

**AMERICAN FOUNDATION FOR AIDS RESEARCH**

**14TH NATIONAL HIV/AIDS UPDATE CONFERENCE**

**GLOBAL EPIDEMIC UPDATE**

**MARCH 21, 2002**

**MR. KEVIN FROST:** Good afternoon, everybody. I think we're going to go ahead and get started with this final plenary of the day. It's obviously a beautiful day in San Francisco. I have one reminder for you that I want to let you all know that immediately following this plenary over in Larkin Hall there will be an international reception. So I hope you can come join us at the reception and join all of our wonderful international guests for that reception.

I'm going to kick off this international plenary by introducing our first speaker. I'll just tell you quickly the format is going to be similar to what you've had throughout the day that each of the speakers is going to talk for about 15 minutes. And then at the end, we will entertain questions and answers. And there are microphones set up if you have questions and answers. But we wanted to give a chance to each of the presenters to present and then we'll come back and do the Q&A and we'll try to moderate that for you.

So without further ado, our first speaker is Mr. Bertil Lindblad. And Mr. Lindblad is currently the Deputy Director at the UNAIDS liaison office in New York. In 2001, Mr. Lindblad was one of the coordinators for the UNAIDS Secretariat supporting the preparations for the historic General Assembly Special Session on HIV/AIDS held in New York in late June at which governments adopted a Declaration of Commitment to expand global efforts to combat the epidemic.

Prior to assuming his current duties, Mr. Lindblad was a senior consultant for UNAIDS USAID in connection with the development of an action plan for HIV/AIDS prevention in the Baltic Sea region. Between 1994 and 1999, Mr. Lindblad served as the senior advisor child protection at UNICEF headquarters in New York.

Prior to joining UNICEF, Mr. Lindblad, a Swedish national, held various positions at Rädda Barnen, Swedish Save the Children including coordinator for Asian programs and three years as resident representative in Vietnam. Mr. Lindblad has also held positions with the Swedish International Development Agency and the Swedish embassy in Moscow. He is a graduate of Pomona College in Claremont, California with a major in international relations and also studied at the Claremont Graduate School as well as the Institute of Politics and Sorbonne in Paris. Welcome, Mr. Lindblad.

**MR. BERTIL LINDBLAD:** Thank you very much. It's a great pleasure to be here in San Francisco for the update conference. And also I would like to say that I am extremely pleased to here representing UNAIDS. In saying that I'm representing UNAIDS, I'm actually representing eight United

Nations organizations making up the UNAIDS family. As you probably all know, UNAIDS is a coalition of AIDS organizations within the UN system working towards an expanded response to the global HIV/AIDS epidemic.

And just for the record, I want to just list them. They are UNICEF; UNDP, the United Nations Development Program; UNFPA, the Fund for Population Activities; UNESCO; WHO; the World Bank; UNDCP, the drug control program; and our newest co-sponsor as of a few months ago, the ILO, the International Labor Organization.

I would like to start by just giving you a very brief overview of the status of the global epidemic. And then I will bring you to the fact that we are now at the turning point where there is hope for great concerted action to reverse the HIV/AIDS epidemic. And then I will talk a bit about the resources issue which is of course a very important one.

As you see on the screen now, this is taken from the AIDS Epidemic Update. Every two years there is a global report issued by the World Health Organization and UNAIDS on the status of the epidemic. The last time such a report was published was in July of 2000. And that report was released at the time of the Durban Conference. The next full report will come at Barcelona this summer. In between, we do have these updates. And this is the most recent one that was published in late November of last year.

More than 60 million people around the world have been infected with the virus since the beginning of the epidemic. And that's nearly double the population of California. And as you see on this slide, the total estimated number of people living with HIV today stands at 40 million people.

Since the epidemic start, 20 million obviously of the 60 million have died. And this is a number that's equivalent to the populations of Texas or New York state.

Last year, there were 5 million new infections globally and there were 3 million deaths worldwide due to HIV/AIDS. It is now the fourth biggest global killer and it's the leading cause of death in sub-Saharan Africa. The life expectancy in sub-Saharan Africa is now down to 47 years when it could have been 62 without the presence of the epidemic.

sub-Saharan Africa as you all know, is the region of the world where the epidemic has hit hardest and where there is a need for massive and immediate interventions. And the epidemic is increasingly threatening the stability of entire societies where the social fabric is torn apart by the epidemic.

The average prevalence of HIV in sub-Saharan Africa is now approximately 8.8, almost 9 percent of the adult populations. And there are seven countries in southern Africa where more than 20 percent of the adult population is infected with HIV. And as I'm sure many of you know, Botswana is now the country with the highest HIV prevalence which has now reached 36 percent of the population.

Very quickly here, you see a map of the world where you have the figures here for the regions. And as you see, Africa stands out with 28 million people. What is very important to note through this latest

report is the dramatic increase in new infections in Asia and the former Soviet Union. There are 1 million cases now in the region and there were at least 250,000 new infections in Russia alone last year. And this is also something that is extremely worrisome that we have regions where the epidemic is in its initial stages.

In Asia, China and India, there are relatively small numbers in terms of prevalence right now but given the huge populations, we are talking about massive numbers of people. India, for example, has less than 1 percent prevalence but that translates into almost 4 million people living with HIV today.

Here is another slide where you can see the estimated numbers of adults and children newly infected with HIV during 2001, where as I said earlier, the total is estimated to be at 5 million. And there, as I said, you see 250,000 new infections in Eastern Europe and Central Asia.

What's also important to point out is that the trends are somewhat different when you look at the different regions of the world. So for example, as I'm sure you all know, the epidemics in Central Asia, in the former Soviet Union, and also to a great degree in China, these epidemics are driven primarily by injecting drug use where as in Africa it's almost exclusively due to heterosexual transmission or mother to child transmission of the virus.

We cannot, as I'm sure you all know, declare that the danger is over in our part of the world or in Western Europe. There are some worrisome trends that safe behavior is on the decline in some populations. And we are seeing also that with access to treatment growing quite extensively in some parts of the Western world, there may be a sense of complacency so we need to be vigilant also in North America, in Latin America as well as in Western Europe.

I will skip a few here and bring you to this rather dramatic slide which was used at the first meeting of the Global Fund Against HIV/AIDS and malaria about two months ago. Here you can see in color the prevalence in different regions. And note here that the bars cannot even fit on the screen when you look at the proportion of increase in new infections for Russian Federation and parts of Asia.

And then to sum up here, you see that we have about 14,000 new infections a day and more than 95 percent still in developing countries. And also as I'm sure you all know, that young people is the population group most affected.

So now this is a very gloomy picture. The epidemic is far from over. However, and this is I would say heartening news, is there is a stronger global commitment by the month. And I think last year, we saw some incredible progress in terms of global commitment that was growing. It's long overdue. But now I think that we can say safely that we are reaching that point.

