



**Global HIV/AIDS and the U.S. Government's Response: The Power of Partnerships**  
**Joan B. Kroc Institute for Peace & Justice**  
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(Introductory remarks were not recorded).

**Ambassador Mark R. Dybul:** I'm going to talk here a little bit about the general approach we take in the Emergency Plan and a little bit broader given the interest of this institute. And then Dr. Coutinho will talk about some of the on- the-ground experiences from TASO and in Uganda and a little bit more globally.

I think your topic here, and we're very grateful to the University of San Diego for hosting us today and particularly the Joan B. Kroc Institute for Peace & Justice, because these are issues that are integral to the Emergency Plan and what the American people are doing. When President Bush talks about HIV/AIDS, when he talks about his activities on malaria, on development in general, he always says to whom much is given, much is required. And I think that has deep founding in concepts of justice and who we are as a people, who we are as an American people.

I think many in this room know that HIV is the Black Death of our time. Thirty-nine million people are currently living with this disease. Twenty-five million have died. Twenty-five million people have died. By 2020 — without action — it's estimated that 70 million could die, which is more than died in

all of World War II. That's the scope of the catastrophe and the reason for action. The humanitarian reason for action. And when the history of global health is written, I personally believe that PEPFAR, the President's Emergency Plan for Aids Relief, will be remembered as one of the most important actions ever, not just on AIDS, but ever. It's the largest international health initiative in history dedicated to a single disease. It's a fairly remarkable statement that the United States took on the largest international health initiative in history for a single disease. And it's not just about size. It's \$15 billion and actually we're on track to exceed that at 18.3 billion dollars if the President's 2008 request is made.

But more importantly than that in many ways it said we had to do something with the money. For many, many years development was about throwing money at problems, but not getting results. So the president set very specific prevention, care, and treatment targets to support treatment for 2 million people, to support care for 10 million including orphans and vulnerable children, and perhaps, most importantly, to support prevention of 7 million new infections. Those are huge numbers in context. Fifty thousand people were receiving therapy in sub-Saharan Africa when the president announced this. Those infections are already at 60 percent reduction in the countries in which we're most heavily involved. And we're actually on track to meet those goals. For just 2 ½ years you, the American people, supported treatment for 822,000 people. Again, compared to 50,000 in all of sub-Saharan Africa when all this began, in just 2 ½ years supported care for 4.5 million people including 2 million orphans. I'll talk a little bit about orphans in a minute. And you supported a massive scale of prevention programs in a comprehensive and effective way averting about 100,000 kids from becoming infected from their mothers, and most importantly, although we don't – we can't measure it in such easy time immediately, massive expansion of services to teach people safe behaviors including a massive condom distribution program.

As Peter Piot from UNAIDS rightly said last month, we're distributing more condoms than the rest of the world combined. But we're doing it in a context that's scientifically sound and evidence-based to change all behaviors, to change the behaviors of young people and older people so that they know how to prevent themselves from getting HIV/AIDS.

The reason we're succeeding, the reason the American people are succeeding, is because of people like Alex – people on the ground doing the work. Eighty three percent of our partners are local organizations. Our fundamental purpose is to support local groups and local individuals in a multi-sectoral way, government, non-government, faith, community-based, private sector, everyone to get engaged to tackle their problems, to own their epidemic and to respond in an effective way. And we're very privileged to have Alex here because he's doing the work.

What PEPFAR is really though, is something much broader. PEPFAR is part of a broad development approach, which is, I think, why this place is an important one to be talking about it. It really has been since the Marshall Plan since the world's seen such a massive commitment to development.

President Bush — with the strong bipartisan support of Congress has doubled, *doubled* development resources. Quadrupled them for Africa. And that doesn't count massive debt relief and doubling of trade which are ultimate engines to fuel full development. Not just humanitarian activities but real development. And it really is a revolutionary approach, a renaissance in development. It's a new

approach not only because of the resources, doubling of overall development, quadrupling for Africa. But because it fundamentally has changed how we approach development. And I think this institute in particular should be very interested in that new approach. The new approach rejects the old donor-recipient approach. The approach established mostly in the Cold War of using development resources as part of spheres of influence, or as guilt money for what had happened in the past, but that didn't really focus on lifting people up out of their circumstances on real development and to do it through partnership. Not through saying, "Here is money, go do what you want with it," but true partnership and partnership means disagreeing from time to time but what partnership fundamentally means is that you respect each other, you work with each other in all sectors and you support local groups and local infrastructure and local capacity building to solve problems and that's a radically new approach. That partnership, the power of partnership is why we're succeeding and why I call it a renaissance in development because it really is a return to the Marshall Plan approach of don't go in and do, go in and support and partner and that's fundamentally why we're different. We fit in with many other approaches, the Millennium Challenge Corporation, the President's Malaria Initiative, the President's African Education Initiative, the Women's Justice and Empowerment Initiative, many approaches in development put together to lift people up, to give them the power to take over their lives.

