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**AHCJ Annual National Conference
US Roles in Global Health: Which Direction?
Association of Health Care Journalists
March 29, 2008**

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JIM SIMON: Well, I want to thank everybody for coming today. I did want to, at the end of the presentations, we are leaving plenty of time for questions and to make sure that folks when they have a question, go to the mic largely that so that all of this can be captured on audio and video. So we do need you to ask your questions go stand or line up to the mic when we do that. So, again, I want to thank everybody for coming for this panel, and I want to thank our panelists for coming. One came all the way, Dr. Dowell, all the way from Atlanta this morning. And I would like to just start off real quickly by ripping off a remark, a favorite remark of mine by my colleague who is a science writer at the Seattle Times, Sandi Doughton. Let me back up for a second.

My name is Jim Simon, and I'm an editor at the Seattle Times. And as I said, I would like to start off ripping off a remark my colleague is fond of making, and she often talks about the amazement. She covers global health issues and science for us. She notes sort of an amazement she sees in the transformation of what was really a once obscured field in some ways known as tropical medicine into, in some ways I'll call it [inaudible] of sorts. Global health has really become a highly visible component of American Foreign Aid and Foreign Policy to some extent. Global health funding is now champion by an unlikely consortium of liberals, evangelicals, Bono, the NBA

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runs a campaign Nothing But Nets campaign, and the amount of philanthropic dollars and spending on research has surged over the last decade or so. Spending for malaria control, for example, has gone from \$19 million in 1999 to \$820 million in 2005. There has been an explosion in sort of both interest and action, I guess.

But also I come to this as a journalist and like many of my fellow journalists out there, the topic of global health I approach as an editor with both sort of fascination and terror. While we have the advantage where I live of being sort of a hub of global health research and philanthropy largely because of the Gates Foundation and some of the spin off of that, we really grope without a cover, this vast and fairly complicated, not just fairly complicated, complicated topic where a lot of the real stories or the stories that we see out there occur continents away.

So, we struggle really with how to write stories and understand the issue in a way that can engage our readers in Seattle or Des Moines or whatever, and I'm hopeful today's panelists, I'm confident today's panelists are going to provide some valuable insight about both the US role in global health and this sort of emerging role, the challenges, and the controversies, and some of that will come hopefully to frame the issue for journalists in a way that you come away with fodder for stories and how to really approach some of these

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stories if you are journalist in Washington D.C. or a
journalist some place else in United States or anywhere else.

So, with that, I'll introduce all of our panelists. To
my left is Rachel Wilson, M.P.H., who is a Director of Policy
and Advocacy for PATH. She is in D.C. and it is a Seattle
based international health organization, and she has 15 years
experience in public health policy and research. Most
recently, worked for the Global Health Council before coming to
PATH.

To her left is Daniel Epstein who is the public
information officer for the Pan-American Health Organization,
which is part of the World Health Organization. He formerly
worked as a journalist covering science and health, and
environmental issues. At the Pan-American Health Organization,
he produces communications and public health materials on a
variety of issues.

And then to his left is Dr. Scott Dowel, who is chief
of the global disease detection and emergency response branch
of the CDC. He established and directed the joint emerging
infections program with the Thai Government, among some of his
other work. This group played a really prominent role in
responding to the SARS outbreak and the avian flu and some of
that work is really sort of the most visible and almost a
poster child of some of the global health work that goes on,

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particularly in some of the American role. So with that, I'll turn it over to Rachel.

RACHEL WILSON, M.P.H.: Thanks Jim and thanks everyone for being here. I know that there are other things that poll like the cherry blossoms, but you have chosen to be here, which is great, but I do encourage you to get out there at some point and see it is beautiful. So, I'm the policy wonk at PATH, which is a global health organization. We do a lot of work in the field, direct services, education around HIV, malaria, TB, child health, you name it, across the spectrum. We also work on developing new tools and innovations to address infectious diseases and other health problems, and work with industry to develop vaccines and other health delivery tools.

What I thought though I'll talk about today, because it's kind of the hot topic on the Hill these days, is PEPFAR. PEPFAR is the President's Emergency Plan for AIDS Relief. So over the last five years, the president has had an initiative that actually authorized \$15 billion for HIV and AIDS. Actually more than that, about \$19 billion, may be a little bit more than that, was actually spent on HIV and AIDS during the last five years. So, we are looking at reauthorization of this bill for another five years and they are talking about \$50 billion, so 550, so that is a lot of money, and so a lot of the issues that come up around the debate, around the reauthorization of PEPFAR are the very themes that we see

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coming up over and over again in a variety of different areas. So that's why I have chosen to frame some of the issues in that debate to give you a sense of where those of us are grappling with systems and policy issues related to global health. So, I figured I would start by talking about the money because that is what people like to talk about around here and in many areas of the world. So, \$50 billion is again a lot of money.

We see increasing focus and resources towards malaria and TB in this upcoming bill that the House and the Senate and the administration are actually working together on to create some common goals. They are right now tweaking it in a variety of different ways, but it does look like there actually may be a compromise you never know for sure, but there may be a compromised bill that gets passed this congressional session.

So, we see an increased focus on malaria and TB and the impact on these increased resources towards HIV and AIDS, the concerns that the community often expresses is what about the rest. So we see child health, maternal health, and family planning while we have seen necessary increases in HIV and AIDS, some people are concerned about what does that mean for the other issues that may actually be either flat lined or when you factor in inflation may actually be decreasing. So we look at whether there are challenges in equity and what does it mean when most of the funding is going through HIV and AIDS and if

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that's the lens that people are looking at other health issues through and what are the implications of that.

The other issue that many people are discussing related to PEPFAR is what we call vertical versus horizontal funding. So do we focus on spending money disease by disease or do we look across the spectrum at integrated programming. So, this is bringing up a lot of that. So have a lot of money on HIV and AIDS here, and family planning here, and child health here, what does that mean for the intersection and whether or not the programs are truly working in an integrated way. So the US is working in this kind of account-based system. While we have got countries like the UK looking more at things at basket funding so that you look more at integrated health systems. Again, there are pros and cons to each. Each of these issues does not have a right answer, but these are things that we are grappling with at this time.