And in 2001 as you heard briefly, really history was made when the United Nations General Assembly addressed a health issue for the very first time. And member states of the world gathered in New York City for three days and adopted the Declaration of Commitment. And this is really key to our response that we now have a set of internationally agreed goals and targets to reverse the epidemics.

And just very briefly, I would like to highlight the few that with target years of 2003, 2005, 2010, there are specific goals addressing every aspect of the epidemic. And I think we can say that this was a great success because it addresses human rights, prevention, care support and treatment and also the social economic impact, AIDS in conflict situations and also resources.

This Declaration of Commitment was historic in the sense that it brought the world together to recognize the scope of the epidemic and also in its final set of goals and targets, it calls for increased resources to combat the epidemic.

Prior to the special session, the UN Secretary General, Kofi Annan as I'm sure you all know, he took a personal interest in addressing HIV/AIDS. And he issued a call to action in Africa prior to the special session. And that's where the origins of the New Global Fund can be traced. The Secretary General called we need a war chest to have the resources to combat the epidemic because as you all know, they were terribly insufficient.

And prior to issuing this call to action, there had been some very important work undertaken by a group of experts convened by UNAIDS and WHO to try to estimate how much would it cost to make a difference. And many of you I'm sure have heard the famous figure \$7-10 billion. That is an estimate that has been worked out what it would cost to have a global expansion of programs addressing AIDS.

There has been some confusion regarding the Global Fund and this figure. It is not related only to the Global Fund but this is what the world would need to set aside as a minimum annually to meet the requirements. And these requirements obviously include everything from prevention, education, advocacy, care support, treatments and other specific interventions to address, for example, the millions of orphans due to the epidemic primarily in Africa, and for example, extensive campaigns in countries like China and Russia to prevent a rapid spread of the epidemic. School fees, for example, will be also important.

So this is the good news. However, we are not yet there. We are far from meeting this target of \$7-10 billion annually. So in this year, 2002, it is estimated that there will be somewhere around \$2 billion spent on AIDS in developing countries--or low and middle income countries I should say, so there is a gap. The gap remains large.

However, as of today, if we take the Global Fund, we have close to \$2 billion in commitments from governments and also from a few foundations to this fund. And this money is in addition to the money from other organizations, for example, within the UN system or other government donor agencies.

The gap is there and it is estimated that we would need to see roughly a 50 percent increase in funding each year over the next four years to reach this target. So this is now where we stand. We have the commitments, we have the I would say political support more than ever to do this. And this is again where the Declaration of Commitment will help because what also is unique about this document is that it will be monitored. Countries also committed themselves to review of progress made.

So already this year in September, there is a required report that will be presented by the Secretary General to the General Assembly on progress made since June 2001 up until now. And this is quite interesting because this is almost a year before the first target because the first target is 2003.

And I should also point out that the 2003 targets for this expanded global response very much relate to having systems in place but also having made progress in all the areas that were mentioned in the Declaration ranging from prevention to care support, treatment and the human rights issues as they relate to AIDS.

So this is the mechanism to be used. And in about two weeks time, there will be a massive questionnaire sent to each government of the world to provide information on the status of progress when it comes to fulfilling these goals and targets. So all countries will need to do that and also indicate if there are any specific problems or obstacles. And this will also be a very important instrument or tool to be used by donor organizations like USAID or CIDA in Canada, the United Nations organizations and very importantly also, civic society.

And I would like to end my presentation by really taking my hat off to civil society when it comes to engagement in terms of the special session last year. It was quite unique that given the short time frame and all the difficulties that came with that, that the whole global network of NGOs and advocacy groups, activist organizations has really rallied together to provide as much input as possible into a very complex process ranging from input to the Declaration, participation in roundtables, and also follow up which is now of course the most important challenge. So for example, ECASO (sp) has issued a guide for organizations how to use this Declaration to make reality. And there are a lot of activities going on in terms of getting involved at country level with the same groups on HIV/AIDS and other partners who work on the response. So this is a very important piece.

And I would also like to mention that the Global Fund is also unique in that sense that it will involve also civil societies in the form of foundations and non-governmental organizations.

The final note on the Global Fund, that is a compliment to ongoing activities, programs and efforts by governments, by the UN system and by other donors. So this a compliment. So it is a new body of the United Nations or a new agency, it's an international effort to rally more money to the programs and activities around the world. And just to say that in a few weeks time, the second board meeting of the Global Fund will take place in New York City and this is where the first round of proposals will be formally approved by the board of the Global Fund.

So I would like to end on this note that there is a very, very critical moment right now where we can see as optimists that the world is coming together finally I would say to really tackle the HIV/AIDS pandemic. Thank you very much.

**MR. FROST:** Thank you very much. I should have begun I suppose by introducing myself. I'm Kevin Frost and I'm the Vice-president of Clinical Research and Prevention Programs at amfAR, the

American Foundation for AIDS Research. And among my responsibilities at the foundation is our global initiatives program.

And what Mr. Lindblad was saying about the epidemic, particularly as it relates to Asia where we've been working rather extensively over the last couple of years but particularly in India where the estimates are enormous, it is sometimes difficult to convey that message when people look at the prevalence numbers and see that there are less than 1 percent infected in India and less than 1 percent infected in China.

And yet, with each of those countries having populations around a billion people, you can imagine how quickly those numbers add up into the millions and millions infected. And I think it is an epidemic that we must pay increasing attention to in Asia. With all of the focus rightly I think on Africa today, we can't allow the epidemic in Asia to slip past unnoticed or we will find ourselves looking at an epidemic there that is similar or if not even more devastating than the one in Africa.

Our next speaker, Sam Worthington has served since 1994 as Chief Executive Officer of Childreach Plan. Mr. Worthington is responsible for the direction of Childreach's marketing, sponsorship services, program development and coordination, public relations, finance, human resources, information systems, and administration teams.

Mr. Worthington helped launch and plays a leadership role in the Hope for African Children initiative, a community based pan-African effort created to address the enormous challenges faced by the millions of Africans affected by the AIDS pandemic.

Mr. Worthington has extensive media experience, appearing on NPR Talk of the Nation, American Public Radio, Voice of America, Talk to America, and World Service among others. And he was featured on the PBS television series, The Visionaries. He serves on the boards of Interaction, the Westminster Unitarian Church, and the World Affairs Council of Rhode Island.

Plan International is global child focused development organization linking through sponsorship people in the US with children overseas. Programs enable children, their families, and communities to meet their basic needs and to increase their ability to participate in and benefit from their society. Programs worldwide impact 10 million children in 43 countries, with an annual budget of over \$300 million. Please help me welcome Mr. Worthington.

**MR. SAM WORTHINGTON:** Good afternoon. We were going to do this in order of the UN, the government, and then the international NGOs, but we'll step I guess ahead of the US government and make some comments from the perspective of an international NGO and try to provide some perspective of the realities of treatment, care and prevention efforts in Africa and try to set an understanding of the stage of what is AIDS in Africa, and offer one positive example of work around the world to help community based organizations.

