

TIME GLOBAL HEALTH SUMMIT
Press Conference on the Pediatric AIDS Corp
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At the TIME Global Health Summit, held in New York Nov. 1-3, TIME magazine convened leaders in medicine, government, business, public policy and the arts to develop actions and solutions to the world's health crises.

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Philip Elmer-Dewitt: Good afternoon. I am not Eileen Naughton. She got tied up. I'm Philip Elmer-Dewitt, and I'm going to stand in for her here. I'm the sciences editor at TIME, and I worked on that issue that you got handed.

Welcome again to the TIME Global Health Summit. We're focusing these next couple of days on focusing people on a bunch of issues and diseases, malaria, AIDS, TB. One of the things we want to focus people's attention on is the shortage of health care professionals in the developing world. The so-called "brain-drain." I should preface this by saying that not every American needs to go to medical school to do something good in Africa or Southeast Asia. But one of the groups we want to point to that's done something successful is the

Pediatric AIDS Corp.

The Pediatrics AIDS Corp. is a unique program that sends pediatricians to regions of the world whose population has been devastated by AIDS and who lacks the health workers and the infrastructure to deal with them. Over the next five years, the program will send 250 doctors to Africa from one to two years to care for children living with AIDS and to train African health workers for the long term. It's a \$32 million program that is jointly funded by Bristol-Myers-Squibb Foundation and Baylor College of Medicine. Approximately, 1.9 million children are infected with HIV, but because there are so few pediatricians and family practitioners, it is estimated that only 1 in 100 African children infected with HIV-AIDS receive treatment of any kind.

Now, I'm going to introduce Dr. Fitzhugh Mullan, who is not part of pediatric AIDS, I don't believe. He's an adjunct professor in the Department of Prevention and Community Health at the George Washington University School of Public Health and Health Services, and a clinical professor of

Pediatrics at the George Washington University School of Medicine and Health Sciences. He's also a clinician and a contributing editor to the *Journal of Health Affairs*.

Dr. Mullan's recent article in the *New England Journal of Medicine*, *The Metrics of Physician Brain Drain*, highlights the exodus of physicians from lower income countries into developed countries and the loss of important health capabilities in lower income countries as a result of this migration, which I can say firsthand, is actually a real serious problem.

Dr. Fitzhugh Mullan: The adage goes that the rich get richer, while the poor get poorer. Now, this is certainly a challenge, as we look at globalization, and this is definitively a challenge as we look at the work force and health in the world today. The brain drain is something that is very much with us. The recent *New England Journal* piece that was referenced contains within it a brief orientation. You will note that the United States is not alone in this study. These are Anglophone countries that are

uniformly well to do.

Their position work forces in the first column are robust, 493 physicians per 100,000 in the United States, and you can read for the others. The percent of international medical graduates that are doctors trained elsewhere in the United States is 25%. One in four physicians in our country is trained elsewhere. The other countries you will note equally, about a quarter of their work forces are borrowed from elsewhere. And in the third column you'll note that the United States, 60 percent of those foreign graduates come from countries that are lower income; U.K. even higher; the other two somewhat less. So substantially, the international workers in this country, physicians, come from poor countries.

Now, if we could look one more at the next slide. If we look particularly at Africa, we looked at the work forces again. That first column represents the physicians per 100,000 in Africa. You recall, the United States was 293,000. We're looking at 293 per 100,000. You're looking at four, five, eight and 10 physicians per 100,000, radically

different.

And if you look in the final column, it shows you roughly the percentage of the physicians trained in that country were working abroad in one of the four Anglophone developed countries, a high of 56 percent in Liberia, on down to the others. So, it's a very substantial part of life in those countries.

What needs to be done about that is a variety of things. First and foremost, countries such as our own need to train something much closer to the number of doctors they need in practice; it's called self-sufficiency. It is a very important theme for public policy and medical education in this country.

In the short time frame, however, we need help, and that means moving physicians, nurses, and others abroad. And what you'll hear about shortly is among the most exciting and creative efforts in this regard. I shared in this through the Medicine Committee several months ago that proposed that we have a global health service in the United States that would mobilize physicians to go abroad. That

idea is being considered in Congress.

