

**Excellence, Innovation & Influence –
Pathways to Results:
Opening Plenary Session: From Knowledge to Will to Action:
Transforming the Landscape in AIDS Prevention, Care and
Treatment
Global Health Council
May 31, 2006**

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[START RECORDING]

FEMALE SPEAKER: Please welcome the president of the Global Health Council, Dr. Nils Daulaire. [Applause]

NILS DAULAIRE: Good morning and welcome to the 33rd international annual conference on global health. It is a delight to have you all here. As of this morning, more than 1,500 of you had registered, and there are more coming in all the time. I see that they will be coming in throughout the morning. We have people from more than 75 countries present today.

We are here to discuss, to debate and to learn together, to engage with each other, to interact, because none of us is as smart as all of us. We are scientists, we are public health professionals, and we are not ideologs or polemicists. So, we make our judgements and decisions based on facts, evidence, and on the ground experience. The symbol of the Global Health Council is what we call ribbon man, who is here in front of me and also behind me on this screen. The red ribbon is for the passion for social justice that all of us throughout the world use as the basis for our energy and activity. The green ribbon is for our sense of celebration, of our accomplishments of the things that we can do together and the things that have given joy and light to our lives. The cool blue globe is for thoughtful reasoning

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and exchange. This conference is about all three of those elements. Our mission is to make global health programs work so that all of our children and all of us can live in a world that is healthier and more equitable. That is why our focus this year is on excellence, innovation, and influence, excellence because good enough really isn't good enough. We need to do things better if we are to achieve our mission. Innovation, because the way things have been done over the past generation no longer serves the needs of our complex interconnected globe, and influence because we can no longer imagine that we can just do things on our own without the active participation of communities and without the vast resources of states and the private sector. That is what we are here to do over the next three days. Now usually I give my annual address to the membership of the Global Health Council at this opening plenary, but this year I will present my call to action at our closing plenary on Friday afternoon right after Jimmy Carter has addressed us. This will give me the opportunity to hear from you over the course of the next three days in terms of what you see as important for your Global Health Council to be doing over the coming year.

So before we start this morning's session, let me introduce this year's conference cochairs. With us here on the stage already are Carol Jacobs and Paul Farmer and I

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believe in the audience who will be addressing us tomorrow morning at the plenary is Tore Godal, and if Tore is there can you raise your? Here we are, right there. Please give them a round of applause. [Applause] Finally, let me thank the generous and essential sponsors of this year's annual conference. Our platinum sponsor, the Bill & Melinda Gates Foundation; our gold sponsor, the Abbott Fund, Beck & Dickinson, Glaxo Smith Klein Biologicals, and Merck; our silver sponsors, the Academy for Educational Development, Management Sciences for Health, Social and Scientific Systems, Quintiles, Population Services International, RTI International, and the University Research Corporation; and our bronze sponsors, APP Associates, Ken Bio Diagnostics, Chemonics International, Family Health International, the International Partnership for Microbicides, I-Pass, Path and the U.S. Fund for UNICEF. And let me note with special appreciation the contributions of the Norwegian government to helping us provide scholarships to many of our participants from around the world.

We have a number of special things going on this year at the conference I want to draw your attention to before I turn this program over to our moderator for this morning. For the first time, we have global health TV, for those of you who are staying at the hotel and have tuned to Channel 2,

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you have seen yourselves and many of our speakers and participants highlighted on this. It is our first effort to bring a sense of immediacy and media coverage right here to the conference. I also want to point out that this evening at the end of many of the special events that are being hosted, we are hosing right here in the Regency Ballroom a special tribute to Alan Rosenfeld for his lifetime dedication to the health of women around the world and we invite all of you for this very special celebration starting here at 7 o'clock. I also want to note that we have a very few number of banquet tickets left for tomorrow evening's awards banquet, and welcome any of you who haven't signed up that would like to join us for this evening of terrific celebration with a Gates award, the Jonathan Mann award for global health and human rights, the excellence in media award, and the best practices in global health award, along with our photography award. Please come and join us. It is a wonderful evening. Now, it is my special pleasure and privilege to turn the podium and this morning's program over to our moderator for this morning's session, Maurice Middleberg, the Global Health Council's vice president for Public Policy. Maurice? [Applause]

MAURICE MIDDLEBERG: Thank you very much Nils and good morning ladies and gentlemen. The title of this

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morning's session is "From Knowledge to Will to Action: Transforming the Landscape in AIDS Prevention, Care, and Treatment" and in fact, there has been a stunning transformation. There has been a stunning transformation of political will over the last ten years to cope with the pandemic. There has been a stunning transformation in the level of financing. New financing mechanisms and new multilateral structures have been put into place. Amazing and miraculous new drugs have been developed to treat those infected with the disease. The number of people benefitting from treatment has escalated enormously. At the same time as we are all painfully aware, we continue to be faced with enormous challenges in extending treatment, in prevention of the disease, in eradicating stigma, and in reaching those who are marginalized and vulnerable. Today, we are very fortunate, indeed blessed, to have a panel of leaders who did so much to bring about this transformation. They did so with the technical skill, political acumen, and moral clarity. The purpose of this morning's session is so that they can share with us the lessons that were learned in leading this transformation so that we might apply those lessons to the challenges that lie ahead and draw inspiration from their leadership. Our first speaker is Dr. Carol Jacobs, who comes to us with a truly remarkable background. Dr. Jacobs is

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currently the chair of the board of the Global Fund to Fight AIDS, Tuberculosis and Malaria. She was elected to that post in April of 2005, having represented Latin America and the Caribbean on the board since 2004. She also serves as chair of the Barbados HIV/AIDS commission and special envoy to the prime minister on HIV/AIDS. Dr. Jacobs was born and educated in Jamaica and graduated from the University of West Indies in medicine. After working for several years at the Queen Elizabeth Hospital, she started and maintained a private medical practice for the past 25 years. Dr. Jacobs has been actively involved in HIV/AIDS for more than 18 years throughout Barbados, the Caribbean, and internationally. Between 1995 and 1998, she was the chair of the Barbados National Advisory Committee on AIDS, represented Barbados and the Caribbean on the board of the global program on AIDS, and subsequently on the program coordinating board of the joint United Nations program on AIDS. She also served as a director on the boards of a number of community based organizations including St. Ambrose Church, St. Gabriel's School, the Barbados Children's Trust Fund, and the Nita Barrow Trust, Big Brothers and Big Sisters of Barbados, the AIDS Society of Barbados, and the Barbados Association of Medical Practitioners and the Optimist Club, and having read that list, it is clear that the old saw about if you want

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something done, give it to a very busy person, and with that, it is my great pleasure and honor to introduce Dr. Jacobs.

