UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT

STATESMEN'S FORUM – DR. RAJIV SHAH:
CENTER FOR STRATEGIC AND INTERNATIONAL STUDIES

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TUESDAY, JUNE 29, 2010
1:00 P.M.
WASHINGTON, D.C.

Transcript by
Federal News Service
Washington, D.C.

LISA CARTY: Welcome. Very glad to have you all here today. My name is Lisa Carty. I'm the deputy director of the Global Health Policy Center here at CSIS. We're very glad that you could join us for what promises to be a very exciting event in our ongoing Statesmen's series of speakers. A particular welcome to Dr. Shah and also to his staff that have joined him today. I'd also like to welcome our several hundred guests who are joining us online. And most particularly, I'd like to bring you all, but particularly Dr. Shah, greetings from John Hamre, CSIS' president who, unfortunately, is overseas today and – (inaudible). It's designed to bring global leaders here and to give them a platform to talk about the critical issues of the day.

There was a time when the a discussion on health and development might not quite have risen to this level, but luckily, that time is long gone, and that's no doubt in part due to the extraordinary contributions of USAID over many decades that I think have proven beyond any doubt that, not only is development the right thing to do, but it's the smart thing to do.

CSIS has been enormously fortunate in having many AID administrators come here and speak in the past, but I believe this is actually the first time we've had two administrators here with us – (laughter) – both a current administrator and a former administrator. So I am really delighted to be able to welcome, this afternoon, Henrietta Holsman Fore. As many of you know, Ms. Fore was AID administrator from 2007 to 2009.

Prior to her work with the agency, she has a very successful career in both the public and private sectors. She's a trustee here at CSIS and also a very good friend at CSIS. Most importantly, she's someone who really cares deeply about development and about creating more opportunities in the developing world. So I'd like to invite Ms. Fore to come to the podium to introduce Dr. Shah. We'll then have Dr. Shah's remarks and we'll have some time for Q&A. So thanks for joining us. (Applause.)

HENRIETTA HOLSMAN FORE: Thank you very much, Lisa, and it is great to see all of you here today. It means that development is alive and well and strong, and that's very important for all of us in the world. I would first like to mention the good work that's being done here at the Center for Strategic and International Studies.

And Lisa Carty, to you and to Steve Morrison, thank you, because it has been seminal work on health, but also, before this, the work on food and other issues. So thank you for leading that. I think it's important that we all talk about and engage in the discussion of what development is and what it can do.

As all of you know, the United States Agency for International Development is the premier institution that leads development around the world. And it leads in peace and security; it leads in infrastructure and economic leadership; in ways that help in legal systems and that help with governance and democracy building; in humanitarian assistance; in education; in health; and of course, in disaster assistance in Haiti.

Our 16th administrator, Rajiv Shah, is with us today because he is a remarkable symbol, as well as a leader, for USAID. There are many experts within USAID, but we are delighted that Raj is a doctor. And as a medical doctor, it means that he can lead with enormous integrity in the field of health. He has initiatives that have spanned from food to entrepreneurship to

health and online activities, and ideas that stress innovation and that stress integration.

And today, he will talk to us about health and about the opportunities with the global health initiative. In a town in which we often do not have bipartisanship, Raj and I have a good relationship. And it is with great pleasure, and an honor, that I am able to introduce Rajiv Shah, the 16th administrator for USAID. (Applause.)

DR. RAJIV SHAH: Thank you. Good afternoon. This is a wonderful group that you've assembled, Lisa – very impressive. It's great to see so many familiar faces turning up to talk about global health. That's very exciting and I look forward to this conversation and to hearing your thoughts, ideas and questions. Henrietta, thank you for that overly kind introduction and wonderful description of USAID. I'm still learning how to do that, so it's helpful for me to take notes as you're doing that.

We are, in many ways, building on some of your important successes, especially in rebuilding the human resources of the agency through the development leadership initiative. Every day, we think about the contributions you've made in that

regard. And I really do want to commend CSIS and the leadership of Lisa Carty and Stephen Morrison for really paving the way toward the integrated health approach that we'll hopefully talk about today.

It was, in fact, your global health policy group, which replaced, I think, the earlier AIDS taskforce and has been really pointing people, conceptually and in practice, to the concept that the future lies in smart, strategic investments in health systems. I'd like to start today just by telling you about two women – two women with one thing in common. They're both pregnant with their third child.

Consider, for a moment, the dilemma of a woman in sub-Saharan Africa, and even one with the unique access to many of our own, U.S.-funded programs. To get the prenatal treatment that is necessary to prevent her from transmitting HIV to her child, she must travel a great distance with an infant on her back and a toddler in hand, to a PEPFAR-supported clinic. And to get her two other children immunized against measles or other vaccine-preventable diseases, she has to make another arduous journey to a different clinic at a different point in time.

Neither clinic is equipped to provide complicated obstetric care. So this mother, like her mother before her and so many others in her village and her community, will likely decide to take her chances and birth at home, because the journey to an adequate facility is too arduous and too difficult. The burden of fear generated by this ordeal weigh on her entire family, and in fact, her entire community.

Now consider for a moment a different situation – that of a woman here in Washington, a woman also carrying her third child – a federal employee whose health plan provides convenient, comprehensive care throughout her pregnancy and a healthy head start in life for her first two children. Healthy children, we know, are more likely to learn, more likely to thrive throughout their lives and as adults. The peace of mind that comes with knowing one's family will be well-cared-for by competent medical professionals spanning a broad range of potential needs, enables this woman, my wife, Shivam, who is due to deliver our third child in November, and her husband – that would be me – (laughter) – in case there was any question – (laughter) – to focus on giving our real, utmost effort to our jobs, our family, our community.

Medical technology and strong health systems have made maternal death a relative rarity in our world. According to UNICEF, an American woman faces a 1-in-4800 chance of dying during childbirth. But in sub-Saharan Africa, the story is very different. The chances of dying in childbirth there are 1-in-22 – 1-in-22. The fact that some women are more likely to be HIV positive and more than 200 times more likely to die during childbirth than a woman in the United States is simply unacceptable.

The president's global health initiative is designed to close that gap and to bring about a convergence between the stories I just described. Health is, in fact, at the heart of human progress. And we recognize that the wellbeing of people around the world is not just an important end in and of itself, but it is strongly linked to the security, prosperity and partnership of our country with our colleagues around the world. And that's why global health is a central part of President Obama's and Secretary Clinton's plan for a more peaceful and a more prosperous global community.

This administration's initiative is about helping partner countries achieve major advances in health by working smarter, by building on past successes and by making some tough

decisions. To achieve these advances, the GHI will invest $63 billion to this end. That's more than double the amount of money we spent on health during the preceding six years, and a significant commitment of resources during a very difficult fiscal time. Through integration and efficiency, we will be very focused on getting more value for every dollar we spend on health, and ultimately saving millions of additional lives, worldwide.

GHI builds on remarkable progress in public health that we've all seen. Over the last decades, we've made huge strides through a variety of disease-specific or intervention-specific campaigns. The president's emergency plan for AIDS relief is the largest single effort by any country to combat a single disease. The first phase alone provided antiretroviral treatment to more than 2 million patients and supported care for more than 10 million people affected by HIV worldwide.

