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"CENTER FOR PUBLIC HUMANITIES"

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"Advancing Global Health: Opportunities and Challenges"
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Ladies and gentlemen, faculty, staff, and students. It is my great honor to join you this evening to speak at your Annual Spring Humanities Symposium. I would like to thank my former student, Dean Joseph Huffman, and his colleague, and my long-time friend, Professor Dean Curry for inviting me to give the keynote address today. I remember fondly speaking here many years ago.

I also remember Ted and Kathy Prescott from years gone by. In the mid-1980s, Kathy painted a portrait of our two children – a little boy and a little girl – which still hangs in our home, and reminds me often of my friends at Messiah College. The little boy, by the way, is a gifted wrestler and youth ministries major, and the little girl is now getting her Ph.D. from Georgetown, and is fluent in Arabic. I was just with her in Cairo.

Messiah College, I well know, has a rich history of liberal arts, service-learning, and study abroad. I have long admired Messiah College and count among my friends several associated with the school. Moreover, to see a former and very fine student, Joseph Huffman as Academic Dean of the School of the Humanities, is particularly gratifying for me.

For all of these reasons, I am particularly delighted to have the opportunity tonight to talk to you about the opportunities and challenges of advancing global health. Let me say at the outset, that what I will present to you over the next few minutes may feel a bit like being subjected to an exploding fire hydrant. There is much to cover, to at least touch on, so buckle your seat belts and hang on. And please jot down questions for the Question and Answer period following my remarks. I look forward to that interchange.

Health status is the single greatest indicator of poverty. Good health lies at the base of stable workforces and productive economies. Good health is also essential for democracy to thrive, since no democracy will be supported or can even be considered successful if it does not invest in its people.

But first we need some context for discussion of international development and global health.

The dramatic events of September 11, 2001, were tragic and pivotal for the United States. Since that extraordinary day five years ago, the U.S. has embarked on a series of reforms that has completely altered the landscape of traditional U.S. foreign policy. Today, international development has emerged as one of the cornerstones of our foreign policy, taking an important place alongside diplomacy and defense. Now called the "Three Ds," the combined priorities of development, diplomacy, and defense are the foundation of the post 9/11 National Security Strategy.

The new Strategy mandates that helping the world's poor is a strategic priority as well as a moral imperative. In short, success will never be achieved or ensured by focusing on defense or diplomacy alone; development is an indispensable requirement. The Strategy states that to ensure the best stewardship of foreign assistance, the United States will:

- Encourage and reward government and economic reform, both bilaterally and multilaterally;
- Engage the private sector to help solve development problems;
- Promote graduation from economic aid dependency with the ultimate goal of ending assistance;
- Build trade capacity to enable the poorest countries to enter into the global trade system; and most importantly;
- Empower local leaders to take responsibility for their country's development.

True transformational development requires far-reaching, fundamental changes in governance and institutions, as well as human capacity and a solid economic structure, so that countries can escape poverty and sustain economic and social progress without permanently depending on foreign aid. To make a real difference, the resources, of the U.S. must be focused on transformational initiatives that are owned by the developing nations themselves. Therefore, U.S. foreign assistance now centers resources around five overarching objectives:

peace and security, governance and democratic participation, investing in people, economic growth, and humanitarian assistance.

This is not merely rhetoric. U.S. foreign assistance is real and is creating positive change. Today, the United States is the single largest provider of foreign assistance in the world. Under the leadership of President George W. Bush, the U.S. has dramatically increased Official Development Assistance at a faster rate than at any time since the Marshall Plan following World War II. In fact, total Official Development Assistance provided by the U.S. for 2005 reached $28.5 billion, almost three times as much as it was in 2001. It should be understood that this is NOT military assistance. The U.S. is also the world's single largest contributor to the United Nations and to the multilateral development banks. In 2005, U.S. donations to multilateral organizations including the UN, World Bank and other multilateral development banks, totaled $2.2 billion.

Indeed, what is perhaps most fascinating about the American involvement in foreign assistance is that most of it does not even occur through the government. I am aware of no country that spawns so much private philanthropy which contributes to international development through NGOS, educational associations, corporate donations, and faith-based organizations. If you add to this the millions of dollars in remittances which are sent around the world to the total of private and public giving to deal with global development issues, the combined figure is truly

remarkable, and far more than is captured in the Official Development Assistance numbers, which are so often cited.