[Applause]

CAROL JACOBS, MBBS, BCH: Good morning everyone. I believe that the theme of this session, "From Knowledge to Will to Action" resonates very strongly with the Global Fund to fight AIDS, tuberculosis, and malaria. Prior to January 2002, studies had provided us with the knowledge of the amount of resources needed at that time to treat these three diseases globally. The G8 countries' commitment to this goal provided the will. To a significant measure, the operations of the Global Fund have provided action to influence fundamentally and urgently funding for health financing on the global landscape in these three diseases. Four years later, by the end of 2005, programs financed by the Global Fund have provided 384,000 people with antiretroviral treatment, driving along with PEPFAR and other partners a threefold increase in access to these treatments across the developing world. Seventy-percent of people reached were in Sub Sahara and Africa, with substantial progress also having been made in East Asia and the Pacific. Global Fund financed programs have reached 1 million people, with effective TB treatment under the DOTS strategy, and ensured the distribution of 7.7 million insecticide treated bed nets to

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protect families from malaria. Each of these results represents dramatic increases over the levels supported by the Global Fund at the end of 2004. Over four years, this fund has grown exponentially to a budget of 8 billion U.S. dollars for the 2006/2007 [inaudible]. It has committed 4.9 billion U.S. dollars to 385 programs in 130 countries and dispersed in excess of 2 billion U.S. dollars to programs around the world. Five countries, China, India, Nigeria, Russia, and Ethiopia represent the second wave countries; five countries with large population blocks and vast land masses ranging from a population of 77 million in Ethiopia to that of India and China at 1.1 and 1.3 billion respectively. The largest share of Global Fund grants currently goes to these five second wave countries. Latin America and the Caribbean, the region which I represent on the Board of the Global Fund, I firmly believe represents the third wave; a multicultural, multiethnic region of primarily middle income countries where prevalence rates in some of the vulnerable groups far exceed national prevalence rates. UNAIDS studies cited across Latin America exemplify this disconnect. HIV prevalence rates in MSMs in Guatemala City are 10-percent compared to the national prevalence rate of 0.5-percent in Lima, Peru. MSMs are 16-percent while national prevalence rate levels are 0.5-percent. In Mexico City, the latest

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prevalence studies in 2005 show rate of 15-percent for MSMs while the national prevalence rate is only 0.3-percent. Similarly, in a series of seroprevalence studies in male prison populations in the Caribbean, performed by the Caribbean Epidemiology Center in 2005, [inaudible] were 3-percent compared to a national prevalence rate of 0.9-percent, and in the small island of St. Vincent the national population prevalence is between 0.5 and 0.6-percent, whereas in the male population in the prisons it is 4.1-percent. Similarly in Dominica, with the national prevalence rate as low as 0.2-percent, that in the male prison population is 2.6-percent. Most of you here would be aware that the Caribbean subregion represents an area of significant vulnerability to natural disaster; an extraordinarily diverse region, which comprises 29 nations and overseas territories. Most of our countries are islands except for Guiana, Suriname, and French Guiana on mainland South America, and Belize in Central America. In the Caribbean, AIDS is the leading cause of death in the 15-44 year age group and it remains the region with the second highest prevalence of HIV/AIDS globally. Our region has high levels of extra and intraregional travel and many of our countries site tourism as the major income generator. In a region with a total population of 46 million people, almost an equal number, 40

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million tourists travel within the region every year. Our borders can therefore never be sanitized and the problem of any one of our neighbors becomes a common challenge, particularly in the area of sex and sexuality and in the context of sexually transmitted infections. Denial of access to international funding based on our classification as upper middle income countries essentially ignores the dynamics of the epidemic within the local context and condemns upper middle income countries in particular to fighting a losing battle in attracting donors. At its April 2006 board meeting, the Global Fund formally recognized the risk of small island states currently classified as upper middle income, some of which have populations of under 1,000 people with the concomitant limitations in human capacity. That decision recognized the proposals from applicants whose economies are classified by the World Bank as upper middle income may become eligible for funding if the applicant falls under the small island economy exception to the IDA lending eligibility requirements regardless of their national disease burden. The building of meaning symbiotic partnerships is critical to winning the battle against AIDS. Strategic public private partnerships build national human resource capacity and minimize the dependence by countries on external resources, human and otherwise. The Global Fund prime

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example of such public private partnership committed to stimulating vital engagement of the private sector and private foundations in areas of health, particularly as it relates to AIDS, tuberculosis, and malaria. The Fund's board structure and governance speaks to partnership, transparency, and accountability. Partnerships with civil society including NGOs from the north and from the south as well as communities living with these three diseases are critical in placing health at the center of human development. The AIDS activist movement has mobilized successfully for wider access for treatment for AIDS. Over the past five years, a few thousand activists have contributed to driving prices of drugs down from 15,000 U.S. dollars per patient per year to what is now a couple of hundred dollars per year. They have catalyzed efforts to bring AIDS treatments to all who need it and have influenced the conversion of the ideal of universal access from a dream to what is now a stated [inaudible]. Universal access brings a very different perspective to future strategies to fight AIDS. However, it must be access to prevention in as much as it is to treatment and care. Treatment without effective prevention will not have the required impact on this epidemic. I fundamentally believe that the prevention message cannot be a fragmented one, and to be politically correct and fully effective, it must

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recognize the continuum of prevention messages which include options from abstinence in elementary schools through delaying the age of first sex, faithful partnering, to the consistent use of condoms. New technologies continue to be relevant and of critical importance, not only in the development of vaccines and in the trials but also through the production of microbicides, which will and must empower women globally, however disadvantaged, to take control of protecting themselves from infection. There must therefore be a rapid acceleration of gender policies with specific reference to the factors which continue to make women and girls vulnerable to HIV.

The Global Fund has not only provided treatment, but has supported other services to fight the three diseases and strengthened basic health systems essential for the scale-up of these interventions. The promotion of rights based programs in order to ensure the protection of human rights is critical and the rights of the vulnerable groups, whatever any individual response may be for that group, must be protected and when necessary, legislative review and responses may be required. It is my conviction that women and youth remain central to any discourse and vulnerability on HIV/AIDS and HIV/AIDS is no exception.

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Initiatives designed to combat stigma and discrimination have been a cornerstone of many Global Fund grants. Countries like Ethiopia, Indonesia, Swaziland, Morocco, Vietnam, Yeoman, and in my own Latin American Caribbean region, Bolivia, El Salvador, Guatemala, Honduras, Jamaica, and the Dominican Republic represent grants in different countries and different context, all of which have significant components designed to combat stigma and discrimination. The provision of antiretrovirals to people living with HIV/AIDS is in itself a significant means of combatting stigma and discrimination as access to treatment enables people to return to more active and relatively healthy daily life. That in itself shifts the perception of HIV positive status from that of a death sentence to that of a chronic disease. The Global Fund is an international financing institution and as such has designed the strategy for the replenishment of funds as well as targeting [inaudible], particularly most recently from governments of the oil rich nations in the Middle East. It is also pursued to innovative private sector channels for funding, to raise additional resources in 2005, and the current highly publicized Red campaign, which I trust many of you will have seen, where companies like American Express, the Gap, Armani, Converse and most recently Motorola, have contributed to this

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campaign. It was initiated by U2's Bono and Bobby Shriver of Debt, AIDS, Trade in Africa (DATA) and was created to raise money for AIDS in Africa. This is a significant and innovative funding mechanism. Non-traditional streams of funding for development being proposed by the international community are also supported by the Global Fund, and these include the International Financing Facility proposed by the U.K. government, and the International Airline Lévi proposed by the French government.

The Global Fund is currently articulating its policy and strategies to take it to 2009. Impressive as these figures may be, they do not equate the universal access, and to align these targets more realistically with those of universal access, the Global Fund will need to approve new grants through the launch of an additional funding realm. The Global Fund policy discussion will over the next few months taken into consideration the size of the Fund. From my personal perspective, the needs of the world in these three diseases and particularly HIV/AIDS which accounts for over 50-percent of the Fund's grants, demand that the size of the Fund be set at the highest scenario possible if we are to ensure access to treatment, prevention and care to all by 2010. The Global Fund strives for excellence through its performance based funding and results today in the case of

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this playing a major role in efforts to reach global targets. I go from here today to UNGIS [misspelled?] in New York, where governments across the world will this week commit to action which has the potential to transform the landscape in AIDS prevention, treatment, and care. It presents a great global opportunity to recommit and to make purposeful strides towards universal access, not only for treatment and care, but equally important for prevention. My hope is that this conference through its presenters and panel discussions will achieve tangible outcomes. You must chart a path here to results, with an urgency that reflects our understanding of the gravity of the issues involved in order to transform this landscape in AIDS prevention and control. Rights based and gender focused policies with full involvement of communities of people living with diseases, commitment and reengagement at the level of each of us as individuals, governments, or donors, must be among the actions which will ensure universal access to this prevention, treatment, and care by 2010. Ladies and gentlemen, colleagues, landscapes are not transformed by small incremental steps, but rather by staunch commitment, by boundless energy, and by definitive and bold actions. I look forward to the outcomes of your conference. Thank you. [Applause]

