effectively?

It's a little bit more complicated than some other areas because of that well-established history, we're not starting with a clean slate, we're starting programs that work well, where we don't want to do any harm to the programs that are working well as we move forward.

I think that if you look at our kind of overall approach – the secretary's speech recently highlighted this – we're going to focus on doing the things that we do well and that we are really effective at in places where we can really make a difference. That's reflected in the principles of our global health initiative because we're going to make that extra level of investment in the countries where we think we can really move the ball forward.

It's in our food security initiative. That's a principle that we've followed as well. It's not something we can do unilaterally. We have to do it with the partners in the countries we're trying to help. They have to have a plan. They have to have ownership of it. We have to tie together the programmatic spending in our diplomacy.

It's not just a question of can we write checks to pay for programs, but can we work with heads of states, finance ministers to build the support for programs like health security into their future budgets – into their own priorities? It's a diplomatic as well as a development challenge. I think in some ways, it reflects what we're trying to do overall in our foreign assistance programs. It's kind of outsized just because our commitment to health is so large, which creates, I think as I said, special opportunities, but also unique challenges.

DR. GAYLE: Let me just follow that up with one and then Bill to wrap up with a last question. You know, your background before was looking at budgets. This is going to be a big-ticket item. This is a tough time. Why are you optimistic that we will find the will to be able to provide the resources that are necessary to move this more broader agenda forward?

MR. LEW: I think we're in a very challenging fiscal environment. We're obviously at a moment where our national deficit and our national economy make the kind of sustained commitments to any program more challenging than they would have been in an environment that existed not that many years ago when we had a surplus and the ability to do things with more ease.

I think you have to ask why, over the last few years, with this growing sense of concern for fiscal discipline and extremely weak U.S. economy – why do we see increasing levels of support for foreign assistance? In the 13 months since we've been in office, we've seen several incidences in the budget appropriation process – quite significant increases in spending in this area.

I think it reflects the challenges of the world we're in. There's a profound sense that our security depends on our having the kind of connection between the programs that we're supporting because they're the right things to do and the kind of world we need to live in to make it a safe world for our people

I think those are not contradictory concepts. You can do something because you want to help people, but you can also be honest about the fact that by helping others, we make the world safer for ourselves. I think that has a lot to do with why we're seeing the kind of support. And I think that the clear focus on results has been one of the hallmarks of recent years.

You know, the PEPFAR program has delivered on the promise to cover people in treatment programs. That's been enormously important. I think we have to, with this initiative, have clear benchmarks of how many lives are we saving? How many mothers are not dying in childbirth? How many children are not dying unnecessarily or diseases of infancy? I think if we can show results and show that it is tied to the security of the countries that we're helping, I'm an optimist.

DR. GAYLE: Great. We need optimists. (Chuckles.)

ADM. FALLON: Jack, just one final question. You know, around this town, people get diverted pretty quickly into the issues du jour and certainly health is in the limelight, but it's domestic health. We've articulated and you've very, very convincingly laid out these connections between our future here in this country and security and tying in the health business. How do you think we're going to be able to keep the political attention on this issue – keep enough attention on it, actually make progress while we're dealing with all these other things that are much closer to home?

MR. LEW: Well, I think in terms of the administration, you have a group of people who care passionately about this issue. So it's not going to take a lot to keep the administration focused on it. It starts out from the secretary of state to the, you know, administrator of USAID, all the way to the president of the United States, the kind of commitment to this issue that's strong and deep.

I think you have, from the last decade, a growing commitment in Congress to take global health issues seriously. I also think, not unimportantly, and as somebody who left Washington nine years ago, came back a year – just a year ago, a different environment in terms of there being a community of interest that expresses its views in an effective way.

Ten years ago, you didn't have effective advocacy for these issues where it showed that it's not just an issue that a few doctors or a few health experts cared about, but it's something that went deep into the values of American communities and it resonates with our security values, the way we're talking about today.

I think we have to maintain that. I think it's very real. It's true, but as somebody who had to defend foreign assistance budgets 10 years ago and last year, it's a different story when

there's a perception that people outside of the room you're in care about it. And I just – I thank you for the work that all of you have done, and for the many people in this room who have made that change happen. I think it's a meaningful difference.

ADM. FALLON: Well, Mr. Secretary, thank you very much for your very, very generous commitment of time and effort, and great thoughts and ideas, to join us here in our health. (Applause.)

MR. MORRISON: We're going to move very rapidly to our next panel. I'd like to invite Mike Merson, Donna Shalala and Joe Rospars to come up and join Helene Gayle for the panel on women and girls. Thank you. (Pause.)

MIKE MERSON: So this panel is on delivering on a new commitment to mothers and girls. We're a little bit behind schedule already, and I had been asked to frame this, but I think it's been beautifully framed already by Helene, by the deputy secretary. Clearly, the state of women's health, children's health in the world today is sadly a picture of death, disability and suffering.

And it's been called the human disaster. It's been called – the situation has been called dire or a health emergency. And there's one clear fact, and that is that the fourth and fifth Millennium Development Goal targets, which are reducing by two-thirds child mortality rate and by three-quarters the maternal mortality rate by 2015 – they are – particularly the maternal rate – we're doing really poorly – about as badly as we're doing on any other Millennium Development Goal.

And I'm not going to recite all the numbers – I think we know them all – but I don't think anyone believes we can let this situation continue. And we have three great panelists who are going to address this issue. And of course, it's also addressed in the report. Let me start with Sec. Shalala. Share with us your thoughts on the report and how it relates to mother and child health.

DONNA SHALALA: Well, I think many of you have made the point that the health of women and children around the world is a proxy for a number of things – international security, the economic development that's in a country – (inaudible, background noise). The report clearly – very clearly lays out the pathway to that.

The report does something else that I wanted to comment on. It may be the first mission I've sat on in almost a generation that didn't represent – that didn't recommend a new agency. Even though the answer to the question of who's in charge here was, no one, in terms of global health, it answers the question in a very strategic way.

Number one, it recognizes the use of interagency efforts, and that an integrated global health plan is not a compilation of the programs of various agencies. It, in fact, has to be carefully integrated and focused on goals, this being a major one. And that requires leadership from the White House, and from the National Security Council, in particular, and from the two secretaries – State and HHS – that would play major roles.

So it actually recommends some organizations – interagency councils, a council coming out of the NSC – as a way to avoid the kind of turf wars that you have between agencies. But it doesn't leave out a recognition that there are numerous congressional committees. I probably had 10 congressional committees on international health issues. And that they themselves – it does no good for the administration to organize itself if the Congress hasn't organized itself.

So if we're really going to deal with the issue of women and children, my point would be that we have to have some organizational form so we answer the question that someone, indeed, is in charge and there is, in fact, an integrated plan properly resourced, that is truly integrated and accountable, as opposed to the usual, trying to get people to run different programs to try to talk to each other.

And I think that the combination of the strategic recommendations on women and kids and organizational form, both at the Congress and the administration, are really the significant recommendations here. And I can spend this much time talking about it not only because I have to run off and catch a plane; because this is the only audience, I think, we'll ever talk to that thinks that organization is sexy – (laughter) – when it comes to inter – and will understand why you have to have some kind of a framework – a carefully put-together leadership team to really pull this off. So thanks, Mike.

MR. MERSON: Maybe before you go, you could just tell us, are you as optimistic as what we heard today from the deputy secretary? It's a lot of money and –

MS. SHALALA: Yes, yes.

MR. MERSON: And getting bipartisan support, and you think we're going to hold it?

MS. SHALALA: Listen, 20 years ago, I debated Jean Kirkpatrick on whether health had any relationship to national security, or to international security, and whether it really should be on the agenda. We have come so far from those initial debates, from Helene and I begging – and you, Mike – begging for money from various congressional committees.

The last thing I did before I left government was, Peggy Hamburg, who's now the FDA commissioner, and I went around to the Appropriations Committees of the military and systematically asked them for money in international health, pointing out the challenge of bioterrorism. I mean, it was like – they were very nice people, but it was like we came from a foreign land, having those conversations. Boy, have we come a long way! And I'm very optimistic.

MR. MERSON: That's great to hear. Thank you.

MS. SHALALA: Thanks. (Applause.)

MR. MERSON: So Joe, you and I – we had a chance to travel together to Kenya. We were in Nairobi, but we also went way out in Western Kenya and saw a lot of the rural areas.

Tell us – sort of, give us your impression of what you saw, and tell us a little bit of how maternal and child health – how what’s in this report links up to what you saw in Kenya and links up to the American public in general. You’re a communications guru, and I think you can put it in the right perspective.

JOE ROSPARS: Yeah, what I think was interesting about the trip was that we got to look at the different parts of the health system, from the very top to the very bottom, the community-based organizers and health workers. And what was interesting was that what we saw there reflected a lot of what we heard from the folks who were participating on [smartglobalhealth.org](http://smartglobalhealth.org).

In particular, maternal and child health was the most popular topic – when we asked people to submit essays for inclusion in the report, was the most popular topic that came in. And people frequently referred to it as a gateway issue to so many others, whether those are other health issues or economic issues or security issues.

And so those pieces of feedback that we started getting, in terms of what folks were already submitting from their feedback around the country, we saw up close, talking to community health workers and folks at clinics in Kenya. And folks can see, on page 41 of the report, the breadth of places that those essays came in from.

