

## THE GLOBAL FIGHT AGAINST HIV-AIDS

February 19, 2009

### TRANSCRIPT

**JOHN J. DEGIOIA:** Good morning. My name is John J. DeGioia and I am the president of Georgetown University. It is my great pleasure to welcome you to the second of the Waldemar A. Nielsen Issue Forums in Philanthropy, in which we examine the role of philanthropy in shaping public policy. The series honors Waldemar A. Nielsen as a historian and critic who called upon philanthropic foundations - especially private ones - to hold themselves to a higher level of accountability to the common good. In this spirit, we hope that the Nielsen forums will spark a public debate on the ways in which philanthropy can more effectively influence public policy.

We wish to first thank the Ewing Marion Kauffman Foundation for its generosity in supporting Georgetown's work in this area. And I would also like to recognize Kathy Kretman and the Center for Public and Nonprofit Leadership at Georgetown's Public Policy Institute for all of their efforts to make this forum possible.

We are looking at an issue of tremendous importance - the global fight against HIV/AIDS. This is one of the greatest challenges confronting our world community. It is one in which our university has deeply invested and it is one that demands collaboration across sectors and across disciplines.

The magnitude of the HIV/AIDS pandemic is staggering. In 2007, 33 million people were living with HIV. Just last year, there were 2.7 million new infections and two million AIDS-related deaths. And while more and more individuals are gaining access to affordable treatment, only three million people in low- and middle-income countries were receiving anti-retroviral treatment at the end of 2007 - just 31 percent of the estimated global need.

The battle against HIV/AIDS truly calls upon the interest and action of the entire global community, and Georgetown is deeply committed to this fight. Our engagement is an extension of our Catholic and Jesuit heritage, values that call us to serve others, to seek justice and to live in solidarity with our most vulnerable sisters and brothers. While we look forward to expanding our involvement and exploring further opportunities, this morning I wish to share with you just a few highlights of Georgetown's current involvement in this global fight.

- We are collaborating with the Southern African Catholic Bishops Conference AIDS office network conducting a case study on the successes and strengths of their holistic HIV/AIDS work at 150 project sites in South Africa.
- We also are collaborating with the Catholic Bishops Conference of India as they strengthen their work related to HIV/AIDS. Just last winter, we hosted the leadership of

this organization and its health commission for a strategic planning workshop, together developing teaching and training partnership opportunities.

- Through Nurses SOAR! - a program of our School of Nursing and Health Studies - we have helped to train and mentor nurses who are dealing with the HIV/AIDS epidemic in South Africa, Botswana and Lesotho and, of course, our faculty work across disciplines to bring in the unique resources of the academy together to address this crisis.

These are just a few examples of Georgetown's engagement in this fight. I hope that these examples indicate that many of our efforts, for example in India or South Africa, are collaborative in nature. This multi-disciplinary approach, this focus on building networks of collaboration, is a contribution that a university community, particularly one such as ours, with a Catholic and Jesuit identity located here in the capital of this nation, is positioned to provide.

It is challenging to work across borders and boundaries of discipline, thought and expertise, but it does allow you to build networks to leverage resources and to ensure that we are using best practices. In essence, collaboration enables us to make a much greater difference than we could ever imagine accomplishing by working alone.

As we will discuss today, the global fight against HIV/AIDS requires the thoughtful, strategic and generous coordination of our expertise, our experiences and our resources. And I know that many of you in the audience today are combating HIV/AIDS in various capacities. We all are in debt to you. We bring a sincere appreciation for your example, for your engagement and for your commitment to wrestling with this challenge of our lifetimes.

Today, I hope we can invite you to think about ways in which you can maximize the effectiveness of your investments through collaboration. This collective action is not only at the core of today's forum, it is exactly what will enable us to win the battle against HIV/AIDS.

Our speakers today will share some of the lessons that they have learned in their own personal engagement, the engagement of their organizations, some of the solutions that they have found, some of the prospects that they have for future work.

Our first speaker is Edward William Scott Jr. He is a true leader in the field of philanthropy. After spending 17 years in government and after founding BEA Systems, Inc., Scott has become an active and generous contributor to many philanthropic causes. He is the founder and chairman of the Friends of the Global Fight, which, along with the Gates Foundation, provides support for the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Along with Bill Gates and George Soros, he also founded the philanthropic organization, DATA - Debt, AIDS, Trade, Africa. He has provided substantial financial and advisory assistance to Compassion International, a faith-based children's development group that helps more than 850,000 children in 23 countries, and he has supported the Center for Interfaith Action on Global Poverty, the Center for Global Development, and several orphanages and child development centers in Central America.

