

TIME Global Health Summit
Welcome
November 1, 2005
5:00 p.m. EST

TIME Magazine Managing Editor Jim Kelly and President Eileen Naughton set the stage and offer TIME's vision for the event and its potential to serve as a tipping point that will make a difference—not only in terms of awareness, but in terms of positive actions to be taken by governments, citizens, civic leaders, religious leaders, corporations and universities. PBS will introduce its groundbreaking series *Rx For Survival*TM

Speakers:

James Kelly, Managing Editor, TIME

Eileen Naughton, President, TIME

Paula S. Apsell, Senior Executive Producer, NOVA, WGBH Education Foundation

A special performance by the Agape Children's Choir.

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.

More information, including archived Web casts of sessions, transcripts and downloadable photos, available online at www.time.com/globalhealth.

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OPERATOR: Ladies and gentlemen, please welcome the president of TIME, Eileen Naughton.

EILEEN NAUGHTON, PRESIDENT, TIME: Good evening. Welcome to New York and welcome to the Time Global Health Summit. My colleagues tonight have high hopes for these next few days. We want to inspire, we want to inform, we want to seize hold of this moment, in fact, seize hold of this week when because of the spotlight of that TIME, CBS, ABC News, CNN and other news media are shining on this issue, hundreds of millions of people possible billions will pay attention to global health this week.

TIME's special issue on global health will be read by nearly 30 million people in more than 200 countries around the world. Our intent is pretty straightforward -- to use TIME's editorial platform and its authority to increase awareness, move political will forward and make global health an urgent priority for all Americans and for all citizens of the world.

Now we quite consciously coordinated the timing of this special issue and summit with the broadcast premiere of "Rx for Survival: A Global Health Challenge". The remarkable six-part series produced by the WGBH NOVA science unit, part of CBS and Vulcan productions. It premieres this evening and after dinner you are invited to stay and watch the first hour here in this theater along with its producers, Paula Apsell, Richard Hutton, Larry Klein and Lisa Herowitz (ph), who will take some questions.

We also quite consciously invited the working press to cover what is said and committed to here this week. Our broadcast partners CNN and ABC news will carry stories and images from summit and we've issued press credentials to 107 journalists so that the stories of ingenuity, determination, grit and hope can be amplified by the world's news media.

So why are we all here? Why are you here? I'm here because I believe that it is within our power to intervene, to live up to the promise of modern life and to radically alter the near term and long term outcomes for more than half the world where disease and poverty sap the quality of life and present a daily threat to mere survival for billions of people.

We're here because globalization has carried far away illnesses to our developed doorsteps, like HIV, SARS and H5N1 avian flu virus. We cannot remain complacent about the health conditions in the rest of the world because frankly, in our high speed, interconnected world, we're all affected in one way or another.

So whether your action is born of compassion or enlightened self interest, I hope you are here to take action. Now in these next two days, I expect a few sparks will fly. You'll hear from or sit next to political leaders, health care workers, scientists, advocates, business leaders, philanthropists, religious leaders, journalists, students and artists. There are more than 600 attendees, many, many more than we expected to attend from South Africa, Bangladesh, Belgium, Botswana, Cambodia, Canada, China, Congo, Germany, Ghana, Great Britain, India, Ireland, Kenya, Mozambique, Nepal, the Netherlands, Nigeria, Rwanda, Switzerland, Tanzania, Thailand, Uganda, the United States and Zambia.

These come from near and far. I'd like to thank you for making the effort to be here. I can promise that these next few days will not be your standard fare public policy debate. It should feel different - a bit like sitting down with an issue of "TIME" perhaps, engaging, provocative, compelling.

We'll confront the pernicious spread of illness and the ability of government's to cope or not with urgent issues and global health. We'll be encouraged by stories of medicine trumping disease and discouraged by how few of the world's population has access to basic medical treatment.