And those essays reflect a level of participation that, as Donna said, there’s a lot of commissions in this town, and they frequently recommend new agencies, but one of the things that they don’t frequently do is open up the conversation to folks outside the members of the commission.

And so what we tried to do here, from the very beginning, was to take the very unique collection of people that CSIS put together – a couple of dozen folks from very different backgrounds – and tried to build a constituency that reflected those backgrounds, but instead of a couple of dozen people, having it be a couple of thousand people.

So over the course of the commission, we tried to document the commission’s work, especially the trip to Kenya, through a lot of content – written, photo, video – as well as to encourage participation in the Q&A around the topics that we were encountering there in Kenya, but also through all of the different commission meetings.

So I would encourage everyone to both look at the report, but also to engage in the further conversation about the report, and about maternal and child health specifically, that will continue on [smartglobalhealth.org](http://smartglobalhealth.org). Because that’s how this report is going to turn into particular advocacy.

There’s a very – you know, it was surprising and encouraging to see just how many people, with such a depth of expertise, whether it’s in academia or in the field or in policy, did gravitate towards the commissions work because they have such a deep level of passion and unique experience to bring to the table.

MR. MERSON: Joe, thank you. You and I – we rode motorcycles together – I don't know whether you remember that – out there in Western Kenya – Muhuru Bay and –

MR ROSPARS: For transportation.

DR. GAYLE: With helmets. (Laughter.)

MR. MERSON: I'm not going to say. We wanted helmets, let me say that. But tell me how the field of maternal and child health – how do we – I mean, the American public – and you know this well – has been very favorable to the previous administration's initiative. And how do we keep – in the context of our domestic situation and all of the crises we face around the world, how do we keep the public focused on the importance of the issue and keep the support, politically, for it? Because as we know, a lot of our votes in the Congress are going to be based on local views on topics.

MR. ROSPARS: That answer is, you have to organize. There is energy out there on maternal and child health, specifically, as we saw in the essays that came in. That's a very deep well of passion for this part of global health in particular. And it's not enough for folks on commissions like this one to just say, oh, whoa is us that the American public isn't engaged on this.

In fact, there are a lot of people who not only are engaged on it at an intellectual and a sort of policy level, but who have actual experience out in the field, whether it's having gone out in the Peace Corps, or working for an organization like CARE, or having taken a global health certification, like they offer at Duke. People have a deep level of understanding, and there need to be, whether it's through organizations convening conversations, like CSIS is doing, or other organizations that are doing legislative advocacy and actually organizing around these issues, people need to be connected and they need to make their voice heard. So there is a constituency there.

MR. MERSON: Okay. So Helene, you articulated, a few minutes ago, in a nutshell, the main strategies or reducing mortality for women and children. We just have lost – we've taken our eye off the ball, for the past decade or two, on these issues. So how do you feel? Do you think we've got a good package of interventions? And how are we going to get them implemented? How are we going to convince people that we really can make a difference, since we haven't had the support that it looks like we have now?

DR. GAYLE: Yes, I think we do have the right tools and the right package. And you know, let me just say – I think, again, to this issue of why this is the right time to be moving this forward, I think, as several of the previous speakers have said, I think we are in a different place than we were, you know, 10, 15 years ago. I think people do recognize the importance of global health, and issues that, unlike HIV, that both you and I worked on for many years – you know, one of the reasons there was such a resonance with HIV is that people here in this country felt it, too.

It was truly a global issue. It was something that impacted us domestically. And so I think it was easier for people to, kind of, make that leap of caring for people in other parts of the world where HIV was also having an impact. I think today, you know, thanks to communication efforts by people like Joe – and I know Pat Mitchell will talk more about why it seems so important to keep the communications aspect – I think, in some ways, we've been able to bridge that gap, where people today understand these issues.

Even if we don't have the same rates of maternal mortality or infant mortality, I think these issues are becoming more real to our public. And I think all the work that's gone on to make the sense of our global interconnectedness real to people means that we're at a different point in time, where these issues really do resonate with the public. So I think, one, you know, I think we are really in a good place to move this forward. Two, I think we have much more knowledge of the interventions, and what makes a difference.

You know, they're pretty straightforward. We know that women need to have access to family planning so that they can space births, to begin with. We know unwanted pregnancies are a huge part of what leads, ultimately, to unsafe pregnancies and maternal mortality. You know, I'm proud that, in this report, we didn't back away from that issue. We know that the issue of family planning can be incredibly divisive.

But I think we took the approach that this is around saving people's lives, and we know that a woman who has the opportunity to space births is healthier – will be a healthier mother, and her children will also have a healthier survival. So access to the ability to space births. Secondly, making sure that people have access to skilled birth attendants, and that, that access is appropriate, depending on the level of health, whether it's at the community level, on up to the national level.

And that there is in place a system for referral when there are complicated pregnancies, so emergency obstetrical care. But you know, another reason why we converged on this as an issue is that doing all those things means that you also have to put a focus on a functioning health system, because it doesn't just happen without having in place a health system that supports the different levels of care that are necessary.

So in some ways, by being able to measure what happens with maternal mortality, it's a way of measuring how well we're doing on strengthening health systems overall. And I think, again, that's something that comes out in this report, that, while it's important to continue to have these very focused efforts in particular diseases, we also want to be able to push towards strengthening the health system more broadly. And I think maternal health does that.

MR. MERSON: Well, said, and I just want to ask you to comment – yesterday, I believe, Kaiser's daily global health report, which comes out – many of you probably read it – every day, had a story that, at least, was of concern to me. And I'm going to quote it. It says that in June, as you know, the G-8 summit is going to be meeting, and the signature initiative of the Canadians is reported to be on mothers – reducing maternal and child mortality in poor countries.

But the Canadian foreign minister said on Tuesday – and I’m quoting here – in the Globe and Mail, that this initiative, quote, “does not deal in any way, shape or form with family planning. Indeed, the purpose of this is to be able to save lives.” This is coming from our northern partner, which normally, as you’ve said to me, is quite enlightened. So I wondered how we’re going to – the G-8 is a critical moment. It’s only a few months away. And how are we going to bring family planning into this?

DR. GAYLE: Well, I think it is of note that this is something, as I said, we didn’t shy away from. I think that the global health initiative that the administration’s putting forward hasn’t shied away from it. I think it is a tough issue for a lot of reasons. It has been used as a divisive issue. It doesn’t have to be. It is about saving lives. It really should be the opportunity for women to have safe pregnancies and to make sure that their children have, you know, the start of safe and healthy lives. We know that children who are born too close together are more likely to have bad health outcomes. So it is absolutely about saving lives.

MR. MERSON: Okay. I think our time is up. I just want to say that I agree with you and the panelists that this is really a great moment for those who have been working for decades in this field. We need to seize it, and think of it as a continuum of care from the home to the health facility. And also, I think we need to think of it as a continuum of care from the mother to the newborn to the child.

And I think, historically, the newborn has been forgotten. We’ve talked about maternal care, maternal health and child health. And I think, as you see in the report, we really emphasize this continuum of care, both in terms of the mother to the newborn to the child, as well as, from a delivery standpoint, from the home to the community health worker to the health facility. So thank you all, and I think we can move on to the next panel. (Applause.)

MR. MORRISON: I would like to welcome – (inaudible, background noise) – panel on accountability and measurement.

RAJEEV VENKAYYA: Thanks, Steve. And thanks, all of you, for joining us today. We’re going to have a panel on measurement, accountability and innovation. And as I was reflecting on the title of the panel, I uncovered some of my biases against the term “measurement,” which sounds incredibly boring to me, and it has ever since I got into the public health sphere.

And I really think we need to be very clear, when we package measurement, that it’s not just about measurement for measurement’s sake. It’s about measuring results, measuring impact and not stopping there. It’s actually doing something about the results that you find, to do better. So data – the results from measurement – that drives decision-making is what measurement is all about. If you don’t have measurement, you can’t have accountability. If you don’t know you’re underperforming, you can’t do better and you can’t fire the person who isn’t doing as well as they should.

And so that, to me, is the important principle underlying this discussion today. And we have a fantastic, very well-experienced panel from the spheres of global health, global business,

global media and communications, all of whom have relevant experience to share with the global health sphere. And I would say that this is a microcosm, if you will, of how we need to be doing global health.

Individuals who jealously guard global health topics because they're the experts in the field are not going to do as well, in their endeavors, as those who open their minds to approaches that have been proven to be successful in other disciplines, whether that be business or any other discipline in which there is a very clear focus on doing the best that you can because people are measuring you.

So in global health, measurement matters for a few things. First of all, showing that what you're doing makes a difference. The fields of medicine, public health and science are littered with projects that began with very good intentions, but when somebody finally got around to measuring whether those things were making a difference, they found that, in fact, they weren't, relative to more traditional practices, or at worst, they were actually doing harm.

Secondly, measurement allows you to identify what's working and helps you to do better, because you can identify lessons learned and you can take those lessons into other programs to improve their performance. Thirdly is a point about accountability. If you're going to tie somebody's compensation to their performance, you have to be able to measure that performance. And this doesn't just apply to the health practitioner in a country; it applies to global institutions, such as the global fund for AIDS, TB and malaria, or GAVI – the Global Alliance for Vaccines and Immunization.