But in addition to the humanitarian concerns, the Marshall Plan recognized that a Europe floundering in destruction and despair was a risk to global peace and security. And I think that's something you all have some concern here with global peace and so to the devastation of HIV/AIDS in Africa which leads to total despair and the destruction of society poses risk to peace and security. The UN General Assembly in its only special session ever dedicated to a single disease, the UN Security Council, the U.S. National Intelligence Council, (former) Secretary of State Colin Powell who knows a little bit about peace and security and many others have called HIV/AIDS a significant risk to national and international security. General Wald, the former Deputy Commander who oversees Africa, the four-star general, called HIV/AIDS the third greatest threat to our own national security and peace behind only weapons of mass destruction and terrorism. Now why would that be? There are two reasons, one is a short term risk and that's just lives lost and I think overall it's important to understand, HIV/AIDS is not like most diseases, it kills people who are fifteen to forty years old predominantly, which means it kills the most productive and reproductive members of a society and that has massive impact. It's not just the 70 million people potentially dying; it's where they live in a society. In one of the places they live is as peacekeepers, Africa provides 37 percent of the peacekeepers for the world and HIV related deaths are decimating our peacekeeping capabilities on the sub-continent of Africa. Forty percent of Malawi's armed forces have died from HIV/AIDS, 40 percent. Recently, South Africa tried to field a battalion for peacekeeping efforts and couldn't field a single HIV negative battalion. In addition to the fact that HIV/AIDS decimates the peacekeepers by their having a much higher rate of HIV; once peacekeepers are deployed they're at a higher risk of getting HIV. There is this vicious cycle of HIV decimating the peacekeeping forces when they go to do peacekeeping they engage in risky activity and become more infected therefore limiting your capacity in the future.

So this immediate impact of peacekeeping is one of the peace and security threats of HIV/AIDS. The second one is a more long-reaching one and it has to do with rending the social fabric of societies. When you're killing 15 to 40 year olds predominately in countries where 30 percent of the adult population is infected, 75 percent of pregnant women in Botswana infected, in (inaudible) 75 percent, you're destroying a social fabric. You're taking out parents and teachers and people who can earn a

living and build an economy. Adults aged 20 to 49 account for about 60 percent of all deaths in people 20 to 49 are now from HIV/AIDS in Sub-Saharan Africa which just gives you a sense of how horrific this is. The impact is far reaching. UN AIDS estimates, up to 20 percent of gross domestic products can be lost in the hardest hit countries, 20 percent. If you can't grow an economy you can't develop no matter how much humanitarian work is done and so we're seeing a tremendous impact. The World Bank has said that Africa is one of the few regions at risk of being left behind as the economy of the world develops, largely because of HIV/AIDS.

But it's not just the overall economic impact where we see the real impact — and if you look at a person-to-person level where we see it most deeply is the death of parents. There are 14 million orphans from HIV/AIDS right now and we're projected to go to 20 million by 2020. Educators are disproportionately infected. So now you have a generation of orphans and no one to teach them and when you have a generation of orphans because parents are dying from HIV/AIDS and then you're losing teachers disproportionately to HIV/AIDS you have no one to teach them, you have no economy growing so you don't have a mechanism to lift people out of poverty. When you do that, all the humanitarian work in the world isn't going to solve anything so that's why AIDS is so unique. It doesn't take much imagination in the post-9/11 world to see a rending of a social fabric, particularly in a continent where 50 percent is Muslim, to see the risk for radicalism, to see the risk for real threat to peace and security. While we respond to HIV/AIDS predominantly and because of the humanitarian concern — and President Bush was absolutely clear that this was an act of mercy, an act of justice in his State of the Union address that launched it — we are concerned about these deeper issues, this tearing of a society and the effects therefore on peacekeeping and the effects on the sustainability of a society.

We're engaged and we're successful and we're moving rapidly to turn the tide against those pieces but we have a lot more to do. We do more than just confront HIV/AIDS with prevention, care, and treatment, we do have an impact on orphans, we're probably going to avert somewhere in the neighborhood of 14 million orphans with our programs to restore those societies. We link our programs and in fact provide education for orphans, we're providing nutritional support and building clean water systems and connecting the dots of development. There's been lots of discussion about whether or not HIV/AIDS programs draws from the rest of society rather than contributes to it, is the concentration heavily on HIV/AIDS programs limiting other health areas or is it affecting other things. Well the data are overwhelming that that's not the truth. The Institute of Medicine just reported and the chairman of the Institute of Medicine said very strongly that what we're doing fundamentally is building health systems. The reason we're building health systems is because we're on the ground supporting people like Alex to expand health systems.

I'll just leave you with one data point about other health. We can talk about the non-health things we do; the education, the nutrition, the clean water, the tuberculosis programs and the other programs that we're connected to and building but on health alone there has been a concern that we're drawing from the health system. Again, the Institute of Medicine said that's not true. Let me leave you with some data from a study that was recently done in Rwanda. A study looked at what happened in a region when you increased HIV/AIDS activities over a six month period and what happened to general health parameters, were we actually drawing from general health to do HIV/AIDS programs as had been thrown around as a possibility and one we need to pay attention to but in the absence of any real data. They looked at 22 non HIV/AIDS indicators and what they found is that 21 out of 22 went up, 17 of

them statistically, significantly, five of them by regression analysis were just associated with an increase in HIV/AIDS programs, another five indirectly associated with HIV/AIDS, and it included a very significant increase in family planning, a very significant increase in antenatal care, a significant increase in measurement of sexually transmitted diseases, and this actually isn't very surprising if you've ever been in Africa. We're going into settings where there's no healthcare infrastructure, we're renovating and building clinics and laboratories, we're training workers in the new way, we're establishing systems of accountability and when you do that for HIV/AIDS in a hospital it spills over to everything else. In a community it spills over to everything else and that's why the head of the Institute of Medicine said we are building health systems. There is a risk we have to pay attention to, we need to make sure we keep doing that over time, but that's fundamentally what we're doing. What we're doing then overall is fundamentally an act of justice, an act of peace and security, an act of compassion.

