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**XVII International AIDS Conference
HIV/AIDS and Health System Reform: Achieving Universal
Coverage
August 4, 2008**

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LUIS SOTO-RAMIREZ, M.D.: Good afternoon. My name is Luis Soto-Ramirez. I am the local co-chair of this conference, and I am going to introduce these new session named HIV/AIDS and Health System Reform: Achieving Universal Coverage.

Our first speaker is Dr. Julio Frenk. Julio Frenk is currently a senior fellow in the Global Health program of the Bill and Melinda Gates Foundation, as well as President of the Castle [misspelled?] Health Institute in Mexico City, and chair of the board of the University of Washington Health, Metrics, and Evaluation. We are very proud as Mexicans that Julio was appointed last July 29 as Dean of the Harvard School of Public Health, a position that he will assume in January 2008. Julio is a visionary leader, insightful analyst, institutional innovator, and pragmatic problem solver. So I am sure you will enjoy his talk on this symposium on achieving universal coverage. Ladies and gentlemen, Julio Frenk.

JULIO FRENK, M.D.: Thank you, Luis, thank you Julio Montaner. Good afternoon to everyone. I am thrilled to finally see this day arrive. As Minister of Health of Mexico from 2000 to 2006, it was my distinct privilege and honor to work side by side with International AIDS Society, in order to realize the dream of holding the International AIDS Conference in Latin America.

Now that we are here, I can only express my deepest gratitude to Greg McClure, Pedro Khan, Luis Soto-Ramirez, the

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international and local organizing committees, and the Mexican authorities for their outstanding efforts to bring us all together.

Two years ago at the closing ceremony in Toronto, when the selection of Mexico City as the host of the next conference was formally accepted, I posed the following question. How does a developing country prepare itself for an event of this magnitude? Part of my answer was it prepares by reforming its healthcare system as Mexico has done so that it assures universal access to comprehensive care, including antiretroviral therapy.

It is therefore fitting that today we are gathered for a special session with President Clinton precisely on the topic of HIV/AIDS and the health system reform. In order to provide the local context for the keynote address that President Clinton will deliver, let me briefly share with you some reflections and lessons stemming from the successful reform that was started in Mexico in 2003, and that has been enriched by the current administration of Felipe Calderon.

In recent months, the Global Health Community has witnessed a burst of interest in health systems. This interest is long overdue and it is very good news indeed. The problem is that it is often portrayed as a conflict with the disease specific initiatives of which the most important, of course, is the fight against HIV/AIDS. The contentious nature of this debate reflects the long standing divide between the vertical

approach focusing in particular on disease criteria's, and the horizontal approach aimed at strengthening the overall structure and functions of the health system, but without a clear sense of priorities.

The solution to this false dilemma is what Jaime Sepulveda, a pioneer in the fight against HIV/AIDS, has called the diagonal strategy, whereby explicit priority interventions are used to drive improvements into the health system. The prevention and control of HIV/AIDS is particularly well suited to foster the diagonal strategy. Because of its intrinsic importance, but also because of what HIV/AIDS reveals about the nature of health challenges in our societies.

This was our approach in the Mexican health system reform. Like all public policies, this reform was supported by three pillars; technical, political, and ethical. The technical pillar was built on the intensive use of sound evidence, which, among other things, revealed an unacceptable paradox. Whereas health is a key factor in the fight against poverty, healthcare itself becomes a cause of impoverishment when hundreds of millions of uninsured families all over the world have to pay out of pocket for services and drugs.

This was precisely the situation that prevailed in Mexico, where half of the population, 50 million persons, most of them poor, were uninsured and therefore faced insurmountable barriers to access. The Mexican Reform of 2003 was designed to correct such a paradox. It did so by introducing a new public

insurance scheme called [Spanish spoken], which is extending social protection in health with the objective of achieving universal coverage by 2010. Enrollment is on target, having reached 22 million people by the end of 2007. A crucial feature of this reform is highly relevant to the fight against AIDS. Indeed, the new insurance scheme defines a set of specific entitlements or benefits that give operational meaning to the right to healthcare enshrined in the Mexican constitution.