We should be measuring all partners to determine whether they are performing as well as they should. Fourthly, in this day and age, where resources are severely constrained, measurement allows you to maximize efficiency and stretch every dollar as far as you possibly can. Because if you're asking others to pony up more resources for global health and you can't show that you got the most out of the resources you already have, you're going to have a much worse chance of getting any additional resources committed to your priority areas. And so demonstrating efficiency is critically important in global health.

And then finally, the bottom line is that you've got to be measuring your progress if you're going to show that you're moving the dial against the Millennium Development Goals or any other goals that you have set for yourself, and so measurement allows us to collectively up our game and do better.

Before I introduce my panel, let me just say that one anecdote from the Gates Foundation. This is an organization that I'm privileged to be part of that has access to significant resources, albeit a drop in the bucket relative to the global need, and also a certain amount of influence.

Now, one can invest a million dollars into an endeavor and save X number of lives. Let's say you save 1,000 lives and you may feel very good about that, and you should feel good about that. But if you don't have a benchmark to know how well you should be doing given that

amount of money, given the influence that you have to measure yourself against, you don't know if you might be massively underperforming.

And so in global health, we suffer because we don't have what business takes for granted. Business has shareholders: shareholders that have a voice. If a company is underperforming, the leader of that company hears about it and he or she has to up their game or they're out of a job. In business, you have competition. In global health, we don't have competition. If you're a grantee, if you're an NGO working on the ground, if you're a donor, you really don't have anybody that you're being measured against to know whether or not you're doing better or worse than they are.

And so the fundamental issue is that we actually do have shareholders. We have beneficiaries that are living in developing countries. The problem is that they don't have a voice. They can't actually influence our actions and so we have to come up with other mechanisms to ensure that we are holding ourselves accountable.

So with that, let me turn to our panel to begin by sharing their thoughts on measurement, accountability and innovation. In a moment, I'll turn to Mike Merson, who is the director of the Global Health Institute at Duke. I'm not going to go through everyone's bio in detail – you have that in front of you – in the interest of time.

Then I'll turn to Rhona Applebaum, who is the vice president and chief scientific and regulatory officer at Coke, then Pat Mitchell, who is the president and CEO of the Paley Center for Media and finally Rex Tillerson, who is the chairman and CEO of Exxon Mobile. So Mike, let me turn to you first and have you give us a couple minutes of thoughts on measurement, accountability and innovation.

MR. MERSON: I think we have two real challenges and there, are addressed in the report, at least two. One, we have methodological challenges. As we heard from the deputy secretary today, the administration and, I think, our commission endorsed the fact that we need to measure impact of programs. That means deaths avoided, new infections avoided.

It's not simply measuring how many people have a bed net or how many health workers have been trained or how many people have been treated, but showing impact and I think this is something you've already addressed and I think it's very important that we work together to come up with a set of indicators and ways of measuring them that demonstrate this impact.

Then our second challenge, I would say, and it's related, is an operational challenge. The commission heard some presentations about what it's like to be in the field having to produce data for different donors. Certainly, the situation's a little bit better than it was maybe five years ago, and PEPFAR has worked to harmonize with other donors.

But I think the commission certainly felt that to all extent possible, the donors need to come up with a similar set of agreed-upon, monitoring and evaluation indicators for measuring the impact of programs that are agreed to with national governments, and that everybody stick with these and not everybody add a few others because if we continue to do that, we make it

impossible in the field. We heard testimony to that in the work of the commission. So you'll see in the report we call for redressing both these methodological and what I would call operational challenges.

The third point I would make is, which has been alluded to already today, which is if we can have – I think Steve Morrison mentioned this – if we can have a 10 or 15-year horizon rather than a five-year or god forbid, a one-year horizon, then I think we can be more patient, we can plan better and then we can look at our evaluation not producing results for tomorrow but producing results over a longer period of time.

If we have the confidence of the funding and the confidence that our programs will be around for a while, as long we can demonstrate impact, I think this would go a long way to advancing the field. I know that many of you are getting money year by year and we did talk about this at the commission.

Certainly you'll see in the report the strong recommendation that those of you out in the field implementing programs not be faced with these year-by-year deadlines because it's very hard to show impact on a yearly basis. But I think we need to be accountable to a common set of indicators, but it doesn't mean we need to expect in reality, particularly with the problems we're dealing with, that we can achieve great success in one year. I think those are some initial thoughts.

MR. VENKAYYA: Great. Thanks, Mike. Let me turn to Rhona.

RHONA APPLEBAUM: First, I'd like to say I agree with a lot of the things, many of the things, not all of the things that have been said. The issue with process is absolutely key from the beginning and to the end and what I mean by that: It's absolutely essential to identify where you are and where you want to be, and make it very clear, to the point that's already been made, that it's not going to be a quick fix.

And in our society, everything, at least, especially in the business world, it's "what is the next quarter results?" They have a tendency to judge things on a three-month basis. We can't do that. In global health, it's a long term – we have to be in it for the long term and we have to plan accordingly. At the same time, we have to also identify what the deliverables are and attempt to meet those outcomes.

One of the points that was made very clear to me – and I was shocked, to be perfectly honest – as relates to the burden that's placed upon those organizations, those individuals that are trying to do the best job that they can, but they're impacted – their efficiencies and their effectiveness is impacted by the burden of reporting. It is so outrageous – please see page 38 of the report, where you see this spaghetti chart, and that's a nice term for it.

When I was listening to the impassioned pleas – "make it easier so we can do our job" – it was just absolutely spellbinding for me. So I applaud the report and I applaud the experts who are making it very clear that we have to reduce that burden, we have to streamline it, we have to make sure that it's more efficient in order to get the job done that we need to do.

There is a lot of – I’m so pleased to hear the commentary this afternoon as relates to “we all have a role to play, we can all learn from each other” and the idea of the embracing that I’ve felt and I’ve heard as it relates to the importance of public-private partnerships are absolutely essential. For a company like ours that’s in over 200 countries, we can’t do it alone.

There’s information that we have, there’s lessons that we have learned that we would like to share. The outreach and the fellowship that we can glean and align and interconnect with in order to make things better for our workforce out there, for our employees, for our consumers and above all for ourselves, would be absolutely essential. The things that we do in business are not strange.

The applications that can be applied to what we need to do in the global health community are absolutely aligned and to be able to do that more and more, share our experiences and in some instances share our resources, we would very much like to do and it’s been a true pleasure in terms of being able and an honor to be able to apply those types of lessons to this report. So thank you.

MR. VENKAYYA: Thank you, Rhona. It’s so valuable for a global health discussion to be informed by perspectives from the private sector and now from media and communications. So Pat, let me turn to you.

PATRICIA MITCHELL: Well, generally, there’s no tool for transparency, accountability, effectiveness and reporting of impact than global media and as someone who’s been in the field for some time and now leading a discussion on the role that global media plays across the landscape, I may just offer some thoughts.

One of the things that we know, we’ve never lived in a time of greater connectivity. We never have been more informed as citizens of the global community. We have never been more informed as people in the field trying to address global health challenges. So we have at our disposal an enormous landscape of technology media that wasn’t there before, that can shine the light in dark places, that can tell the story that not only illuminates the challenges, but also talk very clearly and directly about the programs that are in place, hold them accountable for their results, and then also connect American U.S. taxpayers to the stories that they are actually funding in the field.

The good news on this is the connectivity. Additional good news and emerging news is that new technologies are giving us new tools. There are some small-scale experiments that are turning out to be quite effective. There is mobile technology in places where women, particularly during childbirth and pregnancy, isolated and often illiterate women are getting lifesaving information through mobile science.

We know that this works. We also know there’s new open-source software that allows health workers and health officials to get to disaster areas and deliver very pinpointed aid where it’s needed. So we see a huge opportunity in the global media landscape to deploy these new technologies in a much greater way and with much greater effectiveness.

The bad news is that according to the global media monitoring report that is done every two years of news and information sources across all countries and regarding all forms of media, from new, social media – Facebook, Twitter, et cetera – to the mainstream news reporting and newspapers, magazines and on television, less than 10 percent of these stories are about global health.

Now, of course there's a spike when there's a disaster, when there's an earthquake or when there's an epidemic or a threat of a pandemic. But by and large, global media are still very challenged to find the ways to use this enormous power that exists because of this new connectivity, to bring it to bear in ways that will increase awareness and therefore increase effectiveness.

So that's where you and I come in and, as consumers, demand that our global media pay more attention to these stories on a more consistent basis. And it's also where those professionals working in the media have the challenge, along with the health professionals, to find a way to tell the stories that are compelling and engaging and that capture the developed world's attention.

We've heard today already personal stories that tell the whole story – to the one woman story who dies in childbirth every minute around the world somewhere. We know – empathy research tells us we have to tell those stories that way: one child, one woman. It's so much more effective, and media's learning to do this. Now, I must say that the Gates Foundation has found a way to do that very effectively with their Living Proof testimony that took the effect of their global health programs and told them through the personal stories. So that is, again, an opportunity.

So the good news is we have new ways of telling the stories. The bad news is they're not being told effectively and consistently enough. But I am, as Bill Gates would say, an optimist based on the opportunities we have ahead but a little bit impatient with my colleagues in media by not recognizing and fully deploying media as a power player in both putting into place and supporting a smarter and more strategic global health policy.