My message is one of hope. Hope based on the reality of NGOs working to strengthen local community based organizations meet the challenges of AIDS using their own best initiatives. Hope based on the NGO sector ability to look at and work with AIDS in an integrated manner, addressing not just prevention but treatment, care and support for those affected by the disease.

Hope that we can raise global awareness over the gap in health services that exists, particularly prevalence in rural villages and the need to direct resources to close that gap for a number of deadly diseases, AIDS among them. And finally the hope that those NGOs, religious institutions, governments and the UN are working together to help community led initiatives make a difference for the lives of children despite devastating obstacles.

The stories I will tell you this afternoon are unfortunately depressing because the reality is that a generation or a large part of a generation will die throughout Africa. Our focus needs to be on the next generation because we have seen in case after case after program that we can make a difference, that we can stop the spread of the disease, that we can make a difference in the lives of children.

The programs work because they have communities behind them. Our challenge is in bringing these success stories at the local level into major initiatives that make a difference for millions. It is with this in mind that we have launched the initiative that we're calling the Hope for African Children initiative to try to make a difference in the lives of millions of children.

As a child focused development organization, Plan International works around the world to address issues of health or livelihood, education or gender equity. Over the past ten years, we've seen every aspect of our community development work affected by one crisis - the AIDS crisis. It has worked its way into every aspect of our programs impacting the lives of children, women, and men across the globe.

As an organization dedicated to linking individuals to build relationships between and among different cultures, my message is to you to act on the need to build bridges with African communities. Working together, we can establish a global community that enables all people to live with dignity and all children to grow up to their full potential.

About five years ago, I was in Meru, Kenya, visiting one of our planned programs on HIV/AIDS prevention. I met a woman who was bedridden in a small hut with a dirt floor. She was dying of AIDS. During our conversation, all of her energy was focused on what was going to happen to her nine year old daughter, a little girl who was peering at us behind a hut in the village compound. She said that she wanted her daughter to live with her sister and her sister's husband and that they would be the hope for her child. On saying goodbye, I met the uncle and the aunt of the little girl - the new family that she'd be living with.

After leaving the compound, the plan doctor who was accompanying me turned to me and said did I too notice the lesions that they had, that they too were HIV infected, that they too had been sick. And the whole process of finding another family for this little girl would begin again.

It is difficult to understand the reality of the numbers that we hear of AIDS around the world without coming to terms with stories like the one of this little girl. Unlike any human epidemic, HIV/AIDS spreads violently. And this is especially true in the developing world because it hits the most productive generation in the face of AIDS, the teenage girl.

But despite the devastation of the pandemic, it's an epidemic in its early stages, just 20 years. Its spread is preventable and we can bring it under control. From our perspective, there is hope in the long run.

To understand the context of AIDS in Africa, we need to look at the context of health in the continent overall. In Africa like most developing countries, measles is still a major killer of children. Here in the US, we think of measles as a disease we can easily immunize, something of the past. But the reality is that for children and others in Africa, various infectious diseases whether it's TB or malaria or dysentery are all global killers.

AIDS and poverty are intimately intertwined. In a world where some 500 million people around live on maybe less than \$1 a day and some 2 billion on \$2 or less in a day, AIDS is just one more reality where you need to look for food, security, water, bread, effective education.

There's an enormous health gap. There is no health equity. Here in the US, people living with HIV receive anti-retrovirals -- cocktails that extend life indefinitely. In many African countries, there is no clinic to meet even basic needs not to mention the treatment or the complexities of a disease as pervasive as AIDS. In one district, Bulawayo, Zimbabwe, of a million people, there are but a few doctors.

Money alone cannot solve this problem. We certainly welcome Kofi Annan's push to the world to raise billions of dollars or the 1.9 billion that has been raised for the Global Trust Fund. But it's simply not enough. In addition to resources, we need to work to narrow this health gap between local health care systems and infrastructure and the communities that need the support.

Work is being done on this front by like US Agency for International Development working through government systems and NGOs working from individuals and communities on up to build solutions at the local level. But these solutions that work in small areas need to be scaled up across countries, across the whole continent.

On top of this reality of poverty, this reality of lack of access to health infrastructure, there is a stigma associated with sex, with HIV. And this is particularly true in rural agrarian societies were again as I mentioned, the face of AIDS is a young woman in her teens.

We've all heard the statistics. The reality that AIDS is wiping out two decades of development work when that 70 percent of the problem is in Africa. And while my focus and my comments today are on Africa, we need to look at other places. For example, in Bombay, India, it would take hundreds of

thousands of condoms one night to control the spread of the disease. The resources to cover this need are simply not available. The demand is not being met.

Earlier this year, I was in Tororo, Uganda. And like any one of our 250 field offices around the world, it's one of the poorest communities. Uganda has made enormous progress fighting the AIDS pandemic. The Tororo district which is some 100,000 people, people who live off the land, who trade across the border to try eke out an existence living under a dollar or two a day, the AIDS battle is being lost.

The infection rate two years ago among adults was 51 percent; this year, it's about 38 percent. And whether this is the result of prevention efforts or simply that the people are dying, we do not know. Communities are set up into hundreds of small round huts or tukus (sp) with fast roots. There's no electricity. Access to water is a long walk. In one area we visited, the only school is one built by Plan for some 600 students and 12 teachers who also serve as administrators. There are no medicines. And people live with the daily reality of lives threatened by malaria which is still the biggest killer of children, TB, influenza and yes, AIDS.

We talked and visited with family after family. And in each household, there was a grave and often one family member with some 10 to 15 children. Yet what I found striking in this environment was the exuberance in the children, their will to go on, their will to play, their will to live normal lives in conditions that any of us would find very difficult to accept.

How do you tell a child whose father is dead that their mother is dying and that they have to go to live with cousins nearby, relatives who've lost their parents and who are living (inaudible) father?

You've again heard the statistics. Some 40 million children eventually orphaned by AIDS unless we do something now. That's as if all the adult population east of the Mississippi died and the rest of us were left to take those children into our homes. Loss of this scale has no meaning unless it's expressed in the terms of lives of one child, one family, one little girl in a village of outside Meru, in Kenya.

To respond to this loss on a personal level, parents and affected families are creating memory books. Books that they can pass on to their children - family dreams, expectations, hopes, the first songs shared with a child. And when the parent dies or the parents die, the book is passed on to the children who survive. I can think of nothing more difficult than the idea of seeing a mother spending her last energies writing into a memory book so that her children will have something tangible from their family, from her, from her life.

It is in the midst of these challenges that one is always struck by the power of human compassion. The ability of a neighbor to come over to fix the roof that is leaking or a family member to take in one more child to help.

AIDS not only impacts the families but the children. And an entire generation of African children are living under the shadow of the disease, dealing with issues of family loss, with having to adopt the role of a caregiver at a very young age, inadequate nutrition, the whole concept of property grabbing by other

relatives, loss of inheritance, less access to education, and the ever prevalent risk of being sexually abused.