I'd like to close with something that General Marshall said when he announced the Marshall Plan. He said it's virtually impossible at this distance merely by reading or listening or even seeing photographs and motion pictures, although Alex is going to show you some, to grasp at all the real significance of the situation — and yet the whole world of the future hangs on a proper judgment. It hangs to a large extent on the realization of the American people, what are the sufferings, what is needed, what can best be done, what must be done and as we look at the world today, as we look at the devastation wrought by HIV/AIDS we know what must be done and in fact we're doing it and we're doing it in a way that's revolutionizing and transforming countries. As President Bush said when he launched the Emergency Plan, seldom has history offered a greater opportunity to do so much for so many and it's being done. One of the people who are doing that is Dr. Coutinho, it's a great pleasure to turn it over to him.

**Dr. Alex Coutinho** (Rising and gesturing toward PowerPoint screen): Thank you and good morning. I have to use my laser pointer so I'll stand up. I hope you can hear me at the back, it's a pleasure to be in San Diego. This is the kind of city I could live in if I came to the United States, it's very pretty. I'm going to talk about my organization which is TASO which stands for The AIDS Support Organization. It is the oldest HIV/AIDS care organization in Uganda and the largest in Africa. It would not have done what we have done without the partnership that we have with very many people and nations. Particularly the partnership we have with the American people and more recently the partnership that we have developed with PEPFAR.

What I want to talk about is the reality of HIV and AIDS and what my organization is doing. Just to remind us that there are up to 40 million people living with HIV and AIDS and if you look at that concentration in southern Africa and in east Africa where I come from, that's where the brunt of the epidemic is. Just to remind us where Uganda is, we're right in the center of Africa and we have a population of 25 million but a million people have already died due to AIDS in Uganda and we currently have about 800,000 people living with HIV, it's a very poor country with a per capita GNP of \$400 per year which means that most people live on \$1.00 per day and a health spending of only \$15.00 per person per year. Even as we speak we have 100,000 people who need antiretroviral (ARV) therapy today.

(Pointing to an image on the screen): That's the picture of a typical rural area in Uganda. My organization TASO is the first indigenous AIDS organization. We currently look after about 60,000 clients, we have 11 centers and we are providing 20,000 clients with ARVs at the end of 2006. Now in

2003 we had zero so we've really grown to be able to provide care. If you look at Uganda, we are truly a national organization that is represented in most of the districts in Uganda. As a representation, if we look at new clients who are HIV positive registered with TASO, in 2000 we had about 6,000. That has grown to a peak in 2004 of 25,000 clients registered per year. Life Project was an investment by the American people but PEPFAR particular has quadrupled resources and now we see a continuous growth of new clients coming to TASO for care. In particular if you look at the patients that we started on ART which is antiretroviral therapy which is the drugs that are needed to keep people with AIDS alive, you can see an exponential growth as a result of the injection of PEPFAR funds.

The philosophy of TASO has always been positive living and this preceded the availability of treatment. We believe that if you got early counseling, if you understood how to tackle your disease and if you combine that with medical care and treated infections like tuberculosis and also led a healthy lifestyle and also had a social support system that included nutrition, it could help to keep you alive longer. But of course there comes a time when you need treatment so it's been very important to add on to positive living a packet of treatment. Not only do we give treatment in our clinics, we are able to deliver treatment into rural areas of Uganda and this is on the eastern side of Uganda and that's a typical household, that's where many people live and you often find six or seven people living in a little hut like that. We also make sure that not only do we go and give that kind of treatment because when you go away someone has got to give support to this family, we mobilize the community to be able to do the work that we do when we are not around. So part of our job is to go out and talk about HIV and AIDS, engage HIV positive people to come and talk about HIV so that the community is mobilized to provide support when our staff is not around.

There are of course unique challenges to providing rural care. There is minimal health infrastructure, the population is dispersed and does not have access to transportation, there is extreme poverty, it is difficult to describe that poverty unless you've been there and I have some pictures of that poverty. So there is a difficulty with getting people to take their drugs and yet the theme of this institute is peace and justice and if you are to have true justice you cannot just give treatment to people in towns, you have to be able to take that treatment to the majority of the population that live in rural areas. You have to be able to give treatment to someone like that.