Health system strengthening and the human resource challenge is just a huge challenge overall and because HIV/AIDS is such a huge problem requiring so many resources, it has really come to the forefront with the discussion around this bill. We look at sub-Saharan Africa where 3-percent of the world's health workers struggle to combat 24-percent of the global disease burden, and there is an estimated more than 4 million additional health workers needed to fill the gap.

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The new bill does increase the supply and retention of health workers. The House and the Senate bills both look at training at least 140,000 new health workers and support development of five-year country specific work force plans. Different versions touch on issues of health care compensation and training of health workers. It is really not clear at this point how that will end up in the bill because there isn't agreement across the House and Senate bills at this time. One of the other issues, and I am guessing that many of you have already heard about this, is how prescriptive to be with the funding.

So, one thing you have probably heard about is what people call the abstinence only earmark. And what that is saying that one-third of the funds for prevention need to go towards abstinence until marriage programs. Very controversial issue. Some folks feel that without that earmark, needed programs won't get attention, while others feel that by earmarking specific funds for specific tactics doesn't allow countries to use the funds in order to meet the needs of the community, the specific needs of that community.

So, we see the HIV prevention efforts being clustered in something called ABCs and if you haven't heard of that that's abstinence being faithful and using a condom. In this previous bill where we saw the abstinence only earmark, as people call it, we think that there may be a repeal of that in

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this upcoming bill, which is still yet to be seen but both the House and Senate versions of that bill seem to indicate that.

And then lastly, we see policy restrictions ain funding as a topic that comes up in HIV and AIDS. So, something that many of us in the community refer to as the anti-prostitution pledge where the US government requires that organizations sign up pledge opposing prostitution in order to receive funds from PEPFAR and that pledge is across the entire organizations so not just for those funds. It looks like that policy restriction may remain in the final bill. Again, we do not know, but it does look like it's remained in the House and the Senate. And then there are some vague language around family planning that may indicate some restrictions to that.

So, I could go on and on, I can talk for hours about this. I actually see some colleagues of mine in the room that could probably tell you more details as well, but what I wanted to also leave you with is we've got these challenges. We've got these challenges across the board not only with HIV and AIDS where we do need the \$50 billion, and we actually need more than that and we need money in these other areas, but we are making really great successes as well, and I guess that's part of what I want to leave you with is that there are things that we can do.

So, in addition to reporting about the challenges that we face and the policy issues that everyone is talking about to

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really also pay attention to those things that are working. Now, at PATH, a lot of what we do is working with technologies, and I'm just going to give you a really quick example of something that we are doing, easy, not expensive.

Earlier, a couple of years ago, a pharmaceutical company offered to donate nevirapine to a number of countries. Now nevirapine if it's given to the mother and to the child shortly after birth, if the mother is HIV positive, it can reduce the rate of transmission of HIV by 50-percent or more. And this was a very generous offer to these countries; however, the reality is that a lot of the women who live out in rural areas, they may not be giving birth at a clinic or at a hospital. So they don't have access to nevirapine that they need in order to prevent the transmission.

And so countries weren't taking up this offer of the donation. So we worked with USAID as well as other partners to develop just something very simple. It is a syringe in a package, and this would be given to the healthcare workers and they would fill this with the nevirapine, two of them, put them in this pouch, seal it up, the woman would take it home with her and she would use this or whoever was assisting her in the delivery, both the mother and the newborn would get a dose right at birth.

And so, something like this can save a life. We've got a lot that is out there and I really encourage you to report on

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those things and all of us in the global health community, we need you. So we look forward to working with you in the future.

DANIEL EPSTEIN: Thanks, I liked that focus on reporting on what is good and what is working in international health and that's good, but I think it's also important to see what's not working and what kinds of things we're doing. I was going to give you a little bit of an institutional outlook and focus on international health. Okay, this is about global health and we are all connected.

I work for the Pan-American Health Organization, part of WHO, part of the UN System, part of the Inter-American System. WHO, our parent organization, is really where the health leaders of the world get together and make policy decisions. This is a photo of the World Health Assembly, it's basically where they sit and agree on actions, policies, and budgets, and what WHO is going to do globally, but always in collaboration with Ministries of Health.

This shows a little bit about how thoroughly we cover the globe. There are WHO and PAHO Offices in pretty much every country. In the Americas, we have 27 country offices and about eight scientific technical centers. We have sub regional offices, 8000 public health experts working for us, a lot of ex-CDC folks, and a lot of Ministry of Health folks. There're a lot of doctors. There're a lot of MPH. There're not enough

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communications officers. There's only about maybe 12 or 15 of us and then there are scientists, managers, and administrators.

So there are a lot of people and a lot of offices doing global health stuff including our headquarters in Geneva, Switzerland. One of the important things we do is the crisis management of global health outbreak and outbreak control. And I know we rely very heavily on CDC to help us with that, with expertise.

But the interesting thing about global health is that the politics don't really matter. Your country can be right wing, left wing, dictatorship, or democracy. In health pretty much, most people agree and most doctors are knowledgeable enough to know that it doesn't matter what your politics are. You have to collaborate to improve health to prevent outbreaks and to progress ahead. So that's a good thing about working in international health.

The new thing that has come up now since 2007 is we have a new system called International Health Regulations in which countries are obligated to report events that might be of international significance like SARS or pandemic influenza outbreak or anything that could affect a lot of people and spread from one country to another. So we have a whole group in our office here in Washington that follow on a daily basis every little thing that is happening. I think there are yellow fever cases in Paraguay. We know we have a map where they are,

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who they are. We have the details, the clinical details of each of the persons, where they got it, what the transmission chain was. So they follow in quite a bit of detail all this. And it's important because really this past month it was the first time since 1942 I think that we have had urban yellow fever anywhere in the Americas.