Can we make a difference in these lives of the children? The answer is clearly yes. The organization I work for spends some \$100 million a year, private philanthropy on community level projects that helps millions of children throughout Africa. But the work on one international NGO is but the drop in the bucket when it comes to meeting the challenges of AIDS. We need a radically different approach, one that requires us to holistically address the broad challenges that the people of Africa are facing.

Traditional NGO approaches that focus in on specific projects simply do not meet enough people. They must be scaled up to reach larger populations. And traditional prevention efforts that work through government's infrastructures often do not meet the communities--or reach the communities that most need the message. And very few organizations are dealing with the issues of care and support.

As we all know, HIV/AIDS touches every aspect of human life in a family whether infected or not, adult or child. And the problems do not neatly divide themselves into neat little health boxes or by dumping large sums of money. Multiple all income interventions are needed to respond to the needs of children. AIDS prevention efforts must be linked to home based care efforts for children.

It's with this in mind that we launched the Hope for African Children initiative to address the needs of children orphaned by AIDS, building on existing community capacity, existing community programs to help address the program.

Our chief partners, working with Plan are Care, Save the Children, the World Council on Religion and Peace, local African NGOs such as the Society of Women AIDS in Africa. The Bill and Melinda Gates Foundation has provided major seed funding. And we're not working in isolation. Others on this panel - UNAIDS, USAID, UNICEF, the World Bank, other governments or whether it be Bono's U2, and Artists Against AIDS or the Global AIDS Alliance are all putting support for the initiative - an initiative that is based on the strengthening of existing African capacity of local communities.

The strategic objective of Hope for African Children initiative is based on proven programs that already are in existence - what we're describing as a circle of hope, hope for the children's future. There are four components: building awareness, insuring and extending the life of the parent/child relationship, preparing the family for transition, and insuring the child's future.

In terms--the initiative starts with the need to reduce stigma, and especially in this case to engage the religious institutions across Africa to reduce stigma through behavior change and education. The need for voluntary counseling and testing and for behavior change has been established but cannot happen in isolation.

As we look to extend the parent/child relationship, we're looking at reducing opportunistic infections, issues of malnutrition with food security and the basic health care of family members even if we don't have the resources to introduce drugs.

Preparing the family for tradition is part of this holistic approach. And it goes back to the memory book I mentioned. The planning of the transition, the finding of guardians in advance, knowing that the guardians will not they themselves be HIV infected. In some instances this means providing some economic support for the guardians and helping them adapt to their changed realities.

And finally the initiative addresses the whole issue of positive future for children, providing them with the support they need for continued life skills and education as well as giving caregivers a hand up through income generating projects, micro-credit, and other resources to help them in their new role.

We know through our work in Africa that the spread of AIDS is preventable. We have the capacity to empower local African communities that are already working on the problem with tremendous success stories to make a difference. We need to share this reality with the rest of the world. We cannot simply write off this problem as too big or simply overwhelming.

The world needs to move as it is beginning to move from global inaction to prevention and care and support. As we've all learned over the past months, we are inescapably part of a larger world, a world where we need to act differently. We must do something for the child, for the parent whose life is threatened by AIDS. The world needs to wake up and to realize that we cannot turn our backs on the AIDS pandemic. And the time for action is now. Thank you.

**MR. FROST:** Our next speaker Anne Peterson is Assistant Administrator for USAID Bureau of Global Health. She provides health leadership to this new health bureau. The Global Health Bureau is tasked with technical and program support to field interventions as part of USAID's foreign aid in areas of HIV/AIDS, infectious disease control, reproductive health, child and maternal health, environmental health, and nutrition.

She is an advisor on health policy, testifies before Congress, serves on a variety of interagency groups and task forces, works closely with a non-government organization and with international agencies and host governments throughout the developing world.

Previously she was for three years the Commissioner of Health for the state of Virginia, who is the state's chief health officer responsible for public health of the citizens of the Commonwealth. Major initiatives at VDH under Dr. Peterson's leadership included Right Choices for Youth, the development of e-government and use of data for decision making, and work on public/private partnerships such as the Turning Point project, Healthy People 2010, and the Center for Community Health.

Dr. Peterson has an extensive background in both US and international public health and medical practice. She has served as a consultant to the Centers for Disease Control and Prevention and the World Health Organization in Haiti and Brazil designing elephantiasis treatment training materials and evaluations of educational interventions.

She has spent almost six years in sub-Saharan Africa including Kenya and Zimbabwe doing community development, public health training and AIDS prevention, as well as performing US based research in chronic disease prevention, outbreak investigations and food safety.

Her areas of particular interest are the use of data for decision making, evaluation and cost benefit economic analysis, social marketing innovations, health education design, behavior change strategies and AIDS prevention. The central theme in much of her previous work was integrating epidemiology into behavioral change.

Dr. Peterson obtained her MD from the Mayo Medical School in Rochester, Minnesota and her MPH in preventative medicine residency from Emory University in Atlanta, Georgia. She is board certified in general preventive medicine and public health. Dr. Peterson.

**DR. ANNE PETERSON:** Thank you very much. That was a very long introduction. I want to thank amfAR and Kevin Frost for having me here and especially Mark Silverman who's the conference chair for not only putting together this whole conference but having an international health emphasis within your updating on AIDS.

I am very pleased to be here and I would like to build off one of the previous statements that this really is a critical moment in the AIDS epidemic. There are probably going to be a number of them, but not only are we right now at a point where a lot of attention is being brought to bear, new resources are being brought to bear, but we have for the first time not just program successes and individual very personal successes in interaction but we now have national successes. Domestically we've seen that as the re-infection rates have decreased in scope but now we are seeing it on a national level, internationally as well.

And I started in public health almost 20 years ago. I saw my first AIDS patients in Africa and in the US in 1982. And there was a time during my years living in Africa when you didn't know if we were ever going to turn the corner on this epidemic. And we are beginning to in a few places and with concerted efforts, both financial and people effort, we can turn the corner in all of the rest of the world as well.

So I'm pleased to be with you here today to tell you about the US government's role. And I'll probably flip back and forth a little bit into some of my personal experiences in Africa and elsewhere. But right now I am representing the US Agency for International Development and the President.

And one of the things that I really want to stress that I'm very pleased with is that HIV/AIDS is a priority for the US, for the US government. That next year, our Congress and our President have dedicated \$1.2 billion to international HIV/AIDS. This is in addition to I think it's 9 plus billion that is devoted from the US government domestically. But this is for international HIV/AIDS in 2003 unless Congress of course increases that.

The President was also the first to pledge to the Global Fund with a \$200 million pledge. The total pledged from the US government is now 500 million. That is quarter of all of the funds that have been

pledged to the Global Fund. And he has just recently announced the Millennium Challenge Account as well.

I think you've heard a lot about the numbers and the statistics and the data of where this had impacted on the world globally and how big it is going. I guess the one statistic that is very telling for me is that a new person is infected every six seconds in the world. That is awesome.