Budgetary transfers to the states, which are responsible for the provision of services, are now based on the number of families affiliated to the [Spanish spoken], so that money follows people. This new formula of democratic budgeting guarantees a sustained increase in the level of public funding for health, since the law specifies that budgetary obligations of the federal and state governments in order to adequately finance the entitlement. In this way, Mexico is adding a full percentage point of gross domestic product over seven years to its public budget for health.

For a number of high priority problems, a special track of accelerated universal coverage was introduced. The very first of those priority problems was HIV/AIDS. Thanks to the active participation of civil society organizations between 2000 and 2006, the Mexican Congress approved a 14-fold increase in the budget devoted to the HIV/AIDS program. The additional resources have been used to sustain a strategy based on three

key components prevention with emphasis on condom use, campaigns against discrimination, and universal access to comprehensive treatment, including antiretrovirals.

Through the strategy of accelerated universal coverage, every uninsured person in need of treatment is eligible for immediate enrollment into the [Spanish spoken]. This is possibly the best example of the diagonal strategy by focusing on a high priority problem such as HIV/AIDS; the public was able to link abstract financial and managerial notions to concrete deliverables. In this way, it was possible to build a political pillar of the reform and muster the necessary support to pass a major piece of new legislation, along with the associated budgetary increases.

Once again, the fight against AIDS was the trailblazer in this political effort. But health system reform must be fueled not only by ideas, but also by ideals. And this leads us to the ethical pillar, the last element of my remarks. The fundamental principle underpinning the Mexican reform is that healthcare cannot be seen as a commodity or a privilege, but as a social right. [Applause].

In the case of AIDS, this meant not only ensuring universal coverage, but also launching an open battle to fight stigma, violence against women, and homophobia. To this effect, Mexico amended its constitution and passed laws to prevent and punish any type of discrimination. The progress I have described is the fruit of a longstanding effort that

started in Mexico at the very beginning of the epidemic in the 1980's, and has involved the coordinated work of government, civil society, health professionals, scientists, and the international AIDS community.

One of the heroes of this saga is here with us. HIV positive himself, founder of the first HIV clinic in Mexico City, responsible for implementing the policy of universal access to treatment and care, authoring 2,005 of the first government endorsed anti-homophobia campaign, recipient of the National Gay Marriage award, and representative for Latin America and the Caribbean in the board of the Global Fund, he is a source of inspiration for many. I refer to Jorge Hecapana [misspelled?], whose outstanding leadership was featured in last week's issue of the *Lancet*.

It is very important to recognize our achievements and our achievers. It builds up our spirit and energizes our action, so let us not forget the truly amazing progress that so many of you, in so many countries and continents, have spearheaded immobilization of funds, development and deployment of life saving drugs, design of preventive efforts, and coordination among organizations. Let us also remember and honor those who are no longer with us.

However, we must never lose sight of the fact that we are in the midst of a long struggle. Many countries have lost that to promote respect for the human rights of persons living with HIV/AIDS, yet of the famous historian Lincoln has written

human rights are still ensured to endorse than to enforce. There are still groups out there who oppose human rights, who are looking for ways to ignore them, and who, in the extreme, violate them. Defending human rights is the right thing to do, but in an ironical play of words, groups in the extreme right often wrong the rights of others, especially of persons who are excluded and stigmatized as different.

Yet, the essence of human rights is that they are universal because they are inherent in what President Clinton has called our common humanity. They are therefore rooted in empathy, that human characteristic that allows us to emotionally participate in a different reality, understand it, relate to it, and in the end, value the core elements that make us all members of the human race.

The imperative of this universalistic outlook is underscored by globalization. More today than ever, global health must promote a new ethic, the ethic of universal rights so that every human being may have the same opportunity to achieve his or her full potential. It is there in our ability to care for each other, in our sense of solidarity, in our determination not to leave anybody behind, in our vision of health as a human right where we may find the ideals to inspire our ideas.

No one understood this earlier or better than Jonathan Mann, who saw AIDS as the frontier in the struggle to promote and protect human rights in all places and for all people. A

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rights-based approach to health opens an enormous field of action for international advocacy and global solidarity as the AIDS community has so successfully demonstrated. In our turbulent world, health remains one of the few truly universal aspirations and the cornerstone for global citizenship. More today than ever, health represents a common ground, a source of sure security, a way to give globalization a human face. The struggles for the rights of people living with HIV is the emblem of this kind of constructive diplomacy.

