

## **Global Health Council: “Confronting AIDS in 2002: Moving Forward from the XIV International AIDS Conference”**

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[TAPE 1 SIDE A]

DR. STAVELL: Good morning, I'm Neil Stavell, the President of the Global Health Council. Most of you here are friends, so you know who the council is, but for the few stragglers who've come in, we are the world's largest membership alliance of health professionals and community activists, working to improve health around the world. We're very pleased to be sponsoring this briefing this morning on the Barcelona AIDS conference.

Just two weeks ago, over fifteen thousand professionals, researchers, community activists and persons living with AIDS gathered in Barcelona, Spain. We were there to attend the fourteenth international AIDS conference, and to learn about the current state of the art in AIDS prevention, care, and control, to measure the progress the world has made in fighting AIDS, and to establish a common agenda for global efforts to defeat the virus that has killed or infected more than 60 million people over the past two decades.

What we learned and shared was both heartening and sobering. We learned that AIDS prevention works. That innumerable efforts are being carried out successfully in poor, as well as rich countries, to refine lessons both of changing individual behaviors that contribute to the spread of AIDS, and of making sure the people, especially women, have access to means of protecting themselves. Women and youth, who experience the greatest risk of infection, are becoming the subjects of programs, active participants in the programs, rather than simply the objects. The striking declines in AIDS rates in places such as Uganda show that this can be done.

We also learned that after nearly two decades of relative inattention, significant new steps have been taken in developing and testing new AIDS vaccines. We heard about successful efforts to care for AIDS-infected individuals in some of the world's poorest communities, with effective and humane treatment, including highly active, antiretroviral drugs. And we saw new

possibilities that are opening up, with dramatic cuts in drug prices in poor countries, which have taken place over the last two years. But much more is needed.

Sadly, we also learned that there will probably never be a cure for the AIDS virus, that it mutates so rapidly that the challenges to developing effective vaccines are even greater than we had thought. UN aides also told us that AIDS is spreading more rapidly than ever, and into corners of the world previously considered safe from the virus. That parts of the former Soviet Union are experiencing rates of explosive HIV increase that have never before been seen. That India and China, the world's two most populous nations, are on the verge of full blown epidemics, that could quickly outpace in sheer numbers the already desperate numbers of HIV-infecteds in Africa. That by the end of this decade, more than ninety million people could be infected, and tens of millions of people orphaned, if dramatic efforts are not undertaken today. That

soberingly, we are just at the beginning of the AIDS pandemic, and that much of the world could look in twenty years like the worst afflicted corners of Africa look today. These were sobering realities, and we'll be hearing more about that side as well today.

Now while the nightly news here in Washington may have focused on demonstrators whistling down high level speakers, I can tell you that the level and intensity of real discussion and exchange in Barcelona were striking. The conference participants recognize that the world faces a real crisis, that HIV takes no prisoners, and that it feeds on cracks in human kind's solidarity.

We also talked about next steps, the need to expand prevention programs, and provide access to care and treatment to millions afflicted, the need to look at HIV AIDS as more than just a medical issue, and address it across all segments of society, recognizing its profound interaction with other critical areas of development, such as

agriculture, education, and economic opportunity, and the critical need to include youth and women at the center of discussion in programs in the field.

This is why the Global Health Council is hosting this congressional briefing today. The world cannot afford to delay action, minimize the threat posed to global society, or pretend that this will all go away by itself. We will hear this morning from participants in the Barcelona conference who will share their own views and experiences, and, we hope, convey the urgency of the situation. I'll do more extensive introductions as they get up to speak, but our invited speakers this morning are Ann Peterson, from the US Agency for International Development; Chris Collins from the AIDS Vaccine Advocacy Coalition; Jim Kim, from Harvard Medical School and Partners in Health, and if her plane lands in time, Sophia Mucasa Monaco, from the International Council of AIDS Service Organizations.

The Global Health Council is committed to

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effective action on the front lines of healthcare around the world, and making sure that the resources are there to support that action. Part of our task is reminding US policy makers that this is far more than a humanitarian endeavor, and that our own health, economic, and even national security is deeply intertwined with this looming threat, that could destabilize major portions of the world, as it has already destabilized central Africa. Serious threat warrants serious resources, and we do endorse the call for two and a half billion dollars this year to fight AIDS globally.

I'd like to now turn to a short video clip that was prepared courtesy of the Keiser Family Foundation, who webcast the conference in Barcelona, and then we'll come to our speakers.

[VIDEO PRESENTATION - inaudible]

So now you hear from some of the participants in the conference. There'll be time for questions and answers after the individual presentations, and we hope that everyone in this

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room will stay involved with this issue as we move forward. I'll also mention at this point, at the end of the session, if you would like to visit the tables at the back of the room, they focus on activities of Youth Force and the Women's Caucus.

The US engagement in international AIDS prevention and control has been principally led by the United States Agency for International Development, our principal arm of engagement in health issues in the developing world. And we have as our first speaker, Dr. Ann Peterson, the assistant administrator for Global Health at the US Agency for International Development. Dr. Peterson is a medical doctor who has worked extensively overseas, including six years in East Africa. She has also been the health commissioner of the state of Virginia, so she knows how to manage programs with large institutions and bureaucracies, and was appointed by President Bush as assistant administrator for global health in November, 2001, so she's approaching her first anniversary on the job. It's a pleasure to invite

her to the podium.

DR. PETERSON: Thank you Neil [phonetic], and good morning. I am really pleased to be here, and as I told Neil when I came in, these Global Health Council events are usually the ones that are the most fun. And I loved the video, because it sounded so much more sedate and sort of, you know, straightforward than the multitudinous simultaneously action events that were actually happening in Barcelona. So I am hoping that today we can give you just some small pieces of our participation in Barcelona. As Neil said, USAID is the largest funder of the international AIDS programs for the US government. It's actually the largest funder of AIDS work in the world. And therefore for us, involvement in the International AIDS Conference every two years is very critical.

I didn't bring any Power Point, but I did bring some demonstration pieces, and the first is, you'll see on the back table, these are the lists of just some of the presentations, satellite things that USAID was involved in. Over 200. We

were very involved, both on the technical end, from microbicides and our involvement with the vaccine research that you'll hear more about, to initiatives on mother to child transmission prevention, how to reduce stigma. We contribute both on the biomedical side, in the research presentations, but also on the operations research. How do we really know what works in AIDS programs, AIDS activities? What can be more effective? What lessons have we learned? And a number of the sessions were also talking about those kinds of things.