My boss, the administrator for USAID talks about AIDS being a disaster, just as compelling, just as urgent as a hurricane or as a flood, with every moment delaying meaning that more people are getting infected and more people are dying and that we need to move very quickly.

I really appreciate Sam Worthington's coming in ahead of me and bringing the face to HIV/AIDS because that's the other piece when I now am in the position of dealing with millions of dollars and large population statistics and trying to focus effort is to remember that it isn't just numbers. Every single one of those numbers represents the face of a person who is either at risk of HIV/AIDS or has it or is affected by it. And as he pointed out several times, very often that face is the face of a child or a young person and often a young girl.

And the global pandemic isn't just numbers and it isn't just disease. One of the really telling things when you work and live in a country like any of the ones in Africa, that you will soon hear about Haiti and some of the other countries that are really expanding rapidly is the much greater impact on the social system, on the economics, on the workforce.

I had a friend whose husband ran hotels in Zimbabwe and seven years ago, he was having to train two people for every open position to make sure that he had a workforce to actually run his hotels.

When I would go in and talk with children in schools about HIV/AIDS and how to protect themselves, I'd say, "Well, what do you want to know and what is your greatest fear?" And their greatest fear was that their parents would get sick and that their parents would die, that they would be orphaned or left in charge of their families, their siblings, or have to move.

So the impact, the global impacts of HIV/AIDS are far more than just the numbers or just the health issues. It hits the people in their most productive years, in their parenting years as has been pointed out so dramatically. It's impacting in many countries the economic development as well as the life expectancy and the infant mortality rate. There are more and more children having to move into the workforce to find food to care for their parents who are dying and their younger siblings.

I'm going to tell you just a little bit about in the face of all of that, why I am still optimistic and hopeful. I am part of a--the bureau or the agency that does our foreign aid assistance to other countries. It has just since the new administration has come in, put together a new bureau for global health with a new HIV/AIDS office. You can see that in 2001, our funding for HIV/AIDS was 339 which was our bilateral funding and was 23 percent.

But since then, we have a new global bureau and I will say that for my staff, it's the first time they've had a health person in charge of the health issues within USAID. And we're hoping that together, we can really move things forward much more quickly. We have a new office of HIV/AIDS so that it's getting more attention. And we've had a 500 percent increase in funds in the last four year. That's even faster than the AIDS epidemic is moving so maybe we can get ahead a little bit.

In this year, we had \$485 million, that's 435 bilateral funding and 50 for the Global Fund. And next year, it's expected to go up to \$640 million, 100 of which is dedicated for the Global Fund. And you can see the total contributions for the Global Fund of 100 million in '01, 200 and 200 for the total of \$500 million.

HIV/AIDS is not only a priority for the US government, it is also a priority for USAID. And we've been working very hard since I started four months ago on our new strategy which we call Stepping Up the War on AIDS, and again, really seeing the urgency. We work in more than 50 countries, 23 of them are designated as priority countries where they get a greater amount of resources. The hope there is to get more dollars to the places with the most need or the highest risk. And we've had pointed out that there are many countries at the brink of emerging. We would like very much to move in quickly there, put our hands around that epidemic and stop it from emerging.

There are also places and in some of the success stories that we're seeing internationally that there may be a threshold of dollars and effort that is critical for turning the epidemic around. Uganda has done marvelously and there are many, many factors involved. But a lot of donors and a lot of time and effort is part of what happened in Uganda. Not only do we want to see if we can get other countries up to that threshold as the fact that then what does it take to hold on to that gain, to make sure that we stay ahead, that an epidemic that's turned around in a country stays turned around.

In the rest of the countries what we want to do is focus our dollars and our efforts where the epidemiological need is. Many of the countries in sub-Saharan Africa have widespread epidemics that are generalized in the population. But there are many other places where it is still more narrowly confined, where it is along the truck routes and the commercial sex workers. And more and more, we need to be concerned about the children on the streets, the vulnerable ones who are at higher risk. And we need to focus our efforts in those areas.

We're also as we step up our war on AIDS within--in all of our work, not just on AIDS, we've mainly been a public health oriented agency. That means a focus on the most cost effective, usually the cheapest, usually prevention strategies. In former planning, we have in the past provided some commodities but mainly we've been doing prevention and then recently have been moving into diagnosis, voluntary counseling and testing, mother to child transmission.

And as we step up the war and as we've had increased resources coming to us from the President and from Congress, we are able to move into the orphan issues, the care issues, the treatment issues. And I would say very strongly here, we need to remember that there are huge opportunities for decreasing

mortality, for decreasing suffering by treatment issues short of ARVs, for treating the opportunistic infections by keeping people healthy and well, by providing food.

And one of the advantages our agency has is that we are development agencies with many sectors so that I can work with one of the other bureaus that does economic development and talk about micro-enterprise targeted to families with HIV/AIDS where the father is dead, the mother is sick but she's not too sick. She can still do a home based, you know, little project where she could earn money to keep food in the household for as much time as she has left.

We have food programs, Food for Peace, that target food usually in famine and disaster areas. Well, HIV/AIDS is now a disaster area. And through our AIDS programs that within communities we can begin to bring food aid to those families so that the malnutrition both for those who are sick with AIDS but also for their families will be less of an issue.

Our prevention programs have focused on the BCC as behavior change communication. And that includes many different aspects. The Uganda program which we're now seeing replicated and its successes replicated in Zambia and maybe in a couple of other countries as well, has had a core piece of it, of the message for behavior change communications: decreased number of partners, delay in onset of sexual activity, abstinence messages where it is appropriate.

And when you look at the Uganda data and I wish I had put it in here for you, that one of the critical pieces for turning Uganda around was the young women, especially the young women between 15 and 24 whose infection rates were incredibly higher than the young boys. And as we've seen it turn around, one of the most striking factors that changed was a delay in onset of sexual activity for those young women in Uganda of almost 2-1/2 years. And that is a very significant piece of information: one, young girls are more biologically susceptible to getting HIV/AIDS and, two, the later you start, the fewer the partners, the less you're at risk, and three, because there has been such an inequity in exposure to HIV/AIDS for young girls in Africa, the fact that Uganda could turn it around and have this delay in onset of sexual activity that very often wasn't voluntary in these situations means that they're beginning to deal with some of the cultural issues that have put the young girls at risk. And we're seeing similar success in Zambia as well.

Condom distribution has certainly been critical, especially in places like Thailand and Cambodia. Voluntary counseling and testing is key. And I will say that one--we get to learn lessons because we work in so many different countries that we can take from one place to another. And one of the things we found was if you had a rapid test, we should be--we should have thought (inaudible), but if you have the rapid test and people can come in the same day and especially in a place where sometimes they travel a day or more to get to clinics, you're more likely to have people come in. And in some places, we found twice as many people if you can find out the same day. So rapid testing is becoming a core for voluntary counseling and testing.

