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**A Town Hall Forum with Ambassador Deborah L. Birx
Kaiser Family Foundation
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JEN KATES: Good morning, everyone. We are able to start very promptly. This is terrific. My name is Jen Kates and on behalf of the Kaiser Family Foundation, I welcome you all here this morning. Today's event, a town hall discussion with Ambassador Deborah Birx, the U.S. Global AIDS Coordinator, is part of our ongoing effort to help inform policy discussions about the U.S. role in global health. It is also a part of a tradition of sorts. Many of you were here about five years ago when we hosted a town hall with Ambassador Eric Goosby shortly after he assumed that post.

Today we are particularly pleased to be able to welcome Ambassador Birx to the Kaiser Family Foundation for this event at which she will share her vision for PEPFAR with us. Some of you have heard her speak before but today she will really lay out, I think, for the first time, her broad vision for taking PEPFAR forward at this critical moment.

This is how the event will flow. After I introduce Ambassador Birx, she'll present and then I'll join her for a dialogue on the stage and then we'll open it up to your questions. I know this is not a shy group so we expect good questions.

Turning to Ambassador Birx, Dr. Birx is Ambassador-at-large and the U.S. Global AIDS coordinator in charge of overseeing and leading PEPFAR. I know she will talk about

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PEPFAR and its achievements to date so I will just briefly say that we know that it is one of the most successful global health programs in the world. It is the largest focused on a single disease and it has helped to turn the HIV epidemic around in so many countries. It's shown what can be done with leadership, with resources, with focus, with science, with commitment, and with being bold.

What PEPFAR has accomplished since first being launched more than a decade ago when it was hard to even fathom how the world would tackle the crisis that was the HIV epidemic, is nothing short of amazing. Of course, there remain many challenges, which we will hear about from her today and also I hope from you.

We have not yet won this battle, but Ambassador Birx has been part of it since it began. Sworn in just a little over two months ago, she is the fourth global AIDS coordinator and I am very pleased to say the first woman to hold this position. Ambassador Birx is a world-renowned medical expert. She has been working in the field of HIV for three decades since the beginning of the epidemic. This has included work at the DoD and at CDC where she directed CDC's global HIV/AIDS division and led implementation of CDC's PEPFAR program.

This has included incredible advances she made in vaccine research, in program implementation, and scale-up. This has included helping to realize the success of PEPFAR. In

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addition to all of these accomplishments, and please read her bio which has them there, for those who have heard her speak and those who will today for the first time, what comes through is an incredible passion and personal commitment to combating HIV, to people affected by HIV.

This to me is the key ingredient in addition to all the political commitment, the resources, the science, and all else, what we have seen time and again really makes the difference in the fight against HIV. With that, I want to welcome Ambassador Birx to the podium to share her vision for PEPFAR. I want to thank all of you for being here today and thank her team for making this possible. Thank you. Ambassador Birx?

AMBASSADOR DEBORAH L. BIRX, M.D.: Great. Thank you so much, Jen. She's the only person I haven't interrupted because everybody knows I like very short introductions. Out of deep respect for Jen, I didn't get up halfway through and interrupt her introduction.

I just want to say Jen also illustrates that one person can make a difference. I think those of you who've watched what she's able to do, and help us, and support all of us in our global fight, the ability to put up data in compelling ways that have actually changed policy and investment structures. Thank you. We are all deeply grateful.

I wanted to talk to you a little bit today about the third phase of PEPFAR and talk to you about what success means

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and how it means that we are going to deliver the right thing in the right place at the right time and show how we're going to achieve success with success being towards and AIDS-free generation. I'm passionate about the possibility of achieving this goal.

I'm reminded - and those of you who have heard me talk know that I've talked about President Kennedy and being already a little nerd and hearing about him telling us we were going to the moon. No one questioned that. I brought my props. This is what I had. These were my slide rules. This was my travel slide rule. This was my at-home slide rule. This is my SAT and serious test slide rule. Yes, it came in a leather case, could be personalized and could attach to your belt buckle. I had everything.

This is what we had and we said we were going to the moon. To say that we are going to control this pandemic, to me, is equal to that but possible. I just wanted to go through today some of the ways that we are approaching this now and talk to you a little bit about our past. I know you all remember the AIDS crisis. Some of us were in the halls of Walter Reed watching soldier after soldier die with absolutely no ability to do anything. It was humbling.

I was part of the, yes, I did get a calculator my sophomore year of college. It was 159 dollars from Sears. It was expensive. We believed that we could do anything and do

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all that was possible. I went into medicine thinking about the high-tech CT scans and our ability to control cancer, our ability to absolutely diagnose and have chemotherapy for childhood leukemias. We had the war on cancer and we thought we were winning.

Into the ICUs came dying soldiers, 25, 30, 35. When we had the first HIV test, there were then 10,000 and still nothing. I remember we did the first trial of Fansidar. Many of you may not even know what that is. That was before we knew about Cotrim and how you could control pneumocystis pneumonia with Cotrim. I can tell you when each drug was developed, the nukes, the non-nukes, and finally the protease inhibitors in 1995 when our patients could finally go on triple drug therapy.

Many of my patients who survived to 1995 are alive today and showed the power of combination prevention, combination drugs for treating disease. Translate then years later and I was working in Africa. In Africa in 1998, the pandemic was expanding quietly, silently, without recognition globally. For those of us who were privileged to work in Africa in the late '90s, doing research, when outside of our research laboratory, thousands of patients were dying, turned away by the nurses and physicians in the hospital; not because the nurses and physicians weren't compassionate but the nurses and physicians knew that they would be back two days, five days, 10 days later, and die in the hospital.

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It is a very exciting time to recognize PEPFAR and the announcement of PEPFAR. This just goes through the history, some pictorial of how we finally came aware as a global community about the death and devastation that HIV had wrought on the continent of Africa and in many other places around the world. At that time, we had 10,000 new infections daily, 10,000 new infections every day. Yet there were only 50,000 patients on treatment in sub-Saharan Africa, some of them on bi-therapy, some of them on monotherapy.

Patients were doing anything to get any drug. When PEPFAR and Global Fund were announced, the despair was transcended to hope and we stand at a very different place today. Now we're in a footrace, a footrace between complacency and hope and control of this pandemic. We all know about the life expectancy declines and the amazing transformation power of PEPFAR. These just go through the stages of PEPFAR, from the emergency response when President Bush announced 2 million people on treatment. It was a scary number. It was an incredible number. It was thought to be an impossible number. Through the power of the partnerships with the countries and with the agencies, utilizing the power of USAID with its long-term history on the continent, the technical addition of the treatment parts from CDC and HRSA, together we were able to tackle this pandemic by treating one patient after another and

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preventing infections in others. It brought together DoD, Peace Corps, USAID, and CDC in a new and different way.

Under Ambassador Goosby, we made incredible progress towards sustainability, bringing forward partnership frameworks and partnership frameworks' implementation plans, a new way that the U.S. government worked in direct partnership with countries every step of the way, determining the strategy and sharing in the success. What will we bring with PEPFAR 3 where it's continuing to expand on Ambassador Goosby's vision of sustainability and shared responsibility and adding additional quality, oversight, transparency, and accountability for impact.

You'll be able to see some of these as we go through it today as well as accelerating core interventions that we know will lead to epidemiologic control. This is where we were. That peak of that large blue is the large peak in sub-Saharan Africa of new infections. You can see now we have halved that.