One of the major focus areas, and I'm just going to touch lightly on a number of areas that we were involved in, is now that we had some successes, and many, both at program level and some at national level, how do we scale up? How do we get to national level success that we saw in just a few places, but take the little successes that we have, replicate, scale up. We know that something that works on a local level doesn't automatically scale up to national level

successfully. And we know that something that works really well in Southeast Asia doesn't translate across Africa just automatically. It takes thoughtfulness, reflection, cultural appropriateness in the design. So what we are hoping is that today you will hear some of the stories of what we heard in Barcelona, the technical advances, the programmatic understanding, and begin to synthesize all of that, so that our going-forward actions can be much more effective.

One of the first things that we were part of was the, and you'll see this in the back, the demographic impact of AIDS. UNAIDS presented their data on what was happening right now in the, our expectations on the numbers of AIDS. This goes another step forward, together with the US Bureau of Census, looking at the trends. If we look at the most likely scenarios, given what we know now, what we are doing now, where we are investing our efforts, what could we expect AIDS to do over the next ten years.

So in that partnership, and I'll just touch on a few things that Neil didn't, we're seeing that seven countries in Sub-Saharan Africa have life expectancies less than forty years of age. In Botswana, the expectancy, life expectancy is thirty-nine years. Without AIDS, it would have been seventy-two years. The majority of Botswanans, on average, live thirty years less than they would have if the AIDS pandemic wasn't hitting that country so far. The trend is also seen in Asia, Latin America, and the Caribbean, although due to lower HIV prevalence, the impact isn't as great. In Haiti, life expectancy is now fifty-one, and it would have been fifty-nine if not for AIDS. Asia, Thailand, Cambodia and Burma have loss between two and five years of life expectancy.

In 2010, eleven countries in Sub-Saharan Africa will see life expectancy fall to near thirty years, levels haven't been seen since the nineteenth century. In this region we would have expected life expectancy to be improving, and to

have reach seventy years by 2010. The staggering trend of decreasing life expectancy due to AIDS only strengthens our resolve that we must do more to fight the pandemic.

We also have been very involved, and this was also a joint project, USAIDS have a lot in a partnership...the first time ever that UNICEF, UNAIDS and USAID have brought all of our prediction numbers together to do a joint publication on what are we expecting for children, for the orphan situation, those vulnerable, and those orphaned, generally, and specifically in this publication, by AIDS. It gives details on eighty-eight different countries, and there are distinct trends. During the press conference, when we released this report together with UNICEF and UNAIDS, Dr. Peter Piaf, who you saw on the video, called it one of the most shocking reports released at this conference. The report finds that there are 13.4 orphans due to AIDS in eighty-eight countries studied, and this number is projected to go to more than twenty-five million

by 2010. Because of AIDS this will increase dramatically. In Africa, thirty-four million are orphaned, one third of them due to AIDS. By 2010, forty million will have been orphaned, and the proportion due to AIDS will have increased to half. What this means is that by that time, six percent of all children in Africa will be orphaned due to AIDS alone.

In countries with high levels of HIV prevalence, and a resulting high orphan population, there are major impacts on society at large. We've heard the impact on economic development, poverty, national security. Be we also need to think of the impact on the children. As more adults die, more children are orphaned, with fewer healthy adults to care for the increasing number of children. In 2010, in four African countries, one in five children will be orphaned, and the implications of this are unprecedented.

A key point that captured attention in Barcelona was that even if we could stop the

spread of AIDS right now, today, there was not a single new infection due to AIDS starting today, we would see the number of orphans continue to increase for the next decade. For example, in Uganda, where HIV prevalence began to climb in the early 1990s, the number of orphans continued to grow for another ten years, and it's only now beginning to decline.

In Asia the total number of orphans is larger than in Africa, because the population is larger. However the number of children orphaned due to AIDS is smaller. However, even a very small increase in HIV prevalence in these large population countries could have massive impact on new orphans due to AIDS in the future. So we're going to look at China, India, and those large populations very closely.

And, as alarming as all of those trends are, they still don't include the millions of children whose lives are already dramatically altered by AIDS long before they are orphaned. Countless children are living and caring for

parents who are sick and dying. And having worked in Sub-Saharan Africa in schools where kids still have parent...healthy adults, they would say to me that their greatest fear was that their parents would get sick and die. So for even those not yet impacted directly, their greatest fear is what it will do to their family and their parents.

Current efforts, however, are significant. USAID has seventy-five projects in twenty-two countries, working with children effected by AIDs. We have successful models for reaching children. However, the efforts of everyone working on this problem around the world reach only a small proportion of the children affected by AIDS. We hope that this report will spur on the global community to respond in an unprecedented way to an unprecedented problem.

As you've heard on both the video and from Neil, there has been a long acknowledgement of the gender biases within the AIDS problem. I think we are now beginning to also see youth as a focus has come out as a major theme. They are the age group

where most new infections happen. They are where we are looking to be able to see the first trends in improvement in programs, and the question has been what can we do to reach out to youth successfully?

We have highlighted one of our programs among youth, specifically in Zambia. It's one of the countries hardest hit by the AIDS pandemic, where over twenty percent of the adults are HIV infected. One out of every six urban youth aged sixteen to nineteen is HIV positive. By the age of fifteen, thirty-seven percent of boys and twenty-seven percent of girls are sexually active. And among the fifteen to nineteen year olds, sixty-two percent of boys, and fifty-nine percent of girls have already had sex. Because of this, USAID works with the government of Zambia and Johns Hopkins University to launch a series of campaigns directed at youth. One of these is the HEART program. Helping Each other Act Responsibly Together. In the past five years, HIV infections in fifteen- to nineteen-year-old urban girls have

dropped nearly fifty percent, from twenty-eight to fifteen percent. This remarkable accomplishment may be the beginning of an echo of Uganda's success story.

How did this happen? What changes in behavior led to this decline? Reducing infections in youth, actually in any population, involves three basic strategies that you've probably all heard about, the ABCs. A for abstinence, B for be faithful, C for condoms. This isn't a new concept, but we do have a growing body of evidence that these ABC components, each one of them, contribute to the success against AIDS. We're also gaining a better understanding of the delicate balance between the three strategies. In some communities, the delayed sexual debut is key to reversing the epidemic. In other communities, particularly among young people who marry very early, faithfulness is critical. Prevention success is about changed behavior. Each component of the A, B and C requires behavior change. There was much debate in the past, whether youth,

especially, could or would ever change, especially in relation to abstinence or being faithful. And we now have evidence that they can, and that they will, change their behavior, in delaying onset of sexual activity, in reducing partners or staying faithful in a relationship, as well as in increasing condom use. Zambia is a new and strong example of this. The HEART program demonstrates a program designed for youth, by youth, using mass media, that can dramatically reduce premarital sex among single women from forty percent in the early 1990s, to fourteen percent in the late 1990s.