MR. VENKAYYA: Thank you, Pat. Let me now turn to Rex Tillerson, from Exxon Mobile. Rex, you've gotten involved in the global health sphere in a big way. Let me hear your thoughts.

REX TILLERSON: Well, as a business person, measuring and evaluating is central to any achievement of really large, long-term objectives. For us, our business is pretty long-term and the things I do, we deal with 10, 20-year time horizons. So I think part of the real important element of this report is and has been noted by Mike is that we now want to focus on these issues with a longer-term strategy in mind: a 15-year time horizon.

We know what the objectives are and we know what the results we're trying to achieve are: We want to eradicate malaria; we want to reduce the instant of HIV-AIDS by two-thirds;

we want to save 2 million women a year from dying in pregnancy; we want to save almost two-and-a-half million babies a year from dying in the first month of childbirth.

So we know what the endpoint is but in achieving a strategic plan, you have to have a good set of metrics that will allow you to understand whether you are progressing toward achieving those objectives over this 15-year period. They're going to guide and direct the programs that you undertake, the effectiveness of those and how to improve the effectiveness of those programs.

But equally important, they're also going to guide you on what you want to stop doing because there will be things that work, there will be things that don't work and to continue pursuing things that are not taking you toward that objective are consuming both financial resources and human capacity resources as well. So measuring and evaluating is central to achieving any of these long-term objectives.

And Mike mentioned – and the spaghetti chart has been mentioned. I think the first time I saw that in one of our commission meetings may have been when Bob Reuben, who'd just joined us, held that chart up. And we were all kind of horrified by this requirement that donor nations and donor agencies were putting on host governments' recipients.

And we said, well, gee, that just can't be right. A lot of those are measuring inputs; they're not really measuring what you're trying to achieve. And a lot of them are designed to meet the donor's requirements, not carrying us toward the objective. So I think one of the – that was one of the great learning for me was to see how could this possibly be coming from the business community.

The importance of evaluation really cannot be overemphasized. There was a recent article in *The Lancet*, which I thought just really nailed this, and the title was "Evaluation: The Top Priority for Global Health." And I'm just going to quote a couple lines out of it:

"Evaluation must now become the top priority in global health. A massive scale-up in global health investments during the past decade has not been matched by an equal commitment to evaluation. This complacency is damaging the entire global health movement. Without proper monitoring and accountability, countries, donors and taxpayers have no idea whether or how their investments are working. Evaluation matters. Evaluation is science. And evaluation costs money. It's time that the global community embraced rather than evaded this message."

So it is going to require some dedication of financial and human resources in this area, but it is going to return huge dividends in the effectiveness of how the remaining dollars in human resources are utilized to achieve the objective. Now, in the commission's report, there is a recommendation where I'm getting at some very hard, fundamental, results-oriented measures: an agreement on metrics, coming to a common set of metrics, as Mike mentioned as well.

But also a recommendation that an independent authoritative group be established to develop the evaluation process and to carry out that evaluation process. It could be within an

existing agency. It can build on some of the measures that are already in place – some progress that has been made through PEPFAR.

But let's establish what those set of metrics are. Let's have an independent body track those and report out those to donor countries but to the Congress. The people who are going to make this money available are going to want to know what are we getting. And there can never be a more important time now when you want to have this funding available in good times and in bad times.

In challenging times you want this funding to be maintained uninterrupted because an interruption in the funding or financing – you lose a lot of ground. You give a lot of ground back on progress that's been made in so many of these areas when you have this interruption. So these metrics are going to be vital to ensuring that the long-term financing is available to achieve this 15-year plan.

MR. VENKAYYA: Thanks, Rex. That was fantastic. I think we have a little bit of time left – according to more recent information I just got. I don't know that I'll be able to ask all of the panel members questions individually, but I want to get through as many as possible.

Rhona, in global health, particularly in the vaccine sphere, we always talk about how Coke has been able to reach places that nobody else can. And you talk about 200 countries that Coca-Cola is in. That's just astounding to me. There are some challenges in global health that I think would really benefit from the lessons learned of your experience.

And specifically, aside from the cold chain example that I just referenced, where you actually have refrigeration capability presumably that goes all the way out to very peripheral regions. We have other challenges that relate to maintaining quality of health services and quality of the commodities like – (inaudible, cross talk).

Now, oftentimes we have to rely on local partners to ensure that quality. What lessons have you learned about working with local partners working in country to ensure a certain minimum – but very high actually – level of quality in both services and commodities?

MS. APPLEBAUM: It's a great question, Rajeev. And to start of with, you know, just to be perfectly clear, the standards for whether it's our safety or our quality of our product is the same – (inaudible, cross talk) – whether it's in the United States or whether it's in India or whether it's in South Africa or Nairobi.

But one of the things that we've learned as a company over the last 123 years is it's not necessarily going to be dictated and done by Atlanta. We will think globally, but we'll act locally. And doing what we need to do in country is absolutely essential. Over 85 percent of our workforce is outside of the United States.

So what does that take? That takes the necessary time needed to map what those processes are, needed to map what the critical requirements are and the resources are. But it's

the investment in those local individuals because they are the community – they are our business there – that’s absolutely essential.

What are the capacities – what’s the capabilities that we need, the competencies that we need and the capacity of the workforce that we have to have in country that’s going to make the difference? To make sure they’re adequately trained, they’re adequately enforced in terms of making decisions, that they have the necessary tools and we have the necessary infrastructure.

And it doesn’t always have to be the Cadillac. As you know, being in the producing countries, when I was in the cocoa industry, we’d get Coke anywhere – Fanta. It was great. You know, we’d drink coffee in the morning. In the afternoon until 5:00 when we could have beer, we’d have Fanta and we’d have Coca-Cola because it was a safe product.

But it wasn’t as if they always had trucks to bring it there. They would use their bicycles. They would use a boat. They would use a mule. They would use whatever they could. Again, realizing that this was a shelf-stable product and not perhaps as sensitive as some of the vaccines. But at the same time, as you increase your innovation, you then get refrigerated units that can still be on the back of a bike, on the back of a mule or in your boat when you’re taking it down one of the rivers.

So to that point, it’s been – you know, we didn’t – we aren’t where are – it didn’t happen immediately. It happened over a 123-year period. So it wasn’t done overnight. But this is an opportunity in terms of sharing those best practices and those lessons learned with the global health community to make a difference because when the global health is the best it can be where we operate, it’s going to be better for our business.

We’re going to have a healthier, sustainable business because the workforces that we need, we rely upon, that make Coca-Cola what it is, is dependent upon global health. So I think there’s a lot of opportunities for us to work together, share experiences, share learnings and it’s the only way that it’s going to get done.

MR. VENKAYYA: That’s great. Thanks. Pat, one of the issues around accountability. We talked about measurement here and measuring an individual or an institution’s performance from a top-down command-and-control perspective is one way to ensure that you maximize performance.

Another way to improve performance of actors in the system is to increase demand, particularly demand amongst the public. If individuals who are of little means become aware that there are options to get quality, affordable health services, then they will begin to demand that from the public sector and the private sector.

Being in media and communications, you’re all about informing individuals about the art of the possible. What do you see as the potential role for media and communications in increasing demand and ultimately in increasing accountability?

PATRICIA MITCHELL: I'm so glad you mentioned that because I always like to – it's so easy to blame media and to say media never covers the stories that are important. And honestly, media is not very good as we all know at covering anything complicated or complex. And then we just do – got to find a simple way to tell the story.

But there's a media organization, but there's also a consumer. And what has changed in global media now is the power has shifted. The power has shifted from the people in top-down mainstream media making decisions about what gets covered, what stories are reported to coming up from the grassroots consumers. People with cell phones and who are blogging in social communities and on Twitter – they are themselves delivering a different kind of demand that information be shared.

And you see in communities – and I was in a remote village in Kenya not long ago and the one person who had the mobile phone in the village – and there was one and it happened to be a woman. And she was going around saying, did you know that that clinic is – she was passing out the information. And then putting a demand and an expectation of the health clinic that was there that they do in fact deliver what she had found out through her mobile phone was possible. So it creates a different kind of accountability on the ground for health organizations.

But it also gives all of us as media consumers a way to realize we have that power too now. It's in our hands in a different way. And I think the steps that we began to talk about at the commission is how we take something as wide-ranging and as long-term as this and start to find some strategies where we can build social media communities around the demand.

And most importantly for our conversation today, helping make those connections to U.S. taxpayers who are funding and who are now being asked to step up their funding. You know, what's happening? And we know that. We can get those reports directly from the ground. That's new.

MR. VENKAYYA: That's powerful. Let me turn to my partners here and see how we're doing on time. Okay. Wrap up?

MS. : No, you've got time.

MR. VENKAYYA: Okay, great. Mike, a couple of references have been made to the spaghetti chart – so this Byzantine system of reporting to multiple different donors. You know, we have made a strong pitch here around the importance of measuring results and accountability.

But if we're having this conversation in an attempt to influence how the U.S. government manages its investments and the same dialogue is happening in capitals around the country where bilaterals are deciding how to spend their funds, we may not be solving any problems here. We may actually be creating additional bureaucracy and not, in fact, doing what we intended to do. You've thought a lot about this, I know, at the WHO and since. Do you have any initial thoughts on how we can streamline and actually make this a value-added?