This was the change in life expectancies. This is what drew us all to thinking about this in a different way and a complete call to action was this incredible drop in life expectancy throughout sub-Saharan Africa as mothers, fathers, teachers, physicians, nurses, and parliamentarians succumbed to this disease. In our own U.S. embassies throughout the continent, our host country nationals were dying from HIV/AIDS and we didn't have medication to treat them. On the forefront

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of that were U.S. ambassadors who fought for comprehensive care and treatment for their own staff.

Now, I am often asked where would we have been if there wasn't a PEPFAR, if there hadn't been a global response, if there hadn't been Global Fund, if there hadn't been this attention. We would have been on that blue line. We have halved that blue line in just a decade. Where would we have been with new infections? Epidemics often have a bimodal curve, sometimes multiple peaks. Often the second peak is a little bit less than the first peak and we were headed to a second peak. We are on that blue line now, showing the number of new infections down by nearly a half.

Also, importantly, the economic trends among ART patients show that we've not only returned patients to health but they've returned to the full workforce and productivity and can drive forward the economic development on the continent.

We were just in Durban a couple of weeks ago and I was watching CNN International and they had African voices on and they talked about how in the next decade sub-Saharan Africa will have the largest productive workforce on the globe. We all have celebrated these great successes of PEPFAR, from 6.7 million women, men, and children on life-saving treatment. Secretary Kerry announced just almost a year ago that the one millionth baby was both HIV-free. We're now up to nearly 1.3 million babies born HIV-free.

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The 4.7 million men receiving voluntary medical male circumcision services – when President Obama announced our new targets in 2011, it again was frightening because we were doing maybe 100,000, 150,000, 200,000 circumcisions a year. Within two years we had to get to 4.7 million. I tell you I was a little bit shocked that we made it. Again, it was this coalition of people who believed and did everything possible site by site, program by program, country by country to make this happen.

We also achieved our goals around pregnant women and reached key populations. We have a budget scenario that we are dealing with. Within this budget confines, you can see that we continue to expand all of the services, our service to orphans and vulnerable children, our counseling and testing, our care, our treatment, our testing.

What are the core activities? What is the right thing? What does science tell us we need to do to achieve an AIDS-free generation? Well, we know combination prevention is important. We have multiple papers now that demonstrate its importance. What does that mean? That means PMTCT prevention and mother and child transmission, treatment, condoms, voluntary medical male circumcision and all the wraparound key messages for prevention for the HIV-negative and positive patients. We also know that we need to enhance our effective prevention

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interventions and ensure they are targeted to the risk groups that are most vulnerable, most susceptible.

What are those and where do we still have gaps? We know that there's neglected and hard to reach populations. We know that we have not achieved where we should be with pediatric treatment. We know that adolescent and young girls remain, as well as young adult women, very vulnerable to this disease with incidences that are four and five times those for young boys and young men.

We know in this time, in this age, with the issues occurring on the continent and elsewhere around the world, including Eastern Ukraine; being able to reach men who have sex with men, transgenders, sex workers and people who inject drugs has become more difficult. That means we just need to do more. We also know that we need key and strengthened health systems in order to be effective. Sorry, those slide rules were driving me crazy. I've kept them with me for 40 years. They go wherever I go.

Progress has been unequal. We've been looking country by country, subnational level by subnational level, to look at what defines success and how we have found countries that have either succeeded in beginning to control the pandemic and those who have not. I think it's helpful to pair them side by side. This is Malawi and Mozambique. Both have the same basic degree of epidemic. Both have an HIV-C type epidemic, similar HLA

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types. If you looked and said are the people different, are the virus different, they are not. Yet you can see the deaths in the red line and the new infections in the blue line are dramatically different between the countries.

If you look at what Malawi did, Malawi effectively scaled combination prevention even without all of the tools, without a perfect health system. They said, we are going to go and we're going to achieve greatness, and they have. Mozambique has had delay in their scale-up of combination prevention and you can see the impact it's had both on new infections and deaths.

West Africa remains a conundrum of lack of success for all of us and we need to continue to focus here. You can see in both Nigeria and Cameroon we have continued to have expanding number of HIV new infections as well as deaths. Now, if you compare Kenya and Uganda, really a tale of two countries, Uganda, for all of its early success as measured by the blue line that you can see, reached a low in the late 1990s, and the re-expansion of this pandemic, and again illustrates the importance of leadership and daily concentration and focus on what you're doing to control this pandemic.

What are the right things? The right things are delivering them in the right place at the right time and we must focus again on those elements that are absolutely core to

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controlling this pandemic. You saw our budget slides. You saw where we are with flat funding. In order to achieve successive gains, we must focus on the core and the near core.

I want to just illustrate a country that went through this deep discussion of what is core, what is near core, what is the geographic focus, and that began two years ago in Uganda. When we saw the rising incidence and prevalence, we all got deeply disturbed. The country and the country leadership, from the scientists in the country as well as the USG program, within the same budget scenario, refocused the program and nearly doubled the number of people receiving ART.

You can see by the purple lines the significant increase in the rollout of B+, a prevention of mother to child transmission. The first lady of Uganda went from village to village, community to community, leading this effort and again rallying cry to both protect mothers and protect their babies from HIV. This is what happened with voluntary medical male circumcision. The reason we were able to get to the 4.7 million was a country like Uganda that focused within its budget constraints and expanded these core programs.

Ethiopia, which is beginning to have containment of its pandemic, now has sites that no longer have HIV and no longer have any women presenting with positive HIV. This again speaks to the geographic focus of the right place. We need to be looking at every single site and ensuring that we're maximally

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moving to the sites with the highest yield and move away from the sites that have fewer and fewer HIV-positives. This is an exciting result and this calls for preparing for success in countries that begin to control the pandemic.

Just going to go through a series of countries very quickly to show how we need to focus at the right place at the subnational level. This shows the red. The red areas are the areas of the highest HIV prevalence. The country went through an expansion analysis and have targeted the red areas followed by the orange areas followed by the yellow areas, realizing that they will decrease transmission at the communities as they saturate those communities with lifesaving treatment.

In Nigeria, the same analysis has occurred and you can see by the blue bars the number of people living with HIV in each of those different states and you can see the treatment coverage for those states, which is extraordinarily low. You can see that we have decided to focus on the highest burden states shown in the stars.

Doing the same thing in Tanzania, to really look at what the national HIV prevalence is, about 5.1, and look for the areas that still need focus for interventions, of prevention, care, and treatment. The same thing in Kenya, so each of these have different data coming together. The data is linked in what we call AIDS indicator surveys where you go community by community, household to household and look at both

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HIV prevalence and incidence as well as service delivery coverage.

Key areas and key populations that have remained behind that we have to also focus on. This story from UNAIDS of young women in sub-Saharan Africa compared to young men is a story that should take us all back and remember the early days of the pandemic and realize that this rate of incidence and prevalence in young women is unacceptable and it's throughout all of sub-Saharan Africa, no matter whether they've had some control of the epidemic or not.

Indeed, if you translate this into actual numbers of women infected, 7,000 new infections per week, 7,000 per week. We know that parts of the issues that make young women vulnerable is a biological part of an immature cervix. We also know that violence and violence against children surveys which point out this number of young women who report unwilling first sexual intercourse prior to age 18, it's this data that will lead to the changes in the policy and the legal framework that we need in order to protect young women. We know that young women that are under sexual violence or any type of violence, that they have a four times increase in STDs and HIV.

This is the pediatric issue that I want to just briefly highlight for you. We can see that there, in many countries, the children are being reached at half the rates of adults.

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Even though often their mothers are in the clinic, the children are not getting tested.