Condoms also play a participating, but smaller role in Zambia. Certain HEART participants who are sexually active, use condoms during their last sexual act nearly twice as often as youths who are not part of the program. They tended to be older, and more likely female. We're really excited about the HEART program, and hope it will serve as a model to scale up youth activities not only in Zambia, but also to be replicated in other countries.

Finally, we held a press conference to announce that USAID is working with governments of Kenya, Ghana, and Nigeria to provide antiretroviral treatment to people living with HIV and AIDS. At our press conference in Barcelona, we were pleased to have the senior representative from Ghana and Rwanda discuss these programs. These are the first US Government-funded programs to provide comprehensive ARV treatment for people living with AIDS and HIV. And it's a marked expansion of our programs. We have a very comprehensive program, starting with prevention, that as you've seen, goes through care, support, and now treatment. Until recently, the provision of these drugs was both complex and expensive. The price of the drugs, as you all know, has declined significantly, and we have been working with partners to integrate ARV treatment and management into relevant prevention and care programs. USAID is also a key partner in the new presidential initiative in preventing mother to child transmission. That was highlighted in a

number of side meetings.

Finally - really finally - while this was billed as a technical conference, there was a significant, I don't know if we call it a side show, or a parallel event, that were the press conferences, the political meetings, the partnership meetings, that also contribute to advancing the war on AIDS. We all know that political leadership is a key factor to successful national programs. We've seen that in Uganda, we've seen it in places that don't have political leadership how it is a hindrance. We had the opportunity as the US Government to meet with the more than twenty ministers of health from around the world, who were there, to talk about programs. The international AIDS trust has been sponsoring a gathering of first ladies who are interested in HIV AIDS. And I got to meet with the first lady of Malawy, Rawanda, and the princess of Cambodia, and talk with them about where their hearts are in serving their people.

I will also say that there were political

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highs and there were political lows in Barcelona, relative to the political agenda. As you saw in the video, Secretary Thomson really, really cares about this issue. That is clear in every personal interaction that I have had with him, and every time he has had an opportunity to speak. I frankly was very proud at the way he responded to his time in Barcelona, which was very hard. But he did it with graciousness and good humor, and I would say overall the US government had a chance not just to highlight our programs, but also to facilitate relationships with other governments, with other multi-laterals, with many of the NGOs we've worked with, and it was an exciting and slightly overwhelming time. This has been just small highlights of the multitudinous things that were happening. US AID will be doing a press...an all-day event covering Barcelona and what we did, on Wednesday, July 31, at the National Press come. And there should be an agenda at the back for those who want to hear more about what happened in Barcelona.

So thank you, and thank you Neil for  
partnering with us yet again.

[applause]

[END TAPE 1 SIDE A START TAPE 2 SIDE A]

DR. STAVELL: Thank you very much, Dr.  
Peterson. We're pleased to have with us today not  
only our planned speakers, but also Donna  
Christiansen, from the US Virgin Islands, who is  
the co-chair of the task force on international  
HIV and AIDS, and she is going to give us a few  
comments.

CONGRESSWOMAN CHRISTIANSEN: I just want  
to say a word of welcome, and thank you for being  
here. It's so important that we don't lose  
Barcelona, and let all of the good work and all of  
what was learned and our call to action just die  
out. So I'm glad that you're here. On behalf of  
Barbara Lee and myself, of the HIV and AIDS Task  
Force, I want to welcome you. We were able to get  
to Barcelona, however short our stay there was,  
and we were there early. But we did have an  
opportunity to participate in a few events. I

attended some seminars on the vaccine. I found those very, very informative. I went to the one on the community involvement. And we planned to follow up with some discussions on that at our Congressional Black Caucus annual legislative conference in September. I also had an opportunity to hear about models that are working all over the world. And that was very, very encouraging. I had an opportunity to be on a panel with Sandy Thurman's group, of parliamentarians from all over the world, and came out of that with a renewed commitment to working together, as leaders in a global community, to address the AIDS pandemic.

But we've heard some of the knowledge that was shared there, in that week in Barcelona. And I guess I came away with the sense that after twenty years, we've argued too much about things that we shouldn't have been arguing about, whether prevention or treatment, whether people in poor countries, and with very little resources, would be able to take medication, and even whether the

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young people would respond. They want to live too. And I think the most important thing was the last part [unintelligible] the call to action. I know that the United States isn't doing enough. To me the call to action really means moving our commitment to a global trust fund, letting go of the Population Fund dollars. I was with the first lady of Haiti yesterday, and the first lady of Nigeria. And the first lady of Haiti, of course, mentioned the need for those funds, which provide some of the ground troops for some of the very basic materials that prevent the spread of HIV and AIDS. So we have a lot to do.

Again, thank for being here, for keeping the excitement and all of the energy that was generated at Barcelona going, bringing it here to the Hill. But this is a time for a call to action. And thank you all for being here.

[applause]

DR. STAVELL: Thank you very much, Congresswoman. Our next speaker takes the discussion about prevention to the next step.

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Chris Colling is the executive director of the AIDS Vaccine Advocacy Coalition, an organization that's been set up to accelerate the ethical development and global delivery of vaccines against HIV and AIDS. AVAC provides independent analysis, policy advocacy, public education and mobilization, to enhance AIDS vaccine research and development. Chris also is someone who may be familiar to many of you, because he previously served on the staff of Congresswoman Nancy Pulosi here on Capitol Hill, and was also a principal at Progressive Health Partners, a health policy consulting company, in the period before he joined AVAC. He has a master's degree in public policy from the Kennedy School, and he is going to tell us everything we need to know about the current state of the art in AIDS vaccines.

MR. COLLINS: No I'm not! [laughter]  
Thank you Neil, and same to the Global Health Council for holding this event. I think it's very important that we keep the messages and knowledge from Barcelona alive and talk about it on Capitol

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Hill. Also thank you to Congressman McDermott for his continued leadership and for sponsoring today's event.

What we've been hearing today from the video and from our speakers is that AIDS is not just a scientific problem, it's a problem of economics, and it's a problem of politics. And that is certainly true in the case of HIV vaccines. The science around vaccinology against HIV is very difficult. But so too are there are great many challenges in the political and economic sectors. And that means that elected officials and their staffs have a critical role to play in accelerating the development of an AIDS vaccine, and making sure it's available once we find a vaccine.

What am I supposed to do now?

First a little bit about the context going into Barcelona. As we've heard, the AIDS epidemic remains unchecked, and is spreading around the world. We have prevention and treatment interventions that we know work and are cost

effective. They need to be delivered to everyone at risk at HIV, and who has HIV. We also know that vaccines, in the history of public health, are among the most successful and cost effective interventions that we have available. And there's every reason to think that when we have a vaccine against HIV, it will be our most effective tool to finally stem control the tide of the epidemic. Vaccines eradicated small pox, and they are in the process of eradicating polio. It is hoped, of course, that we can achieve the same kind of success with an HIV vaccine.