Meanwhile, Bristol-Myers-Squibb and the Baylor College of Medicine have taken the bull by the horns, and they're putting doctors abroad as we speak. The Pediatrics AIDS Corp. is significant both for what it's doing to help and as a marker for what others can, should and we hope will do.

Let me now turn the microphone over to Peter Traber, the president of Baylor College of Medicine.

Peter Traber, MD: The Baylor College of Medicine's mission statement includes a commitment to being a leader in community service. We view the community particularly as it relates to medical issues of being a global community. And therefore, we consider our community efforts to be focused on the world and where we can have the most impact.

The Pediatric AIDS Corp. is an outstanding example of choosing a focused area where an organization can have an impact. It's also an example of the strength of collaboration. It represents academia, industry and government working

together to address the public health issue. I think it should be and will be a model for the future.

We're very proud to be part of the Pediatric AIDS Corp. through the work of Baylor International Pediatric AIDS Initiative, which was started by the efforts of a single man, Dr. Mark Kline, who you will hear from in a moment. Dr. Kline is a man of passion, who has done something that is really extraordinarily rare. What he has done is focused on a medical issue and had an impact that can have the possibility of changing a world.

We are very proud to add new members to the Baylor family who are the first individuals in the Pediatric AIDS Corp., and we think that these individuals have those same leadership qualities to help change the world in medicine. They represent characteristics that we've tried to develop in medical communities across this country, and that is pursuing a career in medicine that can make a difference and will represent us extraordinarily well.

Their work will continue to decrease the

number of children internationally who die from AIDS and AIDS related illnesses. This is a worthy effort that we are very pleased to be a part of, along with our partners in this Bristol-Myers-Squibb. And I'd now like to introduce John Damonti, the President of Bristol-Myers-Squibb Foundation.

John Damonti: The statistics are staggering. Of the 2.2 million HIV infected children worldwide, 1.9 million of them live in Sub-Saharan Africa. Yet less than one percent of these children are being treated today. Without treatment the vast majority of children who become HIV positive will die before the age of five. In Africa, a child dies of AIDS every minute of every hour of every day.

Dr. Mullan pointed out; even as many need help—there are far too few to deliver that help. And while Sub-Saharan African bears the greatest burden of the world's AIDS cases, it's home to barely one percent of the world's health care work force. For this reason, at the Bristol-Myers-Squibb Foundation's Secure the Future Program, in partnership with the Baylor College of Medicine,

created the world's first Pediatric AIDS Corp.

Baylor will recruit 250 pediatricians and family practitioners over the next five years to join the Pediatric AIDS Corp. in Botswana, Lesotho, Swaziland, Uganda, Burkina Faso, and Malawi, countries hardest hit by the HIV/AIDS epidemic. But these professionals cannot work in a vacuum. They need the right facilities and the up-to-date health care infrastructure. That's why we've worked with the Baylor College of Medicine and the national government in the region to develop Children's Centers of Excellence, modern facilities devoted exclusively to treating infants and children with AIDS, as well as their families.

Pediatric AIDS Corp. physicians will use these centers not just to treat children, but also to train local health care professionals. The first of these centers and the first in Africa opened its doors in Botswana in 2003. Today, it is one of the largest pediatric AIDS care centers in the world, with more than 1400 children on ARV. Two more centers in Swaziland and Lesotho will begin operations on World AIDS Day of this year; they will

be followed by three others to be located in Burkina Faso, Uganda, and Malawi.

These pediatric centers will serve as the staging areas for the AIDS Corp. to deliver treatment there, but more importantly, to move treatment from these centers into the more isolated and distance areas.

Some \$22 million from the Bristol-Myers-Squibb Foundation and \$10 million from Baylor over the next five years will support the Corp. An additional \$8 million from Bristol-Myers-Squibb will expand the network of pediatric facilities throughout the region. When we first began our \$150 million Secure the Future Program in 1999, which focused on women and children infected and affected by HIV/AIDS in 10 countries in Sub-Saharan Africa, we understood from the outset that medications alone would not solve the crisis. We would have to work to build capacity to create sustainable programs of community support and care, to create new approaches to health care infrastructure in the delivery of treatment. We have tried to do that for more than 200 initiatives, and now our newest commitment to

the Children's Centers of Excellence and, of course, the Pediatric AIDS Corp.