Few persons have been as successful and consistent as President Clinton in making the connection between health and the larger causes of economic development, global security, gender equity, and human rights. During his presidency, he designed a visionary initiative for health system reform, which proved to be ahead of its time, and constantly demonstrated with this his deep commitment to the improvement of health. As a leader and philanthropy, he has reached world champion status by launching the Clinton HIV/AIDS Initiative to close the gap in access to antiretrovirals and improve the components of national health systems required to deliver these life saving drugs.

His innovative schemes to lower costs and link actors have now been extended to other diseases, like malaria. Indeed, he is following up on the vision he articulated at the Toronto AIDS Conference when he said, and I quote, "If we can turn the tide on this epidemic, it will unleash a burst of

energy and belief in human potential that will spill over into TB, malaria, and economic development, and into meeting the challenges of climate change, and to anything else you could possibly imagine." End of quote. This is, indeed, the essence of the diagonal strategy.

You should all know that President Clinton is greatly admired and appreciated in Mexico. No one in this country forgets how, in times of crisis, he had the courage of taking sides with us. Similarly, I am sure that no one in this room will ever forget how he has taken sides with the cause of overcoming HIV/AIDS in the world.

I met President Clinton exactly two years ago at the previous International AIDS Conference. I was introduced to him by my friends Paul Farmer and Jim Kim. The moment I shook his hand, I knew I was in the presence of an extraordinary human being. I am sure that you will all share in this feeling as we listen to his words of wisdom. Ladies and gentlemen, it is with great pride and honor that I introduce the 42nd President of the United States of America, the leader of the William J. Clinton Foundation, and the source of inspiration for all of us who work and are committed to global health. Thank you very much.

WILLIAM J. CLINTON: Thank you very much. Thank you very much, ladies and gentlemen, thank you for the wonderful welcome. I want to thank Julio Frenk for his remarks, for his kind introduction, and for the great work he has done and will

do. To Luis Soto-Ramirez, thank you for co-chairing this conference, and congratulations to the President Elect of the National AIDS Society, Julio Montaner.

Greg McClure, your executive director, and I were talking in the back about the remarkable prominence in the International AIDS Society and International AIDS work of people from Mexico and from Latin America. All from countries with low infection rates, but high rates of committed citizens with extraordinary ability, and I am grateful to all of them for their work.

I am honored to be part of the International AIDS Society conference once again. I think these meetings are very important, not only because they bring more public attention to the ongoing challenges we face, but because they enable us to measure our progress since the last meeting, to openly acknowledge continuing problems, to evaluate the positive and negative new developments, and decide together on what we should do next.

I flew to Mexico City overnight from Africa, where I have been in Ethiopia, Rwanda, Liberia, and Senegal, visiting my foundation's aids and other projects. I go there every year to meet with our people and our partners and those living with AIDS. What I have just seen and heard frames much of what I would like to say to you today.

We all come here with a common purpose. We want to prevent new infections, provide care and treatment to all who

are infected, support the search for a completely effective prevention, and the ever-elusive cure. We all come in the hope that somehow the presentations on this theme, Universal Action Now, will help each of us to determine what more we can do, and we know there is so much yet to be done to expand prevention, treatment, and care. To strengthen underdeveloped health systems, which limit the reach of life saving strategies. To integrate the fight against AIDS with the conversion problems of TB, malaria, other infectious diseases, and the lack of maternal and child healthcare. To evaluate what works and make better use of expanding our still limited resources. And to support the scientists and the inquiries only they can undertake.

I suspect that to most of us, Universal Action Now means all these things, but none of us can do all these things. AIDS is a very big dragon. The mythological dragon was slain by St. George, the original knight in shining armor. But this dragon must be slain instead by millions and millions of foot soldiers. Universal Action Now calls on all of us to make the best use of the weapons at our disposal. I am glad we are in Mexico. Mexico, and its neighbors in the Caribbean, Central and South America, has shown strong leadership in the fight against AIDS, especially in the early start of their treatment program. And many of them, therefore, reflect one of the key challenges we face, sustaining the long term costs of the treatment program.