We'll be touched by stories of personal courage, heroism and hope. As, for example, the story of children of Agape. The children of Agape are orphans from Clazgununatel (ph), South Africa, an area of Sub Sahara Africa with one of the highest rates of HIV prevalence in the world. More than 44 percent of adults are in infected. And as you might expect, this is, too, a region plagued by death, ((inaudible)) and extreme poverty.

These children, the children of Agate, were blessed with amazing voices and through a number of improbable twists and turns, they came to the attention of Alicia Keys, the Grammy award winning musician. Alicia brought them to the United States last year, where for a few weeks, they experienced the wonder of the developed world. They returned to Africa, and sadly, in January, their orphanage, called Agate, which in Zulu means "unconditional love", their orphanage burned down.

They for awhile lived in a cargo container with other children from the orphanage. They now live in a church while funds are being raised to build a new orphanage. Now it may be difficult to believe, but the Agate orphans are the lucky few. Their music has allowed them an escape, however brief, from the harshness of their conditions. They are being cared for and hopefully, with funding, will have a new orphanage to return to sometime in the next year. Their voices are being heard.

These 10 children, ages eight through 16 are here with us tonight to offer a poignant moment of musical relief to remind us of the more than 12 million AIDS orphans in Africa whose voices are not being heard and to touch our hearts. Ladies and gentlemen, please welcome the Agate Children's Choir.

(AGATE CHILDREN'S CHOIR SINGING)

EILEEN NORTON: The Agate Children's Choir - the are global ambassadors to keep a child alive, a charity dedicated to providing treatment and care to AIDS orphans and families suffering from AIDS in Sub Saharan Africa. The children will be with us for another few days. They are actually performing in this room Thursday night at a concert that has been produced by Alicia Keys. If you hadn't heard from me in that email inviting you to join us, there are still tickets available to a concert that Alicia Keys will have here. It will be quite unplugged, quite a blow out. Usher Common, Paul Simon, a taped duet with Bono and the orphans.

Now it's my great pleasure to introduce my colleague and the managing editor of TIME Jim Kelly.

JIM KELLY, MANAGING EDITOR, TIME MAGAZINE: Thank you very much, Eileen. As the editor of TIME, I know the magazine must report and analyze the big, glaring headlines of every week. But an equally important part of TIME's mandate is to cover those stories that are not in the headlines every day, but nonetheless shape out destiny.

That's why we keep casting out spotlights on problems that transcend national borders, whether it be poverty, disease, genocide or global warming. In the past few years we have done cover stories on AIDS in Africa, on the danger of global warming, on genocide in the Sudan and on the work of Dr. Jeffrey Sachs. We want our 30 million readers around the world to know why these problems are interconnected, to understand that global warming helps spread malaria as mosquitoes migrate to newly temperate zones, how civil war makes it immeasurably more difficult to deal with curbing disease and how poverty begets illness and illness begets poverty.

This week, however, we have a very specific mission and that is how to get Americans to care about the health the Third World. We devote 34 pages to this topic in this week's issue and as you can see, we are fortunate to have the photojournalism of James Macway (ph) to help us in that mission. Jim spent several months traveling around the world to document the caregivers of those afflicted by diseases like AIDS, malaria and TB.

Aside from the portfolio in the magazine, you can see his photos displayed in the hallways outside and for those participants in this week's conference, we have a special issue of the magazine with its own cover to commemorate the conference.

Jim, are you here in the audience? I thought you would stand if you are. Do you mind standing? James Macway (ph). You know I was going to do that. TIME was also fortunate to have Phillip Amorduate (ph) as its sciences editor and dozens other of other journalists in New York and from around the work who worked on this week's issue. I think Phil said it best after he returned from Rwanda where he reported on Dr. Paul Farmer and his effort to build a public health system there. Quote, "After three days," Phil said, "I was ready to quit my day job and apply to medical school." Phil, are you here in the audience. Would you mind standing for a round of applause? Phil didn't know I was going to do that, either.