Speaking to concentrated epidemics, we understand that we still have work to do in reaching populations and ensuring linkages to care and treatment. We have a team focused very much on this strategy as well as ensuring that we prevent new infections. Indeed, the prevalence among sex workers also dramatically different compared to the population and this work, no matter where it is, in sub-Saharan Africa or around the globe, needs continued attention.

Finally, men who have sex with men. In our issue of human rights and access that needs to be addressed not yesterday – well, it should have been yesterday -- but today. Today, it's an emergency now. Today it's an emergency because we know if any one of our populations are left behind, if any one of us is left behind, all of us are left behind and we won't control the pandemic.

You all know that lesbian and gay rights in the world are under threat in all of those red and orange areas. In our own hemisphere, there are legal frameworks against gay and lesbian marriage as well as sexual relations. This is translated into a fear for our MSMs to access healthcare. It has resulted in MSMs afraid to be in their communities. I know you've seen slides from both Louise Lords and from Michel Sidibe showing in Uganda spray-painting on their houses and

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telling them to leave. We know that MSMs have been blackmailed and we know that they have been beaten up. This leads to an absolute barrier to public health access of services.

In summary, I've taken you through the right thing at the right place at the right time. What does that exactly mean? The right thing are the core interventions. The right place means we have to focus more geographically as well as to the most vulnerable populations and the right time is that an expanding HIV epidemic is not financially sustainable. We cannot afford as a globe to have this epidemic continue to expand in a whole series of these countries. That is not affordable and never will be.

We need to focus now to prevent new infections in the most vulnerable and focus in the high prevalent areas and ensure the full implementation of the WHO guidelines. We need to map the impact at the community level so we can assure our programs are successful. What is the vision moving forward? Well, you've heard it. That's the framework. What does that mean? Well, our pillars are around accountability, transparency, and impact. Why is that important? Each and every one of you that are here listening today and many of you who are watching on the webcast provided us critical insights from the field and critical information about how we should move forward. You did this not even knowing all of the theses about our program.

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We are committed to having a more transparent program and having our data available to you at all times so you can help us do it better. You should be able to go to the PEPFAR.gov site right now and see all of our budgets posted by countries, by budget code over the last 11 years of PEPFAR. We will then put up the results and then we will put up our quality measures in a serial way. We hope to have the results up by the fall. We are committed to having everything available to you all so you can help us do more.

Our five pillars are this impact agenda and that is clear evidence on a geographic and country by country manner that we're controlling the pandemic. The efficiency agenda that was started under Ambassador Goosby with the expenditure analyses will continue and will expand down to the site level. The sustainability agenda is very much focused on our partnerships with countries and in the global space to ensure that we've maximally coordinated with the country for all aspects of the pandemic and the strategy.

An expanded partnership agenda to ensure that we move forward lockstep with the Global Fund. Now, I think many of you know Ambassador Dybul. He is committed to this. We're committed to this and we will make this happen together to ensure that every U.S. dollar, whether it's invested in the Global Fund or whether it's invested in this bilateral program,

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have maximum impact. Finally, our human rights agenda focused on securing, protecting and promoting human rights.

In light of time, I'm not going to go through each one of these. Behind each of the agenda items we have defined what success looks like and the roadmap to achieving it. I've just distilled a few things on these slides. Part of this transparency and efficiency and effectiveness agenda is this new interagency collaborative announced by Secretary Kerry and is on his YouTube website at state.gov. He announced it two weeks ago at our meeting in Durban.

This is bringing together the agencies in a new way, bringing together USAID, HHS, Peace Corps, Department of Defense, SGAC – that's our home – and the Millennium Challenge Corporation to analyze data, improve quality, and save more lives. We can talk about this more if there's questions. It will be real-time analysis of expenditure data, site level quality data, and routine monitoring and evaluation data. This is the part that will be available on the website. The sites will be masked. You will see it's a site but you won't know who that site belongs to, whether it's a USAID site or CDC site. Each of the agencies will know their sites but you will be able to see the performance down to the site level.

The sustainability agenda is really expanding our government's models and increasing countries' fiscal contribution. Right now, we're working on seeking a principal

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deputy with experience in the World Bank, African Development Bank, or Department of Treasury – to really make the business case for countries, to have the clear business case of an expanding epidemic is not fiscally sound, and what it will take and what it will cost to contain it, and how the out-years then become "handle-able" and cheaper.

Our partnership agenda to work more effectively with people who are living with HIV/AIDS and civil society organizations, no matter where we go in the world, no matter when it is, we always meet with civil society. We had a great meeting Sunday last time I was in Geneva and we had a great meeting in Southern Africa with some groups in Johannesburg. We are committed to this as well as the faith-based organizations and working more effectively with the Global Fund and the U.N. family as well as the private sector.

Finally, the human rights issue. This could overwhelm our ability to be successful. We all have to realize this and collectively around the globe we need to address this issue and ensure that all people know that we're devoted to the public health delivery of services to everyone. This is a human rights issue and that we need to approach it that way.

This week, while you go through your work week, know that 4,000 babies were born infected, 7,000 young women were infected, and 24,000 people died in Africa. There are people who believe this pandemic is over. They believe that we have

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achieved all that can be achieved. We have saved lives. We have begun to change the course of the pandemic but we are not done and I'm reminded that Nelson Mandela said, "It seems impossible until it's done."

Every single target we have had seemed impossible until it's done. Controlling the pandemic may seem impossible but I think it can be done. That's where each of you, every day, and all of you that are listening on webcast need to be focused and committed to this goal because we can do it and we can do it together. Thank you.

JEN KATES: We're resorting to old-fashioned technology here as well with a watch. Thank you so much. It was really terrific to hear you lay that out and I think none of us have been able to hear that in one moment like this. In the interest of time, I'm going to start with just a couple of questions.

AMBASSADOR DEBORAH L. BIRX, M.D.: Great.

JEN KATES: Get some of those out on the table and then I'm sure—

AMBASSADOR DEBORAH L. BIRX, M.D.: —because this group looks excited about questions.

JEN KATES: Yeah, I don't think we're going to have problems getting — soliciting questions from the audience today. One question that came up, you mentioned it, and it's certainly top of mind for I would assume a lot of people here,

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is funding. If you look at the – and this is something we analyze as well at Kaiser and you look at the funding for PEPFAR, the bilateral funding isn't really just flattening. It's actually on threat of decline. It's not all about money. You've shown that. We know it's not all about the amount of resources but money does matter and it's made a huge difference and we haven't ended the fight. How can we go forward? What does that mean for PEPFAR? What does it mean for the relationship with the Global Fund? I know these are hard things to answer but I know it's on top of mind for everyone, particularly in the last week or so as the Congress is considering the current budget.

AMBASSADOR DEBORAH L. BIRX, M.D.: Well, thank you. I will say we are pleased with the House mark and excited about that. I think you can see why we're under so much pressure to focus, to focus geographically, to focus how we work and to focus where we work and who we work with because there really are clear budget constraints. We need to do everything we can to ensure that every dollar is maximized, whether it's our dollar in the bilateral program, whether it's the country's dollar through their programming or the Global Fund dollars. We're absolutely committed to that.

What does that mean? Well, these are words and they have to be translated into action. We've actually formed a task team to pick the five top countries to work intensively

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with the Global Fund on. We did that for Ethiopia. We did it through Nigeria. We did it through Uganda and it was spectacularly successful. That took us a year and now we have to do many countries in a shorter time period.