Julio Frenk deserves special praise for what he accomplished here as Secretary of Health increasing health insurance to benefit millions of people, something I hope his neighbors to the north will soon copy. And if you will give me a moment of personal indulgence, the region has special significance to me because this is where I started the AIDS work of our foundation. In 2002, after I spoke with the Prime Minister of St. Kitts and Nevis, Dr. Denzel Douglas at the Barcelona AIDS Conference. He talked about the magnitude of the AIDS crisis in the Caribbean, he said denial and stigma were not much of a problem, but that the lack of money and organization was. I said Denzel, what do you want me to do about it? He said, "I want you to fix it." Nelson Mandela was standing there laughing me and elbowing me in the side, and he said, "That is what you ought to do." So I decided to try, and in the doing, to join your ranks as a private citizen.

When we started our work six years ago, we focused on lowering the cost of drugs and tests needed to be in treatment. We supported a number of governments in developing and implementing plans and policies to dramatically increase diagnosis and treatment, and over the years we have expanded our work to include a wider range of IRBs in diagnostics, and now therapeutic food and more affordable and available malaria ACTs.

Today, 1.4 million people with AIDS are using medicines purchased under the Clinton Foundation's HIV AIDS agreements,

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about half of all those added to the treatment roles since 2003. And thanks to the incredible efforts of our generic partners, they cost about 120 dollars a year. Increasingly, my foundation has been invited by the governments with whom we work to help develop the health systems necessary to actually deliver prevention, treatment, and care, including the design and management of pediatric and rural HIV AIDS programs, the provision of adequate lab facilities, the training and placement of more health workers.

Now we have more than 500 people working in more than 30 nations. I would like to thank them all, for they do the work, especially the Director of our efforts, Anale Sony [misspelled?], his predecessor Ara Magaziner [misspelled?], and all the donors, both public and private, who finance our work.

There has been important progress in broadening the ranks and level of giving since Toronto. UNITAID was created by France's innovative airline tax, and enhanced by other nation's contributions to make much more money available to fight AIDS and other infectious diseases. I am very grateful to the leader of UNITAID, Philippe Douste-Blazy, who is here in the audience, for this inspired idea of the airline tax. And grateful for the opportunity that my foundation has to work with UNITAID to expand access to pediatric and second line AIDS treatment by lowering the prices and bringing better products to market. We have now the price of the most common pediatric

treatment down to 60 dollars a year. That is down from about 600 dollars a year just three years ago.

The price of second line treatment has been lowered substantially to 670 dollars, but that is still far too high and we are working to get it lower. Just this past week, the United States Congress passed, and the President signed, a bill committing to increase PEPFAR to 48 billion dollar over the next five years. That is a stunning development for which we should all be grateful.

The Global Fund, the foreign assistance programs of other national, the Gates Foundation, and other private efforts continue to invest more and to do it more effectively. The collective action of the people in this room now provide more than three million people with AIDS treatment, a ten-fold increase in just five years, with the percentage increase in children receiving pediatric ARVs even greater.

The 2008 U.N. AIDS report tells us that AIDS related deaths declined last year, that more women are getting ARVs to prevent mother to child transmission, that the number of new infections among children fell, that more children are receiving treatment, and that the long-term funding gap has been substantially reduced by the recent American legislation. The progress made and the future funding committed should convince us that we can now face the persistent challenges that remain. More than 2.7 million new infections last year, increasing millions without access to care or treatment,

including more who need second line drugs because they are living longer, a 30-percent rate of mother to child transmission in developing nations, 15 times the rate in advanced economies, continuing stigma and human rights problems that continue to keep services from vulnerable populations, including sex workers and gay men. I want to say a special word of thanks to the President of Mexico and the Secretary General, Ban Ki-Moon, for speaking out publicly against the discrimination in these groups. We should all be very grateful to them.

The other challenges include substantial shortages of healthcare workers and an adequate infrastructure in developing nations, and a resurgence of infections in the United States, especially among African Americans. As we think about what to do, let us start with what we know. Treatment and prevention must go hand in hand. We have seen for a long time that the availability of treatment increases the uptake in prevention, including testing, counseling, and education about behavior change.