Journalists are not supposed to be affected by the news. We're supposed to be hard-nosed and skeptical about the world around us. But I dare any journalist to see what Phil did and what Jim did and not be affected. And in covering the global health crisis, journalists can still be hard-nosed and skeptical. They can be hard-nosed, for example, about the terrible toll these diseases are taking and we can be skeptical when say the problems are insurmountable or that there is only one to combat a disease.

And now I would like to introduce Paul Affel (ph). Paul is the senior executive producer of NOVA and the director of the WGBA science unit. She joined NOVE in 1975 and became executive producer in 1984, guiding the series in today's highly competitive multimedia environment. Paula has also seen the production of many award winning WGBA science unit specials and she is executive in charge of NOVA's large format film unit. NOVA has seen the production of such shows as Shackleton's Antarctic Adventure and special effects.

NOVA has won every major broadcasting award, including the Emmy's, the Peabody, the AAS Westinghouse Science ((inaudible)) award and the Alfred I. Dupont Columbia University Gold Paton. If I

could go off script just for 10 seconds here and I watched all six episodes just the other day and it's an absolutely terrific series. Each episode stands on its own as a model of story telling and dramatic narrative. It really is a first rate job.

Anyway, Paula has touch has brought science and knowledge into countless lives. Ladies and gentlemen, Paula Apsell.

PAULA APSELL: Thanks very much, Jim. I'm delighted to be here today to introduce you to the Rx for Survival Project and to join you all at this conference as we focus on what is perhaps the most critical issue facing us this century.

Global health is a subject that doesn't appear very often in the television landscape. There is plenty of survivor, but not much about what it takes for people around the world to actually survive with health as the most important requirement. We, at WGBH NOVA Science Unit have wanted to produce a major series on global health for some time. My first NOVA production ever was called "Death of a Disease" and it celebrated one of the 20th century's capstone achievement's - the eradication of smallpox.

For my money, there is no field of human endeavor that draws more on the benefits of science and technology for human advancement or has more fascinating and dedicated heroes who I congratulate the time global health heroes who are here today. Theirs are the kind of stories we try to tell in Rx For Survival. Our six part series, which premieres tonight on PBS, filmed in 20 countries, the television series blends dramatic vignettes of historic public health breakthroughs with contemporary documentary story.

We are delighted to be working together with our host TIME Magazine and also with National Public Radio and Penguin Books, publisher of Phillip Hales (ph) companion book Rx for Survival.

We hope viewers will see that while global health presents daunting challenges, there are many powerful solutions within reach. But there remains an enormous gap between what we know and what we actually do to improve the health of people around the world.

My grandmother always used to say, "If you have your health, you have everything". She lived to be 95, so I guess she knew what she was talking about. You don't need to be an economist to know that good health is a prerequisite for prosperity. As a child growing up in Marblehead, Massachusetts, I was a polio pioneer, one of the original recipients of what was then the experimental Salk polio vaccine. I remember clearly how worried our parents were about polio and can still see that line of little children trying to be brave as we waited to get our shots.

In the short term our bravery was awarded by a Tootsie Pop. But in the long term, by never having to worry about polio again for ourselves or for our children. Of course polio vaccine is now administered orally. When we began our series, we hoped that we would tell the story of the worldwide eradication of polio. My goal is still elusive, so the finish line is in sight. Our series begins tonight with the story of how 165 million children in India were vaccinated in a single week.

Rx for Survival is co-produced by the WGBH NOVA science unit and Vulcan Productions and I'd like to recognize my colleague at Vulcan, Richard Hutton. Richard, stand up or wave or something, who contributed enormously to moving this project forward and ensuring its quality. And I'd also like to acknowledge executive producer, Larry Klein. Larry, stand up. I can't see where anyone is, senior producer Lisa Merowitz (ph), and a team of producers whose vision for the series and passion for the subject are reflected in every program.