Right now we've got more HIV vaccines in the pipeline for testing than we ever have before in history. And we don't know if they work. The only way we can find that out is to ramp up our human clinical trials. Put those products to the test in humans, see if they are protective, see if they elicit an immune response, and see, through those trials, if we can learn about how to make better vaccines. So human clinical trials, in this phase of vaccines, is critically important to

advance the field.

It's also important to know that scientists are thinking about HIV vaccinology differently now, many of them are, than we typically have about vaccines in the past. Usually vaccines work by preventing infection from occurring, or by making infection transient, so that the infecting body is gone very quickly. With HIV vaccines, we've had to shoot for a different target, or some of the products are shooting for a different target. What they would do is, instead, control infection, allow infection to occur but control infection, so that you don't get sick if you become infected, or slow progression to disease, or perhaps not do those...probably they may not be protective against infection, but may work in different ways. We're going to need to continue to do clinical trials and fund research, so...[tape is cut] and expensive human trials all over the world.

Also, the other contextual thing is that we know from other vaccines, is that they just,

there's been horrible inequity in the way they've been delivered. Typically, populations that are in the developing world wait a decade or twenty years to get vaccines after they're licensed in the United States and Europe. Obviously, we cannot let that happen in the case of an HIV vaccine. And to prevent that from happening, we'll need to be acting now, in terms of leadership and in terms of expecting it not to happen, in terms of acting on several specific policy initiatives which I'll talk about in a minute.

So, enough about me, what did we learn at Barcelona? There were several important announcements in addition to the science that came out at Barcelona. First of all, the US Military HIV Research Program, the NIH, the Royal Thai Army and Thai Public Health Institute announced that they're going to move forward with a large-scale phase three efficacy trial of a combination vaccine in Thailand starting later this year. This will combine the Alvac product made by

Aventis with the Vaxigen product made by US manufacturer Vaxgen, in what's called a prime boost approach to vaccination. So that efficacy trial is going to move forward. It's going to be very large - sixteen thousand people - and it is going to cost money, but it steers to make an important contribution to the field by telling us whether this approach to vaccinology works, and we can also learn some things about immunological responses to these vaccines at the trial.

In addition, the international AIDS Vaccine Initiative announced that it has created the neutralizing antibody consortium. Now one way that a vaccine might work is that neutralizing antibodies would actually kill the virus when it comes into the body before it infects cells. As I said, many vaccines that are now being developed actually would work differently. They would kill the cells once they're infected. Neutralizing antibodies have the potential, as they do with other vaccines, to actually prevent infection from occurring, but it's been one of the most difficult

scientific hurdles so far in HIV vaccine science.

So AIV [phonetic] is pulling together a consortium of scientists who are working on this problem to try to share information, standardize the way they're doing their research, and try to tackle this difficult problem.

Very importantly, Iavia's also negotiated intellectual property agreement with the scientists, so that if technology and products come out of this consortium, Iavia will have access to be able to license that so that they can accelerate delivery of that product to developing countries.

AVAC, the organization I work for, issued a call to action that looks at what we need to be doing on a policy level on accelerating R and D on vaccines, insuring access, insuring participant protections for people who are in trials, and insuring ethical trials, and that's up on our web site. And let's see, the HB [phonetic] community, HIV Vaccines Trails Network is an NIH-funded network. It's an international network of trial

sites. Larry Coy, who runs that network, made a very good plenary talk at Barcelona, and said that the network is up and ready to run multiple trials, both phase one and two in efficacy trials of AIDS vaccine.

Finally, Vaxgen, the US manufacturer who is the only company that has a vaccine product in phase three efficacy trials right now, announced that it will have results on its North American trial out early next year, and then it has a Thai trial going on too, they'll have results I think about a year later. We need to watch carefully what happens here. If we get good news and find out that the Vaxigen product works, it's wonderful, but then we need to continue to invest in vaccine research to develop better and better products. And if we find out that the Vaxigen product doesn't work, we must guard against a sense of depression in the public and among policy makers, who are going to need to continue to press forward with working on other kinds of approaches to vaccinology.

One thing I forgot to mention too is that modelers have found that even if a vaccine for HIV is partially effective, it could have a huge impact on the epidemic. So for instance, if the Vaxigen product turns out to be forty-five percent efficacious, rather than what we typically see with a vaccine, maybe eighty-five percent, it's still, if it's widely distributed, or reaches high-risk groups, could have an important effect.

What about the science? Disclaimer first, I'm not a scientist, I'm a policy geek. So I'm not going to pretend to be your source on the science. I will defer to our doctor here on the panel, our scientific doctor. But I do want to give you some of the headlines. I can read headlines, so I thought I'd tell you about that.  
[laughter]

First of all, we continue to hear at Barcelona, and at other conferences this year, continuing good news about what we're seeing in primates, in terms of the ability to use vaccines to protect against infection. And in addition, in

early phase human trials we are seeing that products are showing to be safe, and they're producing immunological responses. So there's reason for hope that several products now being developed can have an effect here.

At Barcelona we also heard two studies reported, one from Uganda and one from Vietnam, which seemed to have identified and documented actual human protection against HIV going on. Now this is very important, because if we can actually figure out how the human body is protecting against infection against HIV, then we can try to mimic that with a vaccine, and help the body make that response before it's infected. If it hasn't developed that response itself.

These studies happened among eight heterosexual couples in Uganda, where the man was HIV positive and the woman was HIV negative, continually exposed to HIV, but yet these women weren't getting infected. Their blood was analyzed, and it turns out they have developed antibodies which are effectively killing the

virus, at least in a Petri dish. In Vietnam, injection drug users were studied who have not become infected. Their blood work was also analyzed, and they also had immunological responses which were killing HIV-infected cells. So that's all good news.

Now for the bad news. And this was a bit of a buzz at Barcelona. A super-infection report from Bruce Walker at Harvard Medical School. He follows people who are HIV-infected and provides treatment to them, and studies their immunological responses. He found in one individual infected with HIV that this individual was super-infected, infected again with a different strain of virus, even though he had mounted an impressive immune response to the first virus. What's concerning there, this was a CTL response particularly that they're talking about. What's concerning there is that this immune response that he'd mounted as a part of responding to infection was described as being more strong than we actually expect vaccines will be able to induce. Now, if he wasn't able to

protect himself against super-infection or additional infection, will a vaccine be able to do that? The answer is we really don't know, but it has many people concerned. It's also important to say that the second virus that he was infected with was very similar, genetically, to the first one, to which he'd mounted an immune response. So it's not clear what exactly this means.