We have a dengue outbreak at this moment in the State of Rio de Janeiro where 47 deaths have been reported. This is a huge problem. It is increasing all over the Americas. Mosquito habitats I guess are expanding. I don't the science of that, but there is certainly more dengue around. There're many more cases now than there were years ago and we're at the top of an epidemic cycle of dengue.

Money, we don't have a lot of money. I think our whole budget is around \$3 billion including about three-quarters of it voluntary contributions from countries. The US of course is the biggest donor. The US pays 25-percent of the WHO budget and a substantial amount of voluntary contributions. Most of the other money comes from other UN agencies, foundations, and some NGOs. We make 2-percent on interest income I see, I didn't know that. Then local governments and cities and institutions also chip in for specific programs that they run.

This is too detailed to look at or to read, but it shows a little about what expenditures are. We attempt to spend as much money in the field as possible and to work in the

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countries and in the regions much more than in Geneva Headquarters, which is an expensive place and a place where a lot of people spend a lot of money doing meetings and conferences and we would rather get away from that decentralizing and do a lot more in the field.

PAHO for this regional office of the Americas, you can see that if you add up, this is a couple of years old, but the proportions are still same. If you add up all of the money that countries contribute, the US contributes about 60-percent, 61-percent of all of our budget. Mexico and Canada are the next largest and Brazil as well. The country contributions are based on the UN assessment scale some geniuses devised, which basically focus on country's ability to pay, but without the US, we wouldn't be able to survive I think or function.

Some of the things we're doing in 2008, just for journalists to know, climate change in health is a focus of World Health Day, which is April 7th and we are really looking at what the IPCC, the Intergovernmental Panel on Climate Change, has written and we are getting experts to look at what effect, if any, the climate change can have on health and what we can do to mitigate that.

Immunization, I think, is probably our most important, most successful program. You know that through immunization we eradicated smallpox globally in 1973, we eradicated polio from the Americas in 1991, and I'm old enough to have been involved

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in a lot of the communications work for that campaign and in that effort to get rid of polio, journalists were very important. Without communication efforts and promotion and community participation, we couldn't have done it at all. We're trying to eliminate measles transmission in the Americas. We're being pretty successful at it, although once in a while imported cases pop up, and we are now working on rubella and congenital rubella syndrome elimination.

Polio was on target to be the second disease to be eradicated globally, but we slipped. We had a problem, I think in Nigeria and in India, and in a couple of places. There're some serious setbacks, and obviously we're way behind, but it's the plan to finish the job of eradicating polio. There're a lot of other special days. There is special day for everything, TB Day, Tobacco Day, Blood Donor Day, et cetera, and these don't really mean much except as an excuse to do press releases to get you guys to write stories and focus attention on the issue. They are not necessarily of any great import, but sometimes they are significant.

Some of the issues that we deal with on a constant basis that are important to countries in the Americas and globally are emerging and reemerging diseases are things that have gone away, but are coming back or new things that are coming up, food safety, obesity, which you think of as a

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problem of fat people in the US eating a lot of McDonald's hamburgers.

Obesity is becoming a real problem among poor people in Latin America and in many developing countries because they are eating junk food basically and so the chronic disease implications of that are tremendous for a lot of people in developing countries that are now faced with this double whammy of being infected by a communicable disease and chronic disease, cancer, diabetes, cardiovascular diseases, rates are all up.

This shows you have little slice of polio eradication where we had 350,000 cases in the world in 1988, and we have got it down as of February to 1,300 or so. Wiped out from most of Europe, wiped out from a lot of African countries, and just India and a couple of countries on the Horn of Africa and East Africa are left.

This shows you how closely WHO, CDC, and other people track every little movement of any virus around the world. The wild polio virus type I and type III circulation figures from August to February, so you can see exactly what's circulated. This shows a little bit of how we have advanced in life expectancy. It used to be that in the 1950s as an average anywhere in the Americas, you could expect to live to be about 50 years old, 48 to 50 years old, and now that average, as an average throughout the Americas is about 78. The increase has

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been tremendous and at the same time, infant mortality rates, which used to be on the order of almost 160 deaths per thousand live births are now down to just over 20. That shows some of the improvements that health systems have made and a lot of it has been through vaccination.

This shows how as vaccination coverage increases and it is now above 80-percent in most countries and above 90-percent in some countries, the number of cases of measles and other vaccine preventable diseases obviously drops. This also shows how closely we track any suspected case of measles, rubella, congenital rubella syndrome, and any of those things.

And lastly, I have talked about chronic disease being a problem, the prevalence of diabetes among adults ranges from about 16-percent in Barbados, a similar figure, 16-percent along the US-Mexico border, but on the US side, that has become one of the areas with the highest prevalence of diabetes anywhere as low as 6.3-percent in Honduras and Chile. That's kind of an indication of how wide the range is, but how the serious the problem is as well.

These are measles genotypes that have been circulating, just another example of some of the specific surveillance stuff that we do. These are the things that in general we are working on. Our main policy and technical and political things, infants death, eradication of rubella, polio, the MDGs, mental health, and maternal mortality are huge issues and

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reducing the impact of chronic diseases, and we also have these problems of diarrheal disease, dengue, TB, and cholera that are serious problems.

New pathogens that are emerging, chronic disease that I already mentioned, and the differences are tremendous, and this is something that we were talking about Bill Gates noticing how in one country infant mortality can be 73 out of every 1000 children, don't make it past their first year and in another, it's only six, I mean only six die out of 1000. That's a huge, huge difference and that's one that we are working on infant mortality shouldn't be that high definitely.

You have read about the millennium development goals that countries committed to at the UN. Four or five of them are health related, so we are making a very special effort to meet these millennium development goals, although it is going to be a hard slog. I don't think we are all the way at the end.