The idea for a public television series on global health came originally from Paul Allen and I'd like to thank him and Jody Patton from Vulcan Productions for the enormous energy and support they've put behind this effort. And I'd also like to thank our funders, the Bill and Melinda Gates Foundation and the Merck Company Foundation, who had the foresight to imagine what such an ambitious project could accomplish.

When we embarked on Rx for Survival, it was our goal not just to make a television series or even a media event, but to bring the issue of global health to local communities across America. To support this campaign called Rx for Child Survival, we have coalitions at 21 PBS stations around the country and we're partnering with CARE, Save the Children, The Global Health Council and UNICEF.

Last night, 6 million Halloween trick-or-treaters carried UNICEF coin boxes to help children and promote Rx for Child Survival.

We hope to create excitement around global health, but we don't want just a media moment. We want to build something lasting. So we've developed a Web site with materials for high school teachers and students. Our education partner, the Johns Hopkins Bloomberg School of Public Health is creating an undergraduate global health course that will be provided free for to any college or university around the world. And to encourage more global health reporting, we've written a 200 page newsroom guide for journalists and editors.

Now that you've heard about many of the moving parts of this project, somehow managed by Ann Zizer (ph), it's time for a sneak preview of this center piece, the television series, Rx for Survival. The narrator you'll hear is Brad Pitt. Of course only on PBS would we give you his voice and not his face, but I think you'll find it does the job. Let's take a look at the clip.

(VIDEO CLIP)

?: All right. We're going to see the first hour for those who are interested. We are now going to hear from three guests to tell us why in the face of all these depressing statistics we can and should be optimistic about making a difference. Our first speaker is Dr. Paul Farmer, who is a mentioned earlier Phil profiled in this issue. Dr. Farmer's first big achievement was building a showcase public health system in Haiti that delivers medical care to about one-sixth of the population. That success led the (INAUDIBLE) Foundation and the Rwanda to ask Dr. Farmer to do for this East African country still devastated by the genocide of 10 years ago to do for that country what it did for Haiti.

Ladies and gentlemen, Dr. Paul Farmer.

DR. PAUL FARMER: Thank you. I'm seldom invited to be the upbeat speaker at conferences of this sort or any sort for that matter. But when I was asked to address the case for optimism in the struggle to improve the health of the world's poor, I couldn't in good conscious refuse.

I think there are reasons for hope and would like to start by looking back to the year 2000, which is really not too long ago and 2000 and 2001, if we were meeting in New York to discuss these same topics, we would be arguing. And the argument would have been about whether or not its even worth bothering trying to treat AIDS, for example, among poor people in places like Haiti or much of Africa.

The drugs alone then cost thousands of dollars per patients per year. At the time were was no such thing as a global fund to fight AIDS, tuberculosis and malaria and PETFAR, the U.S. AIDS initiative was not even a twinkle in the president's eye, and yet the largest charitable foundation had just declared that it would focus its vast resources on the health problems on world's poor.

You can imagine the concernation (ph) of the world's libraries and elite universities on that day. Even this remarkable development, however, did not put an end to the defeatism that has marked public health, and people like me and there are lots of people working on the front lines as you can see from the clip, the PBS special.

We were already very sick and tired of these arguments. To ask doctors, nurses, and other providers to give up on treating the sick because they're too poor to pay was never ever acceptable to my co-workers in the field. Now it's December 2005. The Gates Foundation performed CPR on international health and the patient lived. The global fund, PETFAR, some new vigor at the World Health Organization, the Pan American Health Organization helped move the patient out of the ICU and we're still arguing, it's true, but

we're not arguing about the same things. Instead of arguing about whether or not to treat the poor who suffer from AIDS, drug resistant tuberculosis, drug resistant malaria, we're arguing about what drugs should be used to treat these diseases.