Yes, we learned how to do it but it still takes human capacity and it still takes focus so that people are focused on this every day. I think with the delay of the concept notes coming in, we are absolutely committed to deploying teams to work closely with the Global Fund and the country to ensure that those Global Fund concept notes are written as best they can be. I think we all know that we wanted a 15 billion dollar pledge. We needed that. We needed that to control the pandemic. We have 12, so we need to work within what we have to ensure that we are focused the best we can.

This is not going to be something that the U.S. government alone does. It needs to be done absolutely in partnership with the principal recipient from the Global Fund and with our colleagues in UNAIDS and WHO.

JEN KATES: Related to that issue of funding and how we best allocate the funds is of course what Congress wants – how Congress wants the funds to be allocated. One of the issues that you've pointed out and also has been pointed out on the Hill is the 50-percent PEPFAR care and treatment earmark in a sense and how that needs to be met. It's legislatively mandated. What does that mean for programs now? I know

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there's been some discussion in the community around how do we reach that quickly but not sacrifice the ability to do all of the other things that you said. Where are countries in thinking this through and working with you on that now?

AMBASSADOR DEBORAH L. BIRX, M.D.: When the countries came in, the series of countries where we had had the intensive work, Nigeria, Ethiopia, and Uganda, were well over the 50-percent earmark. We think when countries focus, they naturally get to that. What about the other countries? Well, we worked very closely with the countries over this last four weeks because we didn't have a lot of time, as you noted. It just came two months ago. Our country operating plans had just come in. They were finished. They were finalized. When a country has finally hit the send button for those 750 or 1,000-page document, the last thing they want to hear is now they have to go back and revisit it.

Countries did go back and revisit it and most of the money that will go into the new earmark was actually moving budget codes. Now, what does that mean? That means if our extraordinarily successful SCMS partnership with USAID, which is delivering the drugs and commodities, they were putting the actual delivery of the drugs and commodities -- I'm just giving this quick example. Don't worry. I'm not going to go on and on about drugs and commodities at the site. They put the delivery, they put the cost of the drugs and commodities in our

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budget codes for drugs. They put the cost of actually getting the commodities to the site that needed the commodities under health system strengthening because they were working with the country to strengthen the health system.

We moved that piece into the drug code to create a continuum. We moved both the buying of the drugs as well as delivering the drugs into the drug code. In our other prevention activities, we were very serious about linkages and the continuum of care for everybody who's HIV-positive. There was continuum of care and treatment numbers in the other prevention because it was a continuous program. They divided that up and put them into the care and treatment budget code.

Right now, somewhere around 65 to 80-percent of the achievement of the earmark will be with this reorganization. There are still countries, as I've noted, out there that are stalled in their performance and stalled in their ability to control the pandemic. Those countries we're looking at very carefully to see whether they need to have an augmentation in funding into care and treatment in order to successfully contain the epidemic. If they've agreed to roll out B+, can that be strengthened? Those are ongoing right now. I have every confidence that we will reach the 50-percent earmark. It's still in process and will probably be in process for another four weeks.

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We did not – and we made it clear that the orphans and vulnerable children earmark could not be altered in any way and that we were reassuring with the COPs that came back in after the realignment that the actual funding, millions of dollars contributing to orphans and vulnerable children, actually went up. We know that that was not altered in any way by the teams.

The good news is, is we had the COPs as they submitted them. I can be able at the end of all of this to show you exactly where the dollars came from, what moved and what the consequences were. We're actually in a good place because we're going to have the before and after. We don't often have that. If you ask the country, they would prefer not to have a before and after and just a before, but because of where we are, we have both.

JEN KATES: –which I'm sure answers another question is will the COPs be made available. It sounds like they will. A couple other questions from me, and please get your thoughts and questions ready. On the human rights challenge, one of the statements you put out, I think, it was right after you began, probably week one or two, I thought really highlighted where we are from a public health perspective.

That sometimes has gotten lost in the discussion from my perspective, that it's such a challenge right now with rising anti-LGBT laws and sentiment in some places and in places there are key partnerships for the U.S. and there seems

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to be from our view a lack of understanding of how do we tackle this. It's not that easy.

You put out I think a strong statement around public health. I was wondering if you could just highlight what you meant and what you were trying to say in that statement a little bit more. You started to with the slides. What is it that we need to remember and focus on and what, in a sense, have we been doing already with PEPFAR for the past more than 10 years in that regard?

AMBASSADOR DEBORAH L. BIRX, M.D.: As you all know, it's gotten incredibly difficult for our partners in the field because we had -- really, Ambassador Goosby had -- launched a strategy for key populations and we were actually making tremendous progress. We had men's clinic in the evening in Uganda. We had access sites. We had places where people could go where they felt comfortable. Now, we know that those need to be done for young women also because young women are often terribly stigmatized when they go to the clinic. We know with our populations and our MSM populations we were making progress.

Now, every one of those sites in Uganda is fearful. The staff is fearful. The patients are fearful. They're fearful that they'll come the next time they need medication and the site won't even exist because it will be closed down. We are working very closely with the ministers of health. I

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have to say they strongly agree with us and the approach that needs to be taken. But they're ministers of health. They're often the weakest ministry in these countries. When they say we need public health and human rights and we need access and it's a problem, it often falls on deaf ears.

We have to figure out how to make that argument more effectively and how we move back. For those of us who were part of the early pandemic in the early '80s and watched this happen in our own country, I mean, I was in the military. The stigma and discrimination in the military was deep and shocking. We moved past it. But it took us almost 30 years. We don't have 30 years.

Figuring out how you speed that up and how you approach this to keep people focused on what the real issues are as well as how to continue to deliver lifesaving services, we believe these laws are unjust and the United States believes they're unjust. Right now we have to ensure that people have access to services while that works through the legal framework. It's not just Uganda. We know it's in Nigeria. We know there's a whole series of countries that are under threat. There have been incidents in Kenya. There's been incidents in Tanzania. There's been incidents in Malawi. Every one of these countries are a threat.

There are people who think, oh well, it's just that population. If people feel like the sites are insecure, no

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one's going to come to those sites. No one will come. This is not a question of just all of our key populations not having access, which is bad enough. No one will feel safe in that country.

We're trying to reach young women too and young women will not come if they feel like they're going to be stigmatized like all the rest of them. They feel like when they come, the aunties sort of yell at them or why would they need condoms, they're 18. I mean, these are issues we thought we were getting ahead of and to have this setback should be disconcerting to all of us.

JEN KATES: I have more but let's go to our audience. The way we're going to do this, we're going to take three. So please raise your hand. We have folks with mikes. They'll give them to you, identify yourself and ask your question and please try to be clear and short.

AMBASSADOR DEBORAH L. BIRX, M.D.: Jen's going to remember them.

JEN KATES: I am.

AMBASSADOR DEBORAH L. BIRX, M.D.: Because for those of us who knew slide rules, three might be too many for us to remember, just saying.

JEN KATES: Yeah, okay, so we have one over here, two and someone in the back. We'll start with Matt. I am going to remember them.

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MATT KAVANAGH: Hi, I'm Matt Kavanagh from Health GAP. Thank you so much for all of these slides. They are incredibly clear. We were very excited to see some of the transparency pieces coming forward because, as you know, we've been working for years trying to figure out exactly what was going on inside PEPFAR. It's so refreshing that that will be clearer.

I want to express a worry, right, which is, you kind of talked about ART scale-up and we've seen quite a bit of it and yet we're still only about a third of the way there where we need to get to in most PEPFAR countries. I'm worried about a specific piece which is there's an increasing disparity between north and south that's kind of rearing its head which is when do you get access to ART. In Washington, D.C., you walk into a clinic. You're given the option to start ART immediately. If you walk into a clinic in Harare, you're told go home, come back when you're sick. We know 30- to 70-percent of the people never make it back. A large portion of them die in the process.