If we want to fully realize the potential benefits of the Pediatrics Corp., take advantage of additional capacity available at the growing network of children's clinics, we need other companies, individuals and academic institutions to join us. We need a coalition of the willing to bring more pediatricians to Africa to treat and to train. Nearly three dozen pediatricians have already signed up for the AIDS Corp. and more are joining every day. Soon the 50 slots will be filled. We should not turn away any qualified doctors. We know that others share our belief that HIV/AIDS doesn't have to be a death sentence for many of Africa's children. We welcome commitments by other companies and organizations to help triple the number of the Corp. in this extremely vital purpose.

And now I'd like to turn the podium over to Dr. Mark Kline, Director of the Baylor International Pediatric AIDS Initiative.

Dr. Mark Kline: Thank you, John, and thank you all

for attending this afternoon. The goal of the Pediatric AIDS Corp., simply stated, is to vastly expand access of African children to life saving antiretroviral medications and care. In far too many places across Africa and around the developing world, children are being denied access to care and treatment that we know can save their lives, treatment that has been available here in the United States since the mid 1990s. The reasons for this lack of access are varied. But one of the most important barriers to treatment of children in the developing world, and in Africa in particular, is the dearth of pediatric professionals experienced in administering the medications and monitoring for side effects of the medications in children.

So the Pediatric AIDS Corp. really is intended, on an interim basis, to place American professionals on the ground in Africa to provide the professional capacity necessary for the rapid scale up of care and treatment programs for HIV infected children. We hope to treat about 80,000 children for HIV over the five years of the program's existence.

In year one, we're treating 50 pediatricians and family practitioners for placement at six sites in Sub-Saharan Africa. As you've heard, so far we've recruited 31 physicians for the program in just over three months. These are very, very high quality people, from the best U.S. medical institutions, individuals who very likely would have gone into private practices and done a number of other things here in the United States, but who are moved to help fight pediatric AIDS in Africa. Over the five years of the program, we hope to recruit up to 250 doctors.

But as large as this program is, we really consider it a pilot. We would love to grow it and compose sole health care teams, not just pediatricians and family practitioners, but also nurses and pharmacists and social workers, and so forth.

The nuts and bolts of the program are as follows: the doctors are paid a living stipend, \$40,00 a year; there's a provision for a housing allowance; and there's a student loan debt repayment provision, because many doctors are completing their

professional training now with enormous student loan debts. We did not want this to be a barrier to sending doctors to Africa. So the doctors for each year of service will receive funds to repay student loans.

The doctors commit to a minimum of one year on the ground in Africa; and we hope that most will stay for two years or three years, or even longer. The first doctors are already on the ground in Africa. The large bolus of doctors who will be placed in Africa will be arriving next summer when they complete their current academic year in June of 2006.

Today, we're very fortunate to have four members of the Pediatric AIDS Corp. with us; and I'd like to just briefly introduce these four individuals to you. On my far left here is Ryan Phelps. Ryan is from the booming metropolis of Denison, Texas, often called the Denison Metroplex, a town of about 20,000 people, near Dallas. And Ryan is a graduate of the University of Texas at Austin, Medical School at Duke University, pediatrics training at the University of California,

San Francisco, and a public health degree from Johns Hopkins University. He will be joining the Corp. in July of next year, and has taken an assignment in Swaziland.

Standing next to Ryan is Dineo[ph] Tahani[ph]. Dineo is a native of suburban Washington, D.C. She grew up in the Washington, D.C. area. She's a graduate of Princeton University, Washington University School of Medicine in St. Louis. She did her pediatrics training at the Children's Hospital of Philadelphia. For the past 10 months, she's been working in Zambia on a newborn resuscitation project. And she started work yesterday with the Baylor College of Medicine. After a short orientation program in Houston, she will be assigned to Lesotho, beginning in just a couple of weeks.