One important piece of good news is from Vaxgen, and their two phase-three trials that I talked about in North America and in Thailand is we've learned that it is possible to do large-scale phase three trials in several countries. Vaxgen reported that they've been very successful with enrollment and retention for these trials, and that risk behavior among trial participants has actually gone down in the course of that trial. So that gives us hope for being able to do a series of large-scale trials. Oh, can I go back? One more? Oh. No, I guess that's where I wanted to be. [laughter]

Dialogue. Talking. There, increasingly,

people who work on HIV vaccines in the advocacy and scientific and policy realms are talking more and more with people who work on prevention and treatment, and that's all to the good. There were several very good satellite sessions at Barcelona where this conversation continued. Iadi hosted one, there was a vaccine community session sponsored by AVAC, Iadi, and other groups. Community and HIV AIDS Legal Network had a satellite session. They're bringing together treatment and HIV vaccine advocates. That conversation is happening, and I think the spin you're seeing in the media about do we do prevention or do we do treatment is to some degree concocted. I think all of us know we need to be moving forward on both. We've got prevention and treatment that works today. We need to fund it and get it out there, and we need to move forward with microbicide vaccine and treatment research.

We also need to understand that even when we have a vaccine it's only going to be one part of a comprehensive response that includes

continuing prevention, interventions and treatment, and we need to look for, as we, you know, this is going to be a long-term effort, finding the vaccine. So how, as we continue to fund vaccines, build the clinical trial infrastructure, etcetera, can we move that vaccine funding as opportunities to provide more prevention and provide more treatment in communities around the world?

What are the polity implications? There's a lot of them. And again, this is a political and economic and scientific problem. And members of Congress have an extremely important role here. One thing that needs to happen is the NIH and other government institutes need to seek continued increased funding in HIV vaccine research, AIDS research, and infectious disease research. That's absolutely critical. NIH has played a critical role in this field, and it will continue to. We also need additional funding for public private partnerships, such as Iavi and other groups. We need new centers to catalyze industry, to make

sure industry expertise is brought to bear on this important problem. We're going to need political support and resources to make sure we can launch large-scale clinical trials around the world, we need to improve regulatory capacity around the world, address ethical issues, and again, it's going to be important to act on several fronts in terms of securing vaccine access when we finally have a vaccine. That means delivering vaccines we now have, making them available, anticipating purchase capacity, so we can buy the HIV vaccines when they're available; having political support for tiered pricing, or much lower prices in developing countries and higher prices in rich countries.

The public sector's also probably going to have a role to play in manufacturing capacity. You know if we have a highly effective vaccine it's estimated that we're going to need about six hundred million doses of it. Typically, pharmaceuticals don't size their manufacturing plants big enough to meet that capacity in the

first few years. The public sector's going to need to get involved to help farm [phonetic] and biotechs build manufacturing capacity that can meet the world need.

Some key congressional issues, again, NIH and public-private partnership funding is critical for basic and product research, and for infrastructure development. There's two pieces of legislation I want you to know about: The US Leadership Against HIV AIDS, TB and Malaria Act. A bipartisan legislation from Senators Carry and Frith has passed the Senate, so they're over here in the House waiting for action. There are some important vaccine pieces, including requiring the administration to describe how it's going to anticipate making vaccines accessible and providing sensors for R and D for vaccines. And this bill also authorizes funding for the Vaccine Fund, which makes vaccines available now, and for the International AIDS Vaccine Initiative, which is doing R and D and several policy things on vaccines.

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Also the Vaccines for the New Millennium act introduced in the House. Bipartisan legislation from Congresswoman Nancy Pulosi and Congresswoman Jennifer Dunn, and in the Senate, by the same senators, Senator Carry and Frith, provides R and D incentives and access initiatives for vaccines against Malaria, TB, and HIV.

Finally, there's a lot of resources out there to help you. My organization, the AIDS Vaccine Advocacy Organization wants to be of help to you, let us know what we can do. Our annual report, which we issued in May, is out on the table outside, please pick up a copy. Go to our web site, feel free to give me a call. We're a seven-year-old community and consumer based organization. And thanks very much for coming today.

[applause]

DR. STAVELL: Thank you Chris. As Chris said, the debate, the so-called debate between prevention and treatment has now largely been put aside by the global public health community.

There's a broad recognition that prevention and care need to go hand in hand. But the question had remained in the mind of many public health practitioners, what could you do practically in the area of treatment in care?

Our next speaker is Dr. Jim Won Kim, a medical anthropologist and physician from Harvard Medical School, who is also the executive vice president at Partners for Health, a non profit organization working in Latin America, the Caribbean, Eastern Europe and the United States, on what used to be considered intractable health problems among the poor. The work both at Harvard and at Partners for Health has been groundbreaking in terms of showing what can be done in terms of care of people already infected with HIV and AIDS. The dramatic discussions that took place in Barcelona really made it clear to us that AIDS does not need to be a death sentence, it can be turned into a life sentence, and it's a pleasure to have Jim here to tell us about it.

DR. KIM: Thanks very much everybody. As

sort of the designated science sort, I'm going to take you a little bit through the actual project of what we did. And this is work mostly of my colleague at Parsnell Neilpolt Farmer [phonetic]. My area of interest is also HIV, but my primary responsibilities are to treat multi-drug resistant TB, both in the slums of Lima, and in the prisons of Siberia, two vacation hot spots that I'm sure you've all visited. [laughter]

And TB in fact in many ways is more difficult than HIV treatment. So we've got a lot of experience in doing really difficult things in difficult places.

First of all, let me talk about the conventional wisdom. And you know, we have to remember that it was less than a year ago that probably ninety percent of the global public health community was saying that treatment was not even in the picture. We couldn't even consider it. So in some ways this slide is not necessary, but let's talk about infrastructure a bit. The question really is what sort of infrastructure?

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What we've found with complex health interventions is that it's human infrastructure that's most important. We're not talking about building roads. We don't have a road that goes to central [unintelligible]. If any of you have been there, it's a sixteen mile trip that takes four hours. It's mostly contiguous potholes.

Communities in countries most affected by HIV do not have infrastructure. That sort of infrastructure, whether it be personnel, or roads or clinics, does not exist. When Hangdale [phonetic] started talking about five billion dollars for prevention, we were thrilled, because we think that is what it's going to cost to do good prevention. But to do good prevention you have to build infrastructure. You cannot do good prevention without infrastructure. And that's precisely the infrastructure often that you can use to build treatment programs. That's certainly what we've done. The cost of the drugs was prohibitive, but now we know that the situation is very different. I think both the research-based

pharmaceutical industry and it's [unintelligible] industry are now getting to the point where everyone is most concerned about a long-term high quality sustainable supply of antiretrovirals.