As far as AIDS treatment prices go, the drug prices have fallen rapidly from an average wholesale price in 2001 of \$10,000 per patient per year for the best prices as low as \$130 per patient per year and I'd much prefer to argue about generics versus branded drugs than to ask if some lives are worth more than others. I'd rather argue about the best diagnose and treat and prevent and not spend so much time arguing whether or not we should we should bother introducing modern medicine and public health to regions that have never known them.

Anyone who thinks these are not better, more interesting, more valuable discussions than the old ones does not have to face on a regular basis the destitute sick. We've come a long way, I think, in the last few years. But not far enough, of course. When we finally receive orders from on high to roll out proper treatment plans for difficult to treat diseases, this is a good thing. But policymakers need to understand that changing the mantra from "no you can't do this", to "OK, do the right thing now" is not followed quickly by a magic sort of improvement in public health.

It's not possible to reverse of neglect in the space of a few years by fiat and the result of these past few decades of neglect are not equivalent to those that preceded them. They are worse. For one thing, and here's more optimism, many tools that we need to prevent or treat the diseases of poverty are in existence if not readily in hand and when we're told not to use them on the grounds of their unsustainability or lack of demonstrated cost effectiveness, in precisely those places in which such tools are needed most, we have a far higher stakes argument than arguing over, for example, equal access to leeches.

Here's another example. In Haiti, where we worked for two decades, we wrote again in 2001 a program to integrate our AIDS prevention and care program into a robust effort to introduce primary health care services across all of central Haiti. Two long years later, we received the money to do so and this work is going very well. Our Haitian team has worked with the public health authorities to use what we call the new AIDS funding to reopen and revitalize seven facilities serving again almost all of central Haiti. These are all public health facilities.

But we're not going to meet our goals. Usually when implementers like me say that we're not going to meet our goals, this is a bad thing. But I'm delighted to tell you that we won't meet our enrollment objectives in this project because the AIDS epidemic in Haiti is actually shrinking.

Now people who love debating will debate for years to come why this is so, but I will tell you what I think. I think that when you integrate prevention and care of HIV and link that with public health service, you get success. You can shrink an epidemic even under a difficult circumstances.

So no matter what you measure - AIDS mortality, number of new infections prevented, number of patients received for the first time, anything reasonably called public health care, you can declare success.

Now some things are harder to measure. One of the organizer of the events here, a science editor for TIME was in Rwanda with us and suggested I show you a couple of images. So I am going to ask to have a slide if I could. Now is Joseph, who is dying of both AIDS and tuberculosis. He is about 26 years old. He wasn't really sure of his age. He was lucky enough to end up in one of our global fund expansion sites in Haiti and after a few months of treatment for both of these diseases, he looked like a changed man. Next slide. But in truth, he was merely Joseph again. A year or so later, he really was a changed man, because he became involved in AIDS prevention activities and again, I said some things are difficult to measure and I'd invite all of us gathered here today to just to imagine the impact of many transformations like this on communities, on families, but also on the providers, those of who take care of patients. When we furnish them, the them here, the Haitian provider, Haitian doctors and nurses, when we furnish them with the tools that they need, they can fight back.

That said, there exists only a couple of programs in Haiti, large programs that serve the Joseph, then we need more and of course when we gather in meetings like this, we're looking for large scale scalable, to use the jargon, programs that can serve the tens of millions of people in need.

But there's cause for optimism on that score, too. We can meet these and even more ambitious goals, but the way to move forward is probably take on some of the myths and mystifications of the day and I just want to mention a couple of the doozies.

Myth one - and I hear this a lot. Undue focus on AIDS is weakening the struggle against other killers of the poor. Now this will only be true if we design silly AIDS programs. The fight against AIDS should be indissociable from the fight against tuberculosis, for women's health and primary health care, including vaccination campaigns for primary education and ensure the struggle against for poverty reduction.

Doing a good job in AIDS prevention and care we've discovered in Haiti and Rwanda leads to a marked improvement or can lead to a marked improvement in primary health care.