The United States sees helping the world's poor as a moral imperative. At the United States Agency for International Development (USAID), our philosophy is that improved health for the world's poorest people is not only a moral imperative but also as a pragmatic investment in U.S. funding for peace, security, and worldwide economic growth. Today's foreign assistance workers must build human capacity in addition to physical infrastructure. The experience of the past four decades suggests that these development workers have done amazingly well. Efforts in public health have resulted in eradication of diseases like smallpox, a marked decline in infant and child mortality, a narrowing the of the gap between desired and actual family size, and an increase in life expectancy in many countries that almost matches the rates of developed countries. This is particularly true in Asia and Latin America.

One of my favorite themes is to point out that health ought not to be viewed as simply an "add-on," if you happen to have any funding left over. On the contrary, health ought to be viewed as strategically important to the success of virtually every other part of a development portfolio, including democracy and economic growth. U.S. success in advancing global health in the coming years will build sustainable communities for the world's future generations by providing

economic prospects, strengthening democracies, promoting peace, and alleviating human suffering.

For instance, consider the President's Emergency Plan for AIDS Relief (PEPFAR), a $15 billion initiative to treat 2 million people, prevent 7 million new infections, and care for 10 million people. The United States is recognized as the global leader in the fight against HIV/AIDS. The sheer magnitude of resources the U.S. has committed to fighting this single disease is unprecedented, and beyond that of any other nation.

Currently, USAID is fortunate to have at its helm the first U.S. Global AIDS Coordinator, who is now serving concurrently as Director of U.S. Foreign Assistance and as Administrator of USAID. Ambassador Randall Tobias has said that he believes the early success of the Emergency Plan is due to its overall strategic framework, which reflects the new transformational nature of U.S. foreign assistance. Some of the recent results of PEPFAR support this fact:

- As of September 30, 2006, PEPFAR supported life-saving antiretroviral treatment for approximately 822,000 men, women, and children;
- PEPFAR programs prevented an estimated 101,500 infant HIV infections;
- Cared for nearly 4.5 million people, including care for more than 2 million orphans and vulnerable children; and
- Provided 18.7 million counseling and testing sessions for men, women and children.

The Emergency Plan's high-impact, strategic approach to comprehensive HIV/AIDS prevention, care, and treatment serves as a basis for alleviating the suffering of those infected and affected by HIV/AIDS. The Emergency Plan is central to U.S. efforts to "connect the dots" of international development. PEPFAR programs are increasingly linked to other important programs -- including those of the U.S. Government agencies and other international partners – that meet the needs of people infected or affected with HIV/AIDS in areas such as clean water, nutrition, education, and gender.

In similar fashion to the Emergency Plan, the President's Malaria Initiative is also an essential component of U.S. foreign assistance and our country's transformational diplomacy agenda. Malaria, a largely preventable and treatable disease, is the number one killer of children in Africa. Each year, more than a million people die of malaria -- the overwhelming majority of whom are children under the age of five.

Roughly 18 months ago, President Bush announced an historic, $1.2 billion, five-year initiative designed to control malaria in 15 countries across Africa, with the goal of cutting malaria-related deaths by 50 percent. In December 2006, President Bush and First Lady Laura Bush hosted a White House Summit on Malaria, and helped launch the Malaria Communities Program, a $30 million initiative to advance grassroots malaria-control projects in Africa. The President's Malaria Initiative is using proven interventions, including effective treatment with

combination drug therapies, insecticide-treated mosquito nets, indoor residual spraying, and intermittent prevention treatment for pregnant women.

In a relatively short time, the President's Malaria Initiative is demonstrating remarkable progress. At the December 2006 White House Summit, the First Lady announced eight new countries targeted for expansion under the program. Those countries include Benin, Ghana, Madagascar, Mali, Zambia, Kenya, Liberia and Ethiopia. This is in addition to Tanzania, Uganda, Angola, Malawi, Mozambique, Rwanda, and Senegal, where programs have already started. By the end of November 2006, the President's Malaria Initiative was supporting activities to benefit more than 6 million Africans in Tanzania, Angola, and Uganda.

In addition, just a few weeks ago on January 29, Rear Admiral Timothy Ziemer, former Executive Director of World Relief (the development arm of the the National Association of Evangelicals), and now the President's Malaria Coordinator housed at USAID – named Dr. Bernard Nahlen to serve as Deputy Malaria Coordinator. Dr. Nahlen comes from the Global Fund to Fight AIDS, Tuberculosis and Malaria, and is a commissioned officer in the U.S. Public Health Service. His depth and technical expertise will help guide the President's Malaria Initiative even more.

Because of the sometimes-strained relationships at present between the U.S. and Europe and other developed countries, it is often assumed that there is not good cooperation between the U.S. and international organizations. In fact,

contrary to the newspaper headlines, there is often robust and positive engagement between the U.S. and major international organizations.