This is a big part of our 2 million deaths. We also know that these are known people living with HIV who we're sending home with a high likelihood that they will infect somebody else, despite their intentions. It seems critical that PEPFAR figure out how to go faster and cheaper but also dramatically expand ART over the coming years. I'm worried

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that that won't be possible given budget frameworks and given all of the other things.

How are you thinking about how to tackle those things? In countries that are ready to go fast, how can PEPFAR help strategically leverage other funding but also use your own funding to make it possible so that it's not do everything at once but it's very strategic. Thanks.

JEN KATES: Okay, that's one. I think over here?

JILL GAY: Jill Gay, What Works Association. My question is, given the focus on adolescent girls, how do you plan to infuse gender within the core activities and how do you plan to enforce the December 2013 PEPFAR gender strategy?

JEN KATES: Okay, and last question for this round?

PAULINE MUCHINA: My name is Pauline Muchina. I'm from Kenya and I was glad to hear you say that the first lady of Uganda helped a lot with PMTCT. The U.S. government just issued sanctions, which will affect the ministry of health in Uganda and will ultimately affect what the first lady has been doing with PMTCT. I do not agree with the law in Uganda against LGBT community. I am concerned by the way the U.S. has responded to it and especially because the sanctions they just applied will not only affect Ugandan officials. It will ultimately affect U.S. response on HIV in Uganda.

I'm just wondering whether antagonizing that government is really going to achieve much rather than being more

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diplomatic in the approach and keeping the PMTCT law as it is right now or are you going to stop working with the first lady? I'm concerned that it's not just the approach that will solve the problem and at the same time I want to see that problem resolved because human rights violation is not acceptable in any way. How do we address it?

In your capacity as the ambassador, how are you going to ensure that women and children in Uganda as well are getting the services they need through the ministry of health? I don't know. I would love to hear your views on that. Thank you.

JEN KATES: Do you want me to summarize these three?

AMBASSADOR DEBORAH L. BIRX, M.D.: I think I've got them—

JEN KATES: Got it, okay.

AMBASSADOR DEBORAH L. BIRX, M.D.: —although it'll be tricky.

JEN KATES: Alright.

AMBASSADOR DEBORAH L. BIRX, M.D.: Okay. I think you're asking, Matt, about targets and focus and you notice I didn't talk about targets. I am deeply devoted to President Obama reaching a clear definition of the targets.

The targets will be related to these things about the right thing in the right place at the right time with a geographic focus. How do you do more and control the pandemic with the funding envelope that's either stable or declining? I

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think the way you do that is you have to focus the way Mark is talking about hotspots. I think hotspots could be stigmatizing. I've gone to the right place and consider that we have to go to the right place.

Making sure that like they did in Ethiopia and like needs to be done, we need to have at a subnational level and hopefully eventually at a district level – I had a very exciting conversation while I was in Durban with the permanency secretary or the director general, Precious, who talked about they have 13 districts out of the 52 that account for almost 60- to 70-percent of the new cases.

Ensuring that those sites are flooded, what does that mean? That means we have to figure out how to have the human capacity and all of the requirements at those core sites. That may mean that other sites that are very low prevalence shift resources, instruments, CD4 cell counts and capacities. If you're trying to do more with less or equal, you've got to shift your resources to those places.

I think we're intent on doing that. We're just starting that analysis and that's why we want to get the targets right. It's going to take us a bit of time going through the subnational data, looking at coverage, looking at need and ensuring that.

I think there's now an amazing commitment at the level of the senior ministries officials to take that same approach.

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That's extraordinarily exciting because I think many of you know that many countries took a more distributive approach. Drugs often went where there weren't people to be treated. This will actually concentrate human capacity, commodities, and laboratory where the most need is. We have to see if that's achievable and I know you'll hold us accountable to make sure that that is achievable.

Okay, gender. Glad you asked that question because at the end of this next month, in the end of July remember I mentioned really quickly and I'm sure I went through way too quickly - in this interagency collaborative which is bringing together the quality analyses, there will be key indicators for gender that will be evaluated and enforced down to the level of a site, whether it's a community, whether it's a subnational level, whether it's a district to ensure that the gender strategy is being implemented.

They will be working on the metrics that define that so when the people go out to the site they will be measuring those specific adherents to the gender strategy to ensure that there's quality programming.

The same will happen with our OVC programs, our prevention programs and our care and treatment programs to really ensure that these strategies, which are extraordinary - our new OVC strategy is extraordinary. We want to make sure that they're fully being implemented. We're sure they are.

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We're not sure that they're all being implemented perfectly in every site and we'll be looking for that through this strategy.

The third one on Uganda, the first lady was very critical in the rollout of B+ and I think it talks to the leadership of not only the United States but in many of these countries on confronting HIV/AIDS. Without President Obama at World AIDS Day in 2013 getting up again and reaffirming the depth of his commitment and to be able to work for a secretary who wrote a global legislation even before PEPFAR – Secretary Kerry is deeply devoted to PEPFAR and Secretary Clinton wrote the blueprint.

It's a privilege to work for secretaries that are completely focused on this agenda. The current secretary is willing to take on hard things, really hard things and understands how hard this is going to be but he hasn't turned away one millimeter and he's in Baghdad today. This is a man who really is committed.

On the other hand, what Uganda has done is opposite to all of our values in the United States. There had to be a very clear statement. We've put up statements ourselves about this. President Obama's committed to these statements and I think this is saying to the leadership of Uganda that this needs to be addressed at a leadership way.

At the same time, we're committed, and I've talked to Ambassador DeLisi who is the U.S. representative in Uganda at

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the U.S. embassy. He is deeply devoted to ensure that the people of Uganda receive the services and expansion of services that are key to saving lives as well as turning the course of this pandemic. It's a difficult situation. It is suboptimal. It could be so much better.

I think Ambassador DeLisi is also working on the diplomacy piece. He works on this every day at every level of government and we're trying to provide everything that we can from our side about analysis and site level information. I think there's been such great communication between the LGBT community and Ambassador DeLisi. It's something we watch every single day. It's taken very seriously by this administration and we hope it's taken seriously by the government of Uganda.

JEN KATES: Okay. We have one here, there and there. We'll come back to this side.

FARLEY CLEGHORN: Thanks. Debbi, that was almost perfect. Farley Cleghorn from Futures Group. You mentioned the collaboration between the implementing agencies of PEPFAR, and there are nine of them. I feel confident that you of all people will be able to drive that collaboration. Very often in the field, the atmosphere is toxic, to be frank. Any of the implementing organizations actually work for more than one implementing agency. My question is how are you going to drive that through your tenure?

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JEN KATES: Good model of short question, to the point. Next. I think it was Janet back there and then we'll come over here.

JANET FLEISCHMAN: Thank you very much, Ambassador Birx. My name's Janet Fleischman with the CSIS Global Health Policy Center. I was glad to hear what you were saying about the new gender strategy. I wonder if you can speak more specifically about some of the particular initiatives that PEPFAR has taken, the GBV initiative and the new FP/HIV integration initiative. These have been very important ways that PEPFAR has tried to turn this into programming on the ground and I wonder if you could speak about how you're building on that, how you're strengthening those and what new initiatives we might see particularly focused on adolescent girls. Thank you.

JEN KATES: Okay, and last question this round, right here.