And then just to finish, I called together some of the WHO immediate contacts that I can give you these personally. You can see we have people in Geneva, we have people in every regional office including Washington, and we are here to help if you need anything at all. Thank you.

SCOTT DOWELL, M.D., M.P.H.: I had thought about doing what Rachel did and just talking from notes and then I

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chickened out and decided it would be better off for you if had the crutch of slides, so I do have a few to look at.

So I was going to focus my remarks on global outbreak response and talk about the evolution of the global outbreak response roles at CDC and WHO over the last 10 years or so. In 1995, in Kikwit what was then called Zaire, Ebola hemorrhagic fever emerged after about 12 years of either dormancy or lack of detection, we are not really sure which. That was the time I was a trainee at CDC and this was one of my first international outbreaks. And so you can imagine the impact that that has on a young EIS officer seeing bodies like these being taken out of a hospital and sprayed down with bleach and buried in pits.

The epicenter of the epidemic was Kikwit General Hospital, it's shown in this picture here. Off to the right hand side of the picture, you can see a little tent that was used for triage and that was set up by Médecins Sans Frontières, France. One of the things that I observed and retrospective became more clear is that there were a lot of organizations involved in this response. There was MSF France doing some of the clinical work, but then there was MSF Belgium doing some of the logistics.

You had EPISAN [misspelled?] from Europe doing some of the epidemiology, CDC was also doing epidemiology. We had a German group and an Italian group doing clinical work, a really

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outstanding South African Virology Group trapping bats and trying to look for the reservoir of Ebola. Then you had WHO AFRO coordinating AFRO side of things, but then you had WHO Geneva also there and then CDC doing a little bit of everything. And then finally thrown into the mix with you guys, lots of media, television crews, and media from around the world trying to get images to send back because these were dramatic images.

And I just remember the chaos of that. Fundamentally trying to control what was actually dangerous outbreak and we had colleagues, I had a colleague Maxi Laquea [misspelled?] few years later, he never did figure out what his exposure was, but he was exposed somehow, got infected, and died in the course of the Gloua [misspelled?] outbreak and so clearly a potentially dangerous situation and public health work to be done, but all of these different groups with different agendas.

Just one scene sticks out of my mind when a German TV crew had made it into the Ebola ward itself and started filming with no consent of the patients and no protective equipment for themselves and one of the physicians walked in and there were fista [misspelled?] cuffs and just a mess. In that mix, it really has a consequence of a series of these hemorrhagic fever outbreaks in the 1990s. WHO created GOARN in April 2000, which stands for the Global Outbreak Alert and Response Network, and

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this was a culmination of some discussion over the few years leading up to this of the network of networks concept.

You had a network of Médecins Sans Frontières across the world. You had CDC assignees in different places, but there needed to be a coordination of these networks and this was the role of that WHO filled. It was built on voluntary partnerships and WHO served as the secretariat or the logistical coordinator not having to do everything, but certainly playing the leadership role.

And as Daniel mentioned that WHO did more than that, they also have their own staff that were out there even though they couldn't do everything themselves. Clearly, you had physicians assigned from WHO and this was one of those, you may know his name, Carlo Urbani was a WHO physician assigned to Vietnam. He was assigned there right about the time when I was assigned from CDC to go to Bangkok and establish the emerging infections program there. He was a parasitologist by training, but when a cluster of really strange pneumonia occurred in the French Hospital in Hanoi, he was the one who went there and tried to help the healthcare workers to deal with the patients, take care of them safely, and sending out detailed clinical reports about what was going on.

Although in early parts of March 2003, we had been hearing rumors of clusters of pneumonia in Hong Kong and elsewhere, it really was the French Hospital in Hanoi and

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Carlo's reports that gave us the kind of clinical detail that made it clear to us and others outside of those areas that this was something distinctly different than we had ever seen before, not just because of the severity of the pneumonia, which was killing people, but especially because it was affecting healthcare workers. And that was reminiscent of the hemorrhagic fevers of equatorial Africa, but it is really not seen in pneumonia outbreaks.

This was the chest x-ray from Carlo himself on the second day of his illness and most of you know the story, but to make it short, he, after caring for these people in the French Hospital and on the way to give a talk at a conference in Bangkok, felt feverish, called ahead, was met at the airport and we took him to Bumrungrad Hospital which is the Ministry of Health Infectious Disease Hospital in Bangkok.

His chest exam that first night, I really couldn't hear any abnormal sounds and the x-ray bears that out. The lung fields are nice and dark. The heart profile is normal. Everything about that is normal, but he reported sort of a heaviness to his breathing. We were reassuring to him in the first few days, but it turned out ultimately that he was correct. And it was over days that this picture was unfolding. This is one of the more famous pictures from the SARS outbreak, the Metropole Hotel in Hong Kong at the center and the ninth floor where all of those people staying on that ninth floor

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somehow became infected. We still don't exactly what the event was, but you can see that they took their infection then to Canada and to Ireland, the US and so forth.

The cluster on lower right was the patient who went to the French Hospital in Hanoi and set up that outbreak and then Dr. Urbani who came to Bangkok and setup that outbreak there. These are some of the first images of the causative pathogen, the SARS coronavirus. On the left hand side, you can see the little viruses budding off the surface of that epithelial cell and on the right, the more magnified view, I think you get a vague sense of the surface projections that give the coronavirus its crown-like appearance.

These specimens were obtained actually from Carlo on the first day of his hospitalization, and in the CDC lab and in several other labs, almost simultaneously, the causative pathogen was identified. And it was WHO at the center of that leading that laboratory coalition and exchange of information that led to the identification and probably more importantly to the really quick development of diagnostic tests that allowed people around the world to focus right in on the patients who actually had SARS and ultimately to control the outbreak.

