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**The U.S. Global Health Initiative:
Issues and Perspectives
Kaiser Family Foundation
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PETER LONG: I'm Peter Long, Senior Vice President here at the Foundation who oversees our global health policy work. It's wonderful to see such a large crowd this morning- I think we have overflow upstairs - to talk about the Global Health Initiative.

We're honored that the administration has accepted our invitation to come and speak with you about the Global Health Initiative and what it is. We built the Barbara Jordan Conference Center to have conversations like this where we bring together policy makers, journalists, and other interested people to talk about complex health policy issues and to have a joint dialogue. And this certainly is a complex health policy issue and certainly an important one, not just in the United States, but for our role globally.

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As many of you know, the Foundation works both on domestic and global health policy issues. With regard to the U.S. global health policy, we bring together a combination of health policy analysis, public opinion research, journalism, and communications. You can find a webcast of today's event at globalhealth.kff.org.

I have just three remarks to set the context for today. First, if you're interested in health policy, whether it's domestic or global health policy, and you're not excited about today, I think we should all stop, we should leave the field, because this is an incredibly exciting time that occurs that you may live in interesting times. Well certainly whether it's domestic health policy or global health policy, we definitely live in interesting times.

Interestingly, I think we face, at the Foundation, we work both on domestic issues and on

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global health policy issues and we face a similar set of challenges although we got to this place very differently in global health. Fortunately we skip some of the partisan acrimony and the debate that we had in Washington over the last year on domestic health policy, but we stand poised, I think, in a similar place ready to talk about implementation, to talk about what the future looks like and to begin to forge the future of our health policy.

I think also it's important to remember that improving health and changing health outcomes is an incredibly complex endeavor, one that will take multiple strategies and multiple players. So it's not something that's a linear path that the administration would put out a white paper or put out consultation documents. There will be a set of strategies and they will be implemented as proposed. I think it's an incredibly complex and

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adaptive world that we live in and particularly on an issue as complicated as global health policy that involves foreign policy, international relationships, relationships within the government, relationships between the government and civil society. So I think if you're a health policy person, it's an incredibly exciting time and we're excited to kick off this conversation today with the Obama administration and you all.

The second thing I would comment is just that there is interest around the world in the GHI. This is not just we clearly see the interest here today in Washington. I happen to be in a meeting in Cuernavaca over the weekend and there were folks actually from Brazil, the European Union, and Mexico who all came up to me and said we want to watch the webcast from today's event because we'd like to know what the Global Health Initiative is.

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There's a lot of excitement. There's a lot of energy and a lot of curiosity around the Global Health Initiative not just here in Washington, D.C., but globally. I think it represents a sea change for the American global health policy and an important marker for the global health community.

So without further adieu, let me introduce the panelists and we're going to get started because I think it's a conversation and what I want to spend a lot of the time, and leave a lot of the time, is for you all to ask questions and have a dialogue with all of our panelists. We've assembled a great group and I'm honored to be here moderating them.

First, we're going to start with my colleague, Jen Kates, who's a Vice President here at the Foundation and she's the Director of both HIV and Global Health Policy and she's part of the

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broader team I mentioned who works on global health policy for the Foundation. Jen will frame the conversation and set the context for the discussion. After that, we'll hear from three senior Obama administration global health officials, who are going to tell us why GHI, what it is, how it will work, and what they hope it will accomplish.

First, we'll have Amie Batson who's the Deputy Assistant Administrator for Global Health at USAID. She has many, many years of global health experience at the WHO, UNICEF, and the World Bank. She's focused on the issue of results-based financing mechanisms.

Then we'll hear from Ann Gavaghan who's the Chief of Staff at the Office of U.S. Global AIDS Coordinator in the U.S. State Department. She has extensive health policy experience both on domestic and international health issues formally

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working with Senator Hillary Rodham Clinton and today she's responsible for all of our U.S. global response on HIV.

Finally, we'll hear from Deborah Birx who's a Director of Global AIDS Program for the CDC. She's a renowned expert in the field and supervises a staff of 1,600 in 39 countries. So we're glad that she's made time to be with us today.

Then as a reactor, we're going to hear from Dr. Chris Elias, the President and CEO of Seattle-based PATH, an international non-profit dedicated to improving the health of people around the world by advancing technologies, strengthening health systems, and encouraging healthy behaviors. Dr. Elias sits in an important nexus for this conversation between the world of health policy and implementation in the field. So I think he's

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a perfect person to add his perspective before we launch into questions with you all.

So I think that finally I would say that this is meant to be a dialogue. We'll have these presentations and then we'll leave plenty of time for interaction with you and conversation. So with that, I turn to Jen Kates.

JEN KATES: Good morning everyone. Allow me to show you just a couple slides. It is Kaiser after all. I'm going to echo Peter's welcome to you all and extend my personal thanks to our panelists for making time to be with us today and to all of you. We had a tremendous response to this event.

So as Peter mentioned, I'm just going to provide a few framing comments. Most of them are drawn from a new policy brief that we just released this morning that's in your packets. The brief is designed to highlight some of the key

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issues and questions that are still outstanding on the GHI that we summarized based on our review of public comments that were submitted, documents that have recently come out, and really just tried to put them all in one place.

I think it's useful in stepping back and viewing the whole situation that we're all talking about today is - you're trying to steer a very large ship and move it onto a different course. It's really hard to move this ship. There are headwinds. There's waves and the point is not just to rearrange the deck chairs. The point is to really think about the decks and think about the direction in new ways. That's a massive undertaking. I think we all need to be cognizant of that.

To start, you might have seen this. This is a schematic that we put out actually before May of 2009 trying to get a handle on what is the U.S.

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government's global health architecture. It involves many, many different aspects of the government and this is just a very broad look at it and into this mix comes the GHI. Now we just placed it there. We don't really know exactly where it might go, how it will span. Maybe we'll hear a little more today but to give you a sense that was the before picture and this is the current environment and how do you move this environment, what other new ways might there be?

Another aspect of this response of the U.S. government's response is "where we work." I think this presents both challenges and opportunities. We work in many, many countries around the world and you could see in some countries, the U.S. government is already operating seven, eight, even nine distinct program areas in global health.

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So this was the proposal that the Obama administration announced - a new way of approaching global health, a more comprehensive approach, and the general outline of the proposal was a \$63 billion, six-year initiative looking across the two big buckets here, PEPFAR and malaria and other global health priorities. The brief that we put out and obviously the consultation document have a lot more detail on these things.

I think it's important to note that funding for the set of programs that are defined as the Global Health Initiative has been increasing over time. You can see this here, a couple other points to mention on this. First of all, this isn't all the U.S. government's global health response. It's important to know this is most of it, but there's other things the government does that aren't counted here.

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Secondly, while this may seem like a lot for all of us working in the field, it's less than a percent of the federal budget. It's always really important to remember that. Also if you look at the six-year proposal and the three years of the Global Health Initiative, which is '09, '10, and if you include the budget requests that's about 43-percent of the six-year total. So the second half of the GHI would need to accelerate at a slightly faster pace.

Another aspect that we looked at and I know a lot of people are focused on is how these funds are distributed over time. If you look at the sort of general program areas that comprise the GHI, you actually see that there is some redistribution taking place early on way before the GHI. Certain areas got a lot more share of the funding than others. That's switched and now there seems to be some other shifting going on.

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To meet the broad targets that were put out in the six-year proposal, we know that further shifting will continue to take place or would have to.

So what are some of the key issues that we might hear about today and hope to discuss? And, understand that these are long-term issues that have to unfold over time and not things that could just be answered from a document or a white paper as Peter mentioned? These are outlined in the brief. So I'll just highlight them here.

The first is what will the leadership and governance structure be? So, will that schematic changed from the way I showed it to you? Will it stay the same, but with new ways of doing business?

The second is how much funding will there be, \$63 billion over six years, and how will it be allocated? There's a lot of focus on this aspect of the GHI because funding is such an important

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lever for thinking about discretionary programs in the federal budget. I think it's important to note the new data that just came out this week on maternal mortality drops actually made the point about the challenge of thinking about taking money from one bucket or another. That analysis showed that the countries where maternal mortality has not fallen or even has risen are the countries that are hardest impacted by HIV. So there's a lot of challenges here to how we think about this.