MR. MERSON: It's a tough question because many of the bilaterals are beholden to their parliaments or legislatures to account for the funding. And like we have seen in this country, sometimes the Congress has certain preferences for use of our money and then the Congress changes and a different party takes over and those preferences change and the poor countries have to figure all that out. So this is a very tough issue.

Where I think there's a growing consensus and the question I think is whether the U.S. – I mean, we heard from the deputy secretary – if the U.S. really wants to invest diplomatically in a common set of reporting indicators, it will make a huge difference. But that's got to come down to the ambassadors and it's got to be real.

And many of the organizations in this room which receive resources from PEPFAR or the new global health initiative – whatever it is – they have to know that – they have to believe that this is really going to happen. I don't know any way around it. It's better, but it hasn't happened yet. The U.N. agencies are also part of this.

We have these new look at the Millennium Development Goals, which the current Millennium Development Goals go until 2015. I think you know that there's now a beginning effort by the secretary-general of a dialogue to talk about what the next set of these Millennium Development Goals will be. This is a good time for the donor community to step back and say, okay, are we serious? Are we going to try to come up with a common set?

We tried indicators – you know, in HIV, there was this “Three Ones,” but you'd go to the field and there would be Three Ones and then you'd get countries reporting on this common set of indicators. And then the U.S. wanted a little bit more and the U.K. wanted a little bit more. And it turned out, yeah, there was a common set of indicators, but then everybody had their additions.

So the question in my mind is truthfully whether the U.S. wants to invest diplomatically to make this happen. I don't know a way around it. The U.S. has the most money invested in this field. And if they are willing to throw their weight around and make it happen, it can happen. There's going to need to also be development of new methods and metrics to measure some of these impact indicators. It's not going to be that easy. As I mentioned earlier, it's easier to measure a process indicator, or as Rex said, an input, than to really look at impact.

But I think if we get groups together around the table from different constituencies and get serious about it, hopefully this spaghetti chart, you know, it will be reduced to macaroni maybe. (Laughter.) But I think we need to have some commitment to make it happen. And it will be the first – it will be historic if it does. But it would be a great contribution of the global health initiative.

MR. VENKAYYA: Great. Thanks, Mike. I'm going to turn to Rex for my last question. And that is, you know, Rex, we talked briefly about the fact that institutions in global health don't have the traditional measures of accountability that, say, a business would.

You've managed a huge corporation. What are the other principles, strategies, tactics that you would suggest to leaders of global health organizations that they should consider bringing into their operations in order to increase a level of accountability throughout the enterprise?

MR. TILLERSON: Well, I think you have to engage all of the interested parties from – as I mentioned – from the U.S. government to multilateral agencies to other donor agencies. But you also have to engage the recipient of the – you know, the recipient country. And a lot of these measures can best be defined by engaging with where the rubber meets the road. What is it that we're looking for inside those countries where this effort is directed that will tell us whether we're being effective?

So to develop this really does require a great deal of collaboration from the donor agency or a country all the way down to the recipient. And this is going to require some capacity building within these countries for them to be able to provide those – you know, respond to those metrics that we're asking them for.

And we were having a conversation the other day about malaria, which we're very interested in and how we – we can tell you how many bed nets were distributed every year, but we can't tell you how many children between the age of birth and five years are infected with the parasite. They may not have malaria, but they've got the parasite. Well, we'd really like to know that because that tells us whether we're beating the parasite in terms of infection rates and in terms of vector transmission.

But it means we've got to build some capacity for that to occur, for that to be measured. We've got to build it into an integrated health system so that when a mother brings her child in for some other reason, nothing to do with malaria, while we've got them there, we draw a little blood, we do a malaria test. We got it. It's in the database. So we need to integrate it with a lot of the other health programs that deal with mothers and children and a lot of this infant care that we've talked about.

But it does involve a great deal of collaboration. And that's the way we do it in the business community. We work down throughout our organizations and when we enter developing countries with our own business model, we're putting in place metrics for our business partners that are in those countries as well. So we do a lot of training, a lot of conversation around here's why we're measuring this, here's why it's important.

And in terms of unraveling the spaghetti chart, it is going to be a huge challenge. But I think the central question everyone has to ask themselves (sic) for their piece of information on that spaghetti chart is, you tell me what that tells you about eradicating malaria. And then I'll tell you whether you can have that information or not. And if you cannot directly connect that to the result, you don't need that information. It's going to take that kind of discipline.

And that's what we have to do in the private sector is have the discipline to say, no, we're not going to gather that information because it doesn't really take us to our objective. And you have to get that same mentality, I think, within this process as well. And so – tough, Mike, but it

means we're going to have to have some tough leadership. The United States is putting a lot of money out there in this game. They need to change the paradigm and lead and I think some other people will follow.

MR. VENKAYYA: Thanks for that, Rex. I think we've heard some great messages and guidance from our panel today. You know, I told you at the beginning that there was a time when I thought measurement was pretty boring. Measurement itself is, frankly, a little bit boring, but – (laughter) – but the reality is that it's really – it's really, really – (laughter) – I'm sorry. I had to say it. (Laughter.)

It's really, really important because if you're not measuring, you don't know that you're having an impact. And I think that point has been highlighted in some way, shape or form by every individual on the panel today. It's the critical amount that allows all of us – forces all of us – to up our game. So I hope you all leave today convinced of that fact. Thanks very much to my panel members. (Applause.)

(Off-side conversation.)

MR. MORRISON: Thank you. We're going to move to our third panel – (inaudible, off mike) – and partnership with Robert Rubin moderating, Tom Pickering, Congressman Keith Ellison, I'd like to invite them to come forward. Sen. Shaheen will be joining us momentarily. She's en route from the Hill. But Bob, Keith and – why don't you sit in the middle right here? And we can get – we can begin. Please, right here, Keith.

(Off-side conversation.)

ROBERT RUBIN: I'm Bob Rubin, I'm moderating this panel. I was asked to briefly set the framework for our discussion. Basically three issues we'll be focusing on: One, how should the United States government activities in global health be structured to be most effective? I think an enormously important question. Two, how can public and political support in the United States for global health initiative best be promoted. And how can the United States partner with others to improve the effectiveness of the global health effort, which I think which was discussed a bit at the end of the last panel as well.

And then after setting the framework, I'll pose questions to our distinguished panelists. We have an outstanding panel. Their résumés are in your materials. I won't repeat them. Let me just mention the names of the people: Sen. Jeanne Shaheen, who will be here momentarily I am told. Keith Ellison, congressman from the Twin Cities of Minneapolis, St. Paul. And Tom Pickering, who is, as you know, for a long, long time been one of America's most well respected and well regarded diplomats and foreign policy thinkers.

I think this country is now entering a period – or really has been in a period and is going to continue in this for a long, long time to come – of having to make wrenching choices amongst critical priorities because of an unsustainable fiscal situation. In that context, I think the case for a global health initiative is compelling.

But if this is going to be achieved, it seems to me that a great deal more is going to have to be done to educate the American people that while this is certainly a moral imperative, it is also enormously in our interest. And that discussion would include issues like the spread of infectious disease from countries that don't have public health programs. And it would include our dependence on supply chains to developing countries that can be interrupted through issues around health.

Having said that, I can tell you from my own experience when I was at Treasury, when I was secretary, when we presented similar sorts of points in supporting measures to combat global poverty, the educational effort, both with the American people and with Congress, was extremely difficult. The commission's report, as you know, advocates substantially increased funding and also advocates long-term commitments.

The commission also strongly recommends that we seek more effective ways of using the resources that are committed to global health by changes in what is a highly fragmented, overlapping and, in many ways, inefficient structure in our federal government. The commission recommends there be a deputy director at the NSC to head and coordinate an interagency council – and that would be for planning and for budgets – and that that same council coordinate operational activities.

Having said that, in order to avoid bringing operational activities into the White House, the council for those purposes would be chaired by the representatives from the Department of State and from Health and Human Services. But that would still have an overall reporting relationship to the deputy at the NSC.

Also, in order to provide continuity, the already proposed – the currently proposed \$65 billion global health initiative – the president's proposal – would be coordinated by the State Department official who, of course, would be sitting on this council and ultimately, as I said a moment ago, would be responsible for oversight to the deputy at the NSC. Congress also has a very complicated structure with respect to global health, and the commission proposed that the relevant committees establish a joint House/Senate consulting group, that this be done on a trial, 3-year basis for purposes of policy and also for purposes of budgeting.

And let me say, again, from my own experience in the six-and-a-half years I spent in government, both in the executive branch and on the Hill, the inefficiencies are an immense barrier to effective uses of resources. So I think the importance of these recommendations is exceedingly high. Finally, as was discussed a bit in the last panel, the United States has the opportunity to increase its impact on the effectiveness of the global health effort through its work with WHO, UNICEF, the NGOs, other donor countries, private-sector donors and the recipient countries.

Two points on partnerships: One, many health issues, like infectious disease, are transnational. And you can only get at that through partnerships. And secondly, there is the spaghetti problem that was mentioned at the end of the last panel. And it's interesting when you sit in one of these meetings and see the enormous multiplicity of conditions, forms, processes,

requirements. They really can overwhelm recipient countries and enormously reduce the efficiency of assistance.

With that, let me begin our panel discussion by posing a question, and I guess we'll start with Keith Ellison, since Sen. Shaheen is not here. But then, when she comes in, we'll sort of get her up to speed and let her pitch in. There are those who say that Congress is less effective than it could be. (Laughter.)