The spread continued for the next few weeks. This is another famous image. This is from the flight from Hong Kong to Beijing. The coughing passenger on this flight, if you can see is sat in seat 14E marked with a cross and the two

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passengers in front marked with the dark black boxes became infected as did a number of other passengers seated some more distance away, two flight attendants, a total of 22 passengers onboard that flight became infected, five of them died, a couple of them led to important chains of transmission in Beijing after they died.

Meanwhile back in Bangkok at Bumrungrad Hospital, Carlo had definitely developed pneumonia. He deteriorated over the first two weeks of his illness. In the third week, we were having a lot of difficulty getting oxygen into his blood. He resisted being intubated for several days. He'd seen his colleagues intubated at the French Hospital and didn't feel that they did well, but eventually it became clear that he couldn't sustain it without intubation.

This is the chest x-ray just after the intubation showing a nice placement of the ET tube but really dramatic progression of the pneumonia not just the infiltration of the lungs but that fibrotic appearance that was indicative of the acute respiratory distress syndrome that was what Carlo and other patients who died with SARS generally died with. And he died within a couple of days of this picture being taken.

His death was somewhere in the middle of that large peak there. So there were several more weeks of outbreak work to be done even after the death of Carlo, but I would point out two features about the epidemic curve, one is the end on the

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far right and this wasn't clear to me and to others in the middle of the outbreak that it would end this way, but now we know, it was brought under control.

Again I think a large part of that credit for that goes to the coordinated effort led by WHO to bring different groups and different countries together and identify these patients. And the second part I point out is the left hand side of that curve, a long tail up to the identification of the problem which wasn't until really the early days of March or late February at the earliest, so several weeks of brewing outbreak in southern China that was not either well recognized and was not reported appropriately.

So now we face what some would argue as potentially more problematic outbreak and that's the avian influenza caused by the H5N1 virus. This is a few months' old now but it gives you the global picture anyway. The green dots are the places where poultry outbreaks have occurred. Remember those started in Southeast Asia, Central Thailand, and North and South Vietnam but then they spread on wild bird flyways and also on poultry economy routes through central Asia to Eastern Europe and then even into Western Europe and now into Northern and Western Africa as well.

And then the red triangles are the clusters of human cases. Again, many of the same places, the hot areas for human cases continue now this year to be Indonesia, the Nile delta,

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Nile river area in Egypt, and a few other equally worrisome places.

Daniel mentioned this and I think this is one of the more important steps in global health at least this part of global health in the last few years and that's the implementation of the new International Health Regulations, which have been worked on for sometime but we're really driven by these two events I just described, by SARS and the recognition of the slow response of the world largely because of China's failure to report to the outside world and also the treat of H5N1.

The old International Health Regulations were about 30 years old or so and required reporting of I think four conditions, small pox, yellow fever, plague, and cholera. The new ones go way beyond that and are much more appropriate for the modern world requiring a response to any public health emergency of international concern, and there's a detailed algorithm that helps health officials around the world to figure out what is a public health event of international concern that they have to report on.

The IHR also brings a burden on countries because they are clear expectations from member states not just in outbreak detection and investigation but also in reporting and response, and many of the less wealthy countries in the world have said we don't really have the resources to carry out this mandate,

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and one part of IHR specifies that the wealthier countries should work with the less wealthy countries to help them build up the capacity to carry out the requirements of the IHR.

And that leads me to CDC and Global Disease Detection Program which is in many ways the US response to the IHR. It is to establish Global Disease Detection Centers that are aimed to strengthen the capacity immediately to address this H5 threat but also even if H5N1 is not the source of the next pandemic and something else comes along that we would hope we would strategically position our partners and ourselves against future threats.

These centers are built as centers of excellence focusing on regional surveillance, laboratory capacity, support for the WHO outbreak response through the emerging infections program and then also there is a capacity building component focused on the FETP or the Field Epidemiology Training Program to train epidemiologists and laboratory scientists to build capacity in the countries to carry these things out in the future. And then as the program has grown, there're a number of additional components that I won't go through, but I would be happy to talk about later.

Just location of the centers there. The oldest one I mentioned is in Thailand, the second one was in Kenya. Those are pretty well established with all the components and staffing in place. In 2006, we added three new ones, China,

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Egypt, and Guatemala, and those are in various stages of being stood up, and then I came back last month from Kazakhstan where they asked to be the sixth GDD center, so we will be working on that one this year.

So let me stop there. In conclusion, I would say like both of the two previous speakers have said, it is really incredible how many more resources there are over the last 10 years for doing global health work in general and this specifically more than \$100 million a year, for example, just for H5N1 work has been put forward.

I think we are more organized at CDC than we ever were. We have a centralized system for outbreak information from around the world that comes in, that goes now into one consolidated area and a place to deploy outbreak response teams if requested from the countries and from WHO, so that's an advance. I think WHO is more coherent globally through the International Health Regulations than they were 10 years or so ago. And so I think we are far better off. I would leave the question open about whether we are ready for all pandemic challenges.

MALE SPEAKER: Thank you. [Inaudible]. I just wanted to ask a very quick question of Daniel. [Inaudible]. You say that [inaudible]?

DANIEL EPSTEIN: Yes. At some extent, the IHR reports themselves, depends on the Ministry of Health, which is giving

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them, in cases where they involve, specific clinical details of people, there're not going to be, but certainly the data of the epidemiology, the numbers of cases and all that is open.

MALE SPEAKER: I came in late so if you actually talked about this, I apologize. How well do you think the journalists in those countries cover these crisis and do you have any suggestions for how that coverage could've been improved and maybe in the future that you might work towards that?

SCOTT DOWELL, M.D., M.P.H.: Sure. It's great question. I bet everybody has some to say about that. Let me just choose one thing to focus on and that is I mentioned the consolidation of outbreak information at CDC as one of the important steps I think that we've taken. This outbreak information comes from a number of sources. So the GDD centers themselves send us information, other partners, we get information, they are open source information like ProMed, and GFIN and ARGUS [misspelled?] and other sources.