A third issue is how to assess, measure, and think about the targets. These are very ambitious targets. There are many targets and there's a lot of challenges to measuring them and thinking about them and tracking them over time.

Fourth, how do we reach this goal of country ownership? It means lots of different things. I think the consultation document begins

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to lay this out, but we know that this itself is a challenging area.

Fifth, is the whole relationship of the United States government to international actors whether it's multilateral organizations, other donor partners, the private sector, countries themselves and how do we make that aspect of our engagement more robust and leverage to maximize the impact?

Sixth, there's a big emphasis obviously in the GHI and on many other U.S. international programs and domestic programs right now on women and girls and I think a lot of us are really happy about that. How does that get realized at the country level, at the program level, what are the opportunities there?

Seventh, is the issue of health systems strengthening. That's another big bucket here and one that we all get and at some level know how

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important it is, but how do you define it? How do you measure it and what does it mean in practice?

Then lastly, there are many, many other big efforts that the administration has announced and is undertaking, that Congress is involved in that will effect the GHI or the GHI may be a model for - foreign aid reform, QDDR, etc. So those are all on their own tract. The GHI's on its' own tract. You can't stop things while you wait for all these things to line up. So what do we need to be cognizant of as a community working in health and development as we move forward?

So with that, I'm going to turn it over to our panelists who might answer some of these we don't know. Thank you [APPLAUSE].

AMIE BATSON: Thank you very much. Thanks to Kaiser for organizing this extremely important and useful event and also thanks for this brief because I think it's really very useful for

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everyone to sort have the issues and the kind of questions crystallized so that we can all begin the dialogue around them.

Why GHI and why are we here and so excited to be here? This is an enormous opportunity to build on the successes we've had in a number of different programs, but take the U.S. engagement in global health to the next level and really drive forward to achieve even greater health outcomes and achieve them in a way that is sustainable so that we have enduring success with our health outcomes. Also, to look at it through a business model where we're about having more value for the money that the U.S. government is investing in this field.

So that kind of embodies why we think that this overarching initiative of GHI has so much potential and everyone is so excited and why we're so pleased to be engaging with you here and in

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other forum to get the ideas of all the partners in this effort.

I've been asked to give you a very quick update before we delve into some of the more issues and some of these topics about what this means at the country level. From whence you've seen all the consultation documents, I'd like to say that we've been receiving excellent comments, more than 200 comments have been received from all sectors, from just about every key partner that we're working with and we found that this mailbox has been so useful at bringing in different perspectives and important ideas that we're going to keep it open indefinitely so that this mailbox will continue to be a channel for you to give us comments as we move into each stage of GHI.

We now are going to be using those comments plus some of the additional thinking that's been going on on implementation to revise

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the consultation document into a final strategy, which will be available by early summer.

A second major update is on the governance structure, which is well on its' way to being established and functioning. We have now established what we are calling the GHI Strategic Council, which is the forum for pulling together all of the different government agencies that Jen had shown on that slide that are critical and have expertise towards achieving this Global Health Initiative. This group has partners from Treasury and Department of Defense to NIH, HRSA, of course CDC, USAID, MCC, Peace Corps, and so on. So you can see it really does span the range of government agencies and offices that are engaged and contributing. This group is the group that is helping to define the overarching "whole of government" strategy and is ensuring that we're identifying the opportunities across all of these

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different agencies and offices and the audiences they're speaking to, the events they're involved in, to be using and helping to further the objectives of GHI.

We also have at the more operational level, is, as Kaiser referred to it, the trifecta, which is composed of the USAID Administrator, Dr. Raj Shah, the CDC Director, Dr. Tom Frieden, and the head of OGAC, Ambassador Eric Goosby. They are tasked with defining a shared or joint more operational plan and strategy. Each of them has a deputy. So for example, I am the deputy in USAID and Ann is the deputy for OGAC, where we are tasked then with taking their plan and aligning the day-to-day behaviors, work programs of our agencies to deliver on it.

These groups are meeting now regularly. The GSC or GHI Strategic Council has already met once and is meeting again on Monday. So they have

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monthly meetings and this trifecta actually talks or meets weekly so that they can really be looking at the real time issues and moving forward very concretely in that area and the deputies are probably daily if not hourly in contact.

The last big area, and this is where we really are putting our emphasis, is on the countries. This is designed to be a flexible country-led initiative. It is not meant to be the directive from on high about how things must be done. It's about capturing the different needs in countries, recognizing that each country context has different priorities, different strengths, different weaknesses, and therefore there is no one thou must do it in this way. It really is something that has to rise up from within the country and with a dialogue with our field staff, the government, and the other national partners.

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So we're now engaging very actively with the countries. We're preparing GHI guidance documents that will be going out shortly, which are more about how do you start to think about new ways to engage with your government, what are some other practices that have been used by different colleagues? How do you start to think about opening up your work program to align it more closely - if it needs to be aligned - with the government program? How do you start thinking about a learning agenda where the government is interested in pushing the envelope in a certain area because it addresses a really critical problem that they're facing?

We also are moving forward with these GHI-plus countries, which you may remember is outlined in the document and is about having a few countries where we can have an intensified learning effort, where this is something that

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these countries are very engaged and sort of on the front path of pushing on the learning envelope and where the governments and country counterparts are interested in playing this role that they would like to be something of a learning laboratory.

So we are talking with our country offices about some potential options. They are talking with their governments and other country counterparts. We will have the list of up to 10 GHI-plus countries by the end of this month as promised. There will be another round of dialogue with governments for the 2013 set of up to 10 countries.

So now just switching a little bit to then what does all of this mean given the principles and what we're outlining to the countries as what is GHI, what does it mean, how might you engage with countries differently, I

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would like to talk briefly about three of the principles: integration, collaboration, and coordination.

On the integration front, this actually has two levels. One is, very importantly, integration at the point of contact. We want to make sure that a patient or a client of the health facility has all of their needs met. That it's not a situation of she walks into a facility and is told I'm sorry we can do something for you if you have HIV/AIDS, but if you're pregnant or your child needs to be immunized, you need to go five miles down the road to the other health facility.

That's an enormous missed opportunity. That woman may never get those other services because she doesn't have time to go down the road five miles. It's also when we're interested in saving lives, we want to make sure that when that woman goes to the health facility, she can be

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tested and counseled for HIV/AIDS. She can receive treatment if she needs it. She does receive antenatal care if she's pregnant or obstetric care if she's delivering a child. If she has her other children with her, they do get immunized and receive counseling on nutrition. So that whole set of services necessary to provide that woman, to make sure that she, her children, and her family are healthy are in place.

It's also though about upstream integration, which is how we provide assistance and how our development partners provide assistance. So that, instead of five separate missions on behavioral change, for example, one talking about behavior change related to HIV prevention and control, one on malaria prevention and control, one on nutrition, one on immunization, we start thinking about one form of TA, which is really around behavior change to

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insure a healthy woman or a healthy child and packaging it in that way.

On the collaboration point, the U.S. government is an extremely important contributor to global health, but it is a contributor. This is a shared effort and there is lots of different strengths and skills that we want to build on not only within our own government of course, but with other partners, other governments.

So it is an explicit objective of the GHI to be collaborating even more strongly with our various partners> Clearly the government and the country counterparts being the most important, and Ann will talk about it a little bit more, but also with cross-agency types of efforts such as things like the IHP-plus, which is looking to say how can we streamline the indicators across all of the different partners and therefore ensure we're getting the indicators of important issues but

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we're reducing the transaction cost to the government about having to report on slightly different indicators for 20 different partners.

It's about things like special initiatives that NGOs are engaging with within the country either in the delivery or in the building of national capacity and learning from those; about how FBOs are playing critical roles in the countries and the private sector. So, engaging much, much, more explicitly to learn from and build on these different collaborative partnerships.