Mr. Scott's experience and his generosity speak for themselves. It is now my great pleasure to introduce Edward William Scott, Jr.

**EDWARD WILLIAM SCOTT, JR.:** Thank you very much, Dr. DeGioia. We are very pleased that one of the organizations Dr. DeGioia mentioned, Center for Interfaith Action, has Dr. DeGioia on its board and has Georgetown as a partner. It is a great privilege.

As you think about the science of HIV/AIDS, you also need to think about the political and social context in which that science is applied. Right now, the state of the science is that of social prevention mechanisms, and treatment for people who already have the disease to keep them alive.

When I was first exposed to HIV, I had a very retrograde attitude about the disease. I thought people who got infected had bad luck. They were going to die, too bad. What we really needed to do, I thought, was find a vaccine and everything would be just fine. I was completely wrong. I'm a bit ashamed of that attitude, but it seemed to me at the time to be the logical view.

But the truth is, we have learned that it is very important to keep people who are infected alive not just because of our moral obligation, which seems pretty obvious, but also because those people are needed to socialize their children and to contribute to their societies in the fundamental ways they do - either working in the fields or working in the businesses or working in the governments of the countries where this disease is so rampant.

So the question of how you use and deploy current technology and current modalities to fight this disease is something that goes well beyond science. And it is one of the things that has driven me to do some of the work I do.

I hope that those of you who have never seen somebody dying of AIDS never do. But if you do, your life will be changed forever. I can remember being in a small 8-foot-by-8-foot dark hut just outside Nairobi in Kenya - I have a hard time talking about it - the poor fellow inside was lying there dying. His wife had died, his children had died. He had no friends. The ladies from this NGO called KEMA would come and give him a small bowl of porridge twice a day and they would wipe his body with a damp cloth, and he was waiting there in the dark with no friends, no communication, just waiting for death. It is a horrible thing. It should not happen to nobody.

It is those situations, I think, that drive organizations such as the Gates Foundation and the rest of us who work in this field. Some people have referred to me as a compulsive or serial founder of NGOs. I think in the last seven years, I have been involved with four different NGOs that touch on this disease and they all have a different purpose or different focus.

The Center for Global Development really focuses on the public policy of the rich countries vs. the poor countries. Part of that public policy affects public health and it affects our policy on HIV/AIDS. We have done a lot of work about what is going to happen with respect to this bow wave of people who need to be treated and how long will we be able to financially sustain their treatment.

D.A.T.A., another philanthropic organization that I had the good fortune to be involved in with Bill Gates and George Soros, is a broad public advocacy organization. Most of you know it because it is the platform Bono, the rock star, uses to make his appeals to the general public. They spawned the ONE Foundation, the ONE Campaign, which really tries to get broad public understanding of these issues and support for them.

The Friends of the Global Fight, which also is an advocacy organization, also is supported by the Gates Foundation. (In fact, three of the four organizations I have founded received very generous support from the Gates Foundation and I want to acknowledge that.) Friends is an advocacy

organization that focuses its attention on government, on Capitol Hill, Hill committees, the administration and the multilaterals, trying to get them to understand what the issues are and trying to get them to understand the importance of being supportive of the Global Fund to Fight AIDS, TB and Malaria. The Global Fund is a private-public partnership, headquartered in Geneva, that gives out almost \$3 billion a year to more than 130 countries to fight these three diseases: AIDS, TB and malaria.

Finally, my most recent involvement has been with the Center for Interfaith Action on Global Poverty, which attempts to help the faith community and faith-based NGOs and congregations do a better job. It is not a Christian-focused organization. Our membership includes the Islamic Society of America, the Islamic Relief, Catholic Relief, the American Jewish World Relief, the Adventist organizations. It is a very broad-based organization that has nothing to do with interfaith dialogue. It is all about action and trying to address these diseases.

Very discreet things in the world of philanthropy can have a very stunning impact on global public health and health policies.

For example, Friends was established in the U.S. to focus very specifically on the U.S. government. Our governmental funding process - the congressional committees, Office of Management and Budget, pressure groups, and so on - is a little different than you would find in the parliamentary democracies such as Great Britain or France. Nonetheless, Friends now has been replicated in Japan, France and Jordan, and I'm leaving tonight to participate in the launch of a Friends' organization in Sydney, Australia called Friends Pacific.

I will also mention Compassion International, which is a child sponsorship organization. It is a faith-based group, very evangelical in its orientation, which I am not. I'm an Episcopalian, but I happen to really believe in their work and so I have supported them quite actively for more than 10 years.