This picture was taken in the North of Uganda where there's been a conflict and now peace is returning but returning very slowly. That conflict for twenty years has left behind populations that look like this. (Pointing to image of woman cooking food in a pot balanced on three stones): This is probably . . . the totality of her kitchen is right there, that's her kitchen. That's probably one of two dresses that she owns and you can see the condition of which the children are. With PEPFAR we've been able to release scale-up programs in areas of Uganda that have emerging out of conflict and coming into peace. One of the things that is not so well known is that when communities emerge out of conflict into peace, it's a wonderful ground for HIV to flourish. So while you've invested into peace you must now invest further in assuring that a woman like this is not vulnerable to HIV because she owns nothing. That extreme poverty, almost the post traumatic stress syndrome that she's suffering from may put her at risk of acquiring HIV and AIDS and so we're having a significant investment in the north of Uganda.

We are also extending HIV testing into rural areas. Unless you do that people will not know whether they're HIV positive or HIV negative and in this picture we have one of our clients and she invited us

to her home to test all the members of her extended family and that day we were able to test 31 members of her family, some of whom you can see photographed near her. We were able to test in this kind of environment, in a very rural area, we are able to give the same quality of testing as you can get in San Diego using the latest technology of rapid test kits and we don't even use trained laboratory technicians. We train our own staff, who are basic graduates, who are diplomaed or degreed and we take them through a six-week training course and at the end of that course they are able to do rapid testing in people's homes. This has been possible with the investment that the American people have put in my organization. That's another picture of testing in a rural area, this is the counseling taking place but you need to notice that we are also giving out condoms, there is often a criticism that PEPFAR does not deal with condoms, that's actually a box of condoms. In Uganda PEPFAR is the largest purchaser of condoms and purchases 40 million condoms for Uganda. That's the actual testing taking place.

Now this is a picture that talks to what Mark was saying, about the challenge of orphans. While that is our client and that's the TASO vehicle with our emblem, this is her whole household, most of whom are children. Not all of those are her children because often the children of your brothers and sisters have been left behind and they congregate in one household. By keeping her alive we are providing the support system for that whole family. By going to her home, not only do we talk to her, we talk to those children and talk about HIV and AIDS and so we do a comprehensive family approach. That would not be possible if we were only doing an urban facility based approach to HIV. That's another picture of delivery of antiretrovirals. We deliver them using motorcycles that go up to 80 kilometers, 50 miles away from the centers and again that's a typical rural setting in Uganda.

For me the biggest tragedy is this, children looking after children, the burden of orphans and vulnerable children. You go into homes and find if there is a parent alive that parent has gone out to look for food and you find these children can't go to school, they have to care for each other. If we are to have a peaceful society 20 years from now we have to invest in these children because if we don't we have a time bomb that's going to explode. In order to mobilize I just wanted to show that we engage HIV positive people these are some of our clients that have been taught music, dance and drama and they use music, dance and drama as a medium to go out into communities because it's a very important way to communicate messages in a non-threatening way.

That's a picture of President Bush when he came to TASO a few years ago and launched the PEPFAR in Africa. His keynote speech in Africa was in TASO and that commitment has really translated into reality. This is not about President Bush anymore. People often ask me in TASO, what's going to happen when President Bush leaves office, is the money going to stop and I assure them that this is not about President Bush, this is about the American people. You need to be proud of all the lives that have been saved because I have seen many donations that are just that, donations of money. This is about donations, this is about partnership, and this is about real results. We just need to remind ourselves that there is a lot of work to do. We continue to have 4.1 million cases per year in 2005 and if you minus the new infections from the deaths, you find that we have another 1.3 million cases added every year. Which means particularly in prevention, we need to scale up prevention if we are going to be able to sustain treatment efforts. While we have a range of preventive technologies including male condoms, female condoms and post exposure pills and more recently male circumcision, we need to be

able to invest more resources in a vaccine and finding a microbicide and finding other technologies like pre- and post-exposure pills.

But at the moment the main tool is behavior change so we have to take an approach that really addresses behavior change, knowing that behavior is a very fragile approach where you have to keep reinforcing behavior change every day of people's lives.

Just a few pictures to show TASO at work. This is counseling inside a vehicle so even though we don't have buildings we use whatever facility is there. This is a group of women waiting to get an HIV test, they're being counseled on the top left corner. As you notice these are all women and many of the people who access HIV services are actually women. This is a food supplementation program for TASO, I don't think I need to tell you where the food is coming from (gesturing toward onscreen photo of cans of food with U.S. flag painted on them), the largest contributors for food program for HIV positive people is the United States, either directly or through our food program. This is a TASO outreach clinic that is being done in partnership with the Ministry of Health. The building on the top, that building, belongs to the Ministry of Health so we work in very close partnership with the government of Uganda. This is someone who is HIV positive, the lady on the left and she received treatment but also training on how to start up a little business so she's running a deli at one of the clinics, Uganda style and being able to survive because of these pills. This is some of our orphans who are getting skills in being seamstresses and the lady in the middle is an Irish nun who runs a school that trains girls on how to stitch clothes. These are young boys who are also orphans being taught brick-laying so that they can survive. Finally this is a picture of Agnes with her family of seven, Agnes had a CD4 count of 5, the normal CD4 is 1000 so she was very, very close to death. With antiretrovirals bought for her by the American people she's been able live, her CD4 count is 500 and those children are not orphans because she is alive, if she had died they would have been orphans.