Lastly, coordination, one we've already mentioned, and this is really about the U.S. government. We have a number of agencies that have important expertise and are contributing and what we want to do is maximize the collective impact of this expertise so that we recognize what are the different strengths of the different

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agencies, how can we reinforce those strengths, and how can we avoid any confusion or duplication of efforts? So we are working with our field teams to be thinking, in their own context, are there issues arising? Are there best practices? How can we ensure that the Peace Corps, the DOD, the CDC, USAID, each of these partners, and each of these agencies are working to their maximum strengths and in benefitting the whole of the U.S. government's effort in that particular country? So I'll stop there and turn to my colleague Ann.

ANN GAVAGHAN: Thanks Amie and thank you all for coming today. We're really pleased to see the outpouring of interest around the Global Health Initiative and I think one thing that's encouraged us to date is it's a way that a lot of us are coalescing around some common goals. I want to layout three things this morning for you, talk a little bit about how the GHI is building on

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our successes, talk about the implementing a woman and girl-centered focus and then briefly discuss country ownership.

I think that the slide that Jen put up early, which looked at U.S. government investments from FY2001 onward in global health is a very instructive one in demonstrating in a real tangible way the amount of investment that's happened in global health over the past 10 years.

So before we start thinking about Global Health Initiative in April 2010, the first thing we need to do is backup and think about where we were 10 years ago, where we were before PEPFAR, before PMI, before the Global Fund, before the Gates Foundation's massive and increasing investments in health services and look at what we have managed to achieve in that time. Ten years ago, people would never have thought that we would be able to be here today talking about more than

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four million people on HIV treatment worldwide. People wouldn't have thought we would have been able to talk about our massive successes in vaccination and 75-percent reductions in measles' deaths. People wouldn't have thought we were able to talk about malaria and reductions in mortality that are essentially halving malaria-related mortality in several countries.

So the GHI is not designed to take away from any of those successes, but to say, "let's recognize what's been done, let's recognize what's worked across the board, not only from the U.S. government, but from our partners in countries, our partners from multi-lateral organizations, foundations, and non-governmental organizations, and let's figure out a way to really build those best practices."

The GHI, from my perspective and from the PEPFAR perspective, is exciting to us because it's

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going to be working as an umbrella to help us coordinate and collaborate better across our programs as Amie mentioned earlier. It's going to be an umbrella that allows us to continue our disease-specific and issue-specific successes but then also allow us to make the connections in the field better so that woman living with HIV is able to get the care and services she needs for herself and her family.

So I want to say that the GHI's kind of representing a second phase of where we're going with global health building upon the investments that started 40-50 years ago when we did start doing investments, building upon the successes that we've had in the past 10 years that we've had massive investments, and figuring out how to take what we've learned over the past 10 years and make it all work better so that we continue to have the

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achievements that we've managed to put forward so far.

I want to briefly talk about implementing a women and girls-centered focus. I think the news around maternal mortality, as Jen Kates noted earlier today, is encouraging. I think that just speaks to one of the additional successes that we need to look at and build upon to make sure that we're seeing similar reductions in countries around the world.

When we talk about implementing a woman and girls-centered focus, I view it as having kind of two aspects to it. The first is making sure that we are addressing the health needs of women, the health needs of girls. Not only making sure that they are able to get the services they need in reproductive health, family planning, in primary care, in all of their issues, but also to make sure that we're addressing the larger

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barriers that may limit their access to care whether it's demand, whether it's conditions of facilities not being available, whether it's issues like gender-based violence that increase their risk of HIV infection and may address some of their other concerns around not being able to access care.

So it's looking at what women need from that perspective, but then it's also recognizing not only an attempt to increase health outcomes for women, but looking and saying women are actually a huge factor in impacting the health of themselves, their families, and communities. When women are well that serves as a driver for health in communities. That serves as an economic engine for countries.

So we want to make sure that we're recognizing the centrality of women not only in providing care for themselves and their families,

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but as part of the health care system overall and working to strengthen their role in that health care system because they are such essential providers of care and making sure that we're enabling them to contribute to the health of their overall communities.

So there's kind of that two-focus aspect to it. Number one, making sure that we're improving health outcomes for women, and then, number two, making sure that we're recognizing the role of women and contributing to their overall health in communities.

The third point I wanted to touch on very briefly is country ownership, which has been noted, is a term that means a lot of things to a lot of people. So I'm going to try to unpack it a little bit today.

When we talk about country ownership through the GHI, we're largely focusing on how we

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can work with partner countries to help provide them with the ability to manage, oversee, and operate their programs. I use the term partner countries there because if we're looking at a health system in a country, we need to recognize that there are multiple factors that are contributing to that system. You have public systems that are run by national, local, and district governments. You have private sector providers of care. You have faith-based and nongovernmental providers of care. There are multiple inputs into that system. When we talk about country ownership, one of the things we need to do is look at how we're strengthening capacity across that entire system so that, again, one day we can have a country managing, operating, and overseeing all aspects of care in that country.

From the national government perspective, we'd like to make sure that they're in the

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position of kind of looking holistically at their national health care system and making sure that all the pieces are working well so that we don't have disparities in care between one district and another district where there might be different levels of input. We want to make sure that national governments are in the position of coordinating the inputs coming from various donors, that national governments have the support they need to develop and implement national health plans across sectors, and that they can work with all donors to figure out how to best implement these in an important way.

When we talk about working with country governments, it gets into a lot of different issues. I want to first recognize the extensive work that is going on with many of our country teams and their partner governments. The U.S. government is already working across the world to

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work with colleagues to develop and implement national health plans. There's been a lot of success in this. When people are developing national strategic plans, when people are developing HIV/AIDS-specific plans, a lot of times the U.S. government is helping to provide technical assistance. So this is already going on and we want to strengthen the ability to do this. The U.S. government is a strong provider of TA on the ground and I think that we'd like to recognize and encourage that role.

When we talk about working with governments, we are not saying there is not a role for civil society and there is not a role for nongovernmental organizations. We also want to recognize, as I said earlier, the importance of building capacity at all levels of a country. I think in particular, we want to make sure that nongovernmental organizations are able to connect

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in. Governments recognize the role that they play in health system and nongovernmental organizations are able to connect in and work with that government and help create the demand at the local level for health services and the accountability needed to run health services in that country.

In particular, and I think the larger question is, what happens when a government isn't addressing a particular issue or doesn't want to address a particular issue? The U.S. government has been working all along with nongovernmental organizations to provide services to people in need, provide services to marginalized populations and stigmatized populations. I think that that is going to continue.

Country ownership is about making sure that we're working with local NGOs to provide the services and then also continuing to have a dialogue at governments and with the governments

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over the long-term to make sure that there's recognition of the role of the health needs of their entire country and community.

So those are just some thoughts about country ownership that I'm hoping people might be able to react to. And, I'd like to thank you all for listening and turn it over to Debbie Birx to talk a little bit more about some of the other principles.

DEBORAH BIRX: So two of the principles that we're going to be talking about is research and innovation, and monitoring, evaluation and improved metrics. This was a really exciting element to talk about because when we came together, I guess it was about four months ago, as an interagency group, as a USG interagency group, I am relieved to see that many of the questions that Kaiser outlined, specifically three to eight, were taken up in a very transparent, strategically

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focused dialogue that brought in all of the agencies including a very important work group on metrics and evaluation in that early discussion.

That work group brought in the power of NIH and their thinking along with the implementing USG partners to really begin that dialogue of how do we better measure what is going on out there in the innovation that has occurred already and how do we measure, not only what has worked at the community or the host government level, but how do we measure and know what didn't work so that we can transmit that through all 81 countries that see U.S. government global health assistance so that we don't have to learn and re-learn.

We talk about the agencies coming together and building on strengths to be nonduplicative. In the same way, we have to build on the strengths of all of our partnerships out there at the NGO, of which many NGO, FBO, CBOs, host governments,

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many of you are represented in the room, and learn what you have learned and transmitted that to a broader audience so we don't duplicate mistakes. We do duplicate successes knowing that they have to be culturally adapted and realize at the very level of the community at which they're being implemented and will have to be adapted.

In this work group that was interagency, they brought up many of the topics that you have here and that group was so important that there is now a taskforce led by Ruth Levine on monitoring and evaluation and how really to approach this in a comprehensive manner that is helpful where we categorize and catalogue all of your good work into a way that is transparent to all of us who are working in global health and how to do that.