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MAURICE MIDDLEBERG: Carol, thank you very much for that very thoughtful, comprehensive, informative, and insightful presentation. It is now my honor to introduce the Reverend Canon Gideon Byamugisha. Canon Gideon was the first practicing HIV positive priest in Africa to publically declare his HIV status. Canon Gideon has since dedicated his life to breaking HIV/AIDS related stigma, shame, denial, discrimination, inaction and mis-action, and to mobilizing expanded action against the epidemic at all levels of society. A respected leader, teacher, and pastor, Canon Gideon left his teaching job at Bishop Tucker Theological College in Uganda to start the Church of Uganda Provincial HIV/AIDS program as an educator/trainer in 1993. He later joined the diocese of Namirembe and headed the diocesan HIV/AIDS program for seven years before joining World Vision International, where he now serves as the HIV/AIDS Hope Initiative Team leader as leader of the church-FBO partnership advisor on SSDDIM. Canon Gideon has supported churches, faith-based organizations, people living with HIV/AIDS, NGOs, higher institutions of learning, state and UN agencies around the world to break the pattern of stigma, shame, denial, discrimination, inaction and mis-action. He is founder and chairman of both the African Network of Religious Leaders Living with or Personally Affected by

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HIV/AIDS and the National Forum of PHA Networks in Uganda.
He is an author of five books on HIV/AIDS and former
commissioner with Uganda AIDS Commission. Canon Gideon holds
national and international awards for his contributions in
the war against HIV/AIDS, and it is my honor to introduce a
truly inspiring and distinguished spiritual leader, Canon
Gideon. [Applause]

REV. CANON GIDEON BYAMUGISHA: Thank you. I bring
love and greetings from Uganda. I also bring love and
greetings from World Vision International and from the
African Network of Religious Leaders Living with or
Personally Affected by HIV/AIDS. Carol Jacobs has just
talked about a staunch commitment that is necessary to
transform the landscape of HIV prevention, AIDS care and
treatment. In Africa, we raise a lot of goats and chicken,
and one time the goat and the chicken were moving through the
village and they discovered that there was a fundraising
going on somewhere, so they listened and people were saying
sugarcane, 100 going, 1-2, and then the chicken told the goat
why don't we join the fundraising? The goat said, but we
can't just do any fundraising without anything to contribute,
and the hen said no, we have what contribute, and the goat
said what is it? The hen said you know, when you reach the
fundraising, I will contribute some eggs, and then the goat

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said how about me? The chicken said, you will contribute some meat. [Laughter] The goat looked at the chicken and said you don't know what you are talking about! For you, when you donate eggs, it will be a mere contribution, but for me when I donate meat, it is total commitment! [Laughter] I have discovered really that the level of commitment necessary to transform the tide against AIDS is not just a mere contribution. It is a total commitment, and there are people who are living with HIV or personally affected by HIV/AIDS who have volunteered to join your partnership, support you in a defeating stigma, shame, denial, discrimination, inaction and mis-action. I want to emphasize that last word, mis-action is not in the English language dictionary but it is very important when it comes to fighting HIV/AIDS that you can't be sincere in fighting AIDS but you can be sincerely wrong, and so we have to examine what works and what hasn't worked in defeating the stigma and that is my story. Fifteen years ago when I discovered I was positive, I wanted it to be disclosed to people, but there was a lot of shame. There was a lot of denial, and my religious leaders said well, we will support you, but don't talk about it. People did not want to say anything about HIV. After losing my wife, of course, in 1991 and then I wanted to marry in 1995, people said but why are you marrying? You are dying tomorrow, and that is '95.

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Today, I am thankfully married to Pamela, my wife, who is seated there. Stand up for the [inaudible], Pamela.

[Applause] You have done a good job. And tomorrow has not come, which means that sometimes we point fingers, stigmatize, not knowing what is in store. There is hope against HIV because we have, me and Pamela have managed to break the transmission chain for all those 11 years, and when we wanted to produce children, because we knew our status, we offered ourselves for the prevention of mother-to-child transmission programs, and we have graduated in that program two times with two healthy babies. [Applause] But let me tell you, if you want to transform the landscape on HIV prevention, how do you transform that landscape with nine out of ten people not knowing that they are positive? Not knowing that they are due for prevention of mother-to-child programs, not knowing that they should be accessing the [inaudible] opportunistic treatment infections. That is the starting point, and we must find a way of breaking the shame and the stigma, the denial around this issue so that people can offer themselves for testing. I am sure if I hadn't tested in 1992, or if Pamela hadn't tested her own status after losing her husband, probably we would have made so many mistakes and the new infections would have been new statistics. Thank God we have broken that, in our

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testimonies, in our own relationship, we have again founded what you call the Africa Network of Religious Leaders living with or Personally Affected by HIV/AIDS to help us in that fight and partnership with religious leaders who are positive brings results. We can change attitudes. We can provide accurate information. We can engage with the difficult issues around the [inaudible]. We can provide the supporting environment for those who are struggling to break the pangs of stigma and shame. We can help people to differentiate between what is lawful and what is safe, because that is a confusion also. We promote policies that are [inaudible] focused, results oriented, inclusive, sustainable. We can join programs at the community level for promoting ARVs and for ensuring that it is [inaudible]. We can do a good job in counseling, in promoting shared confidentiality. We can do a good job in authorizing resources at the local level which are needed to augment the international policies. So in summary, what works? If you have a pen, just write down four points. One, there must be the right package on HIV/AIDS, and the right package has five elements. One, people must have accurate information on HIV, they must have the right attitudes on the disease, they must have the right skills for self-protection, they must have the right services and support environment to enable them, live stigma free life.

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The second package is the right interventions. Right now we still have interventions that are focusing only individual alone, but the Ugandan experience is showing that in order to break the stigma surrounding HIV/AIDS, the interventions must be of three M's, they must be [inaudible], they must be multilevel, and they must be multidimensional, involving religious leaders talking about the emotional and psychosocial aspects of the epidemic. The third element is the right clarifications. People should be understanding and right now the [inaudible], people need to focus a lot about that. There is a lot of talk about risky behaviors, but there is no equivalent talk about the risky environments. So we need, if we are to break the stigma around the issues, we need to talk about risky behavior yes, but first when you talk about risky environments that even when you have done the A and the B and the C, but you are operating in an environment where 40-percent of people are positive, the chance of picking an infection is very high. You don't need to sleep around to pick an infection. That is something people must make very clear. The last point should be on the right set of evaluation mechanisms, that right now stigma interventions are not focused, are not funded very well, are not targeted. Partnerships with people living with HIV/AIDS are not scaled up. They are not funded up to the level we

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need, so we need to examine seven fees in that area. Our policies on HIV/AIDS, are they stigma competent? I was visiting one country and I found that they were toying with this idea of having a law to convict [inaudible] transmission of HIV/AIDS. I said well that is a very good law but do you have an equivalent that will also convict people who deliberately acquire HIV from injection? Because if there is someone transmitting, there must be someone acquiring, and both of them have the responsibility so instead of stigmatizing and discriminating people in the AIDS, their responsibility should be shared between those who are positive and those who are HIV serostatus blind, so the policies must be correct. The plans must be correct. The programs on the ground must be correct. The personnel have to be clean. There must be partnerships at all levels, at individual level, at family level, at community level, and at national level, and at the global level, but there must also be another P, which is a very interesting one called PURS, P-U-R-S, amount of money mobilized and distributed to tackle stigma and discrimination, must be in amounts that are able to transform the landscape. Finally, the proclamations, what are we talking about AIDS? What are we talking about people living with HIV/AIDS? Right now in people's mind, it is still a moral issue. It is still a blame issue. It is still