Mark has talked about the millions of orphans and vulnerable children that PEPFAR is helping to save, well that's a picture of seven of them and it really matters that we continue making these investments so that we can continue not only to save millions of lives but to prevent millions and millions of children from becoming orphans. Thank you very much.

**Amb. Dybul:** So why don't we take questions now and we should have apologized for being late, when we were in Los Angeles we accounted for traffic, we didn't think we had to do that in San Diego and we're a little bit late but we have some time left for questions.

Q: In your remarks you commented on the 50 percent prevalence rate of Muslims in Africa, do you have the data of prevalence of HIV/AIDS among Muslims as opposed to non-Muslims in Africa or more specifically sub-Saharan Africa?

**Amb. Dybul:** We do in some places, not in others. In some countries actually you do see, astoundingly when we looked at the maps we saw pockets of zero prevalence among countries of lots of prevalence and it turned out that those were some Muslim communities but those are older data. In Zanzibar, Dar es Salaam, Nairobi, parts of Ethiopia and Nigeria where we've looked, unfortunately we're seeing that there's not a big difference because urbanization overcomes some of the protective effects that we might see in some of the faiths so we're very concerned that there isn't a clear difference

between different faiths and the prevalence of HIV, particularly in the urban settings. I do think that it's an important thing because it raises issue the involvement of the faith community. Farther community has to be engaged in Africa for multiple reasons if we're going to tackle this epidemic. First, half of the health care in sub-Sahara Africa is provided by faith based communities. You can't get prevention, care and treatment services out if you're not involved in these organizations because you won't reach anyone. In fact most of the national plans incorporate faith based clinics and hospitals into the national plan and stick them as a central site for care and treatment services. But it's also essential for cultural change, prevention is the key here. We've got to prevent new infections as Alex pointed out and to do that you need all segments engaged. The fact of the matter is young kids don't listen to ministers of health and anyone else when they go out and talk about protecting yourself. You've got to get into the community, you've got to get in to where people live and you got to change people's behaviors and that involves everyone. That involves tribal leaders in the faith community and the private sector and teachers and everybody so you've got to get everyone engaged and it's taken a little bit longer to get into the Muslim community but we've begun and we have quite a few programs actually working with the imams in the communities. One of the most important things we've done is bring faith leaders together to overcome some of the old approaches of, "God is — this is a curse," and really using faith leaders to teach other faith leaders that that's not correct, just as we had to do in this country. There has been a lot of success there but we have a lot more work to do. One of the things we want to do is bring the inter-faith groups together so Muslims, Christians and Jews are actually tackling the epidemic in their community together but it's a lot of work to do but we've had some good success.

Q: A couple of times both of you mentioned a connection with peacemakers, (inaudible) early on you spoke with the peacemakers and wanted to take on more with the behavior and when peace breaks out it increased the likelihood of contracting HIV, I didn't get the why.

**Dr. Coutinho:** I think we'll both give the response. The epidemic in Africa has been characterized by very high prevalence in any population that has high migrancy rate. With the migrant workers, you have high rates. If you have migrant civil servants you're going to have high rates. Soldiers, policemen, by the nature of their work are high migrants, also soldiers by the nature of the threats that they deal with on an every day basis, the fear that they can die any day are more likely to that higher risk behaviors so unless you have a really good prevention program and soldiers are using condoms consistently and they are taught how to respect women, you could have, and we do see a higher HIV prevalence in those populations. There is, at least in Uganda, an increased investment because the Department of Defense of the United States is receiving PEPFAR funding and is working with its counterparts in Uganda to scale up prevention programs.

**Amb. Dybul:** That's true in all of our focus countries but even more broadly than that with the Department of Defense and other partners to scale up prevention, care and treatment services in the militaries and sometimes we use military hospitals as a base to provide services to the community because they're the only hospital for miles around.

Q: This is all very fascinating to me. I'm the founder of an organization called Just Like My Child Foundation and we're working in rural Uganda with a community of about 600,000 people at (inaudible) so what I'm wondering, I have three questions for you. First of all, what percentage of the

rural population are you actually reaching in Uganda right now. The second question is what is your projected number of patients who will begin receiving ARTs and over what period of time and I know there's an emphasis on pediatric ARTs now in Uganda and I'm wondering, where's the adult treatment because we haven't been able to source it.

**Dr. Coutinho:** You didn't say where in Uganda you're working?

Q: We're working in Luwero, Nakasongola and Nakaseke.

**Dr. Coutinho:** TASO reaches, let me give you the numbers, we have a population of 25 million of whom about 20 million are in rural areas. We reach over a million people through our programs in the mass media but directly we reach about 200,000 people in the rural areas in terms of direct services. It's probably about 1 percent but we are one of 2,000 NGOs and in terms of prevention we obviously reach a much bigger population. Actually our treatment programs have tended to dominate pediatric treatment programs and at the moment only about 6-7 percent of beneficiaries of treatment are actually children. So one actually wants to see programs for children growing at a faster rate than adults. We estimate for Uganda that every year we are adding an additional 20-30,000 people for treatment with current resources.