By all accounts, PEPFAR was a game-changer, and to support its efforts, the administration is increasing funding for PEPFAR consistently and in greater ways than before. Similarly, the president's malaria initiative reduced the intolerable burden of malaria, which causes 900,000 deaths each year, most in Africa and most among children, through a package of proven control

measures. Since the initiative began in 2005, we've distributed more than 19 million insecticide-treated nets and 40 million lifesaving anti-malarial treatments.

These low-cost interventions, coupled with behavior-change programs and real outreach and engagement, has resulted in really remarkable results. In Ethiopia, Rwanda and Zambia, we've seen malaria deaths come down significantly, and in some communities, come down by half or more. The work of the diverse leaders and advocates behind these breakthroughs leaves a legacy that actually goes beyond the lives saved, and that's many of you in this room.

Your work has helped teach the world that rampant disease imperils global stability and must be addressed. Your work has shown grassroots communities that support for global health is critical, and you've triggered an upsurge in attendance in global health courses and colleges around our country, in the faith community's activity and commitment, and even amongst brand-conscious consumers like myself that own RED watches or RED t-shirts, and wear them with great pride.

It has helped expose the weaknesses of health systems in developing countries and forged a bipartisan consensus that we

should do more to spend our resources to save lives abroad. So I thank you for that. And yet, in isolation, nearly all of us agree that disease-specific approaches also have some serious deficiencies.

Visit any African country and you're likely to find a health system organized around diseases and interventions, not the actual patients. You'll find separate clinics in separate places for AIDS, for children's health, family planning and advanced obstetric care. Not only is that bad for the patients, but it is strikingly inefficient for taxpayers. And in many cases, we have ourselves to blame.

Our siloed, single-disease focus means that in many countries, the same health system that can prevent the transmission of AIDS to an infant is unable to prevent that same child from dying of diarrheal disease before she turns five. I saw an example of this myself on a recent trip. In May, I visited an impressive, PEPFAR-supported facility in Kenya. I learned that every government clinic in Kenya once had an area set aside where mothers were counseled about oral rehydration therapy, commonly called the "ORT corner."

As many of you know, ORT is cheap, simple and widely credited with saving millions of lives a year. But when AIDS funding rehabilitated the government clinics in Kenya, the ORT counseling areas were often taken out and replaced by sites for HIV counseling. It is an important lesson, as unintended as it was. Our disease-driven focus can sometimes crowd out other cost-effective, lifesaving interventions, even in Kenya, a country that this institution, CSIS, has rightly highlighted as being on the cutting edge of health program integration.

By integrating health delivery in countries, we can extend the reach of these focused interventions at the clinic and in the community. That means a woman who enters a maternity clinic can receive the full range of services she would need for herself and her child. The global health initiative is therefore about the patient, not just the disease. The initiative will enable country-led health programs to be smarter, more efficient and more effective, will support community-based health systems that are appropriately staffed and stocked to deliver a broad range of health services and to reach back into more formal health systems, when necessary.

But let’s not confuse ends and means. The ultimate target of the GHI is not to simply build health systems for the sake of

building systems. It's to achieve more health outcomes and to sustain those gains over a long period of time. And we do that by rooting our investments in those who are ultimately responsible for seeing them through: governments, NGOs and the local private sector.

And it's worth reiterating that effective systems, as sometimes unsexy as they are – I particularly think a good health system can be quite sexy – (laughter) – save lives and enable our people to be healthy and productive contributors to society. Just like the disease gains that it builds upon, the GHI will use data and clear metrics of success, doubling the number of babies born free of HIV, halving the burden of malaria, cutting the under-5 mortality rate by a third, and reducing maternal mortality – remember, that's been moving in recent estimates – by 30 percent.

But unlike previous health initiatives, GHI will focus, from the outset on as President Obama states, creating the conditions that will reduce the need for future aid in the out-years. As many people here know, the child survival revolution in the 1980s contributed to rapid progress by mobilizing unprecedented global medical systems and political support. That successful movement was driven largely by the force and

charisma of one man's leadership, Jim Grant of UNICEF and of course, Bill Fahey of the CDC and Peter McPherson of USAID and many, many others.

But as we later learned, despite the tremendous successes of that movement to raise immunization rates in many cases to over 80 percent and to greatly expand primary care services to people in need and save millions of lives. Any movement that rests on the tirelessness of one individual or even a small group of leaders is inherently unsustainable.

In the early 1990s, as attention and funding slowly shifted to other areas, immunization coverage and child survival began to slow. In fact, DTP3 immunization rates dropped almost 60 percent, globally, and much more so in many countries where we all spend our time and energy. I mentioned the lack of an ORT corner in the clinic I saw in Kenya. Actually, our DHS surveys documented a more than 20 percent decline in ORT use in Kenya between 1998 and 2003. Fortunately, our experts recognized this trend and have been working to reverse it.

But we, as a donor community, have an obligation to keep countries off of this seesaw of donor trends. That is exactly what underpins the GHI vision. And here are some of its

defining features: First, we believe in doing more of what works – a simple concept. GHI will expand proven treatment and prevention strategies in TB, HIV, malaria and a range of neglected tropical diseases. But it also will expand what works in nutrition, in hygiene, in sanitation, in family planning and in maternal and child health.

All of those areas, statistically, have been under-invested-in through the last decade of increased global health investment. GHI is investing in improving measures and methods for monitoring and evaluation in each of these programs. We're learning about better ways to treat diarrhea and pneumonia in children to save lives and prioritizing vaccines, like rotavirus or pneumococcus, to more effectively prevent disease so they don't have to be treated later.

And we're learning, for example, that simply training more doctors and nurses is not sufficient to ensure a health workforce that's capable of providing care to an entire population. Doctors and nurses – and as a doctor, I feel this is a safe comment – are wonderful contributors to medicine – (laughter) – but they're also the first to be hired away by other countries, who pay a higher wage. And they can be reluctant to work in a rural environment, where they might not

have access to tertiary care services and the ability to provide those services.

So we've learned a lot about the importance of task shifting and the tremendous value of building a cadre of community health workers trained in primary health care, who stay in their communities with the trust and respect of their neighbors. We have more than 10,000 such community health workers in Senegal, where I recently visited. And the commitment and connection they have to their local communities is just tremendous.

And GHI will also create an environment where it's safe to report on things that don't work, because that's ultimately the only way that we can experiment and learn. Second, GHI will focus on expanding existing service platforms. Savings more lives means being smarter about getting the maximum impact for every dollar we spend in health. And this means getting – developing new insights and better methods for using our HIV/TB/malaria treatment platforms to provide a broader range of services.

The good news is that we have strong platforms from which to build. Under PEPFAR, we built strong HIV/AIDS service-

delivery systems in many countries, and USAID's work in primary health care has contributed to widespread maternal and child health platforms with doctors, nurses, clinics, hospitals, pharmacies, community linkages and procurement and product distribution systems.

Similarly, the president's malaria initiative has its own platforms for providing access to needed interventions. These different platforms are the basic foundation for GHI. We can strengthen these platforms by bringing together all of the capabilities across PEPFAR, USAID, CDC and a full range of other, federal global health partners, including the HHS, the National Institute of Health, the Peace Corps and the State Department.