And as we should also expect, if knowing your status and coming and getting tested also means that you are going to get some kind of care, you have people more willing to come in. And so linking the prevention, the voluntary counseling and testing to providing care is very important.

We do have success stories and I'd love to be able to share them with you. In fact, some of our material will be by the door as you go out, both in video on orphans from Zambia, but also some of our publications that show the situation with children in some I hope are success stories. Our most recent publication which will be a report to Congress is I hope at the printer right now and will be coming out in the next couple of weeks which again, shows a lot of the progress.

And I'll again say we're at a critical moment. We're seeing successes and beginning to analyze how we got to those successes so we can do them elsewhere and scale them up as was pointed out. We've got good programs. We're now seeing national successes. How do we scale all of this up to turn it around?

Care and treatments have huge challenges that we still need to deal with and especially to remember that we need to not expend all of our resources in one area, that as we talk about treatment, we still need to remember if we are looking at ARVs that we need to treat TB, we need to treat STDs, we need to treat the other opportunistic infections and give care to the patients.

Okay. And a big and growing area for USAID is the orphan care. We have 60 projects in 22 countries. And some of you have already heard me talk several times today and once specifically on the orphan issue. It is not just that they are orphaned by AIDS and many of them though not all of them are. It's that this is as they grow in population, they are becoming a vulnerable population for getting HIV/AIDS.

So let me conclude that there is more need than we can presently meet. USAID is a government agency, works mostly in partnership and that's why it's wonderful to have UNAIDS who is a partner for us on the multilateral front and has spoken about the Global Fund which is again, an international partnership. But also the NGOs because it is the on the ground governmental--non-governmental organizations and the Ministry of Health and the state based organizations who are really making the difference.

And that's where all of you can make the difference that whatever you're work is here, there's opportunity to reach out through sister organizations, through national organizations, through non-governmental organizations by encouraging Congress to be working that together with the many partners. You've heard of a lot of the different pieces. As we pull all of these pieces together, we have a momentum. And that synergy hopefully will bring us success. Thank you.

**MR. FROST:** Before I introduce our last speaker for this session, I just want to remind everybody that immediately following, there will be a reception in Larkin Hall, an international reception. I hope all of you will come over and join us.

Danielle Penette is a French-Canadian who was living in Montreal working as an administrative technician when she met her husband, Robert D. Penette, who is Haitian. Mr. Penette, an accountant, had lived in Montreal for about 15 years working for the Quebec government in the Income Ministry. They had been married for 27 years.

In 1987, they moved to Haiti, where both of them were immediately consumed by the enormous needs of the population including poverty and the AIDS epidemic. It was then that they began to think about the need for an organization to address these issues. And in 1995, they founded Rainbow House.

In 1996, they opened a shelter which became the home for six children living with AIDS. They now have 37 children. Presently, they have an outreach program that helps 90 children and their families. They have just opened a home care center for these families and will have different activities for the children and their caregivers. Please welcome Danielle Penette.

**MS. DANIELLE PENETTE:** Thank you. Good afternoon. First I would like to thank in the name of the children orphaned from AIDS in Haiti and especially the children of La Maison Arc-en-Ciel, Rainbow House in English, the American Foundation for AIDS Research, amfAR, for their invitation to participate in this 14th national conference on HIV/AIDS.

We are honored to participate in this multi-disciplinary platform and to be able to share our experience, or more precisely, the experience of the institution my husband and I founded in Haiti six years ago for children who are victims of HIV which we named La Maison Arc-en-Ciel, Rainbow House. It was then the first organization of its kind in Haiti and unfortunately, it remains the only one to this day.

In '97, when we moved in Haiti, my husband was returning to his native country after having spent 15 years in Quebec. And for me, it was the experience of a different and very enriching environment.

I was struck by the poverty of the Haitian people as well as by their cultural and spiritual richness. It is in fact through a personal spiritual process that I was inspired with the idea of this house for children who are victims of HIV. My determination and my conviction that we had to devote ourselves to the cause to devote -- I'm sorry -- ourselves to the cause of orphans who are victims of HIV was immediately encouraged and sustained by my husband.

We were then setting out on an adventure, having in hand no resources that would allow us to realize this dream. The Haitian state located us a house for five years and the Canadian government lent us the funds for the renovation and installation of the space for the needs of what was to become Rainbow House.

La Maison Arc-en-Ciel opened its door in July '96 with a group of six children. It has sheltered 50 children since that date. Some of our children are HIV negative because we considered that it is important to show the Haitian community that it is possible to cohabit with AIDS victims without the infected person being perceived as a threat.

We have succeeded in creating a haven of peace and tolerance because our intervention is centered and life and not death. In this way, we have promoted the debunking of HIV by allowing the community to visit us, thereby giving our medical team the opportunity to give advice freely mostly to young people in the community and so contribute to the elimination of taboos. We hope that a year from now, we will be able to offer training courses to student nurses so as to contribute to the reduction of the same taboos in hospitals.

The support we offer at La Maison Arc-en-Ciel consists in receiving children between six months and six years of age, orphans of one parent and from an underprivileged class, and to offer them the family supervision they don't have anymore in their natural surroundings.

The services offered to these children consist of medical support, psycho-social, nutritional and educational support. School integration - we have 18 children out of 36 going to school in the community. We also offer palliative care.

We also have an external program where we accompany about 100 children living with their families and thanks to Plan International who helped us at first to begin this program, which we had unfortunately to reduce to a strict minimum in the year 2000 due to a lack of funding.

The services given freely then consisted of psycho-social supervision, financial assistance for school integration and for burial, distribution of food rations and various donated materials.

Thanks to the recent support of UNICEF, Catholic Relief Service, Haitian Ministries of the Norwich Diocese in Connecticut, the African Methodist Episcopal Church, and NICO (sp) in Netherlands, we are now proceeding with the establishment of a house that will be accessible to families in need. This project is considered as a pilot project for Haiti. The goals are to improve the life of our families and secondly, to empower the communities in giving them the skills to involve themselves.

We will start with few services until we get all the financial assistance to be able to offer the following: medical consultations, distribution of medicines, re-hydration service, psychotherapy, formation programs in family health, family planning, sex education, IT notions, basic management, home visits, creation and formation of support groups, distribution of dry rations, support for school integration and professional formation of older children, cultural for children, health formation activities for and with the children, financial support for funeral expenses.

In 1996, when we started our activities, the (inaudible) of children infected and affected by HIV was not known or very little known by the Haitian population. The vertical transmission was totally unrecognized at that time, despite a rate of transmission of 25 percent.

The mode of transmission amounted to the sexual act for the very skeptical and less educated population would associate HIV with voodoo. Actually, considering the spreading of HIV and the increasing number of children who became orphans or were about to become orphans, more and more

voices are making a stand to start clean in favor of those children and families before the situation gets more out of control.