More than a decade ago, Brazil gave us data showing that the availability of ARVs increased testing rates by 30-percent in a single year. Now there is mounting evidence that treatment itself is a biomedical tool for prevention, reducing the likelihood of transmission among adults and, of course, ultimately eliminating mother to child transmission by reducing the risk to two percent in the countries which provide it

comprehensively, compared to average rates of 30-percent and rates as high as 45-percent where mother to child transmission preventative treatment is not available or is done improperly. Botswana, the Bahamas, and others have shown that we can reduce transmission everywhere if we just treat mothers more effectively.

Besides the prevention of mother to child transmission, we are also seeing the treatment can help to prevent the spread of HIV nationally by driving down the community viral load. We know individuals with lower viral loads have lower likelihood of transmission, the virus to others. And we know the best way to lower the viral load is through treatment. So we know that large scale, high quality treatment, where adherence is high, resistance is low, and patients who receive comprehensive education on avoiding high-risk behavior will prevent new infections.

We also know that with prevention, there is no silver bullet. So we are forced to continue to pursue a number of approaches, including campaigns to change sexual behavior, adopt, direct, and consist in condom use, provide substitution therapy to injection drug users, and increase male circumcision. We need to make testing and counseling available and to promote it in every single health facility in every community so that people know their status and can get care as soon as they need it.

Today, unbelievably after all these years, 80-percent of the people who are HIV positive still do not know their status. That is 26 million people at high risk of transmitting the virus to others. Despite the recent setbacks in research, I believe we must continue to fund the search for a microbicide and vaccine that works. And I am very grateful, personally, for the efforts of those who are searching for the breakthroughs, and those who fund them.

Let me also say that in addition to redoubling our commitment to prevention and treatment, I hope we all will leave this conference with a deeper perspective on another subject of continuing discussion. And that is the relationship between HIV and AIDS, and the overall condition of national health systems. Maybe I am just fixated on this because it is such an issue in the countries where I work. But I believe that the overall capacity of health systems determine whether access to prevention, care, and treatment can be made universal as this conference advocates.

This is particularly true in rural areas where large percentages of those most at risk and already infected, live, in developing countries. My foundation has seen this work firsthand in the work we do. In Ethiopia, the first priorities the government set for us is in AIDS NGO, were to improve hospital management, and to pitch into efforts to build more clinics so the country can go from having just one health clinic per 120,000 people, to having one for every 25,000.

Last week in Ethiopia, we launched a PMTCT program that is founded on improving rural healthcare. Success in PMTCT is not elusive because the pills are not being provided, it is failing because only one in three HIV positive women are accessing the services, and because only 8-percent of infants born to infected mothers are being tested in their first months of life. What are needed are stronger community health networks to test all women, and to enroll and keep all families in treatment and care. That is the approach we are going to take in a new 50 dollar million program we are working on in six nations.

There are many more examples of the importance of health systems. In Malawi, a major constraint to HIV/AIDS care is limited lab capacity, so there our work is focused on recruiting and training lab assistants. In Zambia, demand for services continues to rise without a corresponding increase in healthcare workers, so we work with the government on a long term strategy to increase their supply and productivity. In Papua New Guinea, my foundation is deploying a community healthcare worker model in the eastern highlands that is patterned after Partners in Health, but without any international NGO staff. Listen to this. Just by putting those people out there and training them, the loss to follow up rates among pregnant women testing positive have dropped from 74-percent to zero. People do want to stay alive and protect their children.

In each of these cases, the lab assistants, the healthcare worker, the citizen outreach workers, these people work for a healthcare system. They do not only do HIV/AIDS work, but they have dramatically improved the care, treatment, and prevention possibilities.

It is also true that if you start with the workers, you can improve the system. Rwanda is a good example where the government is making ambitious plans for a nationwide strategy to strengthen district health systems. As it scales up the framework, it is making use of Global Fund AIDS money to cover health insurance premiums and compensation for the community health worker, both of which will keep them in the field fighting AIDS and build a stronger healthcare system.

Now the Global Fund seems poised to give countries more access to funding for strengthening healthcare systems overall. And although we do not yet know the outcome of the current request in the round of proposals now being considered, we should all be encouraged and grateful for this new perspective.

And let me say that funding is not the only way AIDS can be a starting point to building stronger health systems, which in turn make possible universal treatment and care. There is an incredible opportunity to do so in the design and deliver of HIV services by taking into account the need for TB diagnosis and treatment at the same time. In some African nations, nearly three and four people who have TB are also infected with HIV. It does not make much sense for us to be

continuing to ask these men, women, and children to go to two clinics with two doctors and two pharmacies and two strategies to treat one person who has got enough problems as it is.