But the main source of information about what's going on with outbreaks is actually media reports for all of us and that has changed. I don't think that was clearly recognized or not formerly a part of public health surveillance 10 years ago, but it has become that way. And we definitely see that as a former part of public health surveillance. So there are a number of different organizations that go through media reports whether through automated web crawling systems or actual

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linguists reading publications in native languages and picking out stuff. But those are very, very important. The journalists, you are highly trained, you know how to ask the right questions, we don't have to pay you, and you are enthusiastic.

MALE SPEAKER: And they don't.

SCOTT DOWELL, M.D., M.P.H.: Yeah. It's a fantastic source. Now you generate a lot of noise, frankly. So, there is a sifting function that has to be done because a lot of the stuff that comes in turns out to be nonsense but in that is some real information and usually, I was going to say often, but I would say usually that's the earliest information that we have about important outbreaks that are happening.

MALE SPEAKER: Do you see disparities in the quality of the coverage even within the same countries?

SCOTT DOWELL, M.D., M.P.H.: I understand that that's true and I'm not one of the people who sits there is a linguist and reading notes. I know that the people who do that are choosy about which publications they read and they actually grade reliability of reports according to, over time they can figure out who generates more noise and who generates more real stuff. That isn't my area of expertise but I understand that that is the case.

DANIEL EPSTEIN: One part of that, I think the coverage is really variable and spotty. There are reporters who do

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great jobs. There are a lot of sensationalistic reporters, the German camera crew you mentioned that barged into the Ebola ward was probably one of those.

In outbreaks or in panic situations where there are crisis, we find that there are people who are really good but there are also reporters under time pressure or reporters in a very competitive situation, reporters who'll write and publish things that are really little more than rumors. And in developing countries, I think people, we don't really have that many health reporters in South America, for example, who are exclusive health reporters. The guy who does police, fire, and local politics, is the guy who is said to cover a little cluster of 10 people dead in some remote village. He has no idea what it might be due to, and he is going to write what people tell him.

The big city paper or the metropolitan paper might have somebody with more training or more specialization but health journalism in Latin America and in Africa for the most part, isn't really a well-developed specialty and there aren't that many people who do it, so the coverage is variable. Some of it's really good and some of it's really spotty.

FEMALE SPEAKER: My question is for Rachel. You showed us the syringe that mothers-to-be can take home to give themselves shots with HIV drugs and I'm wondering how successful those kinds of programs are. How do you track them?

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How do you know that these shots are actually being administered and that the children are actually showing reduced viral load, et cetera, et cetera.?

RACHEL WILSON, M.P.H.: Well, I need to give you the copy again that I am a policy wonk and not one of our technical folks, so I don't have all the data. But you bring up a really good point in that producing products is not enough and that you need to work with the communities before and during production. We do a lot of research on whether they are affordable or not, whether they are appropriate for the target audiences and not only that but are there the procurement, the cold chain, and all of the things that go into getting products to the people who need them as well as is their demand making sure that you're not creating something that you just think that someone needs but really understanding your target communities as well as really working very closely with the communities to get them out there.

So while I don't have the information that you are asking me for and I can probably get it for you and I would be happy to do that. I think part of what you are raising is a really good point is that the role of the community and working really closely from before you start to develop not just once you've got your product and we see a lot of challenges in looking at potential technology pileups and you've got a lot of things and are they actually being used. So I think that

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assuring that there is that kind of evaluation and tracking is a really important part and often times something that isn't funded well enough. And so it's a real challenge at many times.

FEMALE SPEAKER: My question is to you too. Nutrition is playing a very big role in HIV in most of our countries. I come from Uganda. What is PEPFAR going to do about it? Is the next bill going to address the issue of nutrition and food availability for the AIDS patients because you're giving us the [inaudible] but the patients don't have food.

RACHEL WILSON, M.P.H.: I don't know about that, specifically I haven't heard that as one of the broader level issues but it's something that's absolutely being discussed more and more in the global health community. The role that we actually have [inaudible] a lot more in nutrition is around breast feeding and transmission and there's a lot of interesting information on that and we're actually about to put out a policy brief on the role of breast feeding in transmission as well as we work on fortified rice in some areas in trying to, because you are right, that's an absolutely critical part of the treatment process.

So I am not aware of, doesn't mean it's not there. It's a 150 pages, I haven't read every page of it. But I haven't heard a major focus on it, but again I'm happy to

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actually afterwards get information from you and I can absolutely let you know.

MARYN MCKENNA: Hi, I'm Maryn McKenna. Until recently, I was the CDC reporter at the Atlanta Journal Constitution where I spent my time tormenting people like Scott, and now I am an independent. This is not really going to be a question as much as it is sort of a plea.

I understand that the IHR are the biggest news in global health in a really long time, but I wonder if you folks understand how incredibly difficult a story that is to sell, especially with the contraction of the mainstream media process stories are incredibly difficult except possibly for the Seattle Times since they have the Gates Foundation in their backyard.

And as you have all experienced out in the field, global health coverage has always been a sort of seduced by outbreak coverage and I think that's even more true now. So my plea, and maybe you can react to this in realtime I don't know, is that if you can think of any ways to help us sell these more process-based stories or to orient the process-based stories more toward the real people, real-time situation, anecdotes that we can offer editors, you will be doing the field of global health reporting a great service because we are all having a really hard time. Don't all answer at once.

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DANIEL EPSTEIN: No, thanks. I think what you said is really important and it's a good idea. It's hard for us to get people to cover global health stories that are not outbreaks or numbers or cases, to get people to write more featury things using people as examples of something that's happened. I think with IHR you are right. I think it's very hard. Who wants to write about - it sounds horrible, the international health regulations, what's that, some new thing, they are going to make us all do. It's very hard to sell that as something important, but I think we haven't really made any effort to do that.