We're coming into the new generation of Tweet, and instant information. It's too long for a Tweet but maybe it can be in an Internet

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accessible site like the consultation document and the comment. We also heard from our partners while we've been doing these consultations that some of them may need additional help in writing up their successes and really getting that posted so all of us can realize the benefits and how they've approached these innovations in research.

Now coming to innovation in research that's a broad category and it's really implementation science is in there, operations research is in there, the very strong work that NIH has done in core, clinical controlled trials is in there to really understand and benefit from that information and translate those into program. This was a very broad ranging discussion that is still in a very discussion mode.

We want to build on what has occurred and the importance of what has happened in all of the different areas of research, particularly in

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prevention of all diseases, and translate that into practical programming with monitoring and evaluation so that we continue to learn.

So there's a commitment to the learning labs and this intensification of funding really focused on learning, focused in, like health systems, focus in a non-disease categorical learning way. But at the other 71 countries, there will be that intensity of effort to really work with all of the partners to make sure that innovative research that is occurring, that we know is occurring, but not being well categorized, catalogued, and transmitted to all of us so that we can learn as a collective body.

I look at this room, I see maybe I don't know, 200 people. Behind the 200 people are another 2,000, 20,000 in the field working on these projects. How do we harness their intellectual power, innovation, and knowledge and

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transmit it through the whole 20,000? We know that it's done well among groups but is it done well between groups?

So as we're talking about a whole of government approach, I think what the Global Health Initiative says, we not only need a whole of government approach, we need a whole of global health approach where all of the partners feel part of the solution and all of the partners, including the host government, feel like we're implementing plans and strategies and innovative issues and diseases being addressed in a way that is not only meets the needs of today, but tomorrow. I think we're excited about all the USG participating in this but also all of you all participating in this and giving us your constructive ideas about how to do this better.

Having been one who came from the LIFE Initiative, through PEPFAR, to now this Global

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Health Initiative, for those of us who've been privileged to work in resource-limited settings, this is taking the next incredibly bold step forward. We can all go out and program very successfully, but unless we capture how we did it that was successful, we're going to have to learn and re-learn and re-learn that.

I think the element that is so exciting to many of us that have been implementing is this true commitment to get the information together in a way that's helpful to everyone. And again, to make sure that we're capturing not only our great successes that we love to talk about, but also those things that people are doing that they knew didn't work and move past that and did something different but never thought of telling people that it didn't work at that moment. Knowing how other people's experience resulted in improvements will

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be very important for this initiative to be successful. Thank you.

CHRISTOPHER J. ELIAS: Thank you. Thank you all for being here. It's great to join you today. I want to thank the Kaiser Family Foundation for putting together the brief and for convening this discussion, which I think is quite timely and important. I particularly want to thank Amie and Ann and Debbie for joining us and being willing to update us on the Global Health Initiative and tell us where we're at.

I've been asked to take just a few minutes to talk from the perspective of an organization involved in helping to implement U.S. government-supported global health initiatives around the world and to talk about what some of the challenges might be. So when I was invited to do this, what I did is I contacted our field offices around the world and asked for their input.

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The first thing that they came back with is a tremendous amount of enthusiasm. They're really applauding the efforts. They've read the documents and the press releases and the pronouncement about GHI and they like what they hear, the principles, the focus on the key implementation components, etc. They love the focus on countries and on implementation at country level and country ownership. They like the messages they've heard about the need to invest in capacity to build capability at country level and to allow the countries to help drive this agenda. There's some questions about certain specifics, about why the TB budget's not bigger than it is, and I'm sure you're hearing that in the 200-plus comments that you've received. But, in general, the response is incredibly positive. When they think about now seeing this come into fruition and appropriation and implementation,

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some of the things that they've raised I'd like to summarize and I'm not the only one, I guess today, with three points.

So first about country ownership and the importance of building on what I guess I would characterize as a decade of work in global health that has been increasingly moving towards greater and greater country ownership. If we think about some of the successes of the Global Fund and its' country coordinating mechanisms or GAVI with immunization coordinating committees, the engagement at national level of multiple partners who often didn't work together 10 years ago into a coordinated planning, monitoring, and evaluation and implementation system, not perfect in every place, but certainly moving in the right direction.

Some of the comments from our field offices were that when we think about country

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ownership, we need to realize that that's not just at the national level. Much of the discussion, in the documents, on the panel today, and in other fora here in Washington have been about the relative ownership of the country versus the international donors, multilateral organizations, etc. One of the perspectives from our country staff is that while that's an important debate, it's also important within country to think about the ownership below the national level particularly as we move to implementation and integration, particularly at the district and provincial levels.

So if we look at some of the successes of the last decade and we think about some of the, for instance, the U.S. government-supported work in Kenya where there's been a concerted effort to integrate HIV and reproductive health activities at a regional level in different parts of the

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country. The secret to that success or the not-so-secret to that success has been tremendous engagement and coordination at the district level to get district government officials together with local community-based organizations, faith-based organizations, all of the partners who've been mentioned, engaged in thinking about what does it take here in this place to, if you will, have the national level leadership create an enabling environment that then gets translated into different actions in different districts because the problems are different in different places.

We see a similar thing with the TB and HIV integration efforts in Tanzania or with immunization system strengthening efforts in many countries that the district microplanning and all of the skills that it takes to do that are essential to the actual integration of programs and their implementation at country level. That

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goes through many different aspects of strengthening the health system.

One example from our Zambia work on malaria control was in the importance of understanding the logistic systems. One of the simple changes was instead of moving all the bed nets into Lusaka and then offloading them and reloading them and sending them out to the districts, actually changing the logistics so that they could directly import in that land-locked country straight to the districts where they need it saving significant amounts of money by again thinking through the subnational systems for actual logistics and implementation.

Second point I want to make is about the need to compliment country ownership with what I think I would call community ownership. Much of the focus again over the last decade has been as the resources, which Jen pointed out, have

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increased, has been on producing new tools and technologies and encouraging ways to strengthen systems for delivering them. This is absolutely essential, but it needs to be complimented by investments at community level and understanding how to translate problems into specific demand for specific solutions. Ann mentioned this in her comments about a need to create demand for more efficient and higher quality health systems at the community level.

In many communities because of a legacy of poverty and neglect and underfinancing of broken health systems, there's a lack of specific expectation. People want better health. They want better services but they don't know what they look like. They don't know what that looks like because they've never seen it before.

So, working with communities, and this is where particularly, I think, the civil society,

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the community-based organizations, faith-based organizations, and the private sector who often are better understanding of the market and what demand exists and how to create demand is an important partnership for the GHI.

The third and final comment I'd make is about the research and innovation agenda. This was again another very positively received aspect of the GHI. The importance of innovation throughout the program and throughout the value chain of improving innovations in service delivery, innovations in implementation research and operations research, but one of the things, and I think it's included and implicit in the GHI descriptions, is a need to continue to innovate in the development of new tools and technologies as well.

While much of the focus has been on scaling up what we currently have and that's quite

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appropriate, there are some very important gaps in tools that we don't currently have: vaccines for certain diseases, diagnostics for many, many diseases, improved drugs for diseases where resistance is emerging, etc. That continued innovation for new tools and technologies is incredibly important. I think, as we begin to scale effective delivery of services and programs in the field, we begin to see better what the target product profiles should be for these new innovative technologies.

I think one example would be in the area of diagnostics. We perhaps knew, 10 years ago that we needed better diagnostics, but we know that better now that we're trying to actually deliver antiretroviral treatment to four million people who weren't on it 10 years ago. We've increased the visibility and the urgency of having better diagnostic tools not just for HIV, for

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monitoring viral load or resistance, but also for TB and a variety of other diseases as well where, as we've sought to deliver at scale, we highlighted the limitations of the existing diagnostic services to guide the investments and to guide the use of those resources most appropriately.

So in conclusion, I would say that the feedback from throughout our field operations and our partners in the field is incredibly positive, incredibly hopeful, full of applause. But a concern that we will need to pay attention, particularly country level and at subnational levels within country, into how to realize country ownership in a real way and also whether we'll be able to make the investments in capacity development, not just for building technical capacity, but building the management and leadership capacity, again at all levels of the

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national health system. And if we'll be able to balance what is an understandable impatience for results with some of the longer term investments that need to be made to actually create a capacity that's going to be sustainable for the long haul. So thank you again for asking me to comment.