TIM BOYD: Hi, Tim Boyd with AIDS Healthcare Foundation. I was wondering if you can clarify your comments about the 50-percent contributing care-funding floor. You seemed to be indicating that PEPFAR is having some difficulty meeting that and I was wondering given the international consensus on treatment, there was 15 by '15, 20 by '20, given HPTN052 and the care continuum, shouldn't 50-percent on

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treatment be a given? If there are difficulties in hitting that floor, what are they? Thank you.

AMBASSADOR DEBORAH L. BIRX, M.D.: Okay, great. I think many of you know this is my fourth agency. I have been in Department of Defense, NIH, CDC, and now State Department. I will tell you when I was in the Department of Defense and took over the military program, I was told to bring the Air Force, Army, and Navy together to create a universal DoD research strategy and a strategy that we could all embrace. If you think there's problems between the agencies, let me tell you, the services are amazing, amazing. They tried to do everything to keep the services together.

What did they do? They developed the Joint Chiefs where people, where the agencies or in this case the services, come together on a unified mission to execute a priority. I think the great thing that we have right now is we have amazing shared vision between the agencies and I'm excited about that because that's the starting point.

How does that translate? Well, we've had great meetings with all of the agencies. I think what we're also trying to do is to tap in deeper to the agencies because that was the part that we used with the services to bring them together is recognizing unique talent and bringing that as a solution.

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We've asked each of the agencies to come forward with what do they see as a huge gap within PEPFAR and how they could provide a solution. Each of the agencies have come through with amazing solutions. USAID came forward with an innovative health financing solution that we're really excited to invest in it. CDC came forward with an impact agenda. Peace Corps came forward and said we will be your eyes and ears and go to the district level and the health center clinics with our tablets as far as site monitoring and report on essential commodities and whether they're available or not.

We're working closely with the DoD on their initiative. Everybody else got to volunteer one and I had an idea for the DoD so poor DoD is in a dialogue with me right now. We're making progress slowly. How long will that take to translate to the ground?

The other thing is, to be honest, this interagency collaborative – you're going to have trouble finding the people in the country because U.S. government personnel are going to be out at the sites. They're going to be out at the sites working with the implementing partners doing site monitoring and together coming together both at headquarters and in the field and sharing what they found. I think when people are all focused on improving their activities, hopefully, people will get along. I think it's possible. We've done it before. I hope we could do it again.

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Administrator Shah has been amazing. Ariel has been there every step of the way. He's provided me clear feedback. Every single thing that comes up, we don't agree on, but we talk through it. We work through it and I think - I'm hopeful. Give me feedback of how it looks on the ground because that's the bottom line is - we know you share partners. We know that some of you are partners to both CDC and USAID and we know it's not always easy.

Now, we don't have time. We really don't have time. I hope I've left you with that message. We don't have time for this because we have to be focused on containing this epidemic because we're given a window. We're given a window and there was complacency in the U.S. There will be complacency throughout the globe.

If tomorrow our patients who have been side by side with us, who every morning get up and take their pills, decide it's not worth it, the clinic's too difficult, too stigmatizing, don't want to walk that far, and they stop their medication, we're not going to have 1.2 to 1.5 new infections; we're going to have 10 million new infections. We have a collective moral obligation to get past these issues and work together in a positive way. Was it gender that someone said?

JEN KATES: Yeah, gender.

AMBASSADOR DEBORAH L. BIRX, M.D.: You saw the gender-based violence surveys. Those have been extraordinarily

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helpful to be able to work with governments about legal framework and policies that are affecting young women. We're committed to continuing those but also committed to actually going in at the national level and subnational level during the site monitoring to ensure that those actually are being implemented because it's one thing to change the legal framework. If the police don't implement it, it doesn't help any of us.

You brought up also the family planning, the integrated family planning project. This is another piece that will be monitored at the site level because when women make that long trip to the clinic and they have ARTs but not the family planning commodities because they're stocked out, to expect her to make another round trip to the clinic is very difficult.

I think we're very much committed to see that both of those pieces are there together because I didn't really get to highlight it in this talk. Obviously if HIV-positive women don't have access to family planning, this epidemic will continue to expand because prevalence will continue to mount as fertility rates continues to climb. That could happen in Malawi.

I think you're absolutely right to raise it and it's something that Ambassador Goosby started and was focused on and we're just closing the loop to make sure it actually happened. In the big picture, of course, everybody tells us it's

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happening, but until you go to the site and you actually go in there and say, okay, there are the ARTs, where are the family planning commodities and making sure that they're in the same place at the same time for those women is absolutely key.

JEN KATES: It was the treatment target again – care and treatment 50-percent.

AMBASSADOR DEBORAH L. BIRX, M.D.: Maybe I wasn't clear. The care and treatment target will be achieved. What I tried to also mention is there are some countries that we know are behind in control of the pandemic and will need additional resources. Really focusing and ensuring that those resources are aligned to the countries that have the greatest need and the most difficulty in controlling the epidemic will have to be focused. We will meet the 50-percent earmark.

JEN KATES: More questions? We did solicit questions in advance on Twitter. We didn't get as many as I thought. You guys have got to step it up. One that did come in was around the healthcare workforce and the challenges that remain around healthcare workforce and people wanting to get care, going to a site, and not having a worker there who could help them. There is a healthcare workforce target and the comment was what's the status at PEPFAR with addressing that challenge?

AMBASSADOR DEBORAH L. BIRX, M.D.: Great question, because that gives me the ability to talk about what the agencies have done for me in my cry for help. I talked to all

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of the agency leadership and I said, I need your best and brightest to work on a series of issues, many of them that I raised; pediatrics, young women, increasing prevention, the gender issue, the family planning issue and, most importantly, the healthcare worker, and our comprehensive approach to development and what that means, how we bring together our human resources for health strategy that exists with the NEPI program, which is the nurse initiative, with the MEPI program, which is the medical school initiative, with the FELTP program, which is the field epidemiology program of CDC, with the National Public Health Institute's program. How do we weave that into an umbrella?

Thank goodness, and I think all of you will know this person, Janis Timberlake has agreed to come over from USAID, again, a very senior leader, to work on and we've created a position of a director for development and will bring together those strategies and those initiatives so to ensure that we have a comprehensive approach that's going to lead to real outcomes of retained healthcare workers at the health centers, which I think we are all devoted to. I don't have the precise HRH number and our progress to it. We know what that number is and I should be able to get back to you with the actual.

JEN KATES: Let's go. Back there and we're going to go to this side because I focused on you guys last. One back

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there, there's one up here. Is there anybody I can't see?

Right there, okay.

TIFFANY HAMM: She told me I'm first, sorry.

JEN KATES: Go ahead, you're first.

TIFFANY HAMM: Tiffany Hamm, U.S. Military HIV Research Program. Hi, Debbi.

AMBASSADOR DEBORAH L. BIRX, M.D.: Hi, Tiffany.

TIFFANY HAMM: I apologize to you and to the audience if this is a little bit too much into the weeds. Treatment, as you know, is a big part of the core interventions to stem the epidemic and is one of the largest budget expenditures.

We've been working in PEPFAR over 10 years. We have a significant number of patients on treatment. We probably have an underrepresentation of those who should be on second-lines. We need to consider the fact that we have minimal coverage or, in some cases, minimal coverage in regards to those who qualify for treatment for first-lines to begin with. Many countries don't even have third-line regimens available for those who are going to qualify.

How are you going to be balancing the need to increase coverage in these countries for those who initially need treatment as well as ensure that those who are currently on treatment are going to be on effective treatment to keep their viral load down, to ensure that we're really stemming the epidemic?