That's going to be a difficult task. I was recently asked to serve on the task force on procurement of the global fund. We're going to have a very difficult set of issues to tackle, in terms of making the rules for how procurement's going to go forward.

Just to tell you what we've done. We've just simply tried to keep up. We've tried to do what one would do for a brother or sister or mother, because we've worked in Haiti since 1981. So in '86 we had our first case of HIV, free cytological testing was in '88. We intensified the prevention efforts, but this was at the time of a crew that was very damaging for the central plateau.

In 1995 we offered AZT to President [unintelligible] to prevent mother to child transmission. Prior to offering AZT, the take-up

rate for VCT was about fifteen to twenty percent for voluntary counsel and testing, based on chart review, about fifteen to twenty percent. It went well over ninety percent the minute we offered AZT. And of course, Médecins Sans Frontières, Doctors Without Borders, has shown exactly the same kinds of dramatic changes in interest in voluntary counseling and testing, when they offered AZT in slums of Capetown in South Africa.

By '95, though, we knew that we had to do something, because upwards of forty percent of all our hospitalizations were HIV-related. And we also knew that the local HIV prevention efforts, which were very intense...I mean the women of Cange, a community in the middle of nowhere in central Haiti, made their own video on HIV prevention. We knew that the prevention efforts that were happening in Cange were not going to have an impact, where most of the transmission was happening in Port au Prince.

And also, I'll never forget a meeting in which I was sitting. We were talking about

condoms, and one woman just got up and said I am so sick of hearing about condoms. I control nothing in my life. What makes you think I'm going to control whether or not a man uses a condom? So for them, the video turned out to be about power, and about access to resources, and not just about condoms.

We were also finding that sick young people were coming home to die in the village in which we were working, and half of the young people were turning sick with TB. So we began post-exposure prophylaxis, and this was thanks to recycling programs. I mean at the time, the drugs were fifteen to twenty thousand dollars per person, and we just didn't have the resources to go that. So the recycling program started sending us drugs, and we started offering prophylaxis. But in '98, two years after the advent of HEART, we began offering to a small number of patients triple therapy. And we tried to use AZT 3TC, and often what would could get was a protease inhibitor at that time, so we often used

Indinavir. We really, at that time, were using what we could get.

We called it the HIV Equity Initiative back then, and what we did was we expanded HIV treatment. We took a programmatic approach based on a tuberculosis control program, the so-called Dot's tuberculosis control program. We gave our community health workers exactly two days of extra training so that they could provide antiretrovirals in addition to providing anti-tuberculosis therapy, and we offered follow-up and social support. Now we did directly observed therapy, but we're not recommending that everyone has to do directly-observed therapy. What we found is that people who are going through a difficult illness, like multi-drug-resistant TB or HIV, require treatment support. So for us it's much more like TLC than like DOT. It's not a surveillance system, it's just simply a rational approach to supporting people through difficult treatment. And now a very positive development is that a lot our patients who are receiving

treatment are doing well, are now the outreach workers, providing the support to other patients who are receiving therapy.

There are about 2000 HIV-positive people in our Catchman [phonetic] area. About 200 are now being treated with so-called DOT HEART. And we provide them with an accompignatura [phonetic]. It's different than a DOT worker. We really feel that these people are accompanying poor people with HIV through a difficult treatment process. All patients have responded with weight gain, improvement of health, and less than ten percent of the patients have required changes in medication. And of the first forty-four patients on which we did viral loads, thanks to Bruce Walker, Chris mentioned him earlier at Mass General Hospital, eighty-eight percent of our first group had undetectable viral loads. That's a level that you usually only find in study settings. And this is an antiretroviral-naïve population who are getting social support, and in addition, are getting what we are calling the help

of an accompagniatura.

So what has this done? Well, it's effective. As I've mentioned, according to both clinical and virulogical criteria, it's dramatically reduced HIV-related hospitalizations and mortality. It has dramatically lessened AIDS-related stigma. Let me just say, I work with multi-drug resistant TB patients. And the WHO decided in 1993 that in order to get more people interested in starting the DOTS program, which is probably the best public health intervention that we've come up with in many, many years, they decided to actively stigmatize multi-drug-resistant TB patients. I'm not accusing them. This is what they did with a strategic purpose. But that is in effect what they did. They didn't say we're going to stigmatize MDRTB patients. They said MDRTB is incurable. Therefore, if you want to avoid this incurable situation, you should start DOTS. I think it was a strategy that was well reasoned, they did it with some thoughtfulness, but what happened was, we ended up

trying to treat a group of people who had been actively stigmatized. Because there's hardly any stigma that I know of in the world that is as strong as saying someone is infectious and going to die. Right?

So when we say treatment is not possible, I think that is in effect what we're saying. They're infectious and they're going to die. So I think all the cost effectiveness analyses that are done saying things like prevention is twenty-eight times more effective than treatment, you know, what is the impact of saying that you can't treat, and therefore quite actively stigmatizing a group of people? I think it's significant. I don't think we've done the studies yet. We need to do "operational research" to test it. But as Paul pointed out, Paul Frummer pointed out in Barcelona, you need operations before you can do operational research.

Most importantly, though, what happens is that it responded to widespread demands for equity. If you listen, this is what you're

hearing. Rick Marling, a colleague of mine from Harvard said that when he returned to Botswana and started talking about treatment, the people there used war metaphors. And he now uses those. And while the war metaphors, Dr. Peterson uses them as well, while the war metaphors sort of offend the sensibilities of many, that's what it feels like to us. That's certainly what it feels like to us. And it's certainly the language that Nelson Mandela used.

Let me try to finish. So Paul's primary thing in Barcelona was who should bear the burden of proof. And he started out talking about the Bhopal disaster. What happened with the Bhopal disaster was, it was widely acknowledged that, what was the company again? Union Carbide made terrible mistakes, and that the regulators in India made terrible mistakes. But the burden of proof were on the poor people who suffered exposure to the gas. They had to provide the hospital records. They had to provide the proof that they had been injured. And often claims were

denied because of that. Now, we feel that the burden of proof is back on the poor. People are saying ach, come on, you don't have infrastructure, you can't do this, you can't do that. We feel that the way we measure success, and the way we construct the burden of proof has to be back on us, those of us with resources. When you say there's no resources to provide for treatment and comprehensive prevention for HIV, where is the proof of that? We just raised our defense budget forty-eight billion dollars, which is more than the defense budget of any other country in the world. The increase in our defense budget is more than the defense budget of any country in the world. The combined defense budget is more than all of the other defense budgets of the world combined. Who should bear the burden of proof?