PETER LONG: Perfect, thank you. Thanks to all the panelists [APPLAUSE]. What we can do is actually give the panelists from the administration an opportunity to respond to Chris' and then we'll open it up to questions. And, in the spirit of the trifecta and the three points, we'll take three questions at a time and batch them for the administration officials, but first let me give them an opportunity to respond to Chris and then I'll open it up to your questions.

AMIE BATSON: So thank you Chris. Those were very uplifting comments. It's nice to get such positive feedback, but also to identify some

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of these extremely important issues. I think that one of the really key themes around the whole Global Health Initiative is not to make this, again this directive from D.C., which would tend to focus just on the national government, which would tend to say this is what you must do, but rather to have this be much, much more country-driven. It's about our field staff in the country working with the government, working with the local NGOs, working with the other players that are on the ground who are seeing the real situation and the real issues.

So in the dialogue we've been having, it was amazing the number of the country teams that one of their top priorities was, for example, strengthening the community-based platform both for delivery of services, for enhancing demand and so using that as a mechanism, transparency on the

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quality of the services that the communities were receiving.

So it is a very strongly held view. When you actually push the planning and the thinking down to where it needs to be done, this is the type of issues that actually immediately rise to the top. So I think there's a great deal of congruence with the approach we're taking and with what all field staff, yours and ours and the other partners are seeing and recognizing.

This issue of we've taken a supply side kind of approach for many, many years and the importance now of really stressing the demand side, that often it's these hidden barriers that prevent a woman from going to a facility that she doesn't have the bus fare or the opportunity cost of not working that day or whatever it may be, that those are the barriers not just the supply of services.

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So being able to address that on a country by country basis, it's not a one size fits all kind of solution. It's very, very context-specific. I think GHI, in its' structure, really now gives us the opportunity to move in that way much, much more effectively.

ANN GAVAGHAN: To just actually briefly note something with that, in terms of the decentralization, I think it's important to note that as we're working with countries and looking at their national health plans and as their teams are working to help them develop national health plans, a major thing that's coming up at the country level from national governments is decentralization and how we make sure that services get out to the people they need. So this is a priority that's being identified by countries and that I think we're interested in working with them on as well.

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DEBORAH BIRX: So thank you ladies for letting me comment on the research and innovation piece because I think many of you know this is a passion of my life, but to talk about the issue that you brought up of technology and tools because I just am awestruck of what is really happening over the last five years with, not only HIV rapid testing and the policy changes that needed to occur around the opt-out of those testing because again creating that demand, but the diagnostics in malaria.

Finally for those of you who've been able to work in resource-limited settings, so many of the district hospitals that we all have been in, I was always very interested in the labs, so we would go into the lab and we would see the microscope and I would say how do you diagnose TB, malaria and other diseases, and they would say well we do smears. And, they had the slides that

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had been used and reused and reused, but then I would go to turn on the microscope and it hadn't had a bulb for a year.

So this new technology that FIND has and is working on with PATH, with these new microscopes that are rugged, have long life bulbs that will be able to diagnose TB, but also be utilized across all diseases. I mean each of these technology platforms that are at the fundamental level like of a microscope are not only applicable for sepsis, for UTIs, for TB, for malaria, and the excitement of the laboratory staff of knowing they're going to have reliable supply chain of this microscope that is usable is just really extraordinary.

So I think complimentary to that and very much in concordance with what Chris said is the development of these national laboratory plans, which really tier out services in a thoughtful way

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all the way from the national system to the health clinic. Realizing at the health clinic, there may not be even a lab assistant that a nurse is going to have to implement each of those technologies that are available to her/him, and knowing and the training and the competencies that need to be at each level and maintaining that.

So the equipment and the human capacity, the service and the diagnostics all match in a way that a client can come in, receive a diagnosis and have a test either done there or quickly with a turnaround.

Now we're very good sometimes at testing, not always good at getting the results back and a test without a result might as well not have been done. So I think there's a lot of strategies around this. It's so much illustrated by the need to work both at the community and district level as well as the national level to get the policies

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in place. So thank you for noting the tools and technologies - absolutely essential.

PETER LONG: Thank you. Before I open it up for questions, we'll have people with microphones, if you could just tell us who you are and where you're from, I just want to note that you have in front of you today, I think the three individuals who've been living and breathing this for the last many, many months and just remark upon how thoughtful their presentations are and their passion and commitment and thanking the administration.

I think you read the documents and you have a sense of the vision and the excitement, but to actually hear them present, two things, I think, are very clear not the one, two, three points but two. One is the level of coordination is real and the commitment to coordination, we have three presenters from across different

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agencies here today who presented seamlessly across the topics. And second, I think is the candor and the level of willingness to engage. Often you have panelists and you talk about questions and you give them a brief in advance and they give a totally different presentation. I went down my checklist of the questions that Jen and her team have put together and dutifully the panel answered each of them with great thoughtfulness and care and just also candor that some places they don't have all the answers and that it will involve a conversation with you and many others here in this room and many other forums.

So with that, I'll turn it to you to begin that dialogue now. So we're going to take batches of three questions at a time. If you'll stand up, I said, and give us your name and your

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organization and then we'll have the panelists respond. Let's start in the back here.

ERIC WILLIAMS: Hi, my name is Eric Williams and I work with Physicians for Human Rights in the health workforce advocacy initiative. Thank you very much for having this talk today. You talk about service. You talk about quality. You talk about district level empowerment and decentralization, but you haven't really talked about the health workforce, which is underresourced, which is fleeing, going to other countries with better resources and better rights and safety issues. The consultative document doesn't really address health workforce.

So I wonder if you could share just a little bit with us how the initiative is really going to address health workforce. We already know the 140,000 in PEPFAR, but we need far more

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than that. We need real focus on plans, of human resources for health plans, etc. so thank you.

PETER LONG: Who has the mic here? Let's go in the aisle here.

EDGAR KLEININE: Good morning and thank you very much for a very interesting overview of the GHI. My name is Edgar Kleinine [misspelled?], I'm working for RTI International.

Debbie, thank you very much for highlighting the need to document what we are actually doing in the field and how are we succeeding with so many different approaches. This is certainly also a topic very much to my heart and has come up in previous meetings as well, but how do we do that really well? Implementers are busy doing what they are supposed to do, implementing and not necessarily writing like academia does. So how do we encourage

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implementation practice being written up and published in peer-reviewed journals?

I'm not sure that the existing journals, which are mostly hypothesis-based research, are an ideal home for such success stories but how do we go beyond the gray literature and maybe it's time for a new journal that is peer-reviewed by practitioners and how do we also bring in the people who do writing for a living and can help the implementers document? Thank you.

PETER LONG: Let's go here.

KEN MORRISON: Yes, hello. I'm Ken Morrison working with Futures Group based in Mexico. I have a very simple question. I look at the principles especially strategic coordination integration, strengthening, leveraging key multinationals, other partners and to some extent country ownership, and then I look at the budget allocations and the decrease in Global Fund seems

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to be a direct contradiction of that, if you could comment on that.

PETER LONG: Great. So let's take them, workforce, results, and Global Fund funding.

AMIE BATSON: I'll take the first question on the health workforce. Health workforce is an absolutely critical issue. For some countries, it is the most important priority that they're facing right now. It's a very, very country-specific issue. Again, this is why we want to approach it from the country teams working with the government, and the other national counterparts to identify what is the reason for the problem in that particular country? What are some different solutions that they either tried and that they want to scale up that they think is worth looking at other models and perhaps testing? There's a number of issues in terms of how do you get the right health workforce. Part of it is the

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training. Do you need to have all doctors or do you need to be training extension workers, like Ethiopia is trying to go for?

Another issue is the incentives. You can count the number of people you can train. You can count the number of posts that are filled but, at the end of the day, the health worker doesn't show up or the health worker doesn't provide the right intervention, you're not getting the results that you want to see. So part of the key issue around the health workforce effort is really recognizing that you have these people that need to be incentivized. They need to have their work recognized. They need the proper training. They need the equipment, the tools, the drugs, the vaccines where they're at and that you need that whole package of events in order for, at the end of the day, the child to be immunized, the mother

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to receive her antenatal care, or the counseling for HIV/AIDS.