Expanding these existing platforms and programs will mean providing easier access at a single location for a broader set of medical and health interventions. It means making the shift from diseases to patients. And it means focusing more cleanly on the last-mile problem of getting the full package of basic health services out to those people who are most vulnerable because they lack access to any protective care at all.

These expanded platforms will do more for HIV-positive patients, and it will do more to prevent an HIV-negative patient from contracting the disease. Because the current reality of two new people on treatment for every five new people contracting the disease, frankly, is not enough. Integration just makes common sense.

Third, we will prioritize innovation. Under the GHI, we are identifying, evaluating and implementing a range of entrepreneurial approaches to public health, such as results-based financing and incentives to encourage better and broader utilization of proven services. We're getting many of our best ideas from small programs that are, today, small, but have real potential to scale.

In Zambia, for example, one clinic wanted to get more mothers who come in for prenatal services to return when it was time to deliver their babies. Because we all know the 48 hours around childbirth is the period when 70 percent of maternal deaths occur. So the clinicians promised patients inexpensive "mom kits," that included soap and a baby blanket and a few other things. And with this small incentive, these clinics experienced a boom in birthing visits. It's not unlike the conditional transfers we've seen in other parts of the world.

And we're pioneering entrepreneurial ways to encourage more private-sector participation and financing. In Namibia, for example, we conducted a campaign to convince mining companies that it was in their interests to pay for their employees' counseling and treatment and ARVs by showing them that, that was cheaper and more effective than to hire and train new workers for those that they had lost to the disease.

And we're building on the current experience that's just being created, which is a U.S. initiative called "text4baby" – an effort to actually use SMS text platforms to reach a broader group of people in a more targeted way with more effective health messaging. These types of applications in developing countries could now reach millions of expectant and new mothers with critical healthy baby messages.

Finally, research and innovation are critical to the global health initiative. Game-changing new technologies, such as new diagnostics, will change the economics of treatment across a range of diseases. Tuberculosis is often cited, because we're not that far from new TB diagnostics that are cheap and efficient and can make the distinction between multi-drug-resistant pathways and lower-cost pathways that are less

burdensome. By using these types of new breakthroughs, we can save money, treat more people and save lives.

Fourth, the GHI will focus on country ownership. The GHI recognizes that the United States can simply not do this alone. President Obama, Secretary Clinton and the American public are deeply committed to saving lives around the world, but the global needs for HIV/AIDS, for maternal and child health, for family planning and immunization are genuine global responsibilities that require a full global response.

Every government, every bilateral donor, every multilateral alliance, like GAVI or the Global Fund, and every community, from the American taxpayer to a Ugandan village, must take greater ownership for this challenge. The GHI meets the Obama administration's core development principle of working in partnership, not patronage, by supporting real, country-owned plans and being willing to redirect and realign our investments against those plans.

Rather than building parallel health services that, frankly, are often not even visible to country ministries and country leadership, we want to strengthen host-country systems. We can do contracting through host-country ministries and we can

work more closely with host-country implementing partners. We're stepping up our coordination with critical global health partners like the Global Fund, GAVI, the World Bank and a full range of U.N. agencies. And in fact, our ability to do this will be critical to our ability to align multiple streams of funding that come into countries and better align them with what countries hope to achieve and sustain themselves, over time.

I'm sure many of you watched the G-8 this weekend. I did, from time to time, as well. (Laughter.) While many consider the MCH commitments there to be modest, the G-8 this year made important strides in ending smoke and mirrors when donor countries make commitments. President Obama insists that we ensure credibility, transparency and accountability when the United States makes a commitment. These principles are particularly critical in current times of fiscal constraint. We owe it to our domestic constituencies and we owe it to ourselves to be clear about our commitments, and our commitment to getting more value for money we're spending.

Already, we're doing a better job of coordinating U.S. health spending within our own government. Our country teams are coming together across agency boundaries and developing a harmonized approach to get more value for money. In fact, we

currently have the USAID, CDC and PEPFAR team in Ethiopia doing just that. We've also launched new partnerships, and that will be a major component of how we improve coordination going forward. For example, we've launched a new partnership to increase coverage of newborn resuscitation with the American Academy of Pediatrics and with Laerdal, a private manufacturer of resuscitation devices.

To support introduction, we developed agreements with UNICEF in Ethiopia and we've worked with the National Institute of Health, who will provide an independent evaluation of this approach. The end result is a new program designed to save newborn lives and designed to generate data and knowledge on a set of new strategies that could be applied more broadly and elsewhere.

Our final approach is around focusing on women and girls. Women and adolescent girls are particularly vulnerable to ill health because of their reproductive role and because of really pernicious gender discrimination that still exists, gender-based violence and a lack of respectful care and access to such care. Improving the health of women and girls is important, as an end in and of itself. But each one of us in this room knows that

when a woman dies in childbirth, the survival and the welfare of her offspring is fundamentally threatened.

We also know that when a woman has access to decent care and basic knowledge about nutrition, safe drinking water, sanitation, improved hygiene, she amplifies those benefits to her family and within her community and across generations. But too often, despite this knowledge, we collectively fail to operationalize this insight. GHI will look at better ways to extend health care to more women through simple strategies, but real operational requirements, such as adjusting clinic hours to be more friendly to when women can make a visit, by making certain items, like condoms, vitamins, contraceptive pills and other medications available through a broader variety of commodity-distribution channels, like local kiosks, pharmacies, and even beauty salons.

And it will support systemic changes, such as broadening the range of services offered at existing clinics and extending services into homes through primarily female community health workers. Our health programs already address some of the social and behavioral aspects of improving women's health. In Ethiopia, USAID works with youth, teachers and community leaders

to change attitudes around accepted practices with respect to child marriage.

Girls advisory committees established in more than 3700 public schools, are succeeding in delaying sexual debut and increasing class attendance. This is a critical health intervention, because we know that this is statistically correlated with improving the health and welfare of these girls over the course of their lives and their child-bearing age. And it leads to an important lesson: That family planning plays a crucial role in improving the health of women and their children throughout the world. And it will be a major component of the global health initiative.

By helping women space births at least three years apart, bear children during their healthiest years and avoid unplanned pregnancies, experts believe family planning appropriately could prevent 25 percent of all maternal deaths. Where family planning and other health services are linked, levels of contraceptive use increase. A study in Togo demonstrated that telling mothers about family planning services when they brought their children in for immunizations actually increased their – the family, their awareness of family planning methods and use by up to 58 percent.

So the GHI is already well underway. The defining features of the initiative that I laid about before you are being implemented today everywhere we work. In addition, 10 days ago, we announced the first set of GHI plus countries where starting this year, we will focus intensive technical and management resources to get this right. The eight GHI plus countries will accelerate GHI implementation and the learning that goes along with that implementation so that we can share this with other part of the U.S. government – but almost more importantly, with the entire global health community that simply has to get this right for our gains to be sustained.

Ethiopia is one of those countries. In 2003, the government there made a huge commitment to a new healthcare approach. They recruited, trained and hired and deployed more than 30,000 female health– (inaudible) – workers. So at that time, we had redirected our integrated programming in maternal and child health, family planning, malaria and nutrition to support this new health worker-based strategy.

We assisted local and regional governments in developing their implementation plans. And we worked to fill gaps where governments had needs. In 2007, the Ethiopian government asked

USAID to join them and UNICEF in developing an integrated nationwide computer-based drug and commodity management system. We did that and that system is now up and running.