I recently heard from Congressman Giordani [phonetic], who was in a briefing in which Secretary Rumsfeld said, we can't account for about four billion dollars, I think was the

number. So let's take that. That's just about right. That's about what we need. [laughter] Let's take the amount the defense budget couldn't account for, and say that that's your penalty, you can't have that any more, and we'll move that over for global health.

[applause]

So we think that there's a lot of things that you can measure. And in fact, just to show you that we're not anti-corporate crazies, we went to the corporate world and said what's the best way to scale up and replicate quality programs? And people all said to us, well, you know, it's the Toyota production system method that now is all over the corporate world. And the person who does that best in the world in health is Don Belwyck, and Paul Betolvin, and others who are members of the Institute for Healthcare Improvement in Boston. So they, just last week, came down to the slums of Lima, and have bringing their very Edwards-Demming-based sort of fancy quality improvement model to scale up our drug

resistant TB program. We will soon do this with HIV. And we think that this is not necessarily the only solution, but you gotta start looking, and we have to start looking now. There should be a hundred programs just like this, [inaudible] the world. This is the minimum, I think, that we can do, to face this horrible problem.

This Samwell, and he asked us to use his name, and he asked us to tell you that the antiretrovirals work, that he didn't own a watch before he started therapy, but that he does quite well with his antiretroviral therapies.

And in closing I want to make an analogy that I think is very apt. When I began to study anthropology, I'm also an anthropologist, we, the most striking thing to me was how, when we look back at the kinds of things that we used to do in history, we see them as being so primitive. But the scholars, the brilliant people who lived during those times did not see them as being primitive. They saw them as being quite natural. And in trying to understand where we are right

now, I actually went back to a book by Martin Luther King called Why We Can't Wait. And in this book, he talks about a group of white moderates who told him, and I quote, "all Christians know that colored people will receive equal rights eventually. But is it possible that you're in too great a religious hurry? It's taken Christianity almost 2000 years to accomplish what it has. The teachings of Christ take time to come to earth." To which King responded: "Such an attitude stems from a tragic misconception of time, and a strangely irrational notion that there is something in the flow of time that will inevitably cure all ills. Actually, time itself is neutral. It can be used destructively or constructively. More and more I feel that the people of ill will have used time much more effectively than the people of good will. We will have to repent, in this generation, not merely for the hateful words and actions of the bad people, but for the appalling silence of the good people."

I urge all of you to tell your congress

people that we have to raise this money now. We have to start fifty, a hundred projects right away, and we have to find answers, over the long term, to this most horrible epidemic in human history. Thank you.

[applause and cheers]

DR. STAVELL: Thank you Jim.

Unfortunately our final speaker is still sitting on a runway somewhere.

MALE VOICE: She's not. She's here!

DR. STAVELL: Oh! Marianne Shihama was not the originally scheduled speaker, but she is here to give the talk. I didn't see you slide in, Marianne. I'll introduce the speaker, and then Marianne will give her talk. Sophia Mucasa Monica is a noted AIDS activist from Uganda. That's not Sophia, that's Marianne. But Sophia I will introduce, because you will be seeing and hearing from her at a number of later points coming up later this year. She was the executive director of the AIDS Service Organization of Uganda, one of the first community-based groups anywhere in the

world dealing with HIV and AIDS in a heavily afflicted community. She has served, for the past year and a half, with the International Council of AIDS Service Organizations based in Toronto, a consortium of groups, and she will be joining the Global Health Council as our AIDS Policy Officer starting in September of this year, where she will be up here on Capitol Hill quite frequently, sharing her insights from the ground.

But you will hear her words now delivered by Marianne Shihamba, who has recently left the Global Health Council, and our AIDS program, to work for Family Health International. Marianne herself is a native of what was Zaire, and is now the something republic of Congo. Democratic! I can never remember which one it is! And maybe it's not such a good choice of words. And Marianne has her text here. So Marianne, please.

MS. SHIHAMBA: Well it's the Democratic Republic of Congo this week [laughter]. But Congresswomen and men, distinguished ladies and gentlemen, good morning. [response] The council

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is the International Council of AIDS Service

Organizations, and we work together to strengthen community-based response to HIV AIDS by connecting and representing NGOs throughout the world.

Founded in 1991, the council operates in regional secretariats based in all five continents, and coordinated by a central secretariat in Toronto, Canada. Since '92, the council has been a co-organizer of the International Regional AIDS Conferences.

I would like to start by citing the sentiments of some fellow advocates and hands-on implementers from the front lines, expressed at the start of the fourteenth international world AIDS conference in Barcelona. These are people who remain deacons guiding the council's work, and his words best illustrate what community advocacy is all about.

From a home care worker in Ethiopia: "I'm here because I have AIDS, and maybe I'll need help in the future." The organization's director added that we have twenty-five more people trained to

improve home visits, but only enough money to keep six people busy.

From a housewife and mother in South Africa: "I shared my test results with my in-laws and they left me, and they chased me away. They decided that I was a dead person. But that was way back in the early nineties and I'm not dead today."

From a male sex worker in Kenya: "We're not even recognized here as human beings. The government doesn't care what happens to us. We're gay men and outlaws in their eyes. Personally, to avoid the overwhelming responsibility of looking after seven children of my good friend and cousin, we agreed that I pay for her antiretroviral therapy, and to buy her some years of life to see her children at least finish grade school. Due to pressing needs, we decided to pay the children's schools first, and then continue on relying on [unintelligible] services until I had saved up more money to buy more antiretroviral drugs. She died two weeks ago."

From Jeffrey Sachs, the author of the report of the WHO's commission on macroeconomics and health: "There is no excuse in today's world for millions of people to suffer and die each year for a lack of thirty-four dollars per person, needed to cover essential health services. A just and far sighted world would not let this tragedy continue."

The apparent lack of rapid action by the developed world, and indeed, the governments of the developing countries, to address the HIV AIDS pandemic frustrates most of us who work in community-based organizations. We know what needs to be done, but the richest governments must help pay for it, and until that happens, the epidemic will grow and grow, and millions of more lives will be lost. Many of us who work on the front lines of the war on AIDS have noticed a resurgence of activism in the AIDS conference culture. Such activism ignited a current of optimism when the thirteenth world AIDS conference closed in Durban two years ago. A sense of complacency was

shattered by the urgency and passion our South African hosts stimulated. The conference seemed to break the silence, seemed to manifest an exciting revitalization of raised awareness and accelerated action. The conventional wisdom was, we know what works and what doesn't. Now all we need is the political will and major increases in funding to scale up.

The politicians and the activists met again in New York the following year to convene in the first United Nations general assembly on HIV AIDS, commonly referred to as UNGAHS. Many participants expressed cautious optimism when the meeting resulted in a declaration of commitment, unanimously agreed on by UN member states. Targets were set, action plans were recommended, and unanimously agreed on by UN member states. And a tool for community advocates was born to lobby governments at all levels, and to invest new resources into realistic programs. Although the political will that we all cried out for in Durban had become a reality, the money had not.