I was at a meeting a couple of months ago where a woman who worked for the Toronto Emergency Health System gave a fantastic and amazing presentation about the effects of SARS in Canada and how that affected the whole country and how it affected the local healthcare workers. They were at one point ordered to be quarantined, they couldn't go home, they couldn't see their families, they had to sleep in dorms, because they were all afraid of getting SARS and contagion from SARS. I never saw much about that in Canadian or other media. I think those kinds of stories are interesting. The effect that this has on people is so simplistic but maybe it will help.

ANDREW HOLTZ: I'm Andrew Holtz, now independent but during my incarnation as a CNN medical correspondent I got the test with CDC, PAHO, and others and was part of the CNN

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coverage that [inaudible] from the home-based Atlanta rather than out in the field so no fista cuffs [misspelled?] with anybody treating. But I was thinking again about the role that the US has and how to do stories about the impacted decisions that we're making, that our proxies are making, our representatives here in Washington that Americans who have a lot of money like Bill Gates are making about things that actually seem unimportant to us. They're just sort of afterthoughts and footnotes in our budgets and yet they have dramatic just overwhelming consequences on the ground at places at Africa.

Set the entire health, somebody says, oh jeez, let's do something on HIV/AIDS and put a tiny percentage of a percent of our budget toward that and then an African nation will see their entire health system swing around to deal with HIV/AIDS to the exclusion of almost everything else.

Again, what are the stories there in terms of who's setting the priorities in global health and how do we tell that story here to people about the consequences of people are sitting down at the kitchen tables, writing little charity checks to some foundation that then is taking over the health system of a country. And just to add on to that, thinking about so much of what we hear and what our audiences understand is about specific diseases but if you go to the places there you see that it's not necessarily so much about the end product

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delivering a service when you don't have the foundation of sound institutions of good governance and those things and you can do all you want to try to take care of individual patients. You will never solve the problems if you don't have the infrastructure. It's a whole bunch of questions but they relate to our responsibility here as the source of this mammoth amount of money for those people on the ground.

RACHEL WILSON, M.P.H.: I don't know if I'm going to get all of those, but when you talk about infrastructure, we really do see a lot more attention shifting to health system strengthening. So where there has been a lot of disease-specific focus and I'm not saying its going away. You do see, for example, in PEPFAR a much larger focus on health system strengthening with the [inaudible] lines that does immunization the whole \$500 million toward health system strengthening with a whole variety of different policies.

A lot of people are seeing now that unless you have the health workers, unless you have the systems, unless you have the surveillance section, know what diseases there are that you should be addressing, people are really grappling with this. And a lot of people are looking at the next guy at the table to see who's the one who really should be taking care of this. And so I think we've got some challenges but at least we've got the interest growing in understanding that there are some real systems. As far as prioritizing, I'm here in D.C. and I see

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politics play itself out. Right now, the reason why so much funding is going towards HIV and AIDS, and malaria is because those are the two presidential initiatives that President Bush took a lot of interest in. And so that's where the money has gone and so it shows how much one person in power.

It is interesting when you talk about the intersection of health and other issues. Right now, there is whole foreign assistance for foreign process that was put into place by Ambassador Tobias who used to be the director of the office of Foreign Assistance and it's now Henrietta Fore, which is trying to actually look at health issues. They've now taken the funding and looked at health issues also next to diplomacy issues and civil unrest and all of these other issues that are much complimentary and broader and there's a lot of debate that would be a whole other hour about whether that's good or bad because some people feel that by lumping health with other issues you could be losing the dedication to long-term health issues to short-term political issues in those countries.

So when you talk about those issues that the MCC often takes on of governance. There is a big debate out there about whether you should be linking those issues of governance with the health dollars or whether you should be putting it where the needs are greatest. I think the other issue is around accountability and that's a constant challenge that I see out there and I see it also as something that we're being more and

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more asked about by our policy makers to have result-oriented work, and I think a lot of programs are really struggling with how to actually measure those results. That's a number of different streams of thought in reaction to your stream of questions but I hope I've addressed to some of them.

DANIEL EPSTEIN: I don't really have anything to add. Accountability I think is really important. I don't know if you guys remember that Transparency International, a few years ago, did a study on health and found pretty high levels of corruption in health in developing countries and in many countries. I think that's a serious problem when a country receives \$6 million to build a clinic somewhere and they siphon off half of it, it's not going to happen.

MALE SPEAKER: I just wanted to ask a quick follow up question. [Inaudible] it will be great if you don't want feature stories but you're writing those stories for here and you're relying entirely on an organization who is giving you that information and that, I'm sorry, and that anecdote. So for us to try and do a little truth spotting of those stories having been out in the field myself, it looks very different and if you talk to people who work in the field, then you're being told sort of very neat kind of story from US What is the most effective way and are there outside sources that you can really monitor how money is being spent or how effective that

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is outside of that agency or international NGO? Is there a place to go or is there a way to get that kind of information?

DANIEL EPSTEIN: Probably, but I don't know where. I know there are places like the foundation center, and those kinds of places that track expenditures and I know there is often a gap between what you're told in a press release and the reality on ground. I think it's kind of your duty as a journalist to see what really is the reality on the ground. There was a story yesterday or two days ago in the Tribune de Geneve, the most important paper in Geneva about Haiti and how WHO had spent half a million dollars building a pumping station that was supposed to provide water to Cite Soleil, the poorest slum in Port-au-Prince and was supposed to be ready a year ago and it's not ready yet.

It's a really valid story, very good criticism and it came to me as the guy who got to gather all the reasons why it wasn't ready. This happened on Thursday and Friday and I had to delve into the politics of Haiti, what agency is running it, why the guy who was running it didn't want to finish the job, why the well was built in a community three kilometers away from Cite Soleil and with a hydraulic pump of such high pressure that they wouldn't be able to use water in the place where the well was, they would've to take all the water out of there and send it to Cite Soleil and those people don't have

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water either. So, the local residents protested and it's kind of a mess but still a very valid story.