About four years ago, it became obvious to me that their children were getting sick. They were getting HIV and they were starting to die, and Compassion did not know quite what to do about it. About that time, Bill Clinton and many other advocates in the AIDS community had convinced the generic drug manufacturers to bring the cost of ARVs (antiretroviral medications) down from about \$3,000 per person per year to about \$115, and now it is probably less than \$100. Compassion hired an epidemiologist from Stanford, who put together a plan to get medications to the children. Then they had to fund it.

They decided they would collect the money from the people who already sponsored these children, but they were nervous about it because of their orientation as an evangelical organization - they thought AIDS was a bad word in their community. But they asked people if they would contribute an extra \$8 a month for children they were sponsoring in the high-prevalence countries: Uganda, Kenya, Ethiopia, Rwanda, Tanzania, Burkina Faso and Ghana. They thought they could fund the program if they received a 17-20 percent positive response. They completely misgauged their constituents: they received an 85 percent positive response.

They now raise more than \$7 million a year from these \$8 fees to support this program. They have tested - both children and caregivers - in the last three years more than 407,000 people. They have identified almost 20,000 who are positive and they administer ARVs to almost 9,000.

That is what people can do if they organize themselves appropriately, if they rely on people's goodwill and if they rely on the current science.

That is how philanthropy can express itself - by identifying unmet needs in the social-political environment and by being supportive of those institutions that are doing good work.

**PRESIDENT DEGIOIA:** Thank you very much, Ed.

Our second panelist today is Ms. British Robinson, director of Public-Private Partnerships at the Office of the U.S. Global AIDS Coordinator at the State Department. In this position, she provides leadership and guidance for the public-private partnerships strategies and interventions for PEPFAR and leads the U.S. government's public-private partnership technical working group. Prior to joining the State Department, she served for 10 years as the national director of Social and International Ministries for the Jesuit Conference and the Jesuit Refugee Service/USA. She has also held positions at Catholic Charities USA and the Washington Legal Foundation. Her experience and expertise span the private and public sectors and encompass both secular and faith-based initiatives. It is a pleasure to introduce to you Ms. British Robinson.

**BRITISH A. ROBINSON:** Thank you very much, President DeGioia. I would like to thank President DeGioia, the Center for Public and Nonprofit Leadership and the Georgetown Public Policy Institute for inviting me to speak today. This event focuses on philanthropy in broad terms but I would like to focus my comments on the PEPFAR experience working with the for-profit private sector in the global fight against HIV/AIDS.

My office provides policy oversight and coordination for the U.S. President's Emergency Plan for AIDS Relief or PEPFAR, which is the largest commitment by any nation to combat a single disease in history. Today, more than two million people are on antiretroviral treatment with PEPFAR's support; 240,000 fewer babies have been born with HIV and more than 10 million people have received care, including four million orphans and vulnerable children.

In July, Congress reauthorized PEPFAR for five more years and set ambitious new 10-year goals to support the treatment of three million people and prevention of 12 million infections and care for 12 million people. When they reauthorized PEPFAR, Congress set out to strengthen and enhance America's leadership and the effectiveness of the U.S. response to the global AIDS pandemic. It might surprise you that one of the six components outlined in the legislation for achieving this goal is an expansion of public-private partnerships and an intensified engagement of the private sector.

To this end, PEPFAR has and will continue to engage private sector entities across our HIV prevention, treatment and care programs. Private partners for us include private businesses, foundations, business and trade associations, unions, venture capitalists and social entrepreneurs and high-net-worth individuals through intermediaries, all of whom bring important resources to our mission, including money, in-kind donations and intellectual property. We typically leveraged one PEPFAR dollar with 2 ½ dollars from the private sector.

While the resources the private sector brings are important, we believe their most significant contribution is the talents of their staff through skills transference and capacity building. By engaging that company in what it does best - whether that is writing software, selling soda or entertainment - we can introduce new ideas and fresh thinking into our programming from some of the most creative, well-informed people in their fields.

PEPFAR has been truly fortunate to broker many public-private partnerships. Most recently, we launched the Partnership for an HIV-Free Generation, an 18-partner initiative that has the goal of cutting new infections in Nairobi, Kenya by 50 percent in the next five years. The partnership brings together the marketing expertise of APCO Worldwide, the video game savvy of Warner Brothers, the management ability of Accenture and others like Nike, Coca-Cola and Intel to use 21<sup>st</sup> century approaches to behavior change.