Q: I'm Janine Schooley with Project Concern International and I want to thank you very much for your presentations. Usually I have to go to Washington or Africa to hear such distinguished speakers on this topic, so thank you very much. I won't ask you to predict the future but to look into the future a little bit about PEPFAR and what some of the trends might be when we re-authorize PEPFAR, trends that might be based on lessons that have been learned over these last few years as well as just shifts in the decision making landscape, leadership landscape. So I'm very interested in the future and your thoughts.

**Amb. Dybul:** I was going to answer first because it seemed to be Washington-directed, it might be better to have Alex answer about what he thinks it should look like but why don't I give where I think it's going and then Alex can talk. I think many of you know that there is an Institute of Medicine review of PEPFAR that recently came out and the thing I was most pleased with and if pride weren't a vice I might be proud of it that they called this a learning organization. We are trying to continue to learn everyday, literally, from our programs and what's being done so that we can change them. Things look radically different than they did three years ago in many areas because we're trying to learn and change as we go. If you look to the future there are a couple of things that I think are coming that I think are important. One is that we all know and believe that prevention is the key to this epidemic. You've got to provide care and treatment, that's part of a compassionate response but you'll do a far greater and far reaching work if you can prevent the infection. Unfortunately we are heavily reliant now on behavior change and behavior change probably has limits as to how far it can go. We've seen tremendous responses in Uganda and Kenyans and Zimbabwe and Botswana and we've seen young kids changing their behavior, delaying sexual activity, reducing their partners, increasing their condom use. We're seeing gender equality growing as we're trying to build programs that get to young kids and teach them to respect each other and I think for the future for behavior change that's where we're going, getting to younger and younger and younger kids. We talk in this country about ABC and there's lots of controversy and there is a much deeper thing than that, it really is teaching young kids to respect

themselves and each other and what behaviors flow from that and teaching young boys to respect young girls and it's much easier to do that if you get to younger people. I think you're going to see much more of what we're now trying to do in Botswana and a number of other countries which is on a national scale, get that type of behavior change messaging to very young people, very young people because it's easier to change a ten year-old than a twenty five-year old's view.

The other piece of that is to use people who know how to message things. I'm in an academic setting so I'm going to be a little bit careful. Academic settings are tremendous at doing the research that tells us what we need to do effectively, what's effective, it's academic research that's taught us that ABC is effective in generalized epidemics, that BC is more effective in concentrated epidemics but that's different than taking the messages and teaching kids how to behave. The best people at that are Coca-Cola, Yahoo and Google and Warner Brothers so we're now engaged in public-private partnerships to bring their expertise to bear and to bring technological advances using computers and gaming and cell phones and really getting to kids, creating "Chill Clubs," we call them or other clubs so that we can change the behavior of young people and sustain it because we're going to be relying on behavior change for a long time so we're trying to go deeper and deeper to really affect behavior and I think we'll see more and more of those approaches.

The second is to incorporate, as they become available, new technologies for prevention. So male circumcision is something for the future, we're costing male circumcision and what it would cost to scale up but you have to do all those behavior change things too, we're very concerned about gender and equality, making a resurgence if we do too much circumcision and young men feel they're fully protected and go after young girls again but I do think we'll be expanding male circumcision. Pre-exposure prophylaxis I believe but we don't have the data yet will prove to be effective in high risk populations, militaries and others and we're starting to cost that out as well. As you do more of these expensive technologies we may see a shift towards more prevention funding and less treatment funding as a proportion, not as absolute numbers. The reason we're at the cost that we're at now is because prevention is less expensive than treatment which is another reason you need to do more prevention because it's actually less costly, not just humanitarian. I do think we'll start perhaps to see as these more expensive technologies come, a greater shift towards prevention rather than treatment, not rather than; proportionately not as absolute numbers. I think we're going to see more and more, at least in our view, public-private partnerships that bring the expertise of the companies to bear.

The other area is systems, more emphasis, and again using the private sector to build systems. Really the impediments to scale up right now—people concentrate on health workforce and we need to do that but we need to build logistics, supply chain management, human resource management, financial management, waste disposal. We need to build more systems. The private sector is better at doing that than government and non-governmental sectors and so we're trying to partner with them for that so we can get to full rural scale-up. I think we're going to see more and more emphasis on national—this is the advantage of what we've done with focus countries on a national scale. I think we'll also see a proportionate increase in multilateral work, as the Global Fund and others catch up and as we're building our programs together with multi-lateral agencies, I think we'll see more on that. I think we'll see more interaction and connecting the dots of development, connecting all the different types of programs in a much more intelligent geographic way. We've done a lot of that so far but I think we'll see more and more of it and it's one of our areas of emphasis to ensure that the education programs are

connected to the AIDS program are connected to the malaria programs are connected to the neglected tropical disease programs and we're actually doing some of that in very exciting ways. So I think those are the things we'll be seeing but I can't predict because something is going to pop up that we don't know, what we have to do is maintain our activity as a learning organization so we can incorporate them when they do and we don't get entrenched in bureaucratic stuff.