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something that carries if given [inaudible] positive, then they say oh, how did you get it? I was in one and someone said oh, you said you are positive and you are still preaching. What does that mean? It shows that the way people have an understanding about HIV/AIDS has to change if we are to transform the landscape against HIV/AIDS. We have two good news and we have to walk away. Despite all challenges we have acquired while we are facing in HIV/AIDS, there are two good news. One, we have discovered how HIV is transmitted and how it can be prevented. That is a very important tool to walk away. Number two, we have also discovered how AIDS can be managed so that people who are positive can live longer productive lives and can participate in breaking the transmission chain. Those are two very important valuables and discoveries to walk away around HIV/AIDS. We are not fighting a battle that is immovable stone. At least there is progress, but the challenge we have now is for people to continue asking how come a disease whose means of prevention is known, a disease whose means of management is known, continues to kill people and destroy promising economies? And in this conference, and in this year and this day, the review of the Angus and others, we have an opportunity to transform knowledge to wear and

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finally action, and not just action, but total committed action. God bless. [Applause]

MAURICE MIDDLEBERG: Thank you very much reverend for giving us a living example of what courage and commitment laced may I say with good humor are all about. It is now my great pleasure to introduce John Standish-White. John is the regional manager of the Goedenhoop Colliery, which is the Anglo Coal flagship, a large mining complex in South Africa. Besides his operational responsibilities, he is the custodian and leader-in-chief of the colliery's AIDS drive, which has become the operational benchmark for Anglo American. A mining engineer from the University of Witwatersrand, Standish-White has worked on gold, base metal and coal mines for the past 25 years. His commitment to AIDS dates back to 1998, when he decided that leadership, energy and line commitment were required to meet this challenge. In line with his no-nonsense, operational background, his approach to AIDS is to keep it simple, and to focus on those most affected by the disease, people at the coal face. The innovative and positive ways in which Goedehoop has addressed AIDS have been shared with numerous audiences including the South African government, Anglo American, SA Ford Motor Company, De Beers, BHP Billiton, NGOs and hospitals around

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southern Africa. John, let me welcome you to the podium by saying "amangla." [Applause]

JOHN STANDISH-WHITE: Thank you, Maurice, and yes from Goedehoop, and that is a difficult word to say for Americans. My mother was from San Francisco and she battled to say [inaudible] but we have shortened it to GH and so you will hear me talking a little bit about GH, but it is super to be here and it is a real honor. The whole mine knows I am here with Jackie and it's a very special moment for us. Thank you very much.

Sorry, could we go back one there? I would just like to show you, this is a safety win of 1,000 fidelity free production shifts last year that we had, and we celebrated by having a breakfast at the main offices, and what we did last year, every time somebody tested and did their VCT, we said thank you by giving them a blue t-shirt and during the year we kept on saying to everybody, let's turn our mind blue, let's make sure we are 100-percent blue by the end of the year and so on, so you can see us here celebrating safety but always along with AIDS with all the amount of blue t-shirts there.

I am going to talk a little bit about the impossible barriers that have faced us, and then I will keep it simple as you heard from Maurice, only five elements, the five GH

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elements and measure them, and then go forward to try and perhaps eliminate the pathways to results. Where are we? We all know where South Africa is. That is where Goedehoop is, and we export pretty well all our coal to Europe and the Middle East out of Richard's Bay. We are from Anglo American. We do about 10 million tons a year and we make a fair amount of profits, so I don't want you to think that this is just an AIDS program mine. We do produce a little bit of coal at the same time. [Laughter] Our objectives, though, Somalia Pride, it's a lovely Zulu word for a team, team pride, in our elements, in our drive, in aiming for that 100-percent that everybody on our mine should know their status. It is quite a stretch target.

This is our AIDS team that you see there and you will see there that is how we like to be, a happy non-doom and gloom type of committee, and you will see the essential parts. They certainly include interesting things such as traditional healers. We are from Africa. We have people who throw the bones. We have cultures that need to be totally respected and we need to show that we are in partnership with such people and that we support the program that I am about to take you through. Also need decent leadership, I am certainly on the program in a big way, and our medical guys, too. Either you are on board, or you are not. We merged the

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other day with a big mine and I went and sat in on the AIDS committee meeting, had about 20-22 people, and it came to the end of the meeting and I said how many people here know their status? About four out of the 22 stood up. I said sorry, by the next meeting everybody will know their status or you are actually not behind the AIDS drive so either you are on board or you are on your way. Sorry for that, but with AIDS you've got to be a little bit tough sometimes. Some of the impossible barriers, the fear, the confidentiality, "ah, John, it's not confidential! I'm going to have my test. Everybody is going to know! You are going to know. You are going to fire me!" Rubbish! And confidentiality is a tough one. I will talk a little bit about that. Credibility, do people believe it, and in the fundamental understanding. Other ones, medical system, do we trust it? It can't happen to me. Our education levels are not particularly high in South Africa. Management vs. workers and the AIDS doom and gloom. We make sure that we have a lot of fun on our AIDS program. We don't start every speech with how many orphans and how many people are infected and how many people are dying and all that sort of stuff. It is true, but it doesn't mean we have to all walk around like this as far as AIDS is concerned. We are winning. And it goes back to the trust levels, all you trusted. What is the trust level like on

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your operation? That is what makes the difference. If you have got a high trust level, you can do anything. These are the five elements that we have got on our mind: Status, education, care support, and treatment, partnerships as well as the 100-percent condom program, but these are the three I am going to talk about. The biggest one, the most important one, is the status issue. Do you know your status? Have you been through that little test? Have you had that itchy feeling when you went through that test? Because that really changes your mind and focuses you on AIDS. Status, you can see we have gone through and I am sure I don't need to talk about medical stuff here but we have been through the improvement in the testing from blood tests to the rapid pin prick test and then up to this lovely OraQuick comes from this country and it really helped us a lot. It is an easy toothbrush test we call it and it's painless. You can't have any interaction between the sister or the doctor and the patient who is being tested. It really has helped us a lot. We have gone away from that four days of nervousness maybe, but three or four days while you wait for your results.

Confidentiality, what have we done? We have signed in public these sorts of gatherings with all of our union leaders, all the medical people, even the orderlies who push the files around, these are the excuses you need to take

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away. People keep saying someone will see my file or that sister, I don't trust [inaudible] we sign it up in public. If our leaders come and visit us on the mine, whether they are going underground with me or whether they just come for a visit, we put them a little bit on the spot and say hi, George, do you know your status? [Laughter] We would like you to test, too, and we will actually won't take a picture of your results, don't worry, but we are going to take a picture of you. Our work force likes to see it. There are a couple of our big bosses from London. In Johannesburg, you might recognize [Inaudible], he is quite well known in AIDS circles, and there he is testing and he is pretty old. Maybe I shouldn't say that, but you know, he has been to the mine. He has tested. There is his photo. Everybody has seen it! That is the fact. We make sure there is a lot of transparency, a lot of smiles, a lot of fun.

If people say ah, I haven't got the time. I just can't get there. We say uh, sorry? Where do you work? You work underground. Which section? We will take, you will see a picture there, there is [Inaudible], there is Stephanie Tibeta, the sister and the full-time AIDS coordinator going underground with Johnannes [Inaudible], our mine captain, but he is testing [Inaudible], he is the continuous miner operator and so no excuses, we really make it easy to test.