So I think it's an extremely important question. I'm glad you raised it. It's something that we do see as a priority that, again from the dialogue we started to have with countries, many of the governments have put this as number one on their list. So I think there will be a lot of innovative work around this area. We look forward to hearing from you and from other partners suggestions, strategies, best practices that you've seen that are appropriate for different national contexts.

ANN GAVAGHAN: I'm actually going to talk about all three. Eric, I appreciate your question around health workers and I wanted to note that many of the things that you raise are things that go beyond the health sector particularly in terms of pay, civil service issues. So a lot of them

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are really complicated pieces that get to the larger issues of overall barriers to care.

I think that as we're working with countries, as Amie had noted, when looking at their national plans, the questions we have are what's your human resources for health plan? Do you have a human resources for health plan? How can we work with you to help develop some of these issues to make sure that there are trained health workers?

I think that the safety and workforce issues are ones that we can also get to by strengthening the health system. If we make sure that supply chains are working so that the equipment needed for that worker to be safe in that setting get there then that is really going to help create a work environment for them. So the issues that you raised are ones that we are working on throughout the entire piece here.

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In talking about implementers are implementers and I think that's a very important point. Implementers are implementers. They're out there doing the work in the field every day. So I think one of the challenges from that perspective too that we're working with here is how do we not only document the successes, but then translate them into a format that's replicable so that we can make sure that something that's happened in one country, to the extent possible, can be put into place in other countries so that we are making sure we're maximizing our health outcomes. So that's another piece of that challenge, which I think we're grappling with.

Then in terms of the Global Fund, first of all, I would like to note a couple things here. The U.S. is committed to the Global Fund. It's the largest donor to the Global Fund in the world. This year's budget request was the highest request

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to date. The collaboration between the U.S. and the Global Fund is something that goes far beyond budgets. It's something that is involved in active governance. The U.S. sits on the board of the Global Fund as an active participant in many of its' committees. It goes to country level collaboration. The Global Fund is a financing mechanism and the CCMs were already mentioned at one point during this presentation. The U.S. government is working with CCMs in many countries and the U.S. government is providing technical assistance to make sure that Global Fund grants do get to the people they need to get to. I think that's a very important point.

So we're working with the Global Fund. From the PEPFAR perspective, our success is based upon the success of the Global Fund. You can't delink the two. So the U.S. government is incredibly committed to the Global Fund and will

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continue to be supporting them not only through budgeting but through various technical assistance and cooperation.

DEBORAH BIRX: So I'll just be brief on question two. Thank you for that question and already that's why I love these sessions because we get new ideas, I think this issue about the journal could be very important. I want to just to go back and revisit because it's really three different issues. One of them is how do we get success stories out in a way that is across the board and we talked about this at one of our other meetings. There are excellent writers within the Embassy that could help write for some of these as they come up as different successes.

The second piece of that is, can monitoring and evaluation, done where there's some core factors that we all agree on, then be resolved in pooled data that could result in

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either a manuscript or an article that could be into the scientific literature or into a broader comment piece? I think that's really what this taskforce is looking at very carefully under Ruth Levine is, can we aggregate data in a way that brings together the parts of all of us into a global whole.

The third is hard scientific journals and making sure that the information does get also in a composite way up to those journals where it identifies the gaps because somehow we still have to have that dialogue with our more basic researchers who understand what new tools and technologies we need. They need to read where we are on a regular basis. We haven't been as good in stating where we are and where we think the gaps are in a venue where they would read it and say, "oh this is what they're saying they need." So I think that there is really three elements of

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that. We really need to be responsive to all of those but I like the innovation of potentially another journal.

MAURICE MIDDLEBURG: Thank you, Maurice Middleburg, IntraHealth. Thank you very much to all the panelists for their very interesting presentations. I want to pick up actually on Eric's point with regard to the health workforce and more broadly with regard to health systems and can you describe how you're going to get to greater precision and specificity about the targets and funding allocations for health systems strengthening, including health workforce?

The consultation document is very good in terms of targets around the traditional disease-focused arenas, but when it gets to health systems strengthening, frankly it's pretty vague about what exactly will be done, what the

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accountabilities will be, and what kind of resource allocation there will be.

EILEEN QUINN: Hi, Eileen Quinn with PATH and I have a related workforce question, which has to do with the field staff. It seems like there's now a large onus on the field staff to be consulting with enormous range of stakeholders at the country level and there seems to have been an erosion over time in that capacity. So how will the GHI address that?

DAVID BRYDEN: Yes, David Bryden with the IDSS/HIVMA Center for Global Health Policy. Our experience in achieving more advanced, faster health service delivery has been to set high goals and that helps drive funding. It helps drive congressional commitment.

So my question is, why on the TB goals in the GHI consultation document, you chose to contravene what Congress had instructed in 2008 in

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terms of the targets that they had set, where you're shooting for a goal that's actually much lower. Wouldn't that actually, if you had stuck to the goal that's actually already in the legislation in the U.S. law, wouldn't that help drive more funding, more commitment including for research?

Just a related question on HIV/AIDS treatment, HIV/AIDS treatment is a really important way of getting ahead of the TB threat as well in countries where there's prevalent co-infection, but what we've heard, I heard yesterday from a major implementer is that if programs are actually able to achieve cost efficiencies in their treatment programs that those cost savings can't be directed to expanding treatment, they have to be applied more generally. 'So I wanted to ask about that if that's the experience across the board and in PEPFAR programs. This is what

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we've heard from a major implementer. So it was concerning.

PETER LONG: Okay. Why don't we take those three? We're now getting into the nitty gritty here.

AMIE BATSON: Okay, I'll take the first one and then just touch very briefly on the second from my agency's perspective. So for the issue of health systems strengthening and the health workforce and targets, indicators, funding, I think as everyone in this room knows, the health systems strengthening aspect of this work is probably the toughest one we have to do. It's the area where I think all agencies, all partners have been grappling as to how best to do it, how best to scale it. Often there's tremendous successes in a certain area but then when it comes to trying to scale that up and going countrywide, every agency seems to have run into issues.

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I think that from our perspective, one of the reasons why we didn't just put in health systems strengthening targets and say we need however many hundreds of thousands of health workers as a goal is because this is in particular a very country-specific issue. We are very explicitly committed to strengthening health systems.

I personally believe we're not going to be able to achieve some of these targets, most notably around maternal mortality without having a functioning health system. There are some targets that one can do outside and we've seen how that can work, but there are other targets in GHI that can only be achieved if you have that health system in place. I think that's what keeps us all honest about that investment in health systems.

We also will face challenges between the tradeoff of decisions about using funds to achieve

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on a more immediate, faster goal versus using those funds in a way that will achieve the goal by establishing a system and therefore allow it to be achieved in the years to come.

This is going to be, I mean frankly this is going to be a challenge. This is a big shift in the focus of effort. We are trying to identify the kind of indicators that are helpful, but as I just mentioned in response to the last question, you can set up an indicator for the number of health workers trained. That doesn't mean that that health worker delivers a single service.

So it's an importance about recognizing intermediate indicators, which ensure that you're moving down a path, but that ultimately you've got to have that whole chain of events, which is your health worker, the functioning sort of supply and equipment, the demand side of having people come to the facility. All of this has to function in

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order to get the kind of results that we're all focused on.

So I think part of our strategy really needs to be linking these kind of health system-specific indicators with the health results that we expect to see and which require the whole chain of events not just one piece of the health system puzzle.

On supporting capacity, it is. We are going to be putting more demands. We've been having conversations with all of our field staff in each of the agencies about what do they need, how do they see it. In certain places, the staff are feeling they actually have what they need. In others, they're saying this is going to require some extra support. So we are having it and each looking to see what's the best way to ensure that the agencies and offices collectively have the expertise and the staff on the ground to deliver.

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ANN GAVAGHAN: Just to address all three questions, in terms of health systems strengthening, I just want to really talk about the way that our disease-specific and issue-specific programs contribute to health systems strengthening. The work that we're doing every day in training doctors to provide treatment or the work that we're doing every day in setting up supply chains to deliver malaria medication, these are inputs that really help to impact the health system.