In another partnership, the medical technology company Becton Dickinson, is sending laboratory experts to build capacity and strengthen lab systems in up to 10 PEPFAR-supported countries. In Kenya and in Tanzania, through yet another partnership called Phones-for-Health, we used the know-how of a small software company, Voxiva, Motorola hardware and access to reduce airtime from MTN and other African operators to create a comprehensive health management information system all on a mobile phone platform.

Additionally, PEPFAR works with the private sector to establish and enhance HIV/AIDS workplace programs that use the workplace as a strategic opportunity for HIV prevention. We view workplace programs as a tool of risk reduction for companies because ensuring safe and healthy workforces will lead to greater productivity and more consistent growth.

Now, make no mistake, these partnerships do not come together easily or overnight. Forming partnerships is much more of an art than a science and simply comes down to building relationships both within the private sector and within PEPFAR. Even then, finding where our interests overlap with those of the private sector can be tough. It is not always obvious how a public health program focused on a very complex disease can work with an entity driven by profits.

As companies look for profitable opportunities in the tough economic climate, they looked at countries in Africa and elsewhere, many of which benefit from PEPFAR support, as their next frontier markets. Opportunities for collaboration arise where PEPFAR programs can benefit from a company's desire to demonstrate its relevance and build goodwill among the local people in government. Ultimately, we only want to pursue alliances where the results are mutually beneficial to PEPFAR and to our partners. When partnerships are mutually beneficial, they are the most sustainable. In fact, sustainability is an important reason for partnering with the private sector.

As national AIDS programs develop, ministries of health and other partners will need services from a range of actors, including the private sector. Where there are workplace programs or IT solutions for resource management, partnerships can help embed the private sector not only as a part of the national response to HIV/AIDS but also to support development efforts writ large. Public/private partnerships are new way of doing business for the U.S. government and they are here to stay, albeit the current economic challenges.

Even in these difficult times, we remain optimistic. Engagement with companies will continue as long as we focus on their core competencies and companies continue seeking to enhance or maintain their global position. However, our approach to partnerships must be adaptive. We realize that corporate social responsibility programs may be de-emphasized or even cut. Every investment will be more scrutinized and so must we to engage companies in partnerships that have both direct relevance to their business and demonstrate measurable results. In fact, we prefer to engage companies around their core competency because that is how we get true commitment of both talent and resources.

Partnerships with the private sector will be a critical component in the fight against HIV/AIDS in the coming years. For example, one of the biggest constraints to the further expansion of treatment and testing is the lack of qualified medical personnel. PEPFAR plans to support the training of 140,000 new health care workers in the next five years. Private sector involvement, from using information technology to creating virtual classrooms to expanding the capacity of private schools, will be crucial in meeting this goal.

Another key area of partnership will be in prevention. We cannot treat our way out of this disease and prevention is the linchpin of sustainability. In many ways, the private sector can be the key to this effort, whether by protecting employees and their families through workplace programs or engaging Madison Avenue marketing firms to find innovative ways to bring about behavior change. Whether we are talking about donors, local government, private companies, foundations, NGOs or faith-based organizations, one thing is perfectly clear - none of us has the ability to do it all on our own.

To tackle the monumental challenges of HIV/AIDS, we will need to work together more than we have ever before. Working with the private sector, harnessing their skills and resources to an extent that we never have before will continue to be a fundamental part of the way that PEPFAR does business, and it must continue to be an essential and growing component of the global response to HIV/AIDS pandemic.

**PRESIDENT DEGIOIA:** Thank you very much.

Our third panelist, Dr. Stephen Morrison, offers extensive expertise on policy affecting Africa, particularly in the area of HIV/AIDS. He is currently director of the new Global Health Policy Center at the Center for Strategic and International Studies or CSIS here in Washington. Prior to this position, he directed CSIS' Africa program as well as its taskforces on HIV/AIDS, nontraditional security assistance and the global food crisis. He has held numerous positions within the U.S. government, advising and leading initiatives focused on issues such as global foreign assistance, African affairs and HIV/AIDS. He has served as an adjunct professor at Johns Hopkins School of Advanced International Studies for nearly a decade and a half. He is a member of the Council on Foreign Relations and the International Institute for Strategic Studies. Ladies and gentlemen, it is my pleasure to introduce Dr. Steve Morrison.