The Global Health Initiative draws on examples like this and on expertise across the U.S. government. Now, USAID is a critical part of this effort. I've greatly enjoyed getting to meet the nearly 400 health professionals that work here at USAID in the United States in Washington and to meet the incredibly dedicated and talented teams, especially the foreign service nationals that are often medical doctors or real public health professionals and political leaders that are now part of our expanded team abroad. And I believe greatly in their ability to offer leadership and to implement the program.

Yet, I realize that USAID must improve how we work. And in many ways, we're working hard to do that. Many feel that we are too bureaucratic, perhaps too wrapped in our own programs and processes. And after several months of being there, I agree. Over the years, our offices in the field have been mired in excessive reporting requirements and byzantine procurement practices that do not often serve the larger purpose.

But I also saw a different story when I experienced our response to the Haiti crisis. I saw our team break free of the rules. And I saw our team demonstrate a tremendous amount of entrepreneurial energy and evidence-based decision-making in trying to simply solve problems in a quantitative and smart way.

So we're moving forward with a package of major operational reforms designed to help our whole agency operate like our teams did with respect to Haiti. Free from some of the requirements and the red tape that can be reduced and implementing a major package of procurement reforms that will allow us to cut our contract costs, build more internal program capacity and redouble efforts to support local institutions invest in local ownership and develop local capabilities. And these reforms will also include a major new approach to monitoring evaluation and impact assessment.

We have a unique opportunity with the GHI to figure something out that's been hard learning for over three decades in global health. And it's how we learn to build real health systems and a targeted health outcomes-oriented way. And we intend to capture those learnings through strong monitoring and evaluation.

So we do need to be stronger and we're on the way to get there. But really no one should underestimate what can be done right now. Our agency is determined to make progress in the stubborn numbers that are all too familiar to you – 11,500 people die each day from HIV/AIDS, tuberculosis and malaria. More than 8 million children still die a year before their 5th birthday. Most of those deaths are preventable.

I've met with the mothers who have lost those children over the years and in my work in global health. And now, as I soon hope to be the father of three children 5-and-under, I'm both terrified of that and deeply excited. But I can only imagine what it is like anywhere in the world to lose a child under 5, especially when you know that loss does not have to take place.

By being here today, each of you demonstrates your commitment to help us get this right and to help demonstrate to the world that we can save these lives in an efficient and sustained way. And I want to thank you for being here. Thanks very much. (Applause.)

MS. CARTY: Raj, that was a fabulous overview of where the GHI is and what you aspire to. So thanks so much for sharing it

with this really interested audience. I'm going to take the prerogative of the chair and start off with a few questions.

And I think what I'd like to do first is maybe bring us back up a level or two to sort of the macro level. You know, you've been in place now about six months. You've been on the road a lot. You have an amazing platform to influence how the rest of the world thinks about the United States, how the rest of the world thinks about what's possible not just in global health but also in global development.

I'm wondering if you could just say a little bit about what you've learned over your travels in the last six months and what your hopes are, how you hope to use your platform to shift some perceptions.

DR. SHAH: Well, that's a big question. You know, I appreciate that. I agree entirely. This is a very, very unique platform. And I honor Administrator Fore's history in using that platform for both raising issues but also demonstrating what our country is capable of. And President Obama uses the phrase "our enlightened self-interest" when talking about our commitment to development. Secretary Clinton talks about the

“three D’s” and the need to really elevate development as a central part of our complete foreign policy.

And my experience has been in traveling around the world these past few months – has been that there are high expectations, that people expect more transparency, more accountability, more genuine partnership in all of our initiatives, whether in health or food or economic growth or democratic governance, and that there is a sense of real commitment to think of development not just as charity but as a strategic investment we make to buy outcomes in the most efficient, most sustainable and most important way.

And so as I’ve seen our teams around the world really adapt to that, there’s a real sense of how do I use these resources to get even more outcome for the dollars going in? Or how do I build new partnerships with a country ministry so that in addition to having a wonderful set of implementing partners executing a program, we have the political leadership and coverage and commitment to both shape and see that program through and hopefully someday sustain it in a meaningful way.

And so I’m very encouraged. I’m very excited. I think one of the most exciting things we did was in Kenya. We met with a

group of young entrepreneurs. And I know Administrator Fore was telling me about this when I was back in a prior role and she was in this one. And it's just unbelievable. You have people using SMS text messaging to do all kinds of things in Nairobi and the slums in Kibera, people using GIS platforms to map where services are offered in that kind of a slum community. I just think over the course of the next decade, we're going to see a huge amount of innovation and new ways of tackling old problems that are more effective and more efficient. And that's precisely what the American public expects of us and precisely what we should be committed to doing.

MS. CARTY: Great answer. You used a term, a couple phrases you've used in a lot of your talks over the last couple of months. You talk a lot about innovation and accountability and transparency and bringing a more entrepreneurial spirit both to the process of aid and also the institution of USAID. And I think you've even discussed or maybe you've already begun having what you've termed evidence summits. But I've also heard you talk about failure summits, which is an equally important concept.

So I'm wondering if you could say a few words about what you think the risks are. You know, what are the risks for GHI

as you look out over the next five years? And more broadly, what are the risks for global health? And what could we do wrong that could fundamentally, you know, undermine the goals we've set for ourselves beyond money? We all know money is important. But beyond that?

DR. SHAH: Well, good, I'm glad you said that. That was my first - my first point would have been, you know, I agree with everyone in this room that we need to continue to sustain our tremendous commitment to global health. It is the largest of our programs across our sectors. And we've seen a huge amount of progress over the last 10 or 15 years. So now is the time to really get this pivot to sustainability and systems right as opposed to walking back on the huge progress we've seen.

And I guess I would just say, when I think about what the challenges are, the challenge is that this is really tough. If you look at history and global health, you've seen – aside from fully eradicating a disease like smallpox, you see these trends of performance that go up and down. And when people marshal support and run programs, you see great outcomes on a pretty cost-effective way. And then, when we turn our attention to other things or we pick different diseases or different

countries to focus on, you see backtracking in the places that have lost that shining light.

So that means we need to know how to shine the light brightly everywhere. But it also means that we have to get the GHI right, which is about saying, can we harness all of this disease-specific energy and these resources and use it to a greater purpose? Can we, in addition to getting these health outcomes, really develop the kind of underlying public health and health systems that will sustain themselves for 20 or 30 or 40 years and dramatically improve access to the last mile of 30 or 40 percent of a population that basically might have almost no real access to health care?

And once we start building the kind of local capacity to do this, you see all kinds of new solutions that otherwise don't get considered as much. So I think the biggest challenge will be maintaining a shining light on global health and pointing out that it's a really efficient way to buy lives saved anywhere around the world. And it is core to our overall national interest. But that we're also able to do it more efficiently and in a more sustainable way and we can document that with real evidence and real analytics so that it's irrefutable. You just look at the data and you say, we're figuring out how to do it

better, smarter, in a more sustainable way. But those two, I think, go hand in hand.

MS. CARTY: And to follow up on something you said, you raised the G-8 and the disappointment, I think, among some that the outcomes there were not a bit more concrete, maybe a bit more fully funded. But I think it goes very much to the points you just made about data. You know, it would be interesting, I think, to get your thoughts on why this maternal child health issue has been so stubborn. And it seems like now there is an opportunity. There is some additional money, maybe not as much as people would like to see. There certainly is leadership and focus on the part of the United States.