In rural areas where we have funded projects specifically to deal with HIV and AIDS, we find there is simply no such thing as an AIDS specific or an AIDS only approach. If we want to improve HIV services in rural areas, we must do more to decentralize the delivery of all kinds of quality healthcare by connecting the necessary number of quality hospitals to clinics with trained personnel, which in turn are connected to villages through community health workers with strong ties and constant access to the people.

This paradigm is focused on the most direct delivery of care possible. It is a big advance on the current model that is still in too many places requires people to travel long distances to get the care they need.

If we can turn this model around, we will relieve families from spending literally days every month traveling to a clinic to get medicine, or provide blood samples, or get test results. In some remote communities, patients and nurses wake up as early as 3 am just to draw blood samples to send to a lab. In places where there is no electricity, they often collect samples from patients huddling under the headlights of a car.

We have already seen how HIV rapid tests have revolutionized the delivery of testing and counseling. There

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are other transformative technologies on the horizon that can further decentralize care, particularly point of care diagnostics for CD4 and monitoring. Of course, the funding requirements for this kind of infrastructure and staff are significant. So we will have to raise more money and we will have to spend what we have more effectively.

In order to do that, we come to the next point I want to urge. We need more rigorous evaluation of what we are doing and more rapid application of what we are learning. My foundation tries to keep score on everything we do. If it is not working, we try something new. I think most of us do that. We really want to know whether the money we spend and the effort we exert have positive consequences in other people's lives.

But we also need more objective expert research to guide our limited resources to the most effective action. Learning what works can help us to optimize the design of programs from improving the layout of a clinic to optimize patient flow, to shifting task and responsibilities across different kinds of workers to maximize their productivity. When resources are scarce, we save lives when we use them better.

Evaluation can also save more lives by improving national and international policy. I saw this firsthand yesterday in Senegal, a country by the way with a magnificent comprehensive program. There I joined the World Health

Organization and UNITAID, along with Mr. Duce Buzzey, to support the new WHO guidelines, calling for the treatment of all HIV positive infants, and to announce our determination to implement that policy as quickly as possible.

This is a huge deal, this new WHO policy. It is based on research, on hard evidence, proving that mortality and morbidity among infants living with HIV, which is staggering if untreated, drops four-fold if treatment is initiated right away, as soon as an infant is diagnosed. UNITAID is ensuring flexibility in its current funding arrangements to allow countries to make the switch in medicines as quickly as possible, and we are working with the governments affected to implement the change. The sooner we change, the more lives we save, all because better research on what works, quicker translation of data into policy, and accelerated efforts to turn policy into practice, to save more lives.

Pediatric care and treatment has come a long way since our meetings in Toronto, too. We have tripled the number of children on treatment in just two years. I am proud that our foundation's partnership with UNITAID is responsible for two-thirds of the more than 200,000 children on treatment today, but I am bothered that in a year when about 500,000 kids will die, the ratio of access among children is still much less than that of adults. I want to thank UNICEF and many others in this room for focusing on children and the treatments they require.

[Applause]

Now, let me make two final comments. Universal action on AIDS is blocked not only by inequalities and economics health care and education, but also by widespread, persistent, gender inequity and violence. They too contribute to the spread of HIV and AIDS in much of the world. [Applause]

We all know we need to do more to promote the rights of women and girls to end the epidemic of gender violence. Women already bear a disproportionate burden as wives, mothers, grandmothers, and healthcare workers in the AIDS crisis. Violence and discrimination should not add to that burden. That is why I have decided to support the current effort of many governments and advocates to create a new United Nations agency for women, and I want to thank Steven Lewis especially for his passionate and unyielding support. [Applause]

There are countless other people to thank in the fight against AIDS. I do want to mention one more, Dr. Peter Piot. [Applause]. Long before he came to UNAIDS, Peter was on the front line. And for 13 years at UNAIDS, he has helped to lead the global response and mobilize resources across the U.N. and in partnership with governments, NGOs, and communities. We are all a lot better off because of his leadership.