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That is the trick. We take people on rural turfs to our neighboring countries, in our country, to various hospitals and so on and then into a couple, you will see a nice one of Mozambique there, and I normally take these tours. I love it. I love taking the people. We choose them carefully and you will see that center top one is a lady outside. That is one of the family members looking after her. She is outside lying on a dirt, piece of ground, and she is busy dying of AIDS. I took this crowd of mine into the female ward. Us coal miners are funny, particularly the men. It's when you see a woman, clearly a girl who used to be really pretty with sunken eyes, no more curves, just a skeleton that guys take that story home. We had two union leaders who were determined they weren't going to test on this particular. They came out of that female ward. We had seen one girl with horrible lesions and scars and really she was way down into stage 4, and I only found out that night. They went straight back to the bus, always take a sister with me, they said where is that consent form? I want to test now! That is the sort of impact that these tours have. This guy, who I'm giving a little gift to or so, as I said on the mine, he looks like uncooked spaghetti. That is how he looks, and it is those sorts of stories you've got to take home to make sure that people see it right here. You can't take the whole

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mine to the various hospitals in our country or in the neighboring countries but you can get the message through. We were asked by [Inaudible] chairman and the CEO, if we would make a movie. We did and I would like to show you a little bit of it. We sent it out to 66 countries around the world and it is a story about one of our underground fitters called George Schultz, who came to me on April Fool's Day last year, the 1st of April, and said he wanted to break the silence and talk about it to our work force and save some lives. [Music begins.] Female Voice: *"Anglo American began developing an HIV policy 16 years ago, which focused initially on awareness, education, and prevention of infection. This policy has grown to include a wellness program, voluntary counseling and testing, and anti-retroviral therapy. Anglo American supports the key responses to the epidemic, elimination of stigma and discrimination and prevention of new infections."* George Schultz: *"Good morning. I am George Schultz. I am working for Anglo Coal Mine now for +/- eight years. I enjoy it. I work underground as a fitter. I used to be a blood donor. I gave blood and three weeks later from the blood bank, I got a letter stating this irregular in my blood stream and I must consult my doctor. He took blood tests and it was just before Christmas when I received the letter when I found out*

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I am positive. About eight months later, I went on to the medication." FEMALE SPEAKER: *"It just shows [inaudible] is getting treatment to all its employees."* GEORGE SCHULTZ: *"It was like walking to Paradise. It is hard to say, but you feel at home. It is more like a family. You feel loved."* FEMALE SPEAKER: *"[Inaudible] involved. Everybody is contributing to the success of AFT. From the top to the bottom."* GEORGE SCHULTZ: *"I never expected to get medication free of charge and it don't cost me anything. Totally free."* FEMALE SPEAKER: *"George came to us again and he told us that he wants to disclose." "Anglo American encourage VCT to manage the impact of the epidemic in the work place." "[Inaudible] George [inaudible] more people will come out."* GEORGE SCHULTZ: *"My colleagues seemed to be up in arms, our foreman, everybody that works with me. That is the spirit that is at Anglo Coal."* FEMALE SPEAKER: *"And George, what made him to talk about his status is that he wants that employees should learn from him that it gives one a big relief if you talk about your status, especially to the people you live with, especially to the people that you work with."* GEORGE SCHULTZ: *"And that is why I went public to help Anglo Coal, what they doing to me, I want to do to them as well, to save a life."* FEMALE SPEAKER: *"Today, almost 2,000 employees across all of Anglo American are receiving*

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antiretroviral therapy and 90-percent of them are healthy and back and work."

Thank you to George. He is probably on the ground right now. He is busy fixing and putting [inaudible] on a conveyor belt. He is doing well. Thank you, George.

This is an education tool I would like to show you that we have perfected on the mine called the "slippery slope" and it shows you at the top left from being 110-percent dead right in stage I, sorry stage zero, and then going down the four stages of AIDS to the bottom right where you are 100-percent dead, and we then showed people that, and I am going to take this from Ken and Gideon that we will change that slide and improve it now to adding in risk behavior on the left hand side and also putting in the risk environment is a very useful tip that I have just picked up, very nice. In going through the four stages of sweats and fevers, losing weight, going through the chronic diarrhea stage, until you are in bed way more than 50-percent of the time, but if you know your status, you ain't going there, and the message that we put out on this poster, that you get back into stage II where you are pretty well 100-percent okay. We have got some of our guys still running marathons in stage I who are HIV positive and on ART, so that is the strong message. We make sure it is in three languages. We put it

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out on the pay stub about every four or five months that can reach the families at home as well.

The third element, care, support and treatment, our AIDS committee needs to be nicely trained along with the union leaders, free nutritional supplements, two decent clinics, a great hospital about 30 miles from us, some home based care programs, and the latest figures there from Anglo American. We are now on 3,161 people on ART, of which about 94-percent are back at work. How do we measure our campaign? Absenteeism's improved. We meet at the unions annually. HR climates, production results are still super, and then our VCT and ART in particular. We transparently show on a weekly basis, you can't read that one page there, but if you have got it in front of you, you would, and it shows each department how well are they doing on VCT during the year? It creates a little bit of rivalry from one department to another. You can see the HR department ended the year at 96-percent and one of the shops there a little bit lower. How did we end up at the end of last year? We have a work force of just over 2,000 people, 96-percent of us tested last year, 341 of us are positive and on ART there's about 40-percent, 138, and as I left about 10 days ago, five of our guys were off for some reason, so 83-percent of us are negative, 18-percent of us positive, and in the province that I come from,

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we are running at about 30-percent, so the mine is significantly better than that. If we have a look at how we are doing this year, our work force is reduced a little bit. We are already on 80-percent. I phoned home yesterday back to the mine. We are on 81-percent and it is not even the end of May, so our guys, and this by the way, we set our clock back to zero every year. Every year, we go back to zero and start again because we believe it is like high blood pressure, you should be checking every year. That is where our trust levels are. So, I think that slide shows that we know what is going on. Regrettably, seven people, new infections this year, so we haven't got it licked. It is not yet licked, but we are getting there. Powerful stuff. Why success, leadership, decent easy VCT, good relationships, trust levels, we include in our bonus the VCT should be over 70-percent, AIDS and ART understanding and some decent drugs, and then of course lots of energy add. We are building on our winning formula. We are hugging our HIV positive guys. Lots of energy and leadership, and our real [inaudible] goals are zero new infections, zero people dying or getting sick with AIDS, and zero babies born HIV positive. This is where we have come simply on the testing route, August 2003, our mine on 5-percent; by the end of 2004, 90-percent. We then had the guts to turn our clock back to zero. Head office

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didn't like it, our hospital didn't like it, even see John Wilbell, this is not a good one. We turned it back to zero and you have just seen that fresh tests every year, 96-percent. That is where we are stretching for. By the end of this year, the 81-percent that I spoke about, we hope to bring that way up to the 100 mark. That is our slogan on the mine. Our passion drives us to be the best [inaudible].

In summary, the bullets leadership, energy, trust, fund, and build pride. Our guys are thrilled now with what we are doing on AIDS in our mine. We have become fairly famous in the Anglo Group and we have done quite a bit, as Maurice mentioned, but that makes the guys come, and their families. They feel as though we are at the cutting edge in our country, but I always finish on the real realities, not the head office, it's not for Maurice Middleberg, it's not for the government, it is actually for your family. You should be doing, you should be smart. What do you know? Those are Sontos, that Sontos Family on the left, and John and Jackie's family, our three blonde beacons on the right: 14, 12, and 7, Jessica, Justin, and Julia, they know all about the ABC, they know about running a condom down a wooden penis. They know all this stuff! I'll never forget when I started trying to tell them about 5-6 years ago and I think my daughters were 7 and 9 at that stage, and Jackie just went

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to the kitchen. She was too embarrassed. They said now dad, you talk about this condom thing. They looked at me as if you know, I just don't quite follow, and I had to go and get this wooden member from my car and show them. It just takes a little bit more is my point here, and so I would like to ask people that if they are from our country of beautiful South Africa, what are you doing as a parent? Are you making sure that the next generation is negative and is going to stay negative and is going to turn the tide from knowledge to will to action? We are into the passion and pride part of our AIDS journey. This is superb and I thank you for inviting me to come and meet you all. Cheers! [Applause]

MAURICE MIDDLEBERG: I think we have just seen a remarkable example of what makes for leadership and it is that spirit of optimism linked to an unblinking commitment to the truth and the facts that makes for change, so thank you very much, John.