I think one of the things we're trying to do in the GHI is look across our disease-specific programs and figure out where some of those inputs are and how we can work better to make sure that there is a coordinated emphasis around strengthening health systems.

But I definitely want to stress that we don't see health systems as kind of over here and

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then our programs over here. It really is working together and making sure that as we are implementing programs, there is a health systems element to all of them.

To get to David's point around some of these issues, from the PEPFAR perspective, first of all if you hear any situation where there is an issue in a country, we'd love to hear it from you so we can help track it down and really troubleshoot these issues. PEPFAR's committed to increasing treatment as listed in both our strategy document and the GHI consultation document. We're going to be providing support for treatment for more than four million people over the course of the initiative. So I really do want to follow up with you afterwards to address some of these issues.

Then with some of the TB goals, I can tell you that, from the PEPFAR perspective, we're

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definitely working to make sure that we are addressing the significant linkages, as you had mentioned, between TB and HIV co-infection, which is such a major part of our programs and something that we definitely do need to address.

Finally just getting back to the points around field staff, there are some new skill sets that are going to be required. The U.S. government is staffing up around the board to really help improve the number of field staff out there, but we're also working to figure out how to support our field staff in doing things like reaching out to governments and negotiating more. I know that from the perspective of PEPFAR, we've been working with governments around negotiating partnership framework documents.

We've had a lot of lessons learned from that experience that can really help inform overall government engagement. But it's also

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important to note that there has been, for years, engagement of the U.S. government with our country counterparts in government. There are detailees, ministries of health, etc. So there is some experience of that and as part of all of the GHI, it's how we take those successes and build upon them.

DEBORAH BIRX: Just quickly for every one of us that you see and just I'm sure in all of your programs, there is another 50 to 100 locally hired staff that are really the essential ingredients in implementing these programs and making sure, and it gets back to one of Chris' comments, to make sure that all of our local hired staff that are working with you all are not only just working at the national level and looking at programming there but also at the district and community level and making sure, I think there are some best practices.

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The agencies now go out to partners often together to look at both the facility-based programs, which are sometimes CDC and the community-based programs and health center programs, which are often funded by USAID, so that they have a comprehensive whole. We think that's a best practice. Many countries are doing that and it's starting to pull those groups closer together both at the USG end, but also in country.

I think the TB piece, and I'm probably speaking to the choir, is more than just a money piece. I mean we know where our gaps still are. We know that we've done an extraordinarily good job of testing for HIV in TB clinics, but we know that we've not always linked those patients to treatment and not always facilitated their treatment for HIV.

We are not doing as well in understanding HIV positives' exposure and reactivation of TB.

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It's an enormous problem. There's a couple operational research proposals out there that are being implemented, but really understanding how to diagnose TB effectively among our ART treatment patients is really a huge gap that can't just be filled with funding. It needs to be filled in a way that we understand how this is symptomatically when we don't have chest x-rays and what it means and really have better tools and technologies around that diagnosis of reactivation. I know people are working on reactivation but it will be really essential to have an impact on mortality. So thank you.

PEG WILLINGHAM: Thank you so much. Peg Willingham from Aeras Global TB Vaccine Foundation and it's wonderful to have this panel. I wanted to follow up on two things. Dr. Birx just said that TB, it's not just a money piece, but TB does get disproportionately much less funding. So I'm

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wondering why does TB get so much less funding
when it kills so many people?

And the question I also wanted to ask is
on R&D, it's great, the focus on operational
research, but GHI is actually really silent on new
R&D and USAID has a 30-year history of funding
research on contraceptions and nutrition, but in
the last 10 years on vaccines for malaria and
AIDS, microbicides, drugs. So I'm wondering if
the revised document can acknowledge that and look
for new funding in those areas. Thank you.

BOB ROEHR: I'm Bob Roehr from BMJ. At
first blush, the concept of ownership at the
country level, at the community level sounds all
well and good, but I don't think that the program
would willingly support say apartheid in South
Africa a number of decades ago. So then what is
going to be the response to the human rights abuse
now associated with homophobia, which is really

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quite virulent in certain parts of the world? How are you going to react to that? Is ownership the only criteria or are there other criteria?

LEANN EVANSON: Hi, thank you very much.

My name is Leann Evanson. I'm with JSI, John Snow, Inc. I'm very pleased to hear this, the information on innovation and the spirit of support to innovation. So I want to understand a little bit about the tolerance for non-success because we've talked about capturing our success stories, but we also know that innovation has a high rate of non-success.

So with the tension between making a case for increased funding and continued long-term support, how will we capture these experiments that maybe don't work in a clear eyed way that can then be transmitted to other organizations and other implementers? Thanks.

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AMIE BATSON: So on the issue of new R&D and as has been highlighted here, R&D is an essential piece of GHI and of our global health success. R&D is very much a continuum from the basic to the developing it into a product, to actually getting it piloted into a country, to getting it scaled up and used. I think we really need to look at R&D along that continuum and not just take one piece of it.

I mean right now there's a lot of really interesting products out there that there's a bit of a pile up. They're not actually getting introduced into the country programs and getting scaled up. We need to be addressing that. That has a lot to do with implementation research and all the rest.

As you noted, there is some really interesting further upstream development areas for very, very practical applications and that we want

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to continue to support them and as you noted, USAID has been doing some work in this area as have other partners. That's something that, again as part of a collaboration and coordination, we expect to work very closely with key partners like Aeras and others who are leading that charge.

We also are engaging very closely with key players like NIH who are driving much of this whole research agenda and particularly the more upstream phases of it. So looking at the roles of agencies like that, which is not captured, for example, in the pure GHI budget, but which is an absolutely paramount role and where we are very actively working with the NIH to say what is your role? I mean actually the head of NIH, Dr. Francis Collins, one of his top priorities is in fact global health. So we are working explicitly with him, Francis Collins is represented on our

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GHI Strategic Council, to identify how NIH can help move forward in this research agenda.

The issue about the tolerance for non-success, it is an interesting one and one tries to create the culture. I know we're all working to have a culture of saying we're learning and it's not yes or no, success or failure. I think we'll have to have some learn to talk about a language of learning towards success that you ended here, which was successful, you tried four avenues to get there. So you still get credit for success and you still have to acknowledge the innovations and where there was non-success but not non-success as a dead end, non-success as one pathway towards getting to an endpoint. I think if we can start to be casting our language in this way and give some examples of how countries can do this and how teams can do this then we can increasingly push

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the culture of acknowledging there's huge value in what doesn't succeed and what was tried.

ANN GAVAGHAN: I'd like to deal in the concrete. So I'm going to go directly to the questions around homophobia and first try to address that in the concrete level and talk about how that applies to country ownership overall.

The U.S. government is committed to providing services to marginalized and stigmatized populations. So we work with non-governmental organizations in many countries to make sure that the services to these populations get to the people they need. We want to make sure that men who have sex with men have access to the prevention, care, and treatment services particularly through PEPFAR. We've been working with non-governmental organizations to make sure that they are served by our programs.

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At the same time as we are working through non-governmental organizations at the country level, and again part of country ownership as Chris and others have alluded to is making sure that we're building the capacity of those organizations. At the same time, we're working with those non-governmental organizations to make sure the services are met. We also need to be engaging at the governmental level to have discussions around barriers to care.

I think one of the major successes in terms of engaging with governments around this was in Kenya recently where they did a series of surveys around HIV infection and using the data found that there were high numbers of new infections occurring among MSM population in Kenya. They worked with the government. The government helped with these surveys. Through this, they were able to say with this data we now

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say and we can see that there is a need to provide prevention services targeting these communities. They were able to make sure the programs then reflected the scientific data. So they used really public health and the data collection as a mechanism to engage with the government.

So I do want to stress that, we want to make sure services get to the people in need and as we talk about country ownership, it has to engage on several levels: making sure that we've got the capacity of non-governmental organizations, making sure that we're helping non-governmental organizations particularly those that are dealing with some of these marginalized communities dealing with the issues maybe governments don't want to address like gender-based violence, and then making sure that we are working with governments to make a public health case from a, because we are talking here from a

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series of health programs, I think that we're also working with partners in the larger State Department to address these issues at the political and Embassy level but from the health perspective saying here's how these contribute to barriers in health.