Unlike many NGOs or faith based organization, we actually work with the public sector, because we believe that the public sector is the guarantor of the right of the rights of the people living in poverty. But just to give you an idea of how bitter this struggle gets, last month the Financial Times, citing, of course, public health experts had the following headlines and I quote, "Focus on African AIDS, TB, Malaria Epidemic Diverting Resources from Neglected Diseases Study Says". I love the way the headlines always go like that. Study says.

So focus on AIDS, TB, Malaria epidemic diverting resources from neglected diseases. But if you replace the words "African AIDS, TB, Malaria" with anything else, just try it, like "military expenditures" or "video games" or "pet food", just about everything diverts resources from the neglected diseases of poverty. So now that we finally have some resources for the big three epidemics, the last thing we need to is say that this diverting resources from others.

There are lots of other myths like this and an equally embarrassing one is the one regarding the relative importance of basic science research and interventions designed to bring the fruits of such research to those in greatest need. Make no mistake, this is a silly argument. The tools of modern medicine come mostly from the lab, but we still need an effortor arm and we still need an effector arm to deliver, to use these tools equitably. So we need a malaria vaccine, a safe insecticide, bed nets, combination therapy, that is effective treatment, some of that means transfusions, blood transfusions. These can't be either/or arguments, if we're to move forward.

Another example is preventing the transmission of HIV from mother to child. If this planned and executed sensibly it will, of course, improve or should improve women's health. We've tried to use the new AIDS funding, as we've called it, from the global funding and later from PETFAR to advance these agenda in Haiti and are doing the same with our colleague in Rwanda.

This clock is not telling me how I am doing, actually, it just says zero, zero, zero, but I know that I will be caned off here if I go over.

Another myth is we lack the infrastructure to treat AIDS and other complex diseases. This is not untrue, but misconceived. We can build, or rebuild infrastructure, health infrastructure as we roll our services and we need to do so but the first step that we can take is by capitalizing on the abundant human resources available in places for example like Haiti and Rwanda, two places I know. In our program, every patient has, as Joseph does an outreach worker or an companiato (ph), a neighbor who brings him his medication every day.

Now some people thing we're training outreach workers because they're all we've got. But this is not true. It is true that when we first went to Rwanda earlier this year, there were no physicians in the entire district to which we had assigned by the Rwandan government, but we'd do it this way, even if there were plenty of doctors and nurses around. Treatments that are supervised and community based is simply care for chronic

diseases. This model of care of tuberculosis experts can tell you is the first line of defense against resistance, acquired resistance to many antibiotics and its probably even a good treatment model for malaria, too.

Training outreach workers is step one in a process that can lead to improved care infrastructure as long as we devote adequate resources to stocking and staffing clinics and hospitals (AUDIO GAP) asking cash strapped countries to further gut social services in the name of something called mysterious to me physical austerity.

This approach does not work in setting desperately need of both personnel and infrastructure and greater investments in public health. The infamous brain drain will be slow or be reversed if we provide our African colleagues, for example, with the tools they need to do their jobs properly and pay them a living wage. And a living wage is surely more important for community outreach workers who themselves within poverty than it is for physicians and nurses.

Astoundingly enough, many health care programs have been encouraged to refrain their community health workers. First time I heard this I couldn't believe it. Volunteering sounds OK, perhaps until you ask how can people who themselves live in poverty be expected to work for free when people like me are offered handsome stipends at every turn for consulting. It's not always true that there's not enough money out there. Am I being optimistic by the way? Some Americans would be surprised, I suspect, to learn where the money goes. One commentary in the papers last month cited two foreign affairs specialists who in a study of U.S. foreign aid spending written for Congress said that at least 60 percent of U.S. funding never leaves the United States, but instead is spent on office overheads, travel, procurement of American made cars, computers as well as salary as well as benefit packages.

While we're on this painful topic the idea that corruption is endemic in Africa and that this is a good reason to freeze health programs is another canard. Corruption occurs everywhere as we've

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