**J. STEPHEN MORRISON:** Thank you, Dr. DeGioia. I'm very pleased to be here today.

I thought I would, as the last speaker, try and reflect a bit on the change that is under way here from the Bush era to the newly-arrived Obama era and what that means with respect to HIV. I'm going to divide my comments into very rapidly looking, first, at what happened in the Bush era. How did HIV come to be such a dominant feature of its foreign assistance strategy that we are now spending \$7.5 billion a year on global health? Roughly 30 percent of our foreign assistance budget has become the most prevalent and unified segment of what we do. What accounts for this very rapid historic and substantial expansion of U.S. engagement with special focus on HIV/AIDS?

Second, what does it mean as we transfer to a new administration with a broad and quickly evolving new set of priorities in the midst of a domestic and a global economic crisis? What does that mean with respect to HIV and the broader global health agenda?

First, when we look back on the Bush administration, it was a surprise that HIV/AIDS and related infectious diseases became such a signature part of its legacy and that the administration's efforts were regarded so widely by so many divergent points of view as a success, drawing support from so many different directions.

What are some of the factors that accounted for this surprising outcome? One was sustained White House leadership. I do not think we can underestimate the degree to which the president's own personal investment in this issue - which had a contagious effect on those around him - was paramount in driving this forward. Related to that, there was a great emphasis on picking strong and very effective leaders. We heard a lot about Mark Dybul and I think he is the most prominent example that we can point to.

The approach that was taken had many different facets, but there were two core strategies. One was to be at the table in creating the Global Fund to Fight AIDS, TB and Malaria as a new multilateral global financial instrument for bringing resources to poor countries that need them for the three greatest infectious diseases that burden the poor. The administration was there and it accounts for roughly one-third of the funding. And it intervened at key moments in terms of investment of leadership at fairly high levels.

The other strategy, of course, was the PEPFAR program, which British was speaking about, and what has followed from the PEPFAR organization - the President's Malaria Initiative, the Neglected Tropical Disease Initiative with emphasis upon TB.

So, there have been dual models. One is joining on a multilateral level on this global front; the other, creating the largest single bilateral disease program.

There were other factors beyond White House leadership.

For one, there was a medical crisis that was very apparent at the turn of the decade. As we moved into 2001 and 2002, it was becoming clear. New data on the threat that HIV posed at that time was coming forward. The sharp spike of infections from the early '90s was becoming manifest in a much more visible way, particularly in Eastern and Southern Africa and this had a "shock factor" and was interpreted as both a deep moral challenge and a deep security challenge.

9/11 was not insignificant in bringing about a change in attitudes around security. SARS and avian influenza in the early part of the decade also began to put greater prominence on these issues. If you go back and look at the national security strategy statements from 2002 on, global infectious disease, HIV/AIDS, gets very high prominence.

And then there was the convergence of a new coalition, including foundations.

The Bush era saw creation of a strong, enduring and bipartisan consensus around the value of making these investments. This flew in the face of attitudes from the '90s in the Clinton era that foreign assistance was bad domestic politics and that it did not enjoy a significant base of support. The idea that you could create a new bipartisan consensus over a massive expansion of foreign aid was an achievement that surprised people. Part of the success was due to the engagement of religious conservatives - they came forward as a major constituency that had not been there before.

Foundations - particularly the Bill and Melinda Gates Foundation and Clinton Foundation, and others as well - became powerful factors in this period. They demonstrated they could bring real cash forward for innovative venture investments to prove concepts that then could be adopted. They had speed and agility. They had a political voice. They had the ability to act as diplomatic and political brokers around difficult issues. They had a strong legitimacy, a surprisingly strong legitimacy accrued around those two big new entities, and they acquired the in-house technical expertise, and did so fairly rapidly. The Gates Foundation worked to reinvigorate the scientific side, arguing for preserving our faith in science and shaking up the way science is done. This became part of their mandate.

The Bush administration was receptive to engaging with these new actors and there were many of them. There were the celebrities, the new big campaigns like the ONE Campaign that had a hand in starting the actions by others like Kofi Annan and Nigerian President Obasanjo.

Two other factors marked the Bush era. Budgets were permissive. And the model that was pursued was a powerful and convincing model. It was one that had finite, concrete targets, putting people on treatment and other key care and prevention strategies that were measurable. It was scalable. It was transferable. You could begin to take some of those achievements and build confidence that you could translate those lessons into similar gains in malaria and TB elsewhere. And there was a sense that you did not have to create a new set of institutions, that you could leverage your existing institutions by adding on a strong leader like PEPFAR's Mark Dybul.

This was a success that built upon itself. The \$48 billion reauthorization at the end of July became an icon of soft power, of a way to build and preserve America's standing in the world, do good deeds and have concrete impacts and results. Foundations became embedded in the dialogue and in the policy formulation in a way that we had not seen before.