After Africa, in Latin America and in the Caribbean, Haiti is the country most affected by HIV, with a 5.9 percent rate of HIV on the national scale. Because of this high rate of HIV prevalence, the HIV epidemic is considered as generalized, that is it has spread passing from high risk groups to the population in general.

According to a study in 1998, it was estimated that there were 5.4 to 7.7 percent of HIV positive adults in Haiti, between 250,000 and 365,000 AIDS cases among adults. In 2010, this number would reach 263,000 to 375,000. From now till 2010, the mortality rate will increase from 10 to 20 percent due to AIDS and life expectancy will decrease from 58.8 to 54.4.

The difficulties of containing the epidemic in Haiti are mainly due to the heterosexual transmission of HIV associated with a precocious beginning of sexual activity and the frequent unprotected exchange of partners among more people.

On the other hand, because of the social economic problems known to this country, we see more and more young girls having sexual relations with married men much older than they are in exchange of material favors. These same young girls have boyfriends their own age with whom they have sexual contact which causes the continued growth of the HIV epidemic. Additionally, other sexually transmittable infections are largely spread which facilitates a more rapid spreading of the virus.

An attitude of denial toward HIV/AIDS, the lack of a solid public education on the illness, and the absence of strategies to hinder its progression, handicap the efforts aiming to slow it down, according to a report by Family Health International.

What worries us is the increase of the adult mortality rate in Haiti. One of the tragic consequences of this escalating death rate is that it increases considerably the number of orphaned children. And considering the large number of persons now infected, we can foresee an increase of ten times the number of children becoming orphaned. It is estimated that there are now in Haiti between 153,000 and 235,000 children orphaned by HIV, 440,000 or 3 to 15 percent of children affected by HIV, and 20,000 HIV positive children.

If urgent measures are not taken rapidly, you will see the destruction of the family cell which will have as a consequence an increase in the number of vulnerable children in Haiti estimated at 1.2 million, or between 20 to 25 percent of the population below 15 years of age.

An increase in the number of abandoned children, future street children already estimated at 10,000. The increase of the number of children in domestic service - slave children now estimated at 25,000. Transmission of HIV from one child to another, more children not attending school, the loss of identity and an increase of traumatism for the child, and increase of violence, the increase of poverty, and the

lack of access to preventive and curative health services for the child, an increase in malnutrition, the increase of the mortality rate of children now estimated at 74 per 1,000.

This does not take into account the immeasurable loss of love, affection, and attention the child will suffer, but that we all know is indispensable for the full development of the child.

Due to the economy decline of the last decades, the annual rate of economy growth to our inhabitants between 1990 and 1999 was minus 3.1 compared to .9 from 1865 to 1980. The inflation rate between 1990 and 1998 was in the area of 23 percent.

The children of Haiti have undergone several upsetting experiences and their very existence has certainly been put to the test. We estimate that 70 percent of Haitian homes live below the poverty level. And it is acknowledged that such a situation favors the promulgation of HIV.

Concerning health care in Haiti, the majority of vulnerable children don't have access to basic sanitary services. It is estimated that in general, 70 percent do not have access to drinkable water. 72 percent of children below one year did not receive all their vaccines. 72 percent have access to sound sanitation. 32 percent of children below five years old show stunted growth rate. 138,000 children below five years old die each year.

This already alarming situation threatens to grow considerably worse because of the pandemic. The death of parents, mainly the mothers, since the economically underprivileged family in Haiti is primarily a single mother family, 40 percent of home care are managed by a woman. All this will cause enormous prejudices toward the child. Stigmatized by the community, the orphan child infected and/or affected, born of an HIV positive mother is the victim of numerous prejudices. Because among other things are the intolerance of the social sphere which persists up to this date where people living with HIV, it is impossible to find a home for that child.

According to a study produced in Haiti in 1995 entitled AIDS Family Society, directed by the Haitian Childhood Institute, it has been shown that AIDS and the death which results from it brought about a isolation of the entire family and not only of the infected person, that orphans suffer the same stigmas as their parents. And the communities which took part in the study didn't feel concerned about caring for a family affected by HIV. It wasn't their problem.

Additionally, because of the financial difficulties that confront more and more of the (inaudible) families and their incapacity to face up to the needs of their offspring, 30 percent number six members or more and 18 percent of mothers suffer from acute malnutrition. The concept of the extended family is disappearing more and more in Haiti. 25 percent of families already care for a healthy child other than their own. And the number of dependent persons compared to the number of productive adults is 96 out of 100.

It is equally important to note that according to the results of the study entitled, (inaudible) The Most Vulnerable, Schwartz (sp) 1999, orphaned children are often raised by their grandparents and other

members of the family at the death of their parents, in part because they count on these children to accomplish house chores. The child is looked upon more as an economic asset than a responsibility. The HIV child will then become a little restavek, which is a slave, the number of which is estimated at 25,000 in Haiti.

Because of the unwillingness and incapacity of the community to take charge of all the children who are victims of HIV, orphanages and children's shelters are increasingly in demand. Unfortunately, because of persistent prejudices, the existing centers refuse to accept infected children and La Maison Arc-en-Ciel still remains the only home after six years of existence to care for them and to have developed an integrated support program. This despite the fact that there are at least 200 orphanages in the country and that 200,000 children or more, that is to say 7 to 8 percent among all the vulnerable children live in orphanages or institutions.

Our long term objective is to become a reference organization for the shelters and/or orphanages already existing so as to encourage them to accept children who are victims of HIV until local communities are strengthened and duly informed about HIV so that they will become involved and make a difference.

This process will necessarily take time but in the end, will give everyone the true knowledge and understanding of the illness. One of the objectives of having the house available to families will be to increase awareness and form support groups in the communities where our families live and to give them the necessary information to make a real difference.

However, we know that certain children will be abandoned, left in front of the porch of certain hospitals or simply become victims of the irresponsibility of their surroundings despite the universal principle which requires that the well being of a child pass through his or her family circle. The life of this child will depend on being cared for by an institution. That is why our intervention on those two levels seems essential and is a must in our struggle for life against death. Thank you.

**MR. FROST:** Thank you. We have a few minutes to open this up to questions. And there are microphones here and here. So I would just ask if you have a question that you come to the microphone.

As moderator, I guess I will take the privilege of asking the first question if I may. I was struck in Dr. Peterson's presentation by the representation of our current administration's commitment to HIV/AIDS. A number of speakers at this conference including Phil Wilson who spoke so eloquently on the opening plenary as you recall, have taken to task the current administration for what they perceive as a lack of commitment to HIV/AIDS.

And I'm wondering how Dr. Peterson responds to the critics of the current administration who say that the administration's \$200 million to the Global AIDS Fund represents less than 5 percent of what the Secretary General says is needed in order to combat the global epidemic. That 200 million which represents flat funding from the year 2002 to 2003 despite Bertil Lindblad showed was a 5 million

increase in the number of new HIV infections, or the administration's flat funding of the Ryan White Health Care Act when 45,000 people in the United States were newly infected with HIV last year.