**Dr. Coutinho:** I would add only, one is to use the tremendous power of the results that have come out of PEPFAR to stimulate others to contribute a proportionate share, that's the countries themselves, to know that if they would be investing in HIV/AIDS programs you are going to get real results and the other development partners, the U.S. continues to be the largest contributor for HIV/AIDS programs which is great but there are many more people who need to step up to the plate. The second is a greater investment in reproductive health and in sexuality. As a foundation for programs that address youth and their sexuality and also a foundation to scale up PMTCT [prevention of mother-to-child-transmission] programs unless you have reproductive health systems and services, really scale up in country, it is sometimes difficult to be able to really roll out PMTCT and the tragedy of children being affected at birth and having to deal with that tragedy would be lessened with that kind of investment.

Q: Although most of the HIV/AIDS cases are attributable to sexual practices, I'm curious as to how much of the percentages of non-sexually transmitted HIV/AIDS where the disease comes from medical procedures such as blood transfusions?

**Dr. Coutinho:** Now assuming the blood is unsafe or the procedure is unsafe, you still have probably less than 5 percent, I can't give you an exact percentage. But as you invest in safe blood and as you invest in making sure that people are educated on disposals of medical needles and sterilization, that percentage drops lower and lower and actually gets to less than 1 percent. Some of the challenges are that we have traditional health systems that are outside of the mainstream health systems that, through practices like scarification, using traditional – but we have programs in Uganda addressing that. So it's really a small percentage growing smaller. The biggest non-sexual percentage right now in Africa is the mother to child transmission which we have to address.

Q: I was wondering if PEPFAR is doing the same system building in the United States between African-American community, this is one of the largest killers as opposed to intravenous drug use.

**Amb. Dybul:** PEPFAR is our international program, I'm in the Department of State so that's our international program. The Department of Health and Human Services from which I come, manages the domestic HIV program and this year's budget is around 20 billion dollars for the domestic HIV/AIDS program. In the last couple of years there's been a heavy emphasis on the African-American community, particularly African-American women because of the increased rates, particularly trying to get education and preventative services available to young women and get tested. There's been a heavy emphasis there and there's been some success but there needs to be more success. That is a heavy focus of our domestic program but it's not in our purview because we're international, that's part of the Department of Health and Human Services.

Q: What money, if any is being spent domestically or abroad on a possible vaccination or a cure for HIV/AIDS?

A: Domestic and international is the same in many ways although there may be different vaccines depending on sub-types of the virus. The U.S. Government provides 80 percent of all research for sources for vaccines in the world of governments and then there's a big private sector investment. It's in the hundreds of millions to billions a year if you add the private sector probably. The problem is not money, the problem with the vaccine, if we had the right technological insight and scientific views of the virus, of the immunology and virology we'd have a vaccine; it's not a matter of money, it's not a matter of brains, it's a matter of technology, we don't have the right perspective to see a vaccine, this is not like developing a vaccine for most other diseases, HIV is a very unique type of virus. I'm putting my scientific hat on rather than my PEPFAR hat, its NIH that funds the vaccine work, not our office although it's part of the overall funding for PEPFAR. It's obviously what we want but we're not going to have one, there's nothing on the horizon, nothing on the horizon and that means that we need to re-double our efforts for all these other activities to ensure that we have activity. There is some hope for what's called a therapeutic vaccine as opposed to a preventative vaccine to stimulate the immune system so you can change the progress of the disease but not prevent the disease and there's some new hope for something along those lines but a preventative vaccine is not something anyone in this room can hang their hat on. Now at the same time there could be a technological breakthrough that we can't predict that would radically change that but that's why we really need to focus on just the hard work of prevention, care and treatment because we're not going to have these silver bullets for quite a while.

Q: I am studying here at the university and your presentation has inspired me to ask, What are some ways that we can get involved today to support PEPFAR?

**Dr. Coutinho:** Maybe let me start and Mark can talk about involvement in the U.S. Given that this institute, I'm talking about the Institute of Peace and Justice – there's a lot that we don't know about HIV in conflict and post-conflict settings. Particularly post-conflict settings. If there is a focus to study, to research, to understand, to partner with organizations that are working in these settings and find ways to tackle the epidemic, that in itself would be a tremendous contribution. But in terms of direct support, there's hundreds of organizations, despite PEPFAR, still continue to need help, particularly in the areas of supporting orphans and vulnerable children, areas of developing skills. You saw the lady who had some business skills, there are many, many areas that one can do research and focus on. I was telling a group of high school students that one of the challenges in the north of Uganda in the post-conflict setting is you've got a lot of children who are living in camps that are deprived of the normal socialization that they've had, partly because of war but partly because their parents are now dying of AIDS and one of the best things you can do is introduce play programs that do play therapy that introduce soccer balls and net balls and volleyballs and that brings children together to socialize and play. The sky is the limit when you think of the interventions that you can do that actually make a difference. If you want to help my organization directly I can give you my card. I'm not here for that but since you asked . . .

Q: So once you mentioned micro-financing and helping someone like that woman who had the little deli, what are some ways to get people started with businesses so they can support their families?