Where are we today? In the very early days in the Obama administration, we have two big transitions under way. One is a new Democratic administration coming into power and trying to sort through what its priorities will be. A second is, of course, a global economic crisis that touches us as profoundly as it touches the countries where we have made the greatest investment in global health.

The economic crisis is front and center, dominant, and for the next period it will be the common referent point for making decisions and selling innovations in policy for domestic and international engagement.

The American opinion climate is changing rapidly and that, in itself, creates uncertainty. It is increasingly an inward climate, one of fear and concern for personal security and family security, including health. Foreign assistance is treated with greater skepticism. Here at home, we are seeing poverty and malnutrition increase as we are seeing poverty and malnutrition increase overseas. The question is how do these two phenomena connect or interact in popular discourse?

The stimulus and financial rescue packages that are being moved forward today are unprecedented and will have unprecedented and uncertain impacts on our foreign assistance budgets. We are looking toward national debt levels that will force correction. We are out of the period of permissive budgets. We are moving out of the period of supplemental war financing. There will be new discipline that comes forward in this next period and it will put an inevitable squeeze on things that we hold dear. We have seen a worsening of the partisan environment. It is not clear if that will spill over and damage the bipartisan core that has been the basis for moving the HIV/AIDS program.

Finally, success in HIV and TB and malaria makes it more difficult to continue to mobilize support here in the United States. The exceptionalism of HIV/AIDS, the urgent crisis sense or aura around it from the early part of this decade, has diminished as treatment and other programs have been brought forward. This form of success dulls the edge of mobilizing and it begs the question: If you are going to sustain and accelerate those gains, you have to have a new argument and a new strategy that takes into account how much the context here in the United States has changed.

The new administration is one that was at the table supporting the Bush administration on HIV/AIDS. The president, the vice president and the secretary of state all were supportive. They voted in the Senate on behalf of these programs. They understand and they embrace them. The trick is going to be converting that base support into something that they see as a fresh and distinct contribution to a global health legacy of their own. The White House leadership here - as in the Bush era - is a critical factor.

We do know that they want to do certain things. They want to rebalance the civilian and military form of engagement on foreign assistance, and that dates back to the experiences in Iraq and Afghanistan, primarily. They want to restore the vitality and effectiveness of development and diplomacy agencies, and Secretary Clinton has made that a top priority. They want to change the definition of global security to be more encompassing on climate change and health and energy, and General Jones has made that very clear. They want to rationalize and integrate our foreign assistance programs into a broad developmental and unified kind of effort.

We do not know yet what the strategy will be. We do not know yet how it will be led and what the timeline will be. But global health matters and it is in the mix. But global health standing on its own, as an argument for its own sake, is less effective as an argument today. We need to take account of the crisis. We need to take account of where the Obama administration is moving in terms of its own internal priorities and how it is going to see the world. We need to tie it to this development agenda, tie it to this foreign aid reform agenda.

There are several things that need to happen.

Foundations, the independent voices, will be very important in fulfilling commitments, protecting the core commitments. We have a legacy of two million people on antiretroviral treatment whose lives we have an obligation to sustain morally. We have to achieve new efficiencies, better impact measures and streamline our delivery mechanisms. We need to do far better on the prevention side.

We are not winning the game in Southern and Eastern Africa, in terms of the arc of this epidemic relative to new infections. We need to think more creatively about broad, new health interventions that will bring broad benefits on a very cost-effective basis in the midst of a global crisis. I do not know what form that may take. It could be adding in maternal and child health, a focus on water and sanitation. But as the crisis worsens outside our borders - and we are heading into a period where I do believe you are going to see worsening poverty, malnutrition and instability - we are going to need answers that are quick, cost-effective and have dramatic concrete results.

**PRESIDENT DEGIOIA:** Thank you very much, Dr. Morrison. We do have time for questions. I would like to cluster the questions in groups of three.

**QUESTION:** We hear about the need for a skilled health workforce to address HIV and AIDS and over time, there has been an awareness of the need to expand that to look at health and behavioral health care workforce. Could you speak to the role of behavioral health or mental health care professionals and providers in the global response to AIDS?

**QUESTION:** A lot of critics say that PEPFAR is an enormous entitlement program. With the weak economy and more than 48 million people in the United States without health care insurance, do you think that political will for PEPFAR can be sustained over five years? And aside from public-private partnerships, what is PEPFAR doing to invest in institutions so that these programs can become sustainable? Finally, what is the impact of PEPFAR and increased HIV/AIDS funding on discretionary programs such as agriculture and infrastructure?