FEMALE SPEAKER: My question has changed now that I'm listening to all these other answers. But I wanted to sort of make note that also part of my business is that as a freelancer I work with the U.N. and some of the agencies in Western Europe and have met your colleague in Rome. And being there as you all know and looking back at this big black [inaudible] the United States does spend an enormous amount of money and God bless them for doing that, unfortunately, there are, politics is a huge factor. It wasn't that long ago, for instance and it's just an example, Kyoto aside, that maybe five or six years ago, the US really had not put up its percentage of the U.N. funds because there was some disagreement as to what they thought they should be used for and they had gone for several years without paying their portion.

You hope in the best circumstances that global politics or unilateral politics is not going to make an imprint on how global health and the assistance setup is going to play out but I wonder also if that means that there maybe, as time goes on in the future, a bigger place for NGOs and even something like Doctors Without Borders as you have mentioned, whether or not branches of that or something could come out of that. That also takes care of the issue that the people are actually in the field, right?. And they may, I don't know what the

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legalities of that would be, but they may be able to collectively have interest in raising money for certain things that they know where it may be going.

That kind of thing, particularly when physicians and Doctors Without Borders are followed, I know what it's like doing a story when you're there as opposed to doing it here. There's a whole different interest factor. It's like trudging through sludge, trying to get people interested in what's going on the African continent unless it has something to do with us. So, I don't know, I'm just throwing that out, that's sort of an open question, maybe there's something in that trail.

MALE SPEAKER: I'm sitting here thinking about how you write up an interesting story about events that don't happen and it's challenging. I mean, I've oriented my presentation on how much better off we are because systems are in place and the International Health Regulations are there, and therefore, we should be avoiding big disasters, but I recognize that big disasters are news where the avoiding big disasters is hard to make newsworthy. I think this is a huge challenge.

The one thing that all of us have repeated is that the terrain has really changed and the orders of magnitude that these countries are facing in terms of their money hasn't gone up by two-fold, three-fold, and four-fold, it's gone up by 10-fold, and 80-fold, and a 100-fold. I think it probably will be some years before we look back and recognize the degree to

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which the global health picture has changed with these new funds and there's going to be criticisms before the story has come out about all the good that's done as a result of these funds.

I mean, I would frankly love to hear from anybody else who could answer that question about are there ways to write stories about improved capacity to deal with outbreak threats or do we just continue to write about the disasters and have no way to write about successes?

SCOTT DOWELL, M.D., M.P.H.: Successes, and I think there are different ways to do it but it really depends if you could find a local connection for a lot of us. Sometimes it's simple as a profile of someone who is actually meshed in that kind of work and I actually think that sometimes there are more stories about those successes than people think are out there, but I do think we need to be able to frame those around, a lot of the grey area around those issues and things, but I definitely think there're a lot of opportunities and I think some of those are more visible, thanks to the organizations who've been more open and more visible about some of the kinds of work that they do and I think the public attention around that has created some opportunities to do those stories as well.

ROSE HOBAN: I'm Rose Hoban from North Carolina Public Radio and if you think it's hard to write a story, try selling

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it to your editors, yes, about something that didn't happen. I just ran a story last week on the looming shortage of public health workers. I was just sitting here thinking about one, you kind of stole my thunder like the whole idea of like, you should know the hometown of everybody who works for you so that you can go back and pitch to their local reporters. Because even though my general manager has a degree in public health as do I and so I consider my coverage to be relatively enlightened because she gives me the leeway to push public health stories a little bit, I still have to be incredibly parochial. If it doesn't have the North Carolina connection, it just doesn't matter. So you've got to help us find ways to make connections to back home.

But the other thing that I realized was part of the way that I was able to get my public health worker shortage story written was that I'd been sitting at this idea for a year. I'd talked to a number of people about it and then all of a sudden there were two or three organizations that came out with statements, APHA American Public Health Association, Association of Schools of Public Health and they all got coordinated it right around the same time. So, here I am. I'm getting all these things in my e-mail and then I go running to my editor and say, hey, look! All these people are raising the alarm here's a little bit of - it's like a fig leaf of a news peg. It's a mixed metaphor if it ever was but it was like the

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weakest news peg but still it was like, oh, lots of people are sounding the alarm. And so then of course when I called my state public health people. They were like, oh yes, we've got - and they pulled out the reports that they had written. It was kind of nice when people coordinated efforts and were able to come back and then gave me something to work off of, so.

FEMALE SPEAKER: I am speaking as someone who worked for 12 years in the State of Rhode Island, the smallest state in the country, and we were not allowed to pursue anything that didn't have a Rhode Island angle and the population in the state is small but I did manage to find a Rhode Island angle for an International Colombian Drug Smuggling Ring that got me sent to a number of countries, so it can be done.

What I would like to suggest is one of the issues around healthcare in this country is the economics, to the degree that you can frame what you've accomplished in a process because process stories are death not only to our editors but we pitch them, but to readers because it's very difficult for them to get into it and also just having a dramatic anecdote of a scenario of what might happen if we didn't have this process is a little bit attenuated. But there's a major issue in this country around healthcare cost. And certainly if you develop systems for containing outbreaks, then the cost angle, the savings to the system, and the savings to the infrastructure of healthcare and danger to healthcare workers is a way to frame

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the story and link what we're concerned about almost obsessively in this country to global health and that would be my suggestion.

JIM SIMON: Thank you. Do you want to respond after that?

FEMALE SPEAKER: I just had one thought that spared from me. When we look at the health worker shortage in developing countries, I think sometimes we fail to link it with what's happening in the US. We see shortage of nurses in the US, and we see a lot of people coming from developing countries to work here and how that all links with each other. I think that there are some connections that really could be made there that aren't being made because we're feeling that the nursing shortage here and how that links up. I think it's an opportunity that could be capitalized on.

JIM SIMON: Thank you all for coming and I thank our panelists for that. It was really appreciated. [Applause]

[END RECORDING]