On my far right here is Sarah Kim. Sarah is a graduate of Austin College and the Baylor College of Medicine, where in 2002, she was elected as a Junior to the National Honor Society Alpha Omega Alpha; and in 2003, she was named the top student in pediatrics at the Baylor College of

Medicine. She is completing her pediatrics training at the Children's Hospital of Boston and Harvard Medical School in June of 2006; and in July of next year, she has accepted an assignment to the Pediatric AIDS Corp. for Lesotho.

And then finally, last but not least, Kebe [ph] Jobarte [ph], standing next to Sarah. Kebe was born in Kenya, but grew up here in New York City. He is a graduate of Princeton University, Yale Medical School. He has a public health degree from Harvard. He trained in pediatrics at Columbia University here in the city. He joined the Pediatric AIDS Corp. in July, and since mid-August has been working in Botswana. Ultimately, he will move on to a long-term assignment in Malawi.

With that I'm going to turn over the podium to Kebe and let him make a few remarks. Thank you.

Kebe Jobarte: I'm just going to tell you a story about my time in Botswana. As Mark just said, I arrived in Botswana in mid-August. One of my first experiences there had to do with a little boy that I will name Paul, because I didn't ask him; so I can't

tell you his real name. But it was my first day in the clinic. I walk in. I'm a stranger to everybody. I didn't know any of the children, anybody that worked there.

And one of the patients I saw that day was carried in by a man who I thought was his father. And when I took a look at this young boy, I assumed he was four or five years old. Upon talking to this man, it turns out that it was actually his uncle, and his mother died recently of what sounded like HIV related causes. The father had never been around. And the surprising part was that he was not four or five years old, he was 12; and he was a 12-year old that weighed 12 kilos, which is about 30 pounds.

This boy was very dehydrated and very ill. I admitted him to the hospital, and we watched him very closely and tried to take very good care of him. While he was in the hospital, we started him on antiretroviral treatment. We observed him very closely. He went home, and we followed him in clinic periodically. Just a little while before I came here, I was walking through the clinic, and my

day was starting at 7:30; and the waiting room was steaming with young people and old people and people just waiting to be seen. And every morning in the clinic a song happens. The nurses lead all of the patients and families in prayer, song.

As I'm walking through the waiting room, I feel a little tug on my sleeve, and I hear, "Doctor, Doctor." And I look down—when I first saw this boy, his temples were wasted; he could barely stay awake because he was so sick he couldn't stay awake for more than five minutes, 10 minutes at a time, always falling asleep. And I looked at this little boy, and didn't really recognize him until he said, "Doctor, Doctor, I'm not sick; I'm not sick." That comes from when he was in the hospital, I sat down with him and tried to explain to him that he has a virus, but it doesn't mean he always has to be sick.

And that's part of what we try to do. We try to explain to children that just because they have HIV, doesn't mean they have to live their entire lives ill. And when this little boy told me, "Look, I'm not sick,"—he was still not the healthiest of children—I realized exactly why I'm

doing this, and how lucky I am to be to have had the opportunity to do this work.

As was said, I was born in Kenya, and I grew up between New York City and Gambia, and used to go between the world of have and the world of have-nots on a very regular basis. And I have always known that I want to go back and do this. And the opportunity to make sure that thousands, tens of thousands, hundreds of thousands of little children can say to themselves, say to their families, say to their communities, "I'm not sick," is an incredible opportunity. And I would like to thank all of the people that have made that possible.

Dr. Mark Kline: We'll take questions.

Female Speaker: Dr. Kline, I don't know if you have numbers on reductions in pediatric AIDS in Africa yet. Do you? And if not, can you talk a little bit about what has happened in Romania where you started work?

Dr. Mark Kline: Our longer term data do come from Romania, where we established a clinic and medical program for HIV infected children in 2001. And in the Romanian center, we saw a reduction in the annual death rate for HIV infected children from about 15% to less than one percent over a three-year period, as well as a 90 percent reduction in hospitalizations. This is really very, very striking.

Concomitant with that, we saw the stigmatization of the disease, as hoped returned to the community. There was new emphasis on prevention and on education. It was a transformation that occurred in the community and Romania that was a consequence of making treatment available. We witnessed much the same thing in Botswana, where, as I said, there were 1,400 children now on treatment in our clinic in Botswana.