It is now my true high honor to introduce Dr. Paul Farmer, who as many of you know is the founding director of Partners in Health, which is the international organization that provides direct health care services and undertakes research and advocacy activities on behalf of those who are sick and living in poverty. Dr. Farmer is the Maude and Lillian Presley Professor of Medical Anthropology in the

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Department of Social Medicine at Harvard Medical School, and attending physician in infectious diseases and chief of the division of social medicine and health inequalities at Brigham and Women's Hospital in Boston. He is also medical director of a charity hospital, the Clinique Bon Sauveur, in rural Haiti. Along with his colleagues, Dr. Farmer has pioneered novel, community-based treatment strategies for AIDS and tuberculosis, including multidrug resistant tuberculosis. It is now my great pleasure to introduce Dr. Paul Farmer. [Applause]

PAUL FARMER, MD, PhD: Good morning. I can't see you because it is dark out there but you will see me on Global Health TV I'm sure. That was eye-opening I'll tell you last night to turn on the TV to colleagues inside my hotel room. Very strange. I am going to talk about scale-up, replication, and give an up to date report on what it is like for example, and I hope Carol and others get this kind of experience, what it is like to do a scale-up program. What do these programs mean in small communities? I am going to talk about Haiti and Rwanda but I would also like to talk about transformation, and this is a theme that has already been sounded here this morning, personal transformations, institutional transformation, and to take on a question that is nagging people I know in this room, and should nag us,

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which is we have already heard about the fantastic amounts of new resources on the table, which are still insufficient, but it is certainly a welcome change from only five years ago before the Fund existed, before PEPFAR and some of the other larger initiatives existed, which permitted us to scale-up prevention and care. Some are saying, however, that this funding for AIDS takes resources away from primary health care and this I think is a subject of great interest in this room. Now let me ask a different way, is it possible to develop scale-up and replication programs that do not remove anything from primary health care but instead reinforce primary health care in the public sector which is only chance we have of promoting HIV prevention and care as a right, to strengthen the public sector, and the answer to that question, absolutely, it is possible. First though, transformations. Let me start with a picture that some of you have seen. It is a green button. Does that mean I push it? Point it somewhere? How about you? Some of you have seen this picture and I am going to give you some updates, but here is the way I would like to present this. In August of 2002, our group, a small group working in Haiti and several other countries, fairly small, received word that we would receive a grant from the Global Fund, that Haiti was one of the first round countries approved, and most people do

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not know this story, but we were confident enough. I am looking at Carol, confident enough in the Global Fund that although the money took many, many months to reach Haiti, we actually took out a commercial loan from a bank in Boston in order to begin a scale-up project in August of 2002 in the public sector in a town called Las Cobas, about an hour and a half from where I work and live, and this young man as you can see, March 2003, his name is Joseph and he wants me to use these images as much as possible. Some of you have seen his image before. He arrived in March 2003 to his hometown of Las Cobas to die, and this is his mother with him, but she said to him and neighbors did as well, he was carried in on a confected stretcher, no you shouldn't give up because Partners in Health has come to our hometown into the public clinic, and they have redone this and maybe they will know what you have, and of course we did know what he had. He had AIDS and tuberculosis, and this is the same fellow six months later, and so we want the numbers and I will give you some numbers from the clinic, but we also need to understand I think as a community because we are a community of people involved in global health and social justice in primary health care, regardless of what our training is, we also need to convey to people who are working on these projects, even from Geneva or Washington or London that what a transforming

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experience this is, and this is just the beginning of this man's journey, which I will tell you a little bit more in a minute and I think these pictures actually show up in the Global Fund Annual Report.

Here is the system in one picture. This is why this works, which is to say this is a community health worker delivering antiretroviral care to her neighbor, but she is obviously doing a lot more. This is not really directly observed therapy. It is not supervision. It is something much more akin to solidarity, but we lack the vocabulary in global health to discuss these matters, and as I will discuss in considering Rwanda, it is very important that we learn to do this. Now, when you show pictures of individual patients, of course anyone who has training in the quantitative methods that are so important to our work is going to say well that is just one case. Can this really be scaled up? And the answer was as soon as we got the Global Fund money, yes, and this is what we have done since we received the Global Fund money. Every one of these red dots represents a town across all of Central Haiti in which we have scaled up and replicated our HIV prevention and care program in a public sector institution, but we knew that you can't just go in and do an AIDS project. What about women's health? What about tuberculosis? What about primary health care? What about

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management of injuries, et cetera? So this is what we did. This is Joseph's home town of Los Cobas. The first picture is taken in August of 2002 at noon. It is closed at mid-day, like many facilities that I have been to in Africa or they should be closed because they are not really effective sites in which to purvey this kind of care. Better yet, of course, they should be reopened and that is what we did. We introduced essential drugs to the formulary. Now, the term essential drugs means for some people Thera sulfate, basic antihypertensives, it means that for us as well but it also means AZT, [inaudible], B14, fibrins, et cetera, anywhere where AIDS is the ranking cause of young adult death, then these medications have to be considered essential medication, and this was a long hard struggle, which maybe we will discuss in the discussion session. I won't do that here, but we had our own ideas in 2001 of what we considered to be essential drugs and we followed our own formulary and introduced all of that along with training and starting community health workers. That is another hoax that I would like to bring before you and ask for you to be very suspicious and maybe even militant about the claims that poor people should be community health volunteers. This is ideology. Neal said in introducing us, we are not ideological or pragmatic. This is ideology. Poor people who

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are farming the land in rural Haiti or rural Rwanda cannot afford to leave their millet and corn gardens to go and provide in depth care for their neighbors. They can't do it, as much as they may like to. We, however, should be volunteers as much as possible, but not asking community health workers to work for free to have their labor in that way disrespected. We also introduced aggressive, ZL by the way is the name of our Haitian sister organization. We introduced aggressive TB and sexually transmitted case findings. This by the way was all the Global Fund money and since Carol is here and since it is all going to be on Global Fund TV, I can tell you we spent months and months working with the Global Fund and broadening our agenda, so when you say well AIDS funding takes money away from primary health care, only if you let it do that. We said no, we have to do it this way. We need this money for community health workers and there was reluctance on the part of our funder initially and then we said we need to put TB in there and someone said to us well, this is an AIDS grant, not a TB grant, but more than half of our patients in Haiti and in Rwanda for that matter have TB infections and many of them develop active disease. There is no way to fight one without the other. We said STIs have to be included. That was easier to sell. We said women's health and someone said this is not the Global

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Fund for women's health, and we said you can't do a proper prevention of mother to child transmission project without women's health and that includes family planning and prenatal care, et cetera, and we fought, but the Global Fund agreed with us and I would like to thank the Global Fund publically and encourage them to push their other grantees to do this kind of aggressive work to support the public health sector and also to include primary health care, so here is what happened in Los Cobas. First of all, the clinic was not functional before the Global Fund money came along, and then it became as you can imagine overwhelmed, so people who say, another ideological comment I hear a lot, never from poor people but from my peers and from priests and ambassadors and heads of USAID, is that people don't value services unless they pay for them. Well if that is the case, why are all the clinics that I go to in Haiti and Africa empty until you remove the user's fees? It's just not true. [Applause]