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JEN KATES: Question one. Next, question two?

JANE ANDELMAN: Hi. Jane Andelman, from GMS Project and MSH. Sorry, my colleague wrote in a question. Do pillars such as accountability and transparency mean continued support for good governance through, for instance, CCMS and AIDS control programs?

JEN KATES: Last for this round?

NIVEDHA PANNEER: Hi, thank you so much for speaking with us, Dr. Birx. My name is Nivedha Panneer from the Forum for Collaborative HIV Research. My question is on a sister disease of HIV, hepatitis C. For the first time we have a cure for a viral disease and with the majority of HCV-infected individuals in low- and middle-income countries, many of which receive funding from PEPFAR, I'd like to hear your comments, Dr. Birx, on the potential role of PEPFAR in really building on the leadership that it's offered in the HIV/AIDS arena to addressing the HCV epidemic. Thank you.

JEN KATES: We have the first one was on-

AMBASSADOR DEBORAH L. BIRX, M.D.: Great. Tiffany and targets and expansion. Tiffany, I'm glad you ended that with viral load because those of you who have known me, I've been talking about viral load and access to viral load. The reason Tiffany can talk about viral load is because all the DoD scientists have access to viral load because we made that part

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of the programmatic rollout from the beginning of PEPFAR. It needs to be part of our program now.

The fact that we're making decisions on virologic control, on CD4 cell counts is very concerning to me. When I was in the military, part of the issue was if your CD4 fell below 200, you would be what we called medically boarded out of the military. Many of our active duty military officers did not want to be boarded out of the military and really took great pride in their job and they were extraordinary service members. We all knew – now, don't tell any of my secrets. I hope no one's on from DoD. We all knew–

JEN KATES: I'm sure they're not listening.

AMBASSADOR DEBORAH L. BIRX, M.D.: –we all knew that if the patient came in and their CD4 was 150, that if we ran them up and down the flights of stairs and had them do jumping jacks and push-ups, that we would marginalize their CD4s into their bloodstream and all of a sudden they would have 225 CD4 cell counts. We knew also to draw them in the morning when it was highest because it's lower in the evening. We did all of these. There was a reason we had an HIV clinic in the morning rather than in the afternoon and that was so our service members could have the best shot of not being boarded out.

We know if your patient decides to walk to that clinic that morning rather than take the bus or doesn't get seen until 2 o'clock in the afternoon and was seen at 8 the last time,

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their CD4 is going to be dramatically different. Now, when we started in PEPFAR and it was an emergency, we rolled out treatment. Malawi rolled out treatment without CD4 machines whatsoever. We rolled out treatment with fax scans. We didn't have point of care CD4 machines. We had to figure out right now, and I know a team's working on a strategy as we speak of how we can roll out viral load because we do need to know whether people are virally suppressed or not.

We know from these AIDS indicator surveys that at the community level about 80-percent are virally suppressed, which is extraordinary, extraordinary level of adherence and extraordinary durability of first-line drugs. Now, we really need to know and so we're really working on a strategy to do that.

That way, Tiffany, we'll really be able to know what the choice is. What is the need for second-line or even third-line versus continue expansion. Right now I can't tell you what that is because we know in every study that they've done retrospectively that switch based on CD4 cell count, about 80-percent of the time they were wrong. We have to do a better job there to really provide the information that you're talking about. Second question?

JEN KATES: Was on governance and was that—

AMBASSADOR DEBORAH L. BIRX, M.D.: I think you know from the beginning PEPFAR has invested through USAID in support

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to CCMS and NACs that are absolutely critical to implementing through the principal recipient the comprehensive program of the Global Fund. We're deeply supportive of that and will continue to do that. but I think we would like to expand that to ensure that as we get our house in order and have all of this data, that we work both with the CCMS and the NACs - well, they'll be able to see our data because it will be on the website.

Hopefully, part of this interagency collaborative will have a training site so that countries can come in and learn how to do this. This will be open source data pieces so they can implement it in their countries so they will be able to have the same governance over all of their sites, both PEPFAR and Global Fund sites, to actually look at performance in a quality way and we're excited about that opportunity.

JEN KATES: The last one was on hep-C.

AMBASSADOR DEBORAH L. BIRX, M.D.: Hep-C, so this reminds me about the amazing work that the Clinton Foundation and the FDA has done to really - with ART to substantially lower the drug price and through the expedited review that FDA has done and through the work of the Clinton Foundation to really get the best price. The cost of drugs, which when we all started in 2003 or 2004 that were over 1200 dollars is now down to 78, in some cases 65, and they're negotiating viral load testing at 12 dollars.

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We know that this is possible. I think we're excited that recently we've heard that Gilead has negotiated with Egypt for a 900 dollar for a full course, which is quite a bit less than it is in the United States. I don't know and have the information on that yet. We are going to meet with Gilead and talk about this and talk about this issue, where we have that intersection of hepatitis C and PEPFAR.

That will have to be done in collaboration with the host country because that is a one-time expense but could be a large one-time expense of 900 dollars and really understanding how we would work in partnership with the countries if that's even possible and if that's the right number. I think we're all excited about looking at it in more detail. I can't give you an answer today because we're just starting to look at this.

JEN KATES: We definitely have time for at least another round. If you would like some water, please go ahead.

AMBASSADOR DEBORAH L. BIRX, M.D.: Oh, that's a good idea. Thank you. See, she's good with public health. She knows it's important to stay hydrated.

JEN KATES: It's really important. You have to stay hydrated. Back there is one, two and three.

EVELYN TOMASZEWSKI: Good morning. Thank you very much. My name's Evelyn Tomaszewski with the National Association of Social Workers. I really appreciate the slides

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and the overview. I think when I think of containment, I think of medication treatment adherence and that's very measurable.

I was intrigued by the focus on OVC and holistic care for families. I think we need to look at psychosocial issues, psychosocial cultural issues in the cultural context. I was wondering if you could speak a little bit more about some of the initiatives that have been put forth on social service system strengthening and what the efforts might be in the future.

JEN KATES: Okay, social service system strengthening. Next was here, yeah.

LANI MARQUEZ: Hi. My name is Lani Marquez from URC. We're a USAID partner. I really appreciate the presentation and the leadership you've shown and wanted to know if you could comment on your expectations for the new quality strategy and how you think that's going to make a difference for accountability and impact.

JEN KATES: Last one for this round I think was here, yeah.

STEPHANIE HEUNG: Hello, my name is Stephanie Heung and I was wondering what lessons from PEPFAR can be used to combat the AIDS epidemic domestically.

JEN KATES: I'm glad you asked that because that was one of my questions, so, thank you. Okay, so the first one was

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on OVC and just broadly looking at social services strengthening.

AMBASSADOR DEBORAH L. BIRX, M.D.: Thank you for asking that because I don't often get to do a personal public service announcement. My daughter is a social worker and so I understand how important this is. They are not paid adequately domestically. I'll just put that out there – and is not making a living wage but still living at home. It's good. It's good. It's all good.

I think it points out the importance of the incomplete team and we know domestically that our social workers are an important asset of the complete team. PEPFAR, and I can't tell you the exact figure, has been supporting social work programs and accreditation in a whole series of countries. We're excited about that. Part of this OVC issue and speaking to the quality, so as we're working – and this gets to another question to the quality.