DEBORAH BIRX: Just a short comment on the research question that really was both in questions seven and nine. We have to not only be talking among ourselves to know what the gaps are, but to also have good situational awareness of what MRC, the EU, and other groups, Australia have invested in, are investing in, what projects they have ongoing because we don't want to duplicate key operational research. I think NIH is committed to understanding what all of those teams are bringing so that we don't duplicate research because we think it's a gap that's not being addressed.

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I think back to the capacity piece, what we have heard in country, and I think you all hear is, the importance that countries have the capacity to frame their research questions and have support in building that research capacity. I think the recent announcement that NIH has about medical schools and building capacity and this partnership will really be very important to that because it's very important that the research agenda meets the needs as the country has framed it and not presented a protocol after it's been developed, but are actually part of the development of those elements because it will change the protocol and make it more effective both at the policy level, where they're trying to create the data to give you that policy space, but also at the community and implementation level to make sure it's really answering the right questions. I think we've taken a big step forward

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in this. It's just in its' nascent stage and it needs to continue to develop.

FARLEY CLEGHORN: I have one here. Hi. I'll segue way right into what Debbie just talked about. I'm concerned that the research, I'm sorry I'm Farley Cleghorn from Futures Group. I'm a little concerned that the research agenda, which the needs that we have are for program science, for information to get into programs quickly and I'm referring here specifically to sexual prevention programs.

The kind of approach you just described, to me, sounds a little, bit slow and unwieldy and will take years. We need operations research that will take no more than a year to get results into programs. How are we going to do that? I'd like to ask about the PAG process, which actually was supposed to be fast and ended up being paralytic. What are we doing about that?

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JANET FLEISHMAN: Hi, my name's Janet Fleishman with the Global Health Policy Center at CSIS. Thank you all again for taking the time to come here. I'd like to bring us back to the women and girls centered approach for a minute and ask you to give us some more information about how you're going to learn from the lessons of PEPFAR including the challenges of integrating reproductive health, family planning, with HIV, the problems of getting appropriate guidance, those kinds of issues as well as taking it to the next step in terms of linking with some of the non-health issues, the barriers that women face in accessing care. How are you going to link with some of the broader non-health and development areas in order to increase women's access to services?

MARCIA MARTIN: Hello. I'm Marcia Martin and my question is really about the future. In two

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years, the World AIDS Conference is going to be here in Washington D.C. and a lot of people are going to come looking to see what we're doing in the U.S. and the great work we're doing in building an effective health response to HIV and I'd like to invite everybody here as well as the panel to really start to think about how we take the lessons learned globally and marry them with the ones domestically and maybe start to think about interventions that are global interventions that we could use here locally.

Specifically I'd like to ask the U.S. government representatives to consider not only global coordination, integration, and communication, but to consider talking within your own agencies about lessons learned globally in health to try to help us domestically. I'm not talking about health reform. I'm talking about

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service delivery and service integration and communication.

In many of our communities, I come from Oakland we have serious issues in health and women's health and health workforce and program and the whole package. So while we talk about it externally, I would like to encourage the Obama administration to do that balance between global and domestic. I'd encourage this audience to help us domestically bring back the lessons learned globally to our U.S. needs.

PETER LONG: I'll say here, here to that and then turn it to the panelists to respond to those three.

AMIE BATSON: On the need for sort of more rapid operational research, I think that is a major objective of what we want to achieve and this is one of the ideas behind these learning agendas and particularly the GHI-plus countries

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where we want to be ensuring that there is, where there's interesting learning that we think has great—where the government wants to define it as a priority for themselves and we think other countries would also be interested in learning from this making sure there's the right kind of M&E.

That doesn't mean we need to have sort of the clinical trial that takes five years before the data's released and anybody can act on it. It may mean we need to be doing much faster operational research where the data is provided for decision making today.

Then in tandem, we can be doing, in certain cases where it's merited, be doing very extensive evaluation to have sort of the deeper evidence base, but that it's not in every case we do an evaluation and in every case it has to be done in this way. It's really trying to think

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about this question much more behind what is the decision that's being driven here and how do we make sure that that evidence is most effectively captured for the decision makers to move on? That is the goal.

I think that there's a need, we all have recognized and we've all heard from the field and we've heard from many partners there's a need to be streamlining how certain things are done so that we can move much more quickly and more effectively and more efficiently in ways that will make a difference. This is one of the big objectives in this monitoring and evaluation taskforce that Debbie has mentioned a couple times.

On women and girls, I do think that this is a very broad issue and this is where the value of having a whole of government effort is particularly clear. This is clearly a passion of

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Secretary Clinton. We have various groups in State from Ambassador Verveer and her girls and women's office to USAID with its' broader development platform, which is addressing a number of different issues in a number of sectors, which all come back to addressing women and girls' issues to very health-specific issues with women and girls.

It's the marriage of all of those different groups with their different knowledge, their different audiences, and areas where they can affect change that I think allows us to really make a difference. So I think it's one of the very exciting elements about this whole of government approach.

ANN GAVAGHAN: To once again get concrete and respond specifically, to questions, the PAG process is one that we're looking at in PEPFAR to make sure that it is one that does deliver the

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results that we need. So we're aware of some of the challenges involved with it.

In terms of a women and girls' centered approach, I think that we are trying to learn and, from PEPFAR, we're involving multiple agencies in this effort as we're strengthening our gender pieces to then inform the larger gender work that's happening across the administration, but we have a gender strategy from the first five years of PEPFAR.

I think one of the challenges we faced is how do we actually implement that and translate that into programming on the ground. That's one of the challenges we have here as we're working to implement a woman and girls' centered approach. We've got a lot of good examples from countries and now we're trying to make them replicable and really work with the field.

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We mentioned earlier about some of the additional skills that we're going to need to provide to the field, but we are definitely looking at ways to make sure that they have the guidance necessary. We are looking at ways to support, from a headquarters level, the emphasis on woman and girls in programming.

So there are multiple things cooking in the pot right now, but we do recognize what has happened and we're looking to build upon and learn some lessons. That's happening in an interagency way.

Then I think the point about linking domestic and global health issues is an important one. This is part again of when we talk about a whole of government approach, the helpful piece of that is that you do have agencies that do have that dual domestic and international hat that are working on these things. We are trying to make

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sure that there is that communication. There is communication across the government particularly around HIV/AIDS where there's communication between the Office of National AIDS Policy and PEPFAR. I think that that is happening in broader health programs.

There are multiple examples of things that have worked that can be replicated or that we should look at the possibility of replicating from both sides - domestic to international and international to domestic. So I want to thank you for that suggestion.

DEBORAH BIRX: Yes, thank you. That was a very helpful suggestion because we struggle. I worked a long time in Kevin Fenton's Center and so we have that dialogue between DHAP and GAP all the time and trying to see what we can learn both from their innovative programs on integration that

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they've been working on and how we can learn what they've learned back to the field and vice versa.

I think the other piece of, and thank you Farley, Farley's always very direct. It's good to see you again. But I think part of that and I'm going to speak from the implementer's side, part of that is for us to take some responsibility. We've done a really good job with indicators but we need to take responsibility about the impact monitoring and kind of come together and agree on data dictionaries so we can pool our data and really have a way to learn those lessons in real time.

I think we all together, as doers, need to speak together so that we can use the same definitions and therefore could pool data across communities and districts and even up to national level or across countries. So I think the challenge is both to the PAG process, which is

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actively being worked on, but also to us to come to consensus about how we're going to measure impact.

PETER LONG: Thank you. Although I think we could continue this conversation for quite a few hours, we're at the end of our allotted time, but I've actually talked to the panelists and they'll be available to take questions individually for a couple of minutes afterwards. But with that, I'd like to thank the panelists here today not just for a great presentation and great Q&A but for the work that they're doing.

I mean you can tell that they are living and breathing this every day. I think it's critical not just to the administration and to what we're doing here but to efforts around the world. So with that, the struggle continue, a luta continua. I think as well the conversation hopefully will continue with each of you. We look

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forward to being a part of that. Thank you very
much [Applause].

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