A: Some of these statistics really worry me like 80 percent of all businesses started in the United States fold, they don't make a profit. In other words starting businesses is risky, whether in the U.S. or Africa so 80 percent of business started by people living with HIV also fold partly because business is difficult but partly because of the unique challenges of being sick. However we have found that when businesses are started as a group rather than an individual and you provide skills and ongoing support, that those businesses are more likely to succeed but you do have to invest and there are a number of groups that are beginning to do this, there are a number of micro-finance organizations, some of which come out of the U.S., one is called FINCA for instance that is investing in not loans but in grants because when you're giving loans you're now giving a burden of also paying back a loan until they get well enough to be economically productive you may just be challenging them with fees in order to service their loan. It's a growing area and one of the things we need to look at in sustainable businesses is the area of agriculture, food production, food preservation and food marketing. Again there are many institutions that are investing in this. The approach should be give a grant rather than as a loan to begin with, do a group approach rather than an individual approach and make sure you give ongoing technical support.

Q: Would you say with the behavior change approach that native customs, values and ideals are being replaced with those of the western world or would you say that's pretty well integrated?

A: Let me talk about my children first. I think my children are more American than many Americans and they've only just started studying in America now, last year. The exposure to television, the exposure to the Internet, the exposure to schools is causing a cultural change in many children regardless of what the parents are telling them, regardless of what the government is telling them and one of the things in behavior change is to recognize this transition, that globalization and particularly the globalization of the media communication is bringing almost a uniform thinking around what's "cool" and what's "not cool." On the other hand, if you take the ABC approach which is the main approach that we use for behavior change, abstinence, be faithful and use condoms, if you take the AB part of that, that's always been the mainstay of most cultures in terms of preventing pregnancies and also preventing other infections so AB has not been brought about the United States, AB existed. What's been added is condoms and condoms have been added as a result of the science that has proven that condoms are useful in preventing not just HIV but other infections. So we take the ABC as the foundation and we add other pieces. Some of the very important pieces are D, which is "**Determine** your HIV status." That is definitely a new addition but it's a very good addition, it's good to know your HIV status. It's the E which is "gender **equality**" because unless men and women have equality and equity in terms of men, women, relationships, in the ability to negotiate safe behaviors then the ABC will not work. There is no single culture that is totally bad or totally good, every culture, every tradition has to be analyzed in terms of what is good and what is bad for a particular aspect of life and that can vary in a time period. What was good twenty years ago may not be good today. So there is right now a very critical self-analysis in Uganda of what cultures are good and what cultures are bad. There was a question earlier, is being a Muslim protective, well certain aspects are. For instance, Muslim men are all circumcised and now that circumcision is shown to help with prevention, that cultural aspect was obviously protective but there may be aspects of the Islamic faith that are not good, for instance polygamy in Uganda means that more people may be exposed. So nothing is totally bad or totally good, you just have to check it in terms of the particular issue that you are tackling at that point in time.

Q: Thanks for being here, it's been very inspiring. One of the things you brought up was that determining status was important and one of the ways you're doing that is by community outreach and actually training locals to do testing, etc. Is that also extended to distribution and monitoring of ARV medications and treatment and how does PEPFAR feel about that having non medical or non physicians, it's kind of along the lines of Paul Farmer's approach.

**Dr. Coutinho:** Actually the mainstay of TASO's program is community rural-based ARV distribution system that uses non-medical, but trained people to do so. We call them field officers. We are actually going a step further to make sure that we train HIV positive people who are non medical, not to distribute the drugs but to be there to monitor and support people in treatment and find out if they are getting any problems with the drugs. PEPFAR is funding this and is very happy with this particular program and I think we want to see many other providers supporting this kind of task shifting. It's not just task-shifting in terms of delivering ARVs, PEPFAR is investing a lot of money in task shifting many other activities because you achieve cost efficiencies in an environment where there is scarcity of trained human resources.

**Amb. Dybul:** In fact we do this all over and we're pushing it as hard as we can. For example we support Paul Farmer's program in Haiti and each country does it differently, our concern is not enough people are doing it, it's the only rational way to do healthcare in these settings. We do it in this country, it's not secondary healthcare, and it actually to some degree has been shown to be more effective because doctors like me are not particularly good at managing the overall needs of a patient whereas a community health worker is. We're trying to push this, we're funding WHO to get national and international guidance so we can get this. What we're coming up against are countries with policies that don't allow this and that's a difficult discussion because we're trying to get countries to move as rapidly towards this task-shifted, pyramidal system because it's the only way we're going to get healthcare out in a rapid and effective way and it's not secondary healthcare, it's extremely effective healthcare and may be even more effective. Our approach is to push it as rapidly as we can, set up credentialing and international guidance and that's why we're supporting WHO to do that but it's going slower than we'd like it to. It's more because some of the countries are more resistant to such change and such practices which is understandable but that's why it's going to take some time to move it.

**Elena McCollim:** I think that was our last question but I just want to thank our distinguished speakers and I want to thank Valerie Elston of the State Department who helped make this event possible, our contacts there; Dr. Linda Robinson of the School of Nursing and my colleagues on the IPJ staff – our Interim Director Dee Aker; Events Assistant Lisa Anderson who helped make this possible definitely by putting all the details together and our other staff and volunteers who are very stalwart. Thank you very much.