REP. KEITH ELLISON (D-MN): I'm shocked, absolutely shocked. (Laughter.)

MR. RUBIN: There may be those who say the contrary, but they have a hard time making their case. (Laughter.) In your view, can global health break through that environment in Congress, and how might that best be pursued?

Senator welcome. Sen. Shaheen. (Applause.) Let me – it's nice to see you, too. Let me restate the question, because I'll ask both of you. I'd made the observation that there are those who say that Congress is, perhaps, somewhat less effective than it could be. There seemed to be a general feeling that might be the case.

SEN. JEANNE SHAHEEN (D-NH): The audience didn't agree with that. (Laughter.)

MR. RUBIN: Yeah, well, before you came in, they did. Now they're a little bit – (laughter).

SEN. SHAHEEN: So where are you now? (Laughter.)

MR. RUBIN: Now they're a little bit intimidated, but the question was, is this an issue that can break through what does seem to be a bit of a mire, and some of the partisanship in Congress? Why don't you both respond? We'll start – well, we'll start with the senator, I suppose.

SEN. SHAHEEN: You know, I think it really can, and in fact, it has, in the past. One of the places where, in the Senate – and I sit on the Foreign Relations Committee in the Senate – one of the places where there is the most agreement from both sides of the aisle is on foreign policy. And global health is a place where we've got a great record of being bipartisan in how we approach it. And so I think this is a place where it's an opportunity for us to get people to work together, because we can see what a difference that good policies, when it comes to global health, make.

MR. RUBIN: Congressman?

REP. ELLISON: I agree with the senator. I think the answer is yes. I think there's some clear challenges, but just to confirm the yes, look, you know, both Democratic and Republican administrations have come forward with foreign assistance in the area of health that have been effective. I mean, PEPFAR was a Bush-era program; MCC was as well; and of course, there are

many other initiatives that have come from the Democratic side. So I think it's something we can get together on.

I will say that there's some distinct challenges. One is foreign assistance reform. I think global health – we should consider it within the context of foreign assistance reform generally. And I also think it's important that members of Congress make the case to the American people that, one, it's a small part of the budget, but two, it's doing good for good's sake. We should trust that Americans believe that, that is positive.

And then we should also make some of the more utilitarian arguments, which you made, Mr. Rubin, which are that global disease – infectious disease doesn't care about borders. You know, H1N1 was a plane ride away. And there are many other advantages, as well. But I will say that there is a few things that do divide us.

And we recently had, in the House, a conversation convened by Chairman Berman around foreign assistance reform generally. The points of agreement were around issues of global health, but then the issue of family planning and those things – health issues, to be sure – are still points where we have to work it out. And I'd rather put it up front and deal with it than not.

MR. RUBIN: Let me ask a related question, if I may. Before you came in, Senator I made the comment that, at least in my view, you've got an enormous fiscal problem coming at this country. And I think you're going to have to make wrenching, wrenching choices, and I don't think you have a choice, at some point. In that context – in the context of that debate, which I think is going to go on for years, how do you think this initiative is likely to fare? Either one of you can –

REP. ELLISON: I can – well, let me tell you. I think, because it is smart, it can fare well if we're all willing to make a few sacrifices. Let's grab the low-hanging fruit first. The fact is that, whether you talk to Republicans or Democrats, there is reform in the area of procurement we can do with the Department of Defense that can help wring out savings.

We have Soviet-era weapons systems that even generals say that they don't need, and we need to look carefully at how we can make – help the defense of our country remain as effective and agile as it's ever been, but at the same time, look for ways we can save money in outmoded, outdated systems, and in the area of procurement in particular.

So I think there's gains to be had. I think that health does have a security component. The healthier people are, you know, hopefully, the more stable their societies are, perhaps the more amenable their societies are to our own. And there is a component that we need to reflect on, but I think we are going to have to make some tough choices. But I think that there is room to pay for global health, and it will pay for itself.

MR. PICKERING: Bob, could I –

MR. RUBIN: Oh, absolutely.

MR. PICKERING: Bob, I think you were totally right in pointing out the fact that we're going to quickly going to have to move from stimulus to debt repayment, and that there are huge problems out there. The administration has taken a view, which I fully support, that 2011 is a turn-year for Iraq, that 2011 also will begin some build-down in Afghanistan. Look, we don't know whether that's going to work, but the determination is there.

If we look at the ongoing wartime expenses, I think annually, they run between \$200 and \$400 billion. So if we took the goals of this report – 10 to 15 (percent) now and 25 later – that would be a very small percentage. And if, in fact, we could agree that 10 to 15 percent goes into these kinds of programs and the rest goes for debt retirement, we'd be making some progress. We recognize how big the debt is and how long it's going to take to come down. But I don't think it's an impossibility.

Admittedly, there are big uncertainties about whether we can save the operational costs of war. But at least their palpably possible – I'd put it that way. And we ought to give that some very serious consideration. Now, this in my view, for all the reasons you said, is very high priority. We are vulnerable at home. We have a high potential to lose markets and economic efficiency. And we have a moral obligation, as the world's richest and best-cared-for country, despite all of the problems of health-care legislation – and hopefully, we'll have that well behind us when we address these questions. But it makes good sense for us to move on in this direction.

SEN. SHAHEEN: Let me add to that. I think the report focuses on a couple of things that allow us to spend our dollars very wisely. One is on prevention. The other is on looking at women and children. We know that, when we make investments in kids, that it makes a huge impact later on. And the point that you made, Ambassador, about it being a whole lot cheaper to spend dollars on global health than on war as a way to provide for national security is a very important one.

You know, we had former president Clinton and Bill Gates come before the Foreign Relations Committee in the last week or so. And one of the points that President Clinton made – he talked about going into Tanzania into a little village to announce a health initiative and said that this was a village of, you know, a couple hundred people and 2,000 people showed up. And he said, you know, when you're out there trying to save the children of parents, they're a whole lot less likely to want to go shooting at you.

And this is a way to spend our foreign policy dollars that is going to be very effective. And there are going to be fights about what we do about our debt reduction. There's no doubt about that. And this is going to be a tough argument. But we need to focus on the effectiveness argument, on the results argument. And can we do it better? Yes. I think you're right, Keith. We can make the procurement more effective. And we ought to do that. But we also ought to be able to use the argument that is made in this report, that this is a way to effectively use America's soft power around the world.

MR. RUBIN: Could I ask you a question, Senator? When you're running and you out – (inaudible, laughter) – when you're running for office and somebody criticizes you for wanting

to cut defense in order to do something like global health, can you make this case in a way that people will understand that this is really exactly what you've just said, or what Tom said, I guess – a more effective national security use than the other might be?

SEN. SHAHEEN: Well, I think that's the way we have to frame it –

MR. RUBIN: But will people understand that?

SEN. SHAHEEN: – is, how can we most effectively use our dollars. I think you have – we have to explain it to them. And we have to do a better job than we've done communicating with people in the past. We haven't – you know, as you said, Keith, Americans tend to be very magnanimous, and want to be helpful around the world. Look at our response to Haiti, and what happened there.

But we have to explain to people what we're doing and how it's successful and the difference that it's made. And we also have to tell people what the real story is. You know, one of the things, again, that President Clinton and Bill Gates talked about is, people think we spend all this money of our budget on foreign affairs and assistance to other countries around the world on global health, and when you tell people it's only a quarter of 1 percent, then they say, oh, well. And what you get for it – then people understand that argument and support it much more.

MR. RUBIN: Let me ask you both another question, if I may. You, in the two houses of Congress – do you think that the committee structure, as is currently constituted with its fragmented jurisdiction in respect to global health, is a significant impediment to moving forward? And do you think there'd be a willingness – there's a proposal in the report, as you know, to have a consultative group across the committees try to bring this together. One, do you think it's a problem? And two, do you think that Congress would be receptive to trying to do something of that sort?

REP. ELLISON: I'm going to defer to the senator, but would you like me to go ahead?

SEN. SHAHEEN: Go ahead, yes. Go ahead.

REP. ELLISON: Well, I think that there is a – I think we have chairs of Foreign Affairs in the Senate and the House who are certainly interested in reform in the area of global health and, again, foreign assistance reform more generally. There are different areas of jurisdiction, and I think that we've just got to get about the business of that reform.

I'm confident that, because it's a demonstrated priority for the leadership in both houses in this area, that they'd be open to it. I think I can speak confidently, as a member of the House, that Chairman Berman has been convening us across party lines to discuss these very issues. So I'm confident that Sen. Kerry and other chairs would be as amenable.

SEN. SHAHEEN: Well, I'm newer to the Senate, so maybe – (laughter) – and our rules are a little more obstructionist.

REP. ELLISON: I've heard this. (Laughter.)

SEN. SHAHEEN: Yes. As somebody who's been trying to see how we can get rid of the filibuster – (laughter) – I find this challenging. And committee jurisdiction issues are very difficult to change. But I think the point, and the point that's in the report that's important is what you talked about and what the report talks about, and that is coordinating our efforts better. And I don't care if we do it through some sort of an official group or we do it because we have relationships with committee chairs and ranking members, but the point is to do it in a way that we're not overlapping and that we're being as efficient and effective as possible.