What was needed next was a new source of funding. Heeding the advice of UN AIDS executive director Peter Piot, Secretary General Kofi Anan called for the urgent establishment for a global fund for HIV AIDS, TB, and Malaria. And he set an annual goal of about seven to ten billion dollars to be provided by the world's governments. The fund is now a reality, but the goal for it is far from being met. Only 2.8 billion dollars has reached the fund's coffers, and contributions meeting the Secretary General's targets are highly unlikely.

So we gathered in Barcelona after two years of reinvigorated global efforts, yet to hear the dismal statistics of the epidemic's horrors had not abated. Millions of new infections and deaths, depressingly familiar new regional epidemics raging unchecked, slight progress in getting treatment to those who needed it most, and even slighter gains in prevention efforts, little new money from the world's richest governments, and very little innovation from developing

meaningful government-led AIDS programs in the worst hit countries. Because time, resources and energies are spread so thin at these conferences, ICASO has learned that over the years to focus on new issues that our constituencies identify as paramount for the cross-cultural and cross-sexual discussions that conferences allow.

In addition to convening skills-building sessions for NGOs to learn how to access the global fund more effectively, and launching an updated advocacy guide for NGOs to use to lobby their governments on the principles agreed on at UNGAHS, the council also focused on two other issues: the need to improve the healthcare infrastructure and preventive technology. Finding from a research project conducted by ICASO and it's partners suggests that difficult discussion about inadequacy of healthcare infrastructures to deliver antiretroviral treatments need be expanded to include a broader definition of infrastructure. It's not just dispensing drugs that is needed to adequately treat BWAs in pure countries. Care and

support services for mitigating the impact are also required, and they're too often ignored by program designers and policy makers working on expanding access to such treatment.

Vaccines, microbicides, and other preventive technologies remain critical components to the global response to the epidemic. It is important for communities that they are well prepared to advocate and promote their usage at this level, and that globally we are resolved to insure that they are accessible to all, irrespective of the capacity to pay for them. We cannot replay the egregious injustice of limiting access to antiretroviral treatments to only those who can afford them. When vaccines and microbicides are available, they must get to those who need them most.

There were some ideas raised and launched at the Barcelona conference that should not be forgotten. One which galvanized the attention came through a spirited press conference, in which noted economist Jeffrey Sachs decried the fact

that no group has yet drawn up an action plan for spending the vast amounts of new money being carved around for the global fund. The lack of such a plan has complicated the critical issues, such as how much each country should contribute. A decision was made that the global fund will issue an action plan in ninety days, when the global fund's board meets next, and that will outline what is needed to address the pandemic locally...globally, sorry. WHO and UN AIDS will create and present the plan, which we at ICASO and the entire community-based government will be watching very closely.

On that note, the community commends the US Agency for International Development for the tremendous job it did in providing technical assistance to any valid reform group interested in submitting a program to the global fund. Most groups found that they lacked the professional expertise to navigate the funds proposal process, so USA technical assistance was critical and highly appreciated, very welcome.

Another issue tarnished the Barcelona conference, perhaps irreparably. The Spanish government fired their health minister and issued plaintive apologies, but there's no excuse for the government's systematic denial of visas to HIV-positive people from the developing world. The crisis reminded many of us of the sad fact that the United States, a nation of immigrants and immense opportunities, routinely denies visas to HIV-positive peoples. For that reason alone, the world AIDS conferences will never take place on these shores.

An important new leadership initiative was announced in Barcelona, and given a huge, given the huge gap in political will to scale up our response to the epidemic, we are anxious to see this take shape and take action. Convened by former South African president, Nelson Mandela, and former president, Bill Clinton, a group of former heads of state met in Barcelona and committed to work over the next two years to raise awareness and stimulate action in their countries.

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A report on their progress has been promised for the next world AIDS conference to be held in Bangkok in 2004.

Amid all the protests and speeches and the posters, a gnawing sense of futility weighed heavily on Barcelona conference participants. As former President Clinton said in his closing remarks: "We've been here before. We've heard this before. We've said this before. But we're stuck at a ditch that keeps getting deeper."

ICASO stands behind much of the new, angry activism that caught so many headlines around the world during the Barcelona conference. We respect the frustration and skepticism felt by many of our brothers and sisters living in the hardest-hit regions of the world. We've heard too much rhetoric, and seen too little action, and quite frankly we are tired of the death and devastation AIDS continues to reek on our communities.

What makes us angry is that we know how to stop AIDS. We have known since Durbin that what has gone so completely wrong, that indeed, as

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we've heard in Barcelona, the epidemic is just beginning. It's so painful, and makes no sense to us who work in the front lines on the war against AIDS, that in the year 2002 people in developing countries are dying because they cannot afford to buy the life saving drugs. The gap between rich and poor continues to loom so large. And rich nations like Canada, where ICASO is seated, or the US, as global leaders, do not acknowledge in any meaningful way their responsibility for the health and welfare of the global community.

The best words I've found that encapsulate our frustration come from our friend, Steven Lewis. This is the crux of the sentiments community-based organizations around the world took away from Barcelona. Hopefully policy makers holding the purse strings will hear those words and change the tide of the HIV pandemic. "All my adult life," says Lewis, "along with countless colleagues, sometimes in partnership with people of other ideological belief, I've raged against injustice. But I've never seen anything like

this. I don't know how to get a grip on it, I don't know how to make sense of it. Is the behavior of the Western world just appalling insensitivity? Is it unacknowledged racism? Is it sheer, unbridled indifference? Is it the comfortable assumption of hopelessness in order to avoid contributing money? I feel so angry, and so impotent simultaneously."

Thank you.

[appluse]

DR. STAVELL: I want to particularly thank Marianne, who stepped in very much at the last minute, and was able to convey these words. I appreciate your coming here and delivering them. We, unfortunately, have been told that we have to vacate the room by 10:30, which it is, and therefore will not have the time for questions and answers. I would like to thank our cosponsors, the US Agency for International Development and AIDS Action. And I'd like to note that as you've seen, this is being videotaped, and will be up on a webcast at two o'clock this afternoon, thanks to

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the Kaiser Family Foundation. You'll find outside this orange leaflet, which describes where you can find it on the web. You can refer your friends to it, or you can go back to hear some of the things that you missed if you came in late. Again, I thank you very much for coming. I apologize that we did not have the time we had hoped for for questions and answers at the end, but perhaps some of our speakers will convene outside the doors as we leave this room, so that you'll have the opportunity to have your questions answered. And in any case, please contact us at the Global Health Council for any follow-up that you'd like. Thank you very much.

[end of recording]