You mentioned the importance of working more with partners. So what is the organizational framework, you know, in addition to the money that one needs to bring to get more concerted action across this particular field, the maternal child, neonatal health field? And who is going to bring that? Who is going to sort of get everybody in the room to say, okay, we know what we need to do. But here is how we need to start doing it more effectively?

DR. SHAH: Well, a few thoughts. First, I would just point out that for the United States, four months after the administration took office, President Obama launched the GHI. And in the GHI, the largest increases are in nutrition and maternal and child health and family planning. And if you look at maternal and child health and family planning, the increases from FY ’9 to ’10, and ’10 to ’11 are quite significant. So that’s an exciting and an appropriate commitment to a major, major challenge and a major opportunity.

I’d say, in order to get it right though, we have to do this work in a way that builds systems. But building systems just can’t be an end in itself. And I don’t know if we have – you know, a while ago I tried to study the state-of-the-art thinking on health systems. And for people who have done that in this room, you know they are these pretty complex webs where they’ll put system attributes on different axes and then draw these things that look like spider webs. And they’re very complex. That’s not the right way in my mind.

I think we have to be focused laser-like on a set of health outcomes and say, we’re not trying to build systems for systems’ sake. We’re trying to save maternal lives, reduce maternal death where that’s possible. We’re trying to reinvest in those

simple areas in diarrhea and pneumonia and basic service management for children and so that we're saving children's lives where possible. And we have to dramatically improve access to family planning in an effective way and through all channels because we know that that's one of the critical levers for both maternal and child health outcomes.

And so if we're really smart strategically about what it is we're doing and then we're committed to doing it in a way that is consultative with country leaders, that is building local capacities, that is developing the kind of procurement and drug management and commodity management systems that will be local and will sustain themselves when donors are no longer there. That I think is the right thing to couple with that super–focused approach on health outcomes. But we have to do both, in my mind, and we have to do it with a great deal of focus

MS. CARTY: Thanks. I'm going to ask one more question, a question that's come up, I think, by popular demand. And then we'll open up to the audience.

But I mentioned that we have, I think, about 200 or so people who have joined us online. And we received more than 50 questions ahead of time, actually. So I went through them and

there is a critical mass that you won't be surprised goes to the management structure for the GHI.

So I think it would be good maybe if we could get your reflections on that. You know, there is the operational committee that you're a part of. There is the strategic council that provides broad oversight. A lot of people have been wondering, you know, how well is that working, recognizing that it's only really been operational for a number of months. How well has it been working? What needs to be improved?

And I think in particular, you know, when there are really hard decisions to make or people are going to disagree as they naturally are because some of the issues before GHI are really hard. Who is going to make those hard decisions and tough calls? So any thoughts you can share with us on that.

DR. SHAH: Sure. Well, I think you've alluded to the structures. (Chuckles.) You've captured it better than I could. The strategic council is our ability to bring together the whole federal government that has resources and insights to offer on global health. And we've been rotating our sort of monthly management meeting to different agencies so we can learn about the full range of things.

That’s just – as an aside, I’ll say, you know, we were at NIH last time and Francis Collins hosted us. And we learned about how many NIH-trained alumni are in the countries where we want to work in. So right when we’re saying we want to find local capacity you have a hundred, 120 local NIH-trained Ph.D.s that are in country in different roles. That’s the local capacity. So I think we’re gaining a lot of great new insights by engaging a broader part of the federal government.

Operationally, there are two big, three big programmatic fund flows into our global health programs. One is through CDC; one is through USAID; and one is through PEPFAR. And so Eric Goosby, Tom Friedman and I have constituted the operations committee. And we are operational. We actually this week are sending a draft guidance to the eight GHI countries to start to describe the elements of what an integrated plan looks like, but do that in a light way because they already have plenty of responsibilities to report to USAID on those countries.

So there are a lot of existing processes that govern what they’re doing. I think what we’re trying to say is, can we find those opportunities to get more by bringing this together and to

find those synergies and come up with a planning construct that does that.

I will say – and this is why I get very excited about this – when I was in Kenya and had the chance to meet with – probably from most of the GHI plus countries but also other countries in Africa – the members from all three teams. And they came together and there must have been 50 or 60 of us and we spent a few days together.

And it's just amazing when you see people actually problem solving together in countries and saying, okay, you know, here is an approach to how we can achieve it and do this work, get these outcomes but also leverage this HIV platform to provide nutrition services to these families and then backward link that to community health workers that work in the Kibera slum that happens to be walking distance from this HIV-treatment clinic.

Those are the kinds of synergies and breakthroughs that will get us more impact for the same investment and serve as the groundwork for then increasing our investment. So we're able – you know, the goal is to be able to do that through the operational committee and to review the country plans as they come in.

MS. CARTY: And I think your comments about really seeking to bring in more people who have trained in the U.S. – whether from NIH or trained with CDC as well as the Foreign Service national staff of USAID; there is really a wealth of talent there.

DR. SHAH: There really is. And it goes hidden. So I'm glad that you highlight that. It's very important.

MS. CARTY: So let's open now the floor for questions. And what we'll try to do is take them in groups of three. And what I'd ask you to do is please be very brief and concise because I think there will be a lot of questions; we really do want to try to accommodate everyone. We have folks in the room who will bring mikes to you and please identify yourself and your organization. So Asad (sp), let's start up here in the front row, please? And maybe the lady and then the gentleman sitting right next to her, please.

Q: Hi. My name is Amanda McCulloch (sp). I'm with ICF Macro (sp). I had a question regarding integration of the monitoring devaluation that you talked about as well as measuring health systems. Can you talk to the complexity of

looking at health systems and all of the Webs that we have and all of the ideas and models? And you talk about the importance of outcomes: How do you see the agency measuring health systems and how strong a health system is growing since there isn't really a GHS for health systems right now? Thank you.

MS. CARTY: Let's take two other questions. And then the gentleman, please.

Q: Hello. I'm William Hare (sp) from the University of the District of Columbia, an extension service. You didn't mention anything about the universities in Africa. What role should they be playing?

MS. CARTY: Great, thanks. And let's pass it right to the lady in red there and then we'll move to another part of the room for our next round.

Q: Hi, I'm Mindy Reiser (ph) with the United Nations Association of the national capital area. In the days of Brian Atwood, an administrator way back when, there was some thought about trying to bring back home some of the innovations and developments overseas. And I'm wondering what kind of thought you have of kind of getting the circle back in some ways to some

of its initiators. For example, there were some interesting campaigns in Haiti to get kids vaccinated. How can we apply this to our inner cities?

A lot of interesting things we aren't doing here that we're learning overseas. So how can we use that wisdom in this country.

MS. CARTY: Great.

DR. SHAH: Well, let me start with the first question. Those are all great questions. On the first question I think you're exactly right, that we need to develop a toolkit of strategies and interventions that both allow us to build the right system attributes and measure them and report on them in as sophisticated a way that we can say we've reduced maternal deaths or child deaths.