The second point I want to make, simply because this is a global AIDS conference, is important because before we conclude we have to remember that there is still a lot of work to do in high-income countries. That is what these people holding these signs are trying to remind us of. We have got a

lot of homeless people in rich countries because of the declining condition of the home mortgage crisis, the rising price of food, the rising price of gasoline. [Applause]. The rising cost of living. And when people move out of a known address, they become harder to reach populations that require adjustments in the healthcare systems in wealthy countries as well.

I swear this was in my speech before they showed up. We did not coordinate this. But I want to make this point, and it is a particularly important problem for the United States. The Center for Disease Control just concluded that it has been underestimating the number of new infections in the United States every year, partly because we lack the capacity to test for the virus as early as we can test now, partly because one in four people living with HIV still do not know their status in the United States. That is not nearly as high as the 80-percent in the developing nations, but more than enough to be a major contributor to new infections. In America the magnitude of this problem is greatest among African Americans. They account for about half of our AIDS cases. And I am sure virtually all of you saw the report in the last couple of weeks indicating that people who live in Africa and people of African decent may be more vulnerable genetically to the HIV infection because of genetic changes they developed over many generations to better resist malaria infections in a cruel twist of evolutionary fate.

But for whatever the reason, AIDS is the number three cause of death among African American women in the United States between the ages of 25 and 44. Prevalence among black men is almost 3-percent. That is more than three times the infection rate in Senegal. If African Americans were a separate nation, their country would rank sixteenth in the world in the number of people living with HIV, at least 500,000 of them.

African Americans named AIDS as the number one health problem in America, but only one in two say the United States is not losing ground. The other half say we are, in the domestic AIDS epidemic. For Americans, this should be a wake up call. Even as we keep working globally, we need to do much more to fight AIDS at home, and I intend to do so with my foundation. [Applause].

Since Toronto, with our energy and that of so many thousands of people across the globe, we have continued to grow our movement, to build on our successes, to learn from our failures, to save more lives. We cannot let setbacks in the research agenda obscure the progress made, the money committed, the incredible broad coalition of people determined to act with the same urgency of a mother rushing to get medicines to save a dying child, with the heart of a healthcare worker trudging along dusty roads and rocky paths to save people in settlements so remote they have virtually no contact with people beyond their physical reach. All these people are our brothers, our

sisters, our children, and all their lives have dignity and dreams.

A couple of days ago in Rwanda, looking at the work we were doing with our community health workers, I visited the home of an extraordinary 15-year-old boy named Jean Pierre, [misspelled?] and his 20-year-old sister, Eugena [misspelled?]. They are orphans, and she has been primarily responsible for raising him since she was 12 and he was seven. He has AIDS now, and for a long time he was so sick he could not attend school. Now, with the support and devotion of his community health worker who visits him twice a day to make sure he takes his medicine and maintains his nutritional regime, he is back in school, 15 years old, in the third grade.

He was a quiet and shy boy, so I leaned down and looked him in the eye and I said, "Do not be discouraged by this. Do not quit." He broke into this huge grin and he said, "Quit? I am going to medical school." [Applause] He said, "I want to be a doctor so I can help other sick children." Jean Pierre's story is a stark reminder that the AIDS dragon does not ravage the world alone.

Its partners are the unconscionable inequalities in income, healthcare, and education, all of which we can do something about. No less than you or I, Jean Pierre deserves a chance to follow his dreams. That should keep us going until the day for all the world's children comes when the dragon is

slain and all their dreams can dance. Thank you and God bless you. [Applause]

JULIO MONTANER: It is indeed my great pleasure to close the session. I am Julio Montaner, President-elect of the International AIDS Society. And I would like to tell you from the deepest corners of my heart, President Clinton, those words are extremely fine and really hit on every single important point that the IAS is sorely committed to support. He highlighted the role of treatment of prevention and the synergies that we can derive from that. He addressed head on the current controversy regarding health systems on HIV programs and how HIV programs can indeed be synergistic in building health systems. He spoke eloquently regarding violence and discrimination against women, and we applaud his commitment to that cause as well. We fully support his claim on his call for eradication of poverty, food security, and housing. And finally, we are fully committed with him to support the expansion operational research which is essential to guide future endeavors. President Clinton, thank you from the bottom of our hearts. Thank you very much. [Applause]

[END RECORDING]