**QUESTION:** Could you speak to the students in the audience to give them some suggestions about how they can make a difference on this issue and/or how they could get started in a career on public health?

**BRITISH ROBINSON:** I can speak specifically to a partnership that we just launched a couple of months ago with Becton Dickinson and the International Council of Nurses to bring the mental health issues into some of our programming. The partnership is a pilot program that will look at providing psychosocial support to health care givers in Uganda. The pilot is also running in Lesotho and Zambia. We are looking forward to the outcome of using PEPFAR dollars to provide mental health to health care workers. They are really on the front lines doing their work.

**PRESIDENT DEGIOIA:** Steve, would you offer a perspective on the idea that PEPFAR could be considered an entitlement program and put it in the context of its longer-term sustainability of the program?

**STEPHEN MORRISON:** The question implies that there has been some analysis done. There was a paper out last year that tried to project some of the long-term costs of putting this number of people on life-sustaining therapy, particularly when you factor in a second line of therapy that could be much more expensive as first-line resistance or effectiveness declines.

This is an unprecedented foreign policy commitment to put hundreds of thousands, and now more than two million, people on life-sustaining therapy as a foreign policy priority. It is an open-ended priority. Morally and operationally, it is an open-ended priority. In that sense, it has the qualities of an entitlement and it requires a more robust defense around its merits. You do not start it and turn it off.

Yes, there are huge shortfalls and problems in our own society with respect to health care. The challenge is trying to make sure that the arguments do not become a false clash of tradeoffs. One of the ways to preserve the validity of this commitment is to demonstrate that it can be done on a cost-effective basis. We can make it more cost-effective and affordable.

There are many other interests who are joining in this enterprise. It has very strong benefits to us as a nation, in terms of our standing, and there are broader global interests at stake. In making these investments, we have dramatically galvanized contributions from other sources. Today, there is more

than \$10 billion a year going towards HIV/AIDS and related infectious diseases. That is 10 times the level that was invested 10 years ago. There is no question that large investments made by the United States triggered complementary and large contributions from other sources.

**PRESIDENT DEGIOIA:** Ed, a word about advice you might have for students who are thinking about their own personal engagement in this work.

**EDWARD SCOTT:** The first thing anybody who wants to engage in this area needs to do is to educate themselves. Inform yourself about the breadth and detail of the issue because these issues have many, many different dimensions. They have a science dimension, they have services-delivery-on-the-ground dimension, and they have a sociopolitical dimension in this country.

In the process of informing yourself and educating yourself, you probably will see an opportunity that fits your personality and interest. That could be volunteering for the ONE Campaign to raise awareness and activism locally in the United States. It could be volunteering for a stint overseas through something like the American Jewish World Relief. It could be volunteering to work in clinics overseas or domestically. There are a lot of different ways in which one can be engaged.

I think the process of informing yourself is incredibly important because, inevitably, you will speak to your family, neighbors, friends at church or people in the local school. That has a very salutary effect on conditioning the society's view of this issue.

**QUESTION:** I'm a student athlete at Georgetown and I'm working with a new program called Grassroot Hoyas, which leverages the role-model status of athletes and the fun of sports and games to roll out an HIV prevention program in D.C., which has statistics that are comparable to some Sub-Saharan African countries. How does the philanthropic community gauge the value of education programs for prevention?

**QUESTION:** There are so many NGOs, so many organizations dealing with so many aspects of the fight against HIV/AIDS. What are some of the advantages and disadvantages of having multiple organizations as opposed to larger and more concentrated organizations, in terms of maintaining standards of transparency, efficient allocation of funds, and so forth?

**QUESTION:** I appreciate what Ms. Robinson said, that we cannot treat our way out of this disease. I'm curious whether the three of you think there might be a change of policy toward prevention in the Obama administration.

**EDWARD SCOTT:** Role models are a very important thing. Until there is a vaccine, the only way this disease is going to be brought under control is by behavior change and education. It is as simple as that. Any methods you can use to get people to consider behavior change that is a good thing. Magic Johnson, as an example, made a huge impact on this disease by declaring his own status and by working tirelessly to talk about the disease and to make people aware of his situation.

The faith community is crucial, and not just in this fight but in the fight against all of these key global health scourges - AIDS, TB, and malaria. The faith community in Africa, it is estimated, runs about

half the health delivery system. In some countries, 60 to 70 percent of hospitals are run by some denomination - the Lutheran hospitals, the Catholic hospitals, the Aga Khan hospitals of the Muslim faith. They are just crucial and essential to the delivery of health care.