But I would say that, you know, if you think about vision of success, the vision of success is: Drive improved health outcomes; just get more – buy more health with the level of investment. It's to really in a meaningful way get country ownership. And we've seen examples of success there. If you look at GAVI's – the Global Alliance for Vaccines and

Immunization – the way they do financial sustainability planning with countries, that countries sign on to and do the long-range financial planning related to a plan or a proposal, that appears to be a best practice. And there is a lot of learning in those types of strategies we could employ.

And then it is expand the service delivery platform in a way that it's sustainable. And that's I think where your question is most appropriate and where it's going to be hardest. But we also have some system attributes. We know we can look at the human resource aspect of a system and say, okay, what would this – what is the annual recurring cost? What are the expanded outcomes of investing in different types of strategies for building out human resources and how would you do that most efficiently?

And I didn't mean to be dismissive of the webs, by the way. There is a lot of great knowledge there. I just feel a little bit like sometimes the advocates – and I am one of them – of a health systems approach sometimes make that so complex that it's hard to invite people in and to be analytical and straightforward about it. And so I'm just making the plea that we really focus on health outcomes, country ownership and some core system attributes and drive hard against those outcomes.

On universities, I couldn’t agree more. I think actually when we were talking about where a lot of these NIH graduates are, they are at the universities. So I agree that the universities, the ministries, the local NGOs and the local partners of bigger international NGOs are often the kinds of places where you see a lot of this leadership and capability and wish to engage all of those partners.

For those of you that have been involved in sort of health trials on new medical interventions – and you know that most of those are done in partnership with local universities. And I think that’s very, very important to create that system for reporting on data and so that local leaders and scientists and health experts buy into and are excited about the kinds of breakthroughs that might be most relevant in those communities.

The third question is perhaps the hardest. I think there probably are a lot of opportunities for learning from everywhere around the world and then bringing those learnings back to especially those places in this country where we know there are extraordinary and unacceptable health disparities. When I looked at the Washington data – Washington, D.C., data – on health, on maternal mortality, even in this district, as you all

know, there is probably a 3X differential across different communities in terms of things like morbidity during childbirth. And there are a lot of opportunities to do better there.

So I'm sure there are great opportunities for learning. I'm sorry I can't identify exactly what they are or how we'd use them. I'm personally a big fan of these different strategies of using mobile connectivity for messaging and for communicating and studying what types of messages and communications sent when in the – immediately after birth and in the first year, what types of messages and when should you send them in terms of having the most impact? I think you'll see a lot of progress on those types of systems in this country as well.

MS. CARTY: Great. Moving over to this part of the room, Catherine (sp), why don't we go way in the back, the corner there, the gentleman in the back row?

Q: Hi. My name is Ulag Ulman (sp) from the Norwegian Embassy. First of all, thank you for coming and thank you for your leadership on global health which, as you know, is a key priority often for my country.

I wanted to ask you about PEPFAR. Is PEPFAR and should it still be considered an emergency effort or should it be considered something else? And then, related to that, what is your answer to critics who are a little bit unhappy about the – what they would say a slow increase in the funding for PEPFAR. Thank you.

MS. CARTY: And the lady up a few rows in front here, please.

Q: Thank you. Dr. Shah, thank you so much for your remarks. You talked about the inefficiencies in stovepiped health programs. And I'm just wondering, in the barriers that you talked about for access to health care, you talked about the role of women, which I really see as a democracy and governance issue. And we all know about the problems with ART adherence constraints because of food insecurity or the woman in Kenya that you talked about who has sex without a condom 20 years into this epidemic because she has three kids to feed and she doesn't have a job.

I'm just wondering, can you tell me how you think we might break down the stovepiping in our development portfolios broadly

so that we can have a stronger more cohesive multisectoral development response. Thank you.

MS. CARTY: And, Catherine, let's move over to the corner here.

Q: Hi. Thanks, Lisa. Ann Richards (sp) from the International Rescue Committee. In my travels for IRC, I have seen some really impressive health programs. And they're not all just IRC. Some of them are partnerships with MSH, JPIGO (ph), John Snow, Maurice Stokes (sp), some of these partner organizations that are here today.

And, unfortunately, sometimes these programs are endangered not just because of lack of funding but because of funding gaps and interruptions. So, for example, in March I was in Northern Kivu and there was an AFTA funded program that was strengthening clinics. But it's all going to expire in the coming months.

Similarly, in Pakistan there is a post-earthquake program, PRIDE, because a lot of the things you were talking about in terms of raising standards and training staff and really bringing up the quality of health care to people in very remote locations, it doesn't quite fit the counterinsurgency thrust

right now going on in Pakistan. So that may come to a close. I'm not advocating for programs, that IRC gets funding from AID for going on indefinitely. (Laughter.) But I do think, since some of these programs do fit exactly the goal that you've articulated, what can we do to make sure that they're not just lost in the shuffle?

DR. SHAH: Well, these are another great set of questions. On PEPFAR and whether it's an emergency, I don't actually – you know, I know Ambassador Goosby is committed to the name and believes in the construct. And I, frankly, like thinking of everything in global health as an emergency. To me it's an emergency that 8 million children die a year that shouldn't die and we can prevent that and we know how.

So I'd be for more of an emergency mindset across all of our programmatic activity and across how we think about things. That – what an emergency mindset should lead you to is a sense of urgency, a commitment to be results-oriented, a sense that now is the time to act and a desire to make visible our success and the unit costs of saving lives so that we can get more people to buy into this global emergency that is global health.

And so I don't know if that's a specific answer to PEPFAR in its name. But it is the mental approach that I bring to global health, and I feel very strongly about the need to be urgent and quantitative and outcomes-oriented in how we design our work.

On the question of funding, you know, this administration will of course continue to increase its commitment to funding in this area. It is going to be important to also expand the service platform and reach more people within the current base. And you know, at the end of the day, our goal is saving lives. And our goal is building sustainability in systems. And I think you've got to look at both additional resources and efficiency through integration as the approach to get to that outcome.

On the question about silos and ART adherence and how we think about gender, in particular in the context of development, but also health, I completely agree. I think there are a tremendous number of non-captured synergies, not just across USAID and PEPFAR's health programs, but across our collective global health enterprise, and the whole sector of democracy in governance. One of the great things I've enjoyed about being in this role is getting to learn, every day, about the quality and significance and efficiency of that programming.

And I think you're just exactly right: The more that we can link investments in transparency and public funding and accountability with expansions in global health, the more eyes we have on a health system and the more demand for results and accountability we'll have, that will push partners and ourselves to perform even better.

One example – I just was back from Senegal. And there, we have our education program working with the president's malaria initiative program. And it's an incredible partnership, because it's precisely the schools that we're supporting, training teachers and – that they bring the students together, they sit outside, they get bed nets or they talk to the kids about how to use insecticide-treated nets.

And they've found, statistically, that the kids do really well with this intervention, in part because they get the additional support of being with a trained teacher in a good – you know, in a school that's an improvement over what they had before. I think there are a myriad of other kind of points of connection, where we could get better health and better education and better democracy-in-governance-type of outcomes by

linking these things. And I look forward to more creative ways to do that.

Anna, on your question, I agree with you. I mean, I think in general, we want to support programs that are consistent with the principles we've laid out and that are consistent with building the country ownership and the local systems to sustain them. And I've seen many of your programs, but I've also seen many other implementing partners, do an outstanding job of training, hiring and building a cohort of, I'd call them, health administration managers, that are local, that are efficient, that are smart, and that are going to be the leaders of the health system over time, especially in managing a large, distributed system.