REP. ELLISON: Can I make a quick follow-up? I just want to, again, praise the report and the efforts behind the report, because it can provide impetus for that in-gathering that it calls for. And I think that sometimes, leaders in Congress need some leadership. And I think the report is offering that.

MR. RUBIN: They may need it; they don't always take it. (Laughter.) But in any event, let me –

SEN. SHAHEEN: Spoken like an executive, you know. (Laughter.)

MR. RUBIN: No! I remember when I was Treasurer, I used to try to do that, but it didn't always work. (Laughter.) Let me turn to the national arena for a moment, because the last panel sort of wound up on that with the spaghetti chart, one thing or another. Tom, you're one of our nation's great diplomats. Is there an ability, do you think, globally, to bring greater coordination to these efforts, or are spaghetti charts just a fact of life that we're not going to do much about?

MR. PICKERING: Yeah, Bob, I think there is. I think the report's well-taken. You point out, first, that internally, we need better coordination. My own view is that this administration is less afflicted with the turf disease and more willing to cooperate on a whole-of-government basis than many of its predecessors, including where you and I worked. I think that this is an improvement.

One has to take advantage of that. And my sense is that, for policy coordination, there's no substitute for the White House. That's a job that has to drive this. So the suggestions of an interagency committee led at the White House by somebody senior – somebody like Gayle Smith over here would be ideal. (Laughter.)

And secondly, that State could help on the coordination side to keep the White House at the policy level and not have it, sort of, mire itself – we can put it this way – in operations. Interestingly enough, overseas, the one whole-of-government thing that works most of the time is the ambassador and the embassy.

And ambassadors have a unique opportunity to be whole-of-government people. And they have a unique opportunity to bring their people together. And they should be doing this around poverty reduction and health and other things. Internationally, it's much harder. The

spaghetti chart represents not so much ideal decisions on the part of the recipient country, as we have heard impositions on the part of the donor community.

And so we have to go for the mote in our own eye, or the bead. And we have to work that hard. I think, finally, I have argued, for the last 18 months, that we need to take advantage of the bipartisan commitment to global health represented in PEPFAR and its continuation in the \$63 billion Obama six-year program, and go to the U.N. this autumn – and there will be a summit on Millennium Development Goals.

And here, the critical drivers are our commitments to food and water and health – all inextricably linked. And to use that as a way to bring the international community along, first with meeting their money commitments – something we have not been very good at. Health is a standout, and we have to find a way to pull that along.

And then secondly, to being this process, which we heard about in the last report, of looking at not only what do we do after the goals, but how we take the shortfalls in the present goals in the direction of success, if I could put it that way. These are all great opportunities and serious challenges, and almost every one of them could be driven by and revolves around the health question in a central way.

MR. RUBIN: Do I have time for one more question? Who's my disciplinarian? I'm not sure. We do? Okay. Let me wind up with a final question, then. By the way, Millennium Development Goals are interesting, Tom. I first heard about them – I didn't even know what they were when I was at Treasury. I'll bet you there isn't 1 in 100 Americans who knows what they are. And I don't say we're ever going to coalesce support politically if people don't know about that, but in any event, that's neither here, nor there.

MR. PICKERING: I think that everybody in this room does, so we don't have to explain it. (Laughter.)

MR. RUBIN: Yeah, but this is not all of America. No, I wasn't trying to explain them; I'm just saying there's a lack of public information. My final question: How do we – and this came, actually, from the outside Internet interaction with the conference – how do we get recipient countries to take greater ownership of this process since, in the final analysis, it's only going to work if the recipient countries take ownership?

And I think both Congressman and Tom, at least I'm told, have views on that. Senator you may as well. Congressman, why don't you start?

REP. ELLISON: Well, you know, this issue came out very starkly when we were in Kenya. And the Kenyan government, I believe, is making good efforts toward issues of global health, HIV/AIDS, things like that. But the fact is, without PEPFAR funds, they simply could not take care of the needs of their population. And one of the points that I made when we were gathered together at a hotel, at a gathering much like this, is you know, what are you guys going to do?

Because this is – the operative word in PEPFAR is president’s “emergency” program. It’s not a permanent aid program. It’s designed to affect an acute problem at an acute time. And so I offered that challenge to them, and as a matter of fact, the Kenyans’ response, I think, was positive, which is that we know that this is not a permanent program. We’re going to have to step up.

And they, themselves, were debating among themselves on what the government’s commitment to health expenditures was going to be. So I think one of the best things we can do is provoke a conversation within government to say, what – how are we going to step up? How are we going to reorganize our budget to make sure we’re meeting these health challenges?

MR. PICKERING: Bob, three or four things. I think that one of the first things is attitudinal. We ought to be listening. We don’t do that very well. Secondly, I think it’s extremely important to encourage, on their side, to simplify and delegate responsibilities so that we have single points of contact – one-stop shopping, if I can put it that way.

Thirdly, the huge problem – get the donor community to reduce and standardize and simplify strictures – what have become known in the aid business as “barnacles.” Thirdly, help them look at what works in other places – lessons about functions, activities and organizations that have been successful. And fourthly, target programs to them to help them acquire skills and knowledge in places where there are gaps, so that in fact, we can empower them more and not try to fill all the gaps by the elephants from the outside. And that’s not a political comment. (Laughter.)

SEN. SHAHEEN: I think that’s a really important point, you know. We had a hearing not too long ago on Haiti and what comes next in Haiti. And one of the points that was made is that one of the challenges that they’ve faced has been, because it’s been a place where so many people from outside have come in to provide assistance, that there was never the kind of empowerment and engagement of people in the country to make decisions and to run programs. And that is a critical part of what we’ve got to do.

And I thought the report’s point about making sure that we have partners who we can work with is a very important one. You know, we all want to do as much good as we can around the world, whether it comes to global health or anything else. But the reality is, we have limited funds and we have to pick and choose where we can be most effective for the dollars that we spend.

And spending those in places where we have real partners on the ground is very important. Again, it’s another point that President Clinton and Bill Gates made, is that this is an opportunity for us to help build local governance structures. And we need to be careful about partnering in a way that’s going to allow that to happen.

MR. RUBIN: How am I now? We’re okay? Stop or go on?

MS. : Stop. (Laughter.)

MR. RUBIN: No, I didn't know what my disciplinarian was telling me to do. We thank you all, and it was very nice to be with you. Okay, good. (Applause.)

(Pause.)

ADM. FALLON: Okay, a little technically challenged. Can you hear me in the back? Yes? No? Anybody awake? Got it. Terrific. Well, that was certainly a stimulating panel, and some phenomenal insights from leaders of our nation who have spent many years working problems around the world. Thank you very much, Secretary Rubin, and the rest of the distinguished panelists, and also those from the previous panels, for your terrific discussions.

We're now going to be joined by Gayle Smith, who is well known to many of you, here. Gayle is the senior director at the National Security Council, where she energizes global development, stabilization, humanitarian assistance issues, and is the special assistant to the president. She's critical to White House policy formulation, interagency coordination and other foreign aid matters.

She's been extremely generous to the commission by participating in our deliberations, offering her thoughts and advice to us on several occasions. She's had a 20-year history of working in and on African matters, was a senior official in the Clinton White House. When we were thinking about the best way to launch this report, I requested, from Gen. Jim Jones, that a senior personality from the National Security Council, that they might be able to share with us today. And he immediately and strongly endorsed Gayle.

And so we're very grateful to Gen. Jones for his support, and particularly honored to have you with us, Gayle. Thank you very much for joining us, and I invite you to come on up and take the podium. (Applause.)

GAYLE SMITH: Okay, can you hear me? Is nothing working? Nothing's working? Now it's working? I have two microphones, so I may be in stereo. Let me, first of all, say thank you, first and foremost, to members of the commission, but also to a whole lot of other people who are here.

I think that we have, in the room, many of my colleagues in the interagency, without whom, frankly, I would be useless. We have members of the NGO community and the philanthropic community, who make unbelievable contributions. We have members of the private sector, and also, the advocacy community. And I think that without all of these groups, we wouldn't be where we are today.

And I think where we are today is something that, early in our process within the administration, I referred to as kind of a phase two in the global surge on global health. That we've had a solid decade of leadership, of activity, of the introduction of a lot of new actors to the field, of progress, but we're at a point now where we've got a lot of facts, a lot of evidence and a great deal more experience than we had. And we have a good opportunity to move forward.

We also have something that has been referred to up here on the stage since I've been in the room, which is extraordinary – I wouldn't even say bipartisan – but nonpartisan support. When we made an announcement in May, just four months into President Obama's first term, on the global health initiative, one of the things that was stressed with absolute sincerity and at the direction of the president was the contribution made by President George Bush.

And that was quite meaningful and, I think, quite serious. One of the most enjoyable things to me is that we have been able, in the process of developing our own effort, to work with our colleagues who served in the Bush administration to see how we can build on that foundation and move forward together. We have the same reality, I think, on Capitol Hill. And it's these things that will allow us, I think, to really fulfill our potential as the world's champion on global health.

Now, let me say something about this report: When you're – and I've been on a lot of commissions and things when I was outside of government and had a whole lot of fun saying, you know, they ought to do this and this and this. And then you hear that somebody's doing a commission when you're inside government and you say, hopefully, they'll have some really good ideas and we'll come out okay. (Laughter.)