A fundamental question before the U.S., indeed before all international donors, must be: "how can we most successfully leverage our partnerships to achieve maximum impact and effectiveness?" In other words, how best can we advance global health? The U.S. is committed to working through both bilateral and multilateral programs. In doing so, our goal is to help people get results, and we will leverage our resources in the most effective and efficient manner.

Today, I believe these systems are improving and moving in the right direction. Particularly for the United States, our new strategic focus on delivering foreign assistance is allowing us to engage the international community in a more streamlined, coordinated fashion. Expounding on this theme, I would like to highlight a few instances where I see multilateral and bilateral aid intersecting in a high-impact manner to advance global health, one that gives hope and life to millions of the poor and suffering.

One example that comes to mind immediately is the multilateral and bilateral coordination that is emphasized by the Office of the U.S. Global AIDS Coordinator -- the lead policy-making body for U.S. international HIV/AIDS assistance. In 2004, this office, in conjunction with the Joint United Nations Programme on HIV/AIDS, the World Bank, and the UK's Department of

International Development, adopted key principles for supporting coordinated, country-driven action against HIV/AIDS.

These principles became known as the "Three Ones" – one national plan, one national coordinating authority, and one national monitoring and evaluation system in each of the host countries in which we work. Rather than risk duplication of efforts, the Three Ones foster complementary and efficient action, which represents our promise to developing nations that we will work within their structure and guidelines. Better yet, the Three Ones brings to consensus how to use multiple sources of HIV/AIDS assistance in one country. All major stakeholders and donors have endorsed these principles and committed themselves to their country-level implementation.

The Office of the U.S. Global AIDS Coordinator also is key in U.S. engagement with the Global Fund to Fight AIDS, Tuberculosis and Malaria, of which the U.S. is the leading donor. Complementary to the U.S. foreign assistance strategy, the Global Fund brings together a diverse set of actors – the public and private sectors, donors, recipients, NGOs, and affected communities. Because the Global Fund is a financing mechanism rather than an implementing organization, U.S. technical assistance to Global Fund grantees has been instrumental in helping them expand access to services. In addition, U.S. field personnel represent the U.S. on local Country Coordinating Mechanisms, contributing to the decision-

making process for the development and selection of proposals for Global Fund approval, and playing a role in the oversight of program implementation.

Returning for a moment to the President's Malaria Initiative, this program would not be successful without the support of other U.S. government partners, the Global Fund, the Roll Back Malaria partnership, the World Bank's Malaria Booster Program, as well as NGOs. In June of 2006, USAID launched the distribution of 715,000 long-lasting insecticide-treated bed nets throughout 19 districts in Uganda. This intervention was carefully orchestrated to complement the action of other donors, such as the Global Fund, which is investing heavily in the promotion of artemisinin combination therapy, the drug of choice to fight malaria. Through expert coordination, we are stretching our collective resources even father. These levels of direct assistance are also leveraged by corporate investment with specific assistance tied to measurable outcomes, and include robust monitoring and evaluation of programs, providing a new level of public accountability and transparency.

Yet another excellent example of the intersection of multilateral and bilateral aid is that of the Stop TB Partnership, headquartered at the World Health Organization, which draws on an international platform of support from host country and donor governments, NGOs, and the private sector. One of the most outstanding members of my USAID Global Health team in Washington, Irene

Koek, a TB expert, was recently elected as chair of the Board of the WHO Stop TB Partnership.

The Global Plan to Stop TB was released during last year's World Economic Forum in Davos, Switzerland, and calls for treating 50 million people and preventing 14 million tuberculosis deaths worldwide over the next ten years. To give you a sense of the significance of this call to action, in 2006, former UN Secretary-General Kofi Annan appointed the former president of Portugal as the first Special Envoy to Stop Tuberculosis. He is charged with amplifying the disease of TB within the international political and development agenda, and will work to further expand support for the Global Plan to Stop TB. Undoubtedly, he will work closely with the Partnerships' Coordinating Board. The U.S. will also continue to expand efforts to promote the WHO-endorsed TB therapy, known as directly-observed treatment, short-course strategy, or DOTS. Through the Global Plan to Stop TB framework, the U.S. is the leading bilateral donor on DOTS expansion, and currently assists DOTS programs in nearly 40 countries.

There are so many more examples I could give you of vigorous, engaged action between multilateral and bilateral actors. For instance, I am currently a member of the Global Alliance for Vaccines and Immunizations Board of Directors, a public-private partnership dedicated to increasing immunizations in the world's poorest countries. There are five donor seats on the 18-person board, and the seat I occupy rotates between Canada, the U.S., and Australia. The

Alliance brings together developing and industrialized country governments, vaccine manufacturers, multilateral institutions, NGOs, and other private entities. In addition, the U.S. also provides technical, working-level support to the International AIDS Vaccine Initiative, which receives bilateral and multilateral support for AIDS vaccine research and development.