I don't know the specific cases to which you're referring. I think there is generally a gap between – off the humanitarian assistance programs and global health development-oriented programs. To the extent that, that was your first example, that's an area where we're using the opportunity to learn from Haiti to put in place a sort of bridge strategy so that we have more internal, analytic capability to do relief to recovery to development in a cleaner continuum. I'm not as aware of the specifics around the Pakistan case, but we – you know, it's a

large health program in Pakistan and we're very committed to these principles there.

MS. CARTY: I'll take the gentleman in the back of the room, please.

Q: Okay. Thank you. Good afternoon. My name is Muhammad Ali (sp). I'm with Idea, Inc. and my understanding is that we stopped the humanitarian assistance to go to Somalia, and the reason stated is that it will go into the hands of al-Shabaab. So I have two questions. What type of programs are we assisting with Somalia? And the next question is, are we working with Somali Americans, which I think they have, in their hearts, good interests of the United States and Somalia?

DR. SHAH: I'm sorry, I didn't catch the second part of your question.

Q: Yeah, are we working with Somali-Americans?

DR. SHAH: Oh, Somali-Americans.

MS. CARTY: Please, the lady right to the side of the door, there.

Q: Hi, I'm Heather Heckel from American University. Dr. Shah, thank you for your talk. Your expertise and enthusiasm is very encouraging. My question is actually about water and sanitation. I was wondering if you could speak to the way the GHI is addressing that. With approximately one-third of the world without sanitation and one-sixth without clean access, it seems like a significant public health priority. Thank you.

DR. SHAH: Okay, thank you.

MS. CARTY: Other questions? Here in the front of the room, please.

Q: Hi, Jill Gay, consultant, Open Society Institute. My question is about your comment at the beginning of your talk about having pediatric AIDS. And is USAID going to be promoting prophylaxis or treatment for the mothers? In other words, if it's treatment, then it will benefit the mothers themselves, and you've pointed out the link between maternal and child survival. If it's just prophylaxis, it can injure – it can prejudice the mother's future treatment and it does not do anything for the mother, although it helps the infant survive.

MS. CARTY: Thanks.

DR. SHAH: That's very helpful. Let me start with Somalia, with the second part of your question. I would have to do a little more to understand how we're engaging the Somali-American community, but I think that's a great suggestion. I know, between our counterparts at State – at the State Department, I know there's an active effort to do that, but I'm not able to describe it in detail.

I will say, in general, and one of the things I observed from Haiti is that – and from being part of an extended diaspora community from my childhood and even today – that I believe that the diaspora communities in the United States are a huge source of strength to support the implementation of our work in this area, and we should engage them more effectively over time. So I appreciate your raising that suggestion.

With respect to the whole Somalia program, we do have active programs and activities in Somalia, where possible. There are a number of reasons why for both access and safety and security, as well as a range of other issues, it's not as comprehensive as we'd like. And I'm happy to follow up with you afterwards on that.

On the water and sanitation question – Heather, thank you for raising that – it's such an important insight. Because when you look at – if your real goal is to get large-scale population health improvement that's sustained, you often absolutely have to think about water and sanitation and the strategies to improve performance in that area – and hygiene – in a smart way. We have a range of programs in our WASH program – water, sanitation and hygiene – that really tackle all three of those.

But I'll give you one example: When we were in Senegal, we visited a community health facility, but it was in a catchment area treating about, I think, 7,000 or 8,000 – now, there were 40,000 people in the community that were seeking care in this facility. It was a small, relatively overwhelmed facility, but it was their only health hope. And they had incredibly high rates of diarrheal illness in children and pregnant women and everything, and you wondered why.

And then you saw, well, their source of water was often the nearby – or this was in Sudan, sorry, in southern Sudan – their source of water was the Nile. It was dirty. And they weren't using purification tablets or improved – they weren't protecting the safety of their drinking water, and that was directly

implicating both the service volume that you saw at the clinic and the ability of that clinic to get ahead of the curve, in terms of providing population health.

We have to think of these things in an integrated way, and think about, what's the most efficient way to get population and community-level health outcomes. And in that spirit, I'm really excited that you raised, kind of, clean drinking water, improved sanitation and, importantly, improved hygiene practices, which, where we've seen those things come together, they've made huge statistical gains in some of the diseases that disproportionately affect children and women that we're trying to really concentrate on here.

On the pediatrics AIDS question, I will come – I'll go back to the team and come back to you. I appreciate the distinction. I think it's very important. And if your question was about what USAID does, versus what we think about what PEPFAR does, I'm not exactly sure, and I would go back and find out.

But in general, in that context, I think our overall approach is to find the treatment-led synergy that comes from, you know, providing treatment, doing that in a protective way and making that as – making that service platform as capable of

tackling as much health improvement opportunities as possible. So thank you.

MS. CARTY: Other questions? Peg, please, in the first row here.

Q: Thank you, Dr. Shah. Thank you, Lisa. And congratulations on your family news. I wanted to ask you if you could talk a little bit – you talked about data and metrics. How do you all make the decisions to link resources to, say, morbidity and mortality? For example, tuberculosis kills almost 2 million people in a year, but tends to get less money than diseases with comparable impact. So I was just wondering if you could talk about that, thank you.

(Cross talk.)

MS. CARTY: What about the gentleman beside – right near you here on the end.

Q: Good afternoon, Dr. Shah. It’s good to see you after so many years. Eric Williams from Physicians for Human Rights and the Health Workforce Advocacy Initiative. You talked a lot about the health workforce, and very pleased to hear you talk

about the range of things that need to be done, in terms of the health workforce. WHO, in 2006, identified 57 countries with a critical shortage of health workers. The U.S. has committed itself to 140,000 through PEPFAR, to train. There's also another commitment of 100,000 community health workers through the USAID in maternal and child health.

How can we work, potentially, with the GHI Plus countries to offer technical assistance to assist countries in developing robust, comprehensive plans to specifically look at human resources for health in a way that brings a more comprehensive approach, and also is in the spirit and tenor of the GHI, in terms of country ownership?

MS. CARTY: Let's take one more question. Catherine, what about the person right next to you there?

Q: Yes, I'm Tanya Feel (ph) from – (inaudible) – Corporation. I have been attending some of the presentation of Feed the Future, and today's presentation in Feed the Future, we talked about nutrition. And I would like to have your view on how nutrition will be linked by these two initiatives and what are the objectives of these two initiatives on nutrition. Thank you.

DR. SHAH: Great. Well, those are all excellent questions. This is a really talented audience. On data and metrics, you know, what we obviously try to do is identify the most appropriate opportunities to spend resources in a way that buys health outcomes and accomplishes the other two aspects of the vision of success that I talked about – country ownership and building out the health system.

You know, if you look at the PMI effort, you look at investing in a set of interventions that we have studied that we know work and then continuing to study their both cost-effectiveness and their application and success in different contexts, in different settings, because we all know that context specificity is very important. I know we do the same within TB and within the package of interventions, there.