Part of the OVC quality measurements will be ensuring that this holistic approach is being implemented but also implemented in a quality way. Those metrics will be very critical and that's why this quality meeting in the end of July which will come up with these holistic quality indicators for all aspects of the program will be quite important because then we can tell you very clearly what sites are performing well, what countries are performing well.

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I think we will notice the great thing about having data, we'll be able to tell you that in countries that have utilized a holistic approach to the team and the team structure including having psychosocial support and social worker, how they're performing compared to the other teams. We'll be able to really have objective evidence that we can take to countries about why this is important.

We're very excited about having that transparency and having that data. One comment on the transparency though. I know that opens us up to criticism. I know that you will look at our data and say, oh my gosh, this should be better. Know that we also feel that way but we think this is the only way that we can get your input and we can get your insights on a regular basis. We know that it opens us up to more criticism, potentially, but we're willing to take that risk in order to have the information. The second one was—

JEN KATES: You got two. The third one was around lessons from PEPFAR for the domestic epidemic and I would also say broadly just the connection between the two.

AMBASSADOR DEBORAH L. BIRX, M.D.: Great question. As soon as Doug Brooks got in position, we were the first ones over there meeting with him because we think there are a lot of connections. Certainly, I came out obviously of a domestic program and was working globally. He also, even though he was domestically oriented and a great social worker, also has

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global experience. We know from Shannon Hader who was originally in Zimbabwe and came back to the District of Columbia – brought a lot of her testing strategies and how to improve testing and knowledge of status and access to care to her position at the District of Columbia.

We're excited about having that expanded connection. We've talked to HRSA because we think we can learn from their low resource clinics and how they have developed human capacity in those clinics and we can do actually site visits – exchanging site visits between some of our health centers in Africa with those clinics. We think that both sides will have novel ideas of how to improve.

We're looking at every different level of how this can be done instead of just at a project level, having it be done more systemically and then sharing that information more clearly. I think we're excited about it – see, Doug Brooks and I are both DBs. We are absolutely convinced that we will be able – one gets to be DB-1 and one gets to be DB-2. We're not really sure how that works out quite yet. We're very excited about having more routine engagement between the two programs and really looking at the cities and states that have been successful in implementing the strategy for what we can learn about what those key items were.

JEN KATES: I think we have time for just maybe a couple more because you've been going for a long time now and

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we want to give you a break. We have somebody up here. We'll do our three and then—

AMBASSADOR DEBORAH L. BIRX, M.D.: Good, because she's been waiting. She has been behind Farley so it was difficult.

JEN KATES: You'll start with your view and then keep your hands up so I can figure out who else wants to—

GOULDA DOWNER: Goulda Downer, Howard University. Thank you. The Caribbean sits in the backyard of the U.S. and beyond the need to increase our workforce, I can't call it workforce, our HIV workforce is huge. We now know that stigma and discrimination among our own clinicians is a major issue. What are your plans for the Caribbean?

AMBASSADOR DEBORAH L. BIRX, M.D.: That's a good question.

JEN KATES: In five seconds or less. Yes?

AMY PAUL: Hi. Thanks for your remarks. I had a question about assisting —

JEN KATES: You are?

AMY PAUL: I'm Amy Paul. I'm a graduate student at Johns Hopkins.

JEN KATES: Thank you.

AMY PAUL: I wondered if you could speak a little more about your sustainability agenda? It seems quite focused on financial sustainability. If you think about sustainability of outcomes, it seems like it would require investments in local

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capacity-building, health system strengthening, removal of structural barriers. I was wondering if you could talk more about how those investments align with your sustainability agenda.

JEN KATES: Is there a third question? Going once, twice, two questions. That's it.

AMBASSADOR DEBORAH L. BIRX, M.D.: Thank you for mentioning the Caribbean. The level of stigma and discrimination there and the pervasiveness of that, and I'm glad you mentioned at the clinical level also because I've experienced it in the clinics there. It's really quite astounding. I think it is a wake-up call for how all sub-Saharan Africa could go if we let this expansion of this human rights erosion continue. It's unapologetic in many of the Caribbean clinics. I think so all of the country operational plans came in and you can see that we have a very aggressive agenda and we have a fixed budget.

We are committed to working with the countries in a new way. A series of countries will be coming back to discuss with us. I can't tell you which ones those are because I haven't talked to the Ambassador yet. Some of them may be in the Western Hemisphere and then a series of other countries to really ensure that we're making progress and what indicators we're going to have of progress. If we can't figure out how to

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make it work there, we're not going to be able to take those lessons to other places that are really, really essential.

I think we don't really know or have access to the communities at risk in the Caribbean in the way that we should because of the level of stigma and discrimination. Also they can go island by island so it's really difficult because you don't know who's being seen at a different island because it's less stigmatizing and what that means when they can't get their drugs from that island that time. It's a complex piece but I think we are concerned enough that we want to make sure that the programs there are as impactful as they can be and are looking at that very carefully.

JEN KATES: The second one was on the sustainability agenda and is it just financing or—

AMBASSADOR DEBORAH L. BIRX, M.D.: All of the sustainability pieces that Ambassador Goosby has put into place were really quite extraordinary and comprehensive. What Janis Timberlake will be doing is looking at our entire program and seeing how they could tie together in a more efficient and effective way, both for our human resources piece as well as our infrastructure piece and as well as the long-term sustainability of those pieces. When you step back and you think what part of the HIV/AIDS program needs to exist when HIV/AIDS is controlled, so I believe it's possible. I believe

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you should start planning for success right now in a whole series of countries.

What does that mean? That means who takes on the health system, the health workers, the renovation of the health clinics, the renovation of the district hospitals, the laboratory maintenance. Who takes that one when HIV is controlled? We have to have those discussions now because that's the part that needs to stay when HIV is less. I think you raise an absolutely critical question because it was a place where we were running to put all these pieces in place. Now, to look back and say, okay, in those sites in Ethiopia that I showed you where the epidemic has decreased to a size where there is no HIV-positive pregnant women coming to be tested any longer – so they're doing thousands of tests and there's no positive – who then takes on the nurse and the funding for that nurse and having those discussions with the government.

Part of that is linked to the financials. That's why we're taking the financial piece so seriously because the investment into the health system that PEPFAR has made needs to be maintained when PEPFAR shrinks because the epidemic is controlled. You raise an absolutely critical question that we need to develop a strategy for to ensure that those sustainable in that context of sustaining past control of the pandemic.

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JEN KATES: I think we're going to end taking your questions there. I just want to say because I didn't get a chance to say this earlier, Ambassador Birx and I talked almost the same day as she got confirmed and one of the first things she said was, I want to come and share my vision. I want to be able to talk to the community in Washington.

That community is so important to this program and we actually hoped it would happen earlier but she's been talking to the communities and countries in Africa and around the world. This was really the first opportunity we could do this. I just wanted everyone to know that was as important to her as — you know, we were excited to do it. We've been supporting a transparency agenda as well.

Having her come and share it today, I think you'll agree that, hopefully, you saw the passion I was mentioning but also the information that you shared and how much detail, I think we all have a better sense now of kind of where the program's going. I'd love to keep an open invitation for you to come back and do this again as a follow-up maybe in a couple years.

AMBASSADOR DEBORAH L. BIRX, M.D.: We have lots more details to go through.

JEN KATES: Would you please just join me in thanking Ambassador Birx for coming?

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AMBASSADOR DEBORAH L. BIRX, M.D.: Great questions.

It's good to see some people in the audience who I know that know what a slide rule is but I won't point them out. They're long-term colleagues of mine. Thanks for coming.

JEN KATES: Thanks, everybody. Bye-bye.

[END RECORDING]

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