I wonder, given the number of speakers who have taken the administration to task, how Dr. Peterson might respond to that? You can grab the microphone there.

**DR. PETERSON:** Are we on? Sure. Thanks. I'll try to better with the answer to my question. I think that we need to look at what our expectations are for our government. And I won't speak to the Ryan White because I've not been an aid for four months which means I haven't seen what they did with the Ryan White.

But the Global Fund and the \$7-10 billion was meant to be coming from many different sources, many different countries including the recipient countries and foundations in private sector. It was never meant to come from the US government alone.

And US government is doing a quarter of all that's been pledged so far. There is no other country that is even coming close. We have 1.2 billion going for international HIV/AIDS next year between what is going into the Fund, what is coming into USAID's bilateral programs, NIH dollars dedicated for international HIV, and CDC's dollars that do monitoring and surveillance. That is a lot of money. No other country comes even close to that. That's a third of what the international donors are doing. So we really can commend our President and this administration for doing a lot.

Is there more that needs to be done, that should be done? Of course. The need is far, far bigger than has been met yet. I think as far as, you know, is that going to happen? There certainly has been a call for much more dollars to go to the Global Fund. The hesitation there hasn't just been on the President's part. It has also been on a number of Congressional leaders who are saying let's just wait, get through a couple rounds of these grants and see whether the Fund is really working.

But then there is great impetus to perhaps put more dollars into the Global Fund. I hope that as Global Fund gets more resources, that they will be as generous with our own government programs that work very, very well with the NGO sector in countries and are a compliment. The Global Fund will always work through Ministries of Health and I think as you've heard probably from other presentations, I hope certainly from this one, is that we need different kinds of partners involved.

So there is much that has been done. I think we can commend the President. Could he do more, is it enough? You know that's another question.

**MR. FROST:** I think I saw a question here.

**UNIDENTIFIED WOMAN:** Yes. I--.

**MR. WORTHINGTON:** If I could just comment on the answer there because just from an NGO perspective. Foreign assistance has never been popular in this country. And we need a constituency,

which for AIDS is the domestic AIDS organizations. We need to hear your voice on Capitol Hill, something that someone in the government can't say. But we need your voice on Capitol Hill now because there are discussions in the realm of \$1 billion on the Hill. And if there are enough voices coming from the general American public, we can turn this around and increase the numbers by perhaps adding a zero.

**MR. FROST:** Go ahead.

**UNIDENTIFIED WOMAN:** I guess my question is related to what the last speaker just said which is what the suggestions are from you who are speakers about how we could get more involved. I'm not sure a lot of us really know how to get effectively involved in international work. And I'd be interested in your thoughts about--for those of us who've done a lot of work here, are well established, would like to be more involved.

I've been to South Africa a couple of times as part of a research project. But what struck me when I was there is the fact that you could get there as part of research but not get there as part of an interchange of just information which seems so desperately needed. So anyway, that's just a statement and a question.

**MR. WORTHINGTON:** Launch the attack, just commented—commented from the NGO perspective. There are about 160 international organizations based in the US that are actively involved on the ground. And we work through an organization called Interaction. You can look it up at [www.interaction.org](http://www.interaction.org). My organization will be listed under there, organizations like Plan International or others that have been around for decades doing this work. And I think one of the realities is work with those who are already doing the work to link up, to make those linkages with Africa or Asia. It is possible to do that by simply reaching out.

There are also advocacy organizations. I know the National Organization Responding to AIDS has an international group. Again, it's only been in the last few years that the domestic AIDS constituency and organizations are beginning to reach out. And through other NGOs, there is a whole range of possible partnerships that we would love to work with you on.

**DR. PETERSON:** Can I just concur with that. I mean, I'm a government agency and so we have staff. But we do most of our work through other private organizations - the private voluntary organizations in the US. One of the good or bad things about the government is we're supposed to buy America. That means the first line is we're looking for groups in the US who are interested in international issues and are willing to have groups working overseas. So that's certainly one avenue.

On the ground in different countries, there are many sort of counterparts to our own civil society groups. We work with girl guides and Girl Scouts in Kenya and other places. Rotary Club is working on vaccine initiatives. There are a whole host of ways to, if you've got a country in mind, to go and link up with civic society that is working in those areas.

And what we are trying to do within the government sector is have mechanisms for grants to those kinds of organizations to be able to enhance those opportunities. So if you've got the people and I will say, it's not just dollars we need. It is people who care, who will go out, who will learn the issues and will make the difference so that, you know, we need the people also to go out. And we're trying to make the dollars that we get available for those of you willing to go. I'd be willing to go.

**MR. FROST:** Okay. We're almost out of time so I'm going to try to make the questions as quick we can so we can get through them. Go ahead.

**UNIDENTIFIED WOMAN:** Sure. For those of us who are doing AIDS work and who have been doing this for a long time, we work in very poor communities. And we see the multiple levels of oppression and poverty here. And I'm just wondering how do we kind of make that leap towards working and talking to the folks that we work with as well about our role as kind of a global citizen in doing international AIDS work as well because I think that there's oftentimes such--we see such needs here that it's so hard to kind of get outside of that and think about well, the rest of the world also needs the services that we actually do have here. So I'd like to hear particularly from those of you who don't work in this country. Thank you.

**MR. WORTHINGTON:** Only about 2 percent of all international--US charitable giving leaves this country. Our focuses are on our domestic needs. And the challenge is do we see ourselves as a global neighbor. There are numerable ways to reach out, whether it be as a small support group here based in San Francisco with a small support group in Kenya. There are organizations that can create those type of linkages.

And I think our challenge is to put a face on this. The numbers are too big. They're too daunting. And to really get down to that yes, in my small group here, we are sponsoring a child in an environment that is going through this or working through another support group and that we have exchanges going back and forth. I think we need to make it real and personal because otherwise this is too big and we go back to looking at our own challenges which are daunting here. But we shouldn't write off the rest of the world.

**MS. PENETTE:** I would like maybe to add something to this. As a little NGO, Haitian NGO, I think a lot of times we are searching for organizations in countries like here who have more power, not power but more--that could give us something. And we do not know how to search I think maybe for organization.

And I think it's good to encourage the exchange between here and developing countries. I don't know if the best way would be because a lot of organizations like in Haiti won't have access through Internet. But I think from organizations like here, maybe a good way to establish this contact would be through international organizations like Plan, USAID, trying to find out the organizations that are helping, working in the field that we are working here and trying to make the link.

**DR. PETERSON:** I'm going to drop out of my government role for a moment and say that my six years in sub-Saharan Africa were not as a government worker. I went in NGO capacity, in fact working with local national NGOs. And I think there was a very good point. We need to give the issues a face. We also need to give very discreet opportunities. And when I would come back and say, "Here's what I've been doing. Here's how you, other people in the US community could participate", (inaudible) able to work with the (inaudible). So NGO workers on the ground in other countries have to make the opportunities for people to come and work with you, try a couple (inaudible).

END

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