The short term outcome for the children in Botswana were so good that the government of Botswana established an national antiretroviral program for children across the entire country. This was the first national program for the

treatment of HIV infected children on the African continent.

In Uganda, where we have a clinical program now that is barely 10 months old, we've seen some very interesting early data. We looked at rates of hospitalization and death. For the first quarter of 2005, compared to the second quarter of 2005—to put this in context, this comparison was being done at a time when huge numbers of children were coming into the clinic for the first time. So we were serving a much larger population. So all things being equal, one would anticipate that hospitalizations would actually increase and deaths would actually increase because the denominator was so much larger. But in fact, we've seen a marked reduction in hospitalizations and deaths just between the first quarter and the second quarter in the very front end of our treatment program.

There were 42 deaths between January and March of this year, and 23 deaths between April and June. And so this is very striking. It's something that we will track very closely. But I guess the take home message is that the drugs really are

amazing. The medications, given correctly to children, mean the difference between living and dying. It's as simple as that. And we're not talking about extending the life of a two-year old to age two and a half or three; we're talking about the difference between dying at two years of age and living to be 30 or 40 or 50 years of age.

These are children who will grow up; have an opportunity to go to university; to have families of their own; to live long and full lives, if we do the job correctly today.

Frederick: My name is Frederick, and I'm with the AIDS Institute [Inaudible]. And I also recognize the work that Baylor is doing and Bristol-Myers-Squibb, as a public and a private organization moving forward. When Senator Frisk had talked about putting a Global Peace Corp. together—and evidently, you guys forged ahead of them in that—are you expecting more money from Congress to lift that up a little bit? And as far as the Pediatric AIDS Corp., is it also going to have continuum care for other diseases in your clinic? Will they treat malaria,

TB, and the Pediatric AIDS Corp. is kind of a highlight to get treatment to children?

Dr. Mark Kline: We very much would like to see this grow into a full fledged public/private partnership. And we would love to be in partnership with PEPFAR and with other U.S. government programs to scale this program up. As I said previously, as large as it is, it's only a pilot program. We need to expand it dramatically, not just with doctors, but nurses and social workers and other classes of professionals.

In answer to your second question, yes, we provide both primary care and HIV specialty care. And in all of the clinics, we provide family base care. So the child is the point of entry into our system, but we offer testing and care and treatment to every HIV infected family member.

In most settings across Africa, adults are being treated for HIV and their children are being therapeutically abandoned. Because of the nature of these centers, the potential exists for us to treat the children and therapeutically abandon the adults.

But we haven't provided much of a service to these children if we leave them AIDS orphans.

And so we are attempting to treat the child and all infected family members in one setting to ease the burden of disease, help demystify the treatment of the disease for both the adults and the children. In Botswana, at least, this has been very, very effective and very well received by the family. Thank you.

Male Speaker: Let me just make one comment about the fundraising piece. The Pediatric AIDS Program is currently funded through a grant from Bristol-Myers-Squibb, of \$22 million, and a \$10 million commitment from the Baylor College of medicine. We have to go out and raise that \$10 million to have a total of \$32 million. We see this as a beginning of a larger fundraising effort that will go both through corporations, BMF and private foundations, and individuals through the college in order to raise additional money for a bigger effort.

Christy(sp) Hause(sp): I'm Christy Hause from New

World Outlook Magazine. I have two questions. One is, are the doctors that are being recruited only young doctors, just out of medical school, or are there older practicing doctors also being recruited? And the second one is, in the Botswana clinic, are there also Botswana doctors that are being trained and learning to do this for their country?

Male Speaker: I'm so happy you asked the second question, because I neglected to mention that a very important aspect of this program is not just the care and treatment of the HIV infected children, but local capacity building. So, yes, we are doing what we can to recruit and retain local professionals.

If we were to try to staff these clinics with local professionals today who had experienced in the care of HIV infected children, we would not be able to do so. Those professionals simply do not exist. But we have to build that capacity. And a very important role of the Pediatric AIDS Corp. is to help build that local capacity. So, yes, that is happening.

In answer to your first question, no, we

are not just recruiting young doctors. The fact of the matter is that most of the applicants have been young doctors who are either fresh out of pediatrics training or out of Fellowships in Infectious Diseases. But we do have some mid-career and even more senior pediatricians who have applied to the Corp, and we are considering all of those applications on an equal basis.