And they have the sustained connection with the community. The NGOs, they come and go. But the churches and the faith community are there the whole time and they are the people who can deliver whatever the solution is, whether it is education, testing, counseling or changing moral values.

One of the biggest problems in the spread of HIV is the diminished status of women in the developing world. Women are abused both within and outside of marriage. The infection rate for young girls between the ages of 19 and 24 is three times what it is for boys in that same age group. Older men are taking advantage of these young girls and infecting them. There has to be some value shifts. Value shifts are not made by a billboard on the road from the airport in Kampala. Value shifts are made by instruction of those institutions that communicate values, and that is principally the churches, the mosques, the synagogues and the faith institutions.

**STEPHEN MORRISON:** Around the time of the Mexico City International AIDS Conference in August, new CDC data on the American epidemic was released showing that prevention services were now only reaching a small minority of key vulnerable populations. There has been a call to analyze how the CDC is going about its work, a call for streamlining U.S. domestic programs, which are very complicated, a call for having a unified U.S. national plan. I think all of this is promising.

There is a renewed focus on our domestic epidemic. Here in D.C., there is an alarming rate of HIV prevalence among adults. We have had now strong leadership in the last year and a half and I think it is quite possible that we can turn this around.

With regard to the Obama administration, we already have seen one change, which was the decision by the president on the first week that he was in power to lift the "Mexico City Policy," (which banned U.S. funding for international health groups that use their own funds to perform abortions, lobby their governments in favor of abortion rights or provide counseling about terminating pregnancies.) There seems to be an effort at moving carefully in order to preserve the coalition and not have a too sharp a rise of tensions between different constituent parts of who take different views around the question of sexual prevention strategies, but that remains to be seen.

**QUESTION:** What are the efforts to monitor and evaluate the effectiveness of the PEPFAR program in terms of hard measures like reductions in mortality, reduction in cost to hospital systems and life-years gain?

**QUESTION:** It is great to know that PEPFAR is going to produce 140,000 skilled workers around the globe in the next five years. But the question is: How do you retain them with the globalization and the trend of migration of skilled workers around the world?

**BRITISH ROBINSON:** PEPFAR's efforts around monitoring and evaluation are quite robust. I think after the first five years, PEPFAR has seen some of the capacity gaps within our evaluation programs and we are working very hard to change those. But we are also working across the other bilateral donors, along with the global fund, to make a better effort at standardizing some of the evaluation

frameworks and performance measures, which will make our program more efficient as well as some of the other donor-based programs.

Regarding retaining health care workers - that is a struggle, but, again, something we are addressing in collaboration with a number of foundations; the Gates Foundation, the Doris Duke Foundation, to name two. A consortium was just developed, headed by Duke University, to look at strategies to train and retain these 140,000 health care workers, addressing things such as scholarship funds, salaries, benefits, all of which we call our human resources for health technical working group.

**EDWARD SCOTT:** I think the fight against AIDS is incredibly important because of what it teaches us about how to tackle these kinds of problems. It raises the issue of how to create public-private partnerships, such as the Global Fund. It raises the issue of how to get drug companies to start thinking about providing generic drugs at low cost. It raises the issue of how to change values in societies and convince people to behave differently. It raises the issue of whether or not to have bilateral programs or multilateral programs, is one better than the other, do you need both? Should we have a global fund? If we have so-called siloed programs, will they siphon off resources?

We are beginning to learn more and more how to do this work. But you cannot separate this stuff from the issue of development. Development is really what it is all about. People used to do specific population programs - go out and hand out condoms, provide training, provide sterilization - but you know what they found out? The best way to control population is to make the country richer. The richer countries get, the fewer children people have. It is a very simple fact. The notion that a rising tide raises all ships is a fundamental reality of how societies organize themselves.

So, we cannot view these diseases outside the context of the economic environment in which these countries find themselves. Helping countries improve their educational systems, eliminating barriers to trade that keep countries in poverty - where Bangladesh pays more tariffs to the United States than France does, it is crazy, it is just nuts. Addressing the fundamentals of helping poor countries develop will play a huge role in solving these disease issues.

**PRESIDENT DEGIOIA:** A word of thanks to all of you for being a part of this forum. And, again, a word of thanks to Kathy Kretman, the director of our Center for Public and Non-Profit Leadership at the Georgetown Public Policy Institute, for coordinating this Waldemar Nielsen Issues Forum in Philanthropy on such an important and urgent topic. Finally, a word of thanks and deep appreciation to our panelists for a terrific conversation this morning. We are grateful to have you here and have the opportunity to benefit from your experience and wisdom.