We saw a massive uptake in patient visits, and by the way, these are young people who are gathering these data every day. We have daily reports that come up from Haiti where young people, many of them haven't been able to really complete high school, who are learning how to use spread sheets, epi info, computers, these are young Haitians doing this, and now we have Rwandans. I got a daily report last

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night in his hotel room along with the scary images of my colleagues on Global Health TV. [Laughter] But this is what happened, all recorded by my coworkers. TBK's detection, of course there is this first pass phenomenon, in a town of 50,000 people in Haiti, you expect at least 150 incident cases of TB in a year. In the year prior to our arrival, there were 12 cases and about half of those patients were lost to follow-up. In the 11 months after our arrival, we diagnosed 200 cases of active TB and you know how public health people have no sense of humor, or bad sense of humor, the community health workers made this joke which they thought was hilarious, that everywhere partners in health goes, there is an epidemic of tuberculosis, and then they laugh. [Laughter] As you did, too. Now, HIV, this case detection and proper VCT as John has pointed out and as Carol pointed out in her comments on integrating prevention and care can't occur unless you are doing serology, unless you are doing VCT, so prior to August 2002, of course there were no HIV case detections. They were coming over to our hospital and clinics an hour-and-a-half away, which is a dangerous thing to do in Haiti in the middle of military coups and bad roads, et cetera, but as you can see, we increase case detection but it has remained high and now as

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much VCT takes place in this small clinic, as takes place in our major medical center an hour-and-a-half away.

Here are some other things that I think are important. Prenatal care, well we are not responsible for providing prenatal care or administering vaccines. The vaccines are entirely procured by the Ministry of Health, but look what happened just by having us there doing a so-called AIDS project funded by the Global Fund. Is we radically strengthen the quality of care including family planning, afforded poor women in this part of Haiti and saw a very sharp uptake in vaccine administration and this is of course is DPT, measles, et cetera, the standard list, so that is our answer. Do these AIDS programs weaken primary health care? The answer is no, unless we design them foolishly and without thought to how important it is to strengthen the public sector and to strengthen primary health care.

Now I want to speak briefly about Africa and my great friend and colleague, Dr. Inez Binagwaho is here and she will be a witness to, she can confirm or deny my stories about Rwanda, but I actually wanted to go back to Joseph's story, the young man who was dying of AIDS, so Joseph is now an AIDS outreach worker, and does other work as well with us, and this is now three years later after the Global Fund came along and again I hope people in Geneva and elsewhere working

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in the Global Fund, and PEPFAR too, for that matter, understand just how dramatic the impact of this can be on lives and on communities, but he came back and has been very involved in our work and I brought him back copies of the World Health Report with his picture and he looked it and said, yeah I'm a star! [Laughter] But he didn't know how big a star he was. I was in rural Kenya, and some of you are from Kenya here today, in a place near Lake Victoria, in this little tiny VCT center because this terminology VCT has been completely adopted. Of course, the funding drove it, so in the middle of Luoland and you will see this big sign that says VCT which means nothing in Luo, by the way, or probably means something obscene or who knows? Anyway, so I had already seen this VCT center on a number of occasions, and the community health workers were meeting with someone outside and I wanted into the VCT center and I looked at the wall and I said, no way! And this is what I saw, I saw Joseph's picture on the wall in rural Kenya. So I said to the Kenyan nurse here with me, that is my patient from Haiti. She said no it's not, look it says Government of Kenya, and sure enough it did say Government of Kenya. [Laughter] ART works, underneath Government of Kenya, we are very proud and I brought that back to Joseph also, so Rwanda, and I know I have very little time, but I want to give people here the

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feel of this effort, so can it be scaled up? Yeah, we scaled it up across Central Haiti with Global Fund money. Can we replicate it elsewhere, this model that strengthens primary health care? The answer is yes! And Rwanda is a special case because Rwanda has a lot of similarities, structural similarities to Haiti. It is certainly is not as ecologically devastated as Haiti is but a place that is small, over-crowded, and torn by violence, at the same time now in Rwanda there is a very superb and highly committed government who is pushing forward this agenda, to strengthen primary health care and at the same time provide universal access. That is the goal there. The goal, I think as John has shown in his very engaging talk, that having [inaudible] line of work, we can't be gloom and doom as John said. We have to have high goals, and the Rwandan government has done that. Now, the way I ended up here was we went to a hospital with Dr. Binagwaho, who is sitting right here, went to a hospital in Northern Rwanda, and this is in November of 2004, to look at the hospital with partners in health that choose to work there and we said we don't care, you send us where you want us. That is something that took us ten years to figure out. We don't need to be imposing ourselves in that way on ministries of health. We said you choose, so when they showed us this hospital, electricity and doctors, and I

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said is that all you got? We are used to Haiti. This is too easy, and that is where Enya sent us. [Laughter] So, the next thing I know, Dr. Binagwaho has said to the ministry of health, she is director of the National AIDS coalition, "put partners in health in the most rotten part of Rwanda and they will flourish." I looked at her and said "Is that a compliment?" She said "It is. Just go." So, this was [Inaudible] Hospital 15 months ago. Here is it, the words on the left, and here it is on the right now, today, actually that is the Ministry of Health, Dr. [Inaudible], they are visiting and [inaudible] means "partners in health" and this is the pediatric ward.

Now, that is inpatient care but what about enrollment and outpatient care and what does it take? Well here I would like to focus very briefly on this image. These are members of our Haitian team. Dr. Laon, who some of you know, and [Inaudible], the head nurse of the AIDS program. They are going to Rwanda not only to train but to recruit staff and help us organize this. They have been major players and we have also used the same system with electronic medical records, using high speed internet access. Again, much less expensive than phone lines, we later understood. We had to redo the hospital, just as we did in Los Cobas, putting in a modern pharmacy and a modern lab. Now what about personal

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transformations? I don't want to be accused of using only the same photo, although I am not a good photographer so I didn't take these either, but this is a man we saw last summer in Rwanda, a [inaudible] man with, as Joseph, HIV and TB, and in order to do this transforming work, you not only have to support community health work, we also make sure people have enough to eat as John said in the vastly more wealthy South African companies dealing with employed people. These are unemployed peasant farmers with not enough to eat, but this is the same guy again, just a few months ago. This is actually two months ago, and it doesn't look like the same person, in fact people in Africa have said to me that the two pictures of Joseph are not the same person. I actually have to flash them back and forth on my computer to make [inaudible]. Here is another equally profound transformation, and this goes on every day in our work, so last image, where does this drag us? Not only does this drag us into primary health care, which is where we should be dragged. It is our job to be dragged there. That is where we belong. [Applause] But it also drags us in, as Neal said this morning, in the fight for social justice. That means employment with dignity, primary health care, primary education, clean water, and food security, and that is why these pictures here of both our pediatrician, we don't have

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many American doctors, we have three, but doing a home visit to do prevention of mother to child transmission. This requires substantial investments to make sure that we wipe out pediatric HIV, substantial investments in engineers and water programs and proper food security, ratcheting down our expectations and lowering the standard of care that we deliver to African women and their families is just simply not an acceptable path for it, although that is the de facto path and what we have to fight against. The last image on the bottom is perhaps one of our more radical programs, I guess is the term, and it is a picture of Dr. Binagwaho, you can't see her very well, in blue with the white t-shirt, and administer of health, at a home because we have started housing projects as well and we labeled this project "Project on Social and Economic Rights" but that is just my example of where we need to go and I borrowed all this of course from Haitians and from people living in poverty, we need to take our AIDS money or our tuberculous money or our maternal mortality money or whatever it is, and make sure that it becomes the battle horse for this broader movement which inspires us all, and that is the movement towards health care as a human right. Thank you very much. [Applause]

MAURICE MIDDLEBERG: Well what Paul has shown is that part of leadership is challenging assumptions and to have the

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courage to do so consistently. I think we have time to switch, can we have the lights now? I think we have time for some questions. There are microphones on either side of the stage so let me invite those who are inclined to please come up to one of the microphones and give your name and where you are from and ask a question of one or several of our speakers. I know this isn't that timid a group. There we go.