And I don't know whether it's because we're all smart and we're all thinking in the same direction, or some of this is inevitable when looking at some of the same facts and evidence, but there's a remarkable coincidence, I think, of direction pointed to by the commission and some of the conclusions that we have come to, as well. And let me just comment, briefly, on your five pillars.

Maintaining the U.S. commitment to fight against HIV/AIDS, tuberculosis and malaria. That's a commitment that's absolutely maintained and a commitment that will grow, over the course of the initiative. We've added to that, as well, a focus on neglected tropical diseases, given the very high infection rates, given the ability, while you are treating one set of diseases, to also treat another set.

Prioritize women and children to build stronger families and communities. One of the new, very prominent and, indeed, ultimately central elements of the global health initiative is the focus on maternal/child health. And there are a number of reasons for that. There was an absolute gap, worldwide, when we looked at the facts and the evidence, of what this global surge had registered over the last decade. But I think we also know, as members of your commission obviously know, that you get an extraordinary return when you invest in women and girls.

Bolster prevention, emergency response capabilities in poor countries to reduce premature deaths and build the capacity to prevent, detect and respond to health hazards. This one, we're coming at in a lot of ways, and there are a couple really interesting points here. You've heard mention of – and I'll say a little bit more of – our desire to help build the capacity and capabilities of partner countries to more effectively manage more of their health systems and their health challenges, broadly.

This is driven by the global health initiative, but it is also driven by, for example, the strategy that our Health and Human Services Department puts forward on things like, how do we manage national health security in global pandemics. Think about H1N1. Think about the other challenges we will face, or what some of our national security colleagues think about when they think about biothreats, and managing biothreats and biohazards.

The common denominator in all of these is, you've got to have good surveillance, you've got to have good detection, you've got to have trained people, you've got to have the ability for skilled people to communicate with one another, and you get multiple benefits. So this notion of prevention and detection and this common element of surveillance is something that I think, through the course of this initiative, but also the other things this administration is doing on global health, we'll be able to do a great deal on.

On the capacity issue, writ large, our hope and plan is to be able to do two things at once. One is to save lives, but the other is, again, to invest in the ability of our partners. We've seen two trends over the last decade: one positive and one negative, but absolutely correctible. On the positive side, we've seen the emergence of some extraordinary leadership in the health community on the ground.

Whether it is health ministers that have taken the charge or health workers on the ground, there is extraordinary potential in the men and women that have taken leadership in their communities and their countries. We've seen governments take health much more seriously than was the case in the past.

On the negative side, I think we have seen – to say this politely, I think sometimes we smother our partners with our collective enthusiasm. A rush of multiple actors, perhaps less investment than we might make in capacity-building and really focusing in a meaningful, as opposed to just rhetorical, way on things like country ownership and partnership. And as – and I think Tom Pickering was referring to this – an enormously high transaction cost for our partners on the ground.

So that if you were to do a diagram – I think I know what spaghetti chart you all were talking about in here – but if you did a diagram of the relative amount of time health professionals in the developing world spend managing us, as opposed to managing their health challenges, it would probably suggest to us that we need to make some corrections. So our goal is to help build the capacity, and over time, start to change our role a little bit from one that is, perhaps, too compensatory and one that is much more rooted in partnership.

Make smart investments in multilateral institutions to demonstrate U.S. leadership and catalyze increased support. This is something we've focused on quite a lot in the global health initiative strategy, and not just with respect to the global fund, but with an eye to the multiple multilateral institutions, private-sector organizations, private, philanthropic organizations and NGOs with whom we partner, and with whom we can partner more strategically.

Tom raised a really important point about donors standardizing some of their operations and methodology. That may seem like a bureaucratic, boring thing in the world of headlines, but

I think anybody who's served in the field knows how important that is. Leveraging is another extremely important piece of what we can do, is using our leadership to call on and challenge others to join in the game. And that's something we very much intend to do.

Let me shift from there – and I will say one thing: On the comments on structure, I'm not going to touch it, but I am going to say this. (Laughter.) Because I think we learned a couple of things in the evolution of this initiative. And one of the things that we did at the beginning was, we got all of the people together across the interagency that are working on global health. Importantly and significantly, a lot of these people are the career men and women that serve successive administrations and make sure we've got the continuity, and also have a great deal of knowledge about our history and the genesis of certain policies and programs and practices.

And what we said is, everybody take off your agency hat, and let's not be HHS and State and AID and DOD and CDC and NIH. I am an acronym expert at this point. But let's all just think together about, if this were a phase two. And given the facts that we have about the last year – there have been some incredibly important studies that have been done, looking at global health over the last year, whether at donor performance, at the role of assistance – what's worked and what hasn't – at the nature of interventions, at results on the ground. Given all of that, what should we think about?

It took not time for people to start thinking together and to want to seize the opportunities to work together. Now, none of that suggests that you don't need some kind of structure that's clear about roles and responsibilities and who's on first. I'm confident that we have a way to do that; I'm also confident that we've got extraordinary points of very senior support and leadership across the executive branch to carry this forward. But I think there's another element we sometimes overlook.

As important as structure is that the entire team across the U.S. government that is working on this initiative have a common vision. They may come at it from different perspectives – different areas of expertise – may have different programmatic roles and responsibilities. But if we have a common vision going forward – and I can leave the room and my colleagues who are here from AID and State and NIH can answer the question in my absence – but I would wager that part of what we have been able to do is forge a common vision and a common plan, against which we can align the multiplicity of resources, agencies, departments, offices and individuals we have across the U.S. government working on this.

A couple other things about what our focus has been – and I think these are reinforced by your report, or perhaps our initiative is reinforcing your report. But I think they're going to be really critical moving forward. One of those is this notion of being able to evaluate, learn, create a foundation of knowledge and be nimble enough to make mid-course corrections. There's been a lot of focus, and I think absolutely correctly, on results. We want to put a premium on sustainable outcomes.

But what we also want to do is enable our people, as this initiative progresses, as the world makes more progress in global health, to be able to take stock at every stage of what we're doing, see if it's working, make sure there's not gaps and duplications, see if there are ways we

can do it better, see if we can bring innovation to bear in ways that we might not have thought of in the planning stages, and be nimble enough to make those adaptations.

I think there's certainly a desire that we be able to do that, and I think there's an understanding on the Hill that it's important to be able to do that. For us to be able to do that, I think we're going to have to put a much greater premium on evaluation, on metrics, on results, on outcomes, and on being tied to facts and evidence every step of the way.

I think we're in a very good position to do that. We've spent a great deal of time on that in the interagency. We've got great expertise on that in certain parts of our government. We have a new AID administrator who knows something about that, and is very committed to that, as are the secretaries of Health and Human Services and State. But that's going to be a key challenge. I think that's going to be something a little new and different, and I think we hope it will be new and different.

The second is to keep our eye on the notion of building capacity and saving lives at the same time. We want to invest in those places where we can help build systems, but we don't want to do that at the expense of assisting people in countries where that's less possible. Finding the balance there – we're going to try, with a number of countries, to give them a head start, to make some extra investments to really fast-track, kind of, the reorientation of the program and see where we get.

Hopefully, that will have a big impact on the other countries, but it will allow us to maintain a balance between these two objectives. I think the last thing I would mention is working as we do this on the global architecture for global health. During the campaign, President Obama spoke about something called global health architecture 2020, which was a vision of a world in which we would be able to better manage our common security and our common humanity.

And I think one of the experiences that we had a few months ago was with H1N1. And realizing very quickly that we had a number of challenges to address, not just for our security, but for the security of men and women around the world, given that there's a limited supply of vaccine; given that some had access and others didn't; given that limited supply; given that we needed an international mechanism to make sure that countries could access vaccines; given that we needed mechanisms on the ground to make sure that it could be distributed effectively.

On the management of HIV/AIDS over time, I think we've absolutely learned we've got to have a global architecture that serves all of us. So one other piece of this that I think is very important is a vision of building, over time, an increased number of communities and countries that are able to manage their health challenges, but also participate and work with others to reinforce that collective security and collective humanity. Those are the big challenges.

We've set an ambitious set of targets, in terms of outcomes. I am extremely, extremely proud of the fact that the State Department and USAID put a consultative document on their Web sites, asked for comments and are in the process of taking them. We've done a fair amount of outreach, so I think we've gotten some really wise advice, which you'll see reflected. And

this won't be the first or the last time – I mean, this won't be the last time – yeah, this won't be the last time that we ask for that.

So I would simply say we very much want to do this in partnership with all of you. We've talked to the commission and very much look forward to working in partnership with the commission. And it is our hope that, together, we can build on that humanitarian instinct that runs all across this country and ensure that, at the same time, we save lives and we invest in people and make this country proud. Thank you. (Applause.)

ADM. FALLON: Thanks. Well, Gayle, thank you very, very much for joining us, sharing your thoughts and observations. And I can tell you that I strongly endorse, and can confirm, your idea of a common vision. It was clear that the commission came to this point pretty early on, and that it's critical for us moving forward.

As we wrap up today, I would encourage each of you in the audience, and those online and those that can access it online, to read the report. We want your inputs. We value them. And particularly those that would help us to move forward as we try to get these recommendations implemented. Thanks to everyone. Thanks to our commissioners. Thanks to those of you who are here today participating. And we wish you the very best, and enjoy the rest of a beautiful day. Thanks. (Applause.)

(END)