captured events that led to a blood draw (even if the results were within normal range) or temporary cessation of the study drug. Inclusion of these types of events was helpful in differentiating the bleeding profile across rivaroxaban doses, which was the primary aim of the phase 2 ATLAS ACS-TIMI 46 dose-escalation study. However, to combine bleeding requiring medical attention in a composite net clinical outcome with death and recurrent ischaemic events would seem unbalanced. Ultimately, clinicians and clinical trialists will need to continue to develop methods to assess adequately the safety and efficacy of antithrombotic and antiplatelet medications, particularly as the number of treatment options increases.

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Towards a global fund for the health MDGs?

As we had expected, our Comment proposing a global fund for the health Millennium Development Goals (MDGs)[1] sparked a lively debate. We would like to address some of the reactions published in *The Lancet* (June 20, p 2110–11),[2-4] which echo those in other fora.

Alvaro Bermejo[2] voices concern that a global fund for all the health MDGs (including the health systems needed to deliver health services and key areas within the social determinants of health) will divert attention and resources from "priority diseases", thereby jeopardising recent gains. We concur that broadening the remit of the Global Fund and GAVI will require substantial additional resources, a point we made explicitly. We think, however, that the gains made in tackling some priority diseases are intrinsically fragile, since they often depend on fragile health systems, or on parallel health systems set up for selected diseases only. The limitations of disease-specific interventions operating within weak health systems have recently been examined:[5] a comprehensive system-strengthening approach would sustain and expand the gains in control of some priority diseases. We should not fall into the trap of pitting diseases or conditions against each other or against health systems.

We concur with Helen Epstein[3] that it is difficult for global health funding mechanisms with disease-specific focuses to fully support national health priorities, since they cannot respond to needs beyond their specific mandate. Broadening their mandate to health systems strengthening and all the health MDGs is a first step towards improved alignment.

Jeffrey Sachs and Paul Pronyk[4] are correct in pointing out that the Harvard Consensus Statement did not assume that health systems were "functioning reasonably well". That line in our Comment referred to the establishment of global health initiatives that bypassed national financial autonomy criteria *only* for disease-specific interventions. We apologise for the confusion we might have created. Sachs and Pronyk propose the establishment of additional funding windows by the Global Fund, in line with its present modus operandi. In the long run, however, countries should be allowed to submit proposals based on their comprehensive health plans, without having to disaggregate them into narrower components that fit within specific funding windows.

GC is a member of GAVI Health System Strengthening Task Team; his views are not necessarily those of Save the Children UK or of the GAVI Alliance. GO, AS, and PZ have no conflicts of interest.

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Monitoring and evaluation of PEPFAR treatment programmes

We appreciate Peter Navario's suggestions (July 18, p 184)[1] for building on PEPFAR's success in improving access to HIV care and treatment during the first 5 years of the programme. PEPFAR is a learning organisation and much has changed during the evolution from an emergency approach to more sustainable treatment programmes.

We agree that ensuring patients remain on treatment once started is of crucial importance for all HIV treatment programmes, including those supported by PEPFAR. We also agree that routine monitoring of retention rates will help develop innovative interventions to successfully retain patients. Earlier this year, we revised our indicators for 2010 and future reporting, adding "Percent of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy". Identification of an appropriate indicator for adherence has not been