And that's what leads me to the comment I made during the discussion, that perhaps new diagnostic breakthroughs will make a big difference, because a lot of the challenge is knowing which route to go in what timeframe and whether you need MDR treatment or otherwise. But in general, our approach to making these decisions should be based on saying, what is the most efficient and effective way to achieve the three outcomes we

talked about, while making investments in those interventions that we know are a cost-effective way to buy health outcomes?

On the health workforce, Eric, thanks for the comment. It's nice to see you again, too. And I really appreciate that because it's an opportunity here to really get this right. and that doesn't mean that we're exclusively focused on community health workers, but we are thinking a lot about how you extend service through that last-mile problem that has been such a challenge for so many different parts of global health for so long.

And the way to plug into that would be to work with the GHI deputies and the teams that are put together. Amy Gadsden on the USAID team could be a place for you to plug in on that and we can get you her information. We would welcome your both analytic guidance and support, and ideas, in the eight GHI Plus countries, which are, of course, public. And so we could talk about that and work together on that. Thank you.

On Feed the Future and the overlap with nutrition, I want to thank you for raising that question. I'll point out, I was at the Department of Agriculture before coming to USAID. I just think this is very, very hard. Population-level nutrition

improvement has eluded country after country, and it really does require a rethink on our basic approach. And here's some aspects of that rethink: One is that I think we have to do a better job of building nutrition outcomes into programs across all relevant sectors. So water, sanitation, hygiene programs, health programs and agriculture programs, I think, should all be kind of cross-linked to the other outcomes so that we can start to look at what's the most effective way to improve nutrition.

We know in some parts of South Asia, for example, that clean drinking water is often the most effective nutrition intervention for certain populations of kids, and it improves their internal GI absorption of nutrients and they do much, much, much better than simply targeted feeding programs or medical interventions. But then we know that that's not going to be the same strategy in some parts of Africa where, you know, you would have a different approach.

The second thing I'd say is that the health package of interventions is incredibly important, and we're increasing the investment on health-related nutrition interventions. So we know that the minus-9 to 2 years of age time period is the critical point for intervention. We know kids that – (inaudible) – series that came out a couple of years ago proved

this without question. The kids that are chronically malnourished in that first period will have less brain development and less ability to thrive through the rest of their life. So we know that that targeted intervention is an important part of a solution and we'll work hard to get it right in that targeted infant/young child feeding component.

And then I would add that I think one of the things that we don't think or talk enough about are the agriculture-related interventions. And it's why I'm so excited that the Feed the Future effort has a strong nutrition focus. I was just in Bangladesh, where, if you look at, over the last 15 or 17 years in Bangladesh, the diet mix of the population has essentially stayed the same.

There's been no – despite some income improvement, there's been no improvement in access to protein and improved micronutrient food like vegetables. And it's still very heavy on staple grains like rice. And then, if you look back at the agriculture-sector statistics you see the price relative – the real price of rice has fallen by about 50 percent. The real price of animal protein – dairy and meat – has gone up more than 150 percent, the real price of vegetables up more than 100 percent. And in that context, it's actually a rational thing to

do to have your food basket lean more heavily towards rice. And that's why you haven't seen the improvement.

So I think that to really tackle nutrition, we have to get the WASH component right. We have to fundamentally reinvest in infant/young child feeding on the health side. And we've got to get much better at understanding what are those agriculture system investments that can change population-level consumption of improved micronutrients and proteins for populations that are deficient that way? So I appreciate the question. I don't think it's easy. I think that it's tough. And anything that's that interdisciplinary is going to be tough. But it's fun to have the chance to work on it in a really focused way.

MS. CARTY: And I think we probably have time for just one more quick round of questions, but let me just make a further comment before we go on, which is, you know, the complexities of these challenges and how you need lots of people working on them. We actually hosted a discussion on Friday here on innovative finance that Amy Bassenberry (ph) kindly came and joined us for.

And it was sort of similar to the issue that Eric raised – I mean, there was a real willingness among the people in the

room to be helpful or be a part of any kind of ongoing dialogue, or whatever, to try to help move the issues forward. So I think across the board, whether it's human resources or finance or many other issues, there's a community here that would welcome the opportunity.

DR. SHAH: That's great.

MS. CARTY: So let's maybe take two more questions, if we can – the gentleman here in the middle.

Q: Thank you. My name is Andrew Trautner (sp) from American University. With austerity measures being popular – (inaudible) – Americans who don't, essentially, directly benefit, nor would they exactly care about the benefits. Thank you.

MS. CARTY: And one more, please. The lady right here, please.

Q: Hi, I'm Chris Levinson (ph) with IntraHealth International. And Dr. Shah, my question for you – you mentioned, earlier – you touched briefly on procurement reform. And is the fact that the advent of the GHI and procurement

reform coming at the same time going to risk delaying the rollout of GHI?

DR. SHAH: Both great questions. Let me address the second one first. On procurement reform, no, it shouldn't really delay anything. You know, to some extent, all these programs are programs that are underway, and we're trying to create a framework that allows for integration and finding those synergies across the programs where that is both efficient and more conducive to getting health outcomes. So we'll continue to do that with existing programs without waiting for a set of procurement reforms to be adopted.

Where the two are very aligned is, a fundamental component of the procurement reform approach is to say that our work should be more visible to countries, that there should be greater opportunity for country ownership and there should be more thought placed on long-term sustainability, which often means accelerating what so many of our partners who are in the room today do quite well, which is building local capabilities and local staff and really providing for that kind of capacity development in the execution of our work. So I think when these things start to align, they'll align very, very, very well and very efficiently.

On Andrew's question, I think this is a great question to perhaps close on. You know, I would just take a bit of an issue with the phrase that Americans don't care or don't necessarily care, and I know you're saying that – (chuckles) – yeah. I think Americans care deeply about this. I think they care deeply about this. And when I walk around and see people wearing RED t-shirts because that's a symbol of their commitment to saving lives around the world, or when I look at the fact that more than half of all American families gave, in some form or another, to the Haiti relief effort, it's an overwhelming thing.

You know, when we talk about more than half of all Americans coming together to watch the Super Bowl, we consider it a big national moment. Here, you had more than half of all American families coming together to save lives and express our common humanity. And that is, in my mind, much more of an American moment than, perhaps, some others.

So I think Americans do care, and I think if we can demonstrate that we do this work efficiently, that we're hyper-focused on value for money, that we are smart about building the systems that will sustain themselves so that we're not needed

endlessly in this enterprise, and that this is directly related to how the world perceives us and to our long-term safety, security and ability to partner with other countries and other peoples, I think the commitment to support this work will just continue to grow.

And we should all do our work with that fundamental understanding, that people and Americans especially do care. That's why we have to make the work more efficient, more transparent, and invite them in to support the common enterprise.

And with GHI, you know, the case here is that by taking an integrated approach, by focusing on efficiency, by doubling our commitment to innovation in the program and by being very outcomes-driven, we can achieve the kind of efficiency improvements, save more lives, do it disproportionately for women and children, and make an even stronger case to an American public that is already willing to be deeply supportive of this portfolio of work. So thank you for raising the question, and I'm very optimistic about it. (Applause.)

MS. CARTY: Thank you all very much for joining us. Raj, a special thanks to you. Your energy and optimism really is

contagious. And a special thanks to Henrietta Holsman Fore for being with us today, as well. Thanks very much. (Applause.)

(END)