We anticipated from the beginning that most of the people who would be interested in this very likely would be fresh out of training or recently out of training, without huge home mortgages, and Porsche's and so forth to pay for, and without families to move to Africa. Although, quite a number of the AIDS Corp. participants are married, and are moving to Africa with their partners, and a number of them also have children.

Male Speaker: Comment on the last two questions about the potential federal involvement or government involvement in this. At the request of PEPFAR, the president of Emergency Fund for AIDS Relief, the Institute of Medicine said about looking

at what it would take to mobilize many more Americans to go abroad to combat AIDS. And a long study down to just a few words, volunteerism was talked about a great deal. And the spirit of volunteerism is very important. But when you're talking about health professionals, you're talking about people who almost definitionally, are mid-career, that is, at least they're mid-life. They have been in school long enough, and they have accumulated enough debt, that they have families; they have commitments; and they have mortgages; and we call that, generically, the mortgage factor. So if people were going to be encouraged and enticed to move abroad, you needed to deal realistically with what the needs of 28 and 32 and 38 year olds would be with that kind of background.

The committee felt very strongly that a national program in which the government played an important role was at the center of it, but that it should encourage volunteerism and collaboration of all sorts. One of the questions that came up is, if you mounted a program like this, would there be a response from the medical community? And one of the

very exciting things about the Bristol-Myers-Squibb/Baylor Program is that it has demonstrated in one part of the medical community, the pediatric community, that the well head of good intent and preparedness to put lives and careers on the line is there.

So in terms of the folks in Congress, Senator Frisk and others who are deliberating this, I think the message should come forth from this experience that there is a very substantial set of the best of what we have to offer coming out of our education system of marvelously trained, young clinicians who are ready to hit the road, but they need a little help, a little loan repayment, modest salaries, and they're ready to go on the road. I think it's very encouraging in that regard, but we need to keep pushing our Congress to help us along.

Female Speaker: We have a question from the line of Lisa Windman(sp), the *World Policy Journal*. Please go ahead.

Lisa Windman: Thank you very much for bringing this

press conference today. It's quite informative. I had a question about how the doctors might interact with Cuban counterparts, because it's my understanding that Cuba has more doctors abroad, particularly in Africa, working in developing health care resources in those countries, than the entire U.N. system. So I'm curious as to whether the Cuban example has been looked at all in the formation of the group, and also whether it's anticipated that there might be some working collaborations with Cuban counterparts?

Male Speaker: Thanks very much for the question. We do interface with Cuban physicians in several of the settings in which we work, particularly in Botswana and in Lesotho. But we interact, as well, with ex-patriot physicians from many other countries. And the situation with the Cuban physicians is the same really for the local physicians, and that is that they're very few of them who have any special training in pediatrics, or familiarity with the care and treatment of children.

So we have had Cuban physicians

participating in a number of our training programs. We will continue to do so. But the interactions, I would say, have been more on a one-to-one basis and an informal basis than they have any formal collaboration with the Cuban medical community.

Male Speaker: [Inaudible] I have a question [Inaudible].

Male Speaker: So the question is, what percentage of the dollar is spent on student loans?

Male Speaker: The student loan debt repayment provision is as follows: the doctors are eligible for repayment of student loans at a rate of 40 percent of their outstanding student loan debt per year of service, to a maximum of \$40,000 per year. So if a doctor had \$100,000 in student loan debt, he or she would receive \$40,000 in the first year, \$40,000 in the second year, and then the program would pay off their student loan debt in the third year.

Now, there are some doctors out there who

don't have student loan debt, so we wrestled with how to deal with that. Would we pay a higher salary to those particular doctors. And we ultimately decided that that would not be appropriate. We did not feel that repayment of student loan debt should be the draw, or the living stipend should be the draw to the program. We believe that it's not. We believe that these are people who are genuinely motivated to do something very meaningful with their lives, and to impact, to help with huge numbers of huge children. And so everyone draws the same salary, regardless of how much student loan debt repayment was provided.

Male Speaker: Thank you very much.

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