DR. JEAN MOCK: I am Dr. Jean Mock. I am a medical mission sister and I have worked in Ghana, West Africa, implementing the primary health care strategy through the years of 1977-92, so I know it works, so Dr. Farmer, can you please give us some idea of the investment that can start to do those transformations and I think what you are really describing is the level which always gets ignored, which is the middle level. It's not the big hospital and it is not the little village clinic. It is that, what is Ghana is "the district" and it is important to be strengthened so that money can be shaped by the real needs of a real population and it is population based, which is that primary thing, so can you give us some of the nuts and bolts of the financing to strengthen that middle level which always gets ignored in the investment?

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PAUL FARMER, MD, PhD: Thank you very much. First of all, I would like to say that all of these scale up efforts, including those in Rwanda, have occurred at the district level, because after 10 years of doing this work in Haiti, we realized some of the errors that we have made, which was A) to start our own NGO, not an error because now we are repenting. Not to use overly Catholic [laughter] thought in front of a missionary sister. [More laughter] We knew that we hadn't done enough. I know you are going to come tell me you are a protestant now, right? [Laughter] We knew that we hadn't done enough to strengthen public health in the primary health care system, so all of our scale up efforts everywhere, Peru, Russia, anywhere, maybe with the exception of Boston, but it's all been through the public sector and that is very important and the district level, as you said, that is what gets neglected. You can have all the good will in the world in a capital city like Kigali, but they need, you know, people like Dr. Binagwaho, need effector arms on the ground. Now, the nuts and bolts, I have to say and I hope I don't sound overly praiseful to Global Fund, but our scale up efforts in Haiti are due entirely initially to the Global Fund, and I will tell you exactly how much the grant was. We received \$2.4 million dollars in year 2003, awarded in 2002, and that was the annual slot, so we were scheduled

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for a very large chunk of change over the following five years, certainly more than we had handled before in Haiti, but with that money and some other assistance, more recently of course we have had PEPFAR funding in Haiti as well. We have. We didn't apply for that initially, but we have also had support from the Agence Française de Développement, but we have rebuilt every single major district hospital in all of Central Haiti in those four years, so those were the kind of annual investments we are talking about. To redo the whole public health infrastructure, to maintain all the public health staff, and do the opposite of the brain drain, the brain drain to rural Haiti. You know, we have people, we are the number one site in the middle of the "sticks" as they say, we are the number one site for placement for all social service residents, doctors and nurses.

DR. JEAN MOCK: But then the next question is where does it go from your region to the national? And then I would love to see Haiti and Rwanda bring it in to the international, so what is your next step to scale up so that they whole country reflects that investment?

PAUL FARMER, MD, PhD: Well, in Rwanda, it is easier than in Haiti, for the reasons I told you, 1) there is ample political will, there is a lot of security there, transportation infrastructure is excellent, the government is

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easy to work with. When you say no, we don't agree with that, my experience is that the government is going to say show us the data, which is fine. We need to be held to those standards. So that is why I think we are going to have more luck with national scale up in Rwanda than in Haiti, although our aspirations in Haiti are national as well, but there is another group in Port of Prince that is doing superb work. We have worked with them for years, Gescio [misspelled?], but in Rwanda I think we have the shot but when we finish this training center we are building in rural Rwanda near the Tanzanian border, the government will definitely use us as their national training program for the rural AIDS initiative, and I think we need to go there and provide something more than traditional technical assistance but we will have this training.

MAURICE MIDDLEBERG: I'm sorry, we have to move on to another questioner. Thank you very much. We will talk after.

DR. ANNE MARIE NELSON: Hi, I am Dr. Anne Marie Nelson and Dr. Farmer is familiar with some of the work I did back in the 1980's at Projadedda [misspelled?] in Kanjasa, I was probably one of the first pathologists to work in Africa and documented that TB was a major killer, and one of the problems that I find with pathologists to start with but also

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with funding for projects is that accurate quality assured diagnosis is lacking, and having that I think is an essential part of any program. You can do a CD4 count and a viral load in Uganda but you can't do an adequate malarial smear or you can't diagnose tuberculosis correctly, and I think that we should think about ways that we can strengthen that and one of the ways that some of us have talked about is actually doing a Flexner report on medical education in developing world and focusing on several schools to improve the quality of medicine, and I think that would be one of the great answers to the brain drain, and laboratory medicine is part of, as you know, of Welch and [inaudible] and important part of good medical care.

MAURICE MIDDLEBERG: Would one of the panelists like to comment? Perhaps in talking about diagnostics, low resource settings, and Paul I know that is one of the issues you have grappled with.

PAUL FARMER, MD, PhD: [Inaudible] say that I agree wholeheartedly with my colleague and that what I would ask here in this setting, Global Health Council, is that we need to strongly support this, because there is a trend, let's be honest, there is this trend inside Global Health at International Health, which is very [inaudible] and very gloom and doom, to use John's words. "We can't do it, it's

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too expensive, we will never get the funding." These are major epidemics, as everyone here knows, and in order to take them on effectively, just as one example, I have said already that half of our patients in Rwanda and Haiti have TB infection, maybe more than half. That means that it is the leading cause, serious opportunistic infection. We do not have a diagnostic for tuberculosis in part because of lack of funding and in part because people in the tuberculosis community as we call ourselves, said we don't need another one. We need the smear microscopy. It is cheap. It is cheap and it is bad, and we have to have new diagnostics.

MAURICE MIDDLEBERG: We have time for one more question.

WILL MIDDLETON: My name is Will Middleton. I am from Hope College in Holland, Michigan. My question is for the gentleman from South Africa. You mentioned your own efforts in talking about prevention and treatment with your own family, I was wondering if you have extended the status in testing to the coal miners family or the coal workers families, so not only the workers know their status but their extended families as well, or if you have already done that?

JOHN STANDISH-WHITE: No, we haven't. We are busy going that way. In Anglo Coal in South Africa, the nine mines that make up Anglo Coal, for example, we are at about

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64-percent VCT amongst all the mines and we leave the mines by a mile in South Africa. We are busy going on to all the families as well, and to try and catch up with some of our colleagues, such as De Beers, who have done that in Southern Africa including Botswana in South Africa and so on, and getting our education levels up to make sure that the families can benefit. Our community peer educators get out into the families. We hold talks in the villages and around the mine quite a lot, but it is not yet completely free for the families but I would hope by half year we will be there. Thank you.

MAURICE MIDDLEBERG: One more comment, please.

DR. INEZ BINAGWAHO: Thank you very much. I am Dr. Binagwaho, the poor friend, and I want to add something, because this man is very modest. I don't know if modest is a good word in English, but really we send him in the worst spot of Rwanda and he made this part one of the best of Rwanda and you talk about scaling up, now we ask him to do the same in [inaudible] district and I am sure he is going to do so. The important and what I learn of all those panelists who are very [inaudible] is that you had success because you integrate your program in the national program, and this is the key issue of success. As you say, Pastor, multisectoriality, integration international programs so that

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you upgrade the national program and when you leave, we have something to continue to work with, and I just want to point that out because this is the most important for people like us who are decision makers and working in the field, those are true partners. This is the true way we would like to work with partners in the future. Thank you very much.

[Applause]

MAURICE MIDDLEBERG: With that, ladies and gentlemen, please join me in thanking our panelists for a truly inspiring opening plenary. [Applause]

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