One other important aspect of advancing global health is being able to respond quickly and rapidly no matter where crises occur. For example, we are watching avian influenza spread across nations and continents right before our very eyes. In fact, I just returned yesterday from a trip to Cairo as part of a U.S. delegation meeting with Egyptian government officials on recent bird and human cases of H5N1 avian influenza.

In order to respond rapidly to outbreaks and develop on-the-ground surveillance networks, it is crucial to have international collaboration, as well as host government cooperation. We must respond to immediate crises and build capacity for future challenges simultaneously.

Some of you may be familiar with the book *The Great Influenza* by John Barry. It is a brilliant piece of intellectual history about the 1918 influenza epidemic worldwide, and specifically about the pandemic in the U.S. In many ways, the book reads like a riveting novel. Barry estimates that between 50 and 100 million people may have died worldwide during the 1918 pandemic. If a similar pandemic hit today, with a population several times higher than in 1918,

the results would be staggering. We know that there have been about 10 pandemics in the last 300 years. The ones in 1957 and 1968 were not nearly as severe as 1918, and the fears today are that what is on the horizon could be more like the 1918 one than those later in the century, but no one knows for sure whether the current pandemic among birds will reassort such that it would be easily transmitted between human beings. So far, when humans have gotten it, they have been infected by birds and not by humans. The danger, of course, is that the more birds who have the H5N1 virus, the more opportunity there will be for the mutation to occur which would make it possible for H5N1 to transmit like a normal human influenza.

Highly pathogenic H5N1 avian influenza first emerged in Hong Kong in 1997, and re-emerged in 2003 in Southeast Asia as a threat to both poultry and humans, sparking concerns that the virus could mutate into a form capable of producing a global human influenza pandemic. In late 2005, the virus moved outside Southeast Asia and has infected poultry in South Asia, Eurasia, Europe, and the Near East. To date, more than 50 countries have reported outbreaks in birds. Human cases of avian influenza infection have been reported in 11 countries -- Azerbaijan, Cambodia, China, Djibouti, Egypt, Indonesia, Iraq, Nigeria, Thailand, Turkey and Vietnam. As of February 19, there have been a total of 275 human cases reported of which 167 (or over 60 percent) have been fatal. Furthermore, more than 200 million birds have died either from direct infection or

in containment measures against the disease, causing challenges for agribusiness, trade, economic growth, and nutrition.

The U.S. Government is providing $434 million in assistance to prepare for a possible pandemic to more than 70 countries, as well as to the World Health Organization, the Food and Agriculture Organization, the World Organization for Animal Health and regional organizations. USAID is on the frontlines of this action, focusing on five key areas -- avian influenza and pandemic preparedness, communications and social mobilization, disease surveillance and detection toward early warnings about outbreaks, provision of non-medical commodities, and emergency outbreak response. Let me name a few key actions we've supported. USAID has:

- Built a stockpile of 1.5 million sets of personal protective equipment, or PPE, for surveillance workers and first responders to outbreaks, and has deployed over 200,000 sets of PPE to 71 countries. We are also pre-positioning PPE kits, decontamination kits, and laboratory kits in 20 countries in preparation for potential additional avian influenza outbreaks.
- USAID is working with local communities and mobilizing social networks to generate awareness about disease risks, healthy behaviors, and to participate in disease surveillance. Particularly in Indonesia, USAID is working with two local NGOs to generate community awareness and to mobilize active surveillance in 27,000 villages across the country.

In the face of the avian influenza threat, there have been successes. In Vietnam and Thailand, the disease was rampant in 2003 and 2005 in poultry, with 88 percent of the global total of animal outbreaks. In 2006, after introducing aggressive outbreak control measures, the total animal outbreaks fell to 29 percent of the global total. On the human side, the disease killed 56 of the 115 people it infected in this same timeframe – 78 percent of the global total. But in 2006, there were a total of 3 cases, less than 3 percent of the global total. There have been notably fewer outbreaks this year compared to last. While there may be many factors contributing to this, there has been significant progress over the past year in disease monitoring to strengthen early warning surveillance and in capacity building for rapid response in affected countries. As a result, we are hearing earlier about suspected outbreaks and countries are more able to mount rapid response. In several places, the time lapse between onset of outbreaks and reporting of outbreaks has shortened from 3-5 weeks to 48 hours.

One of the greatest challenges at present is how to persuade those who raise chickens in their backyards to report fully and quickly when their birds become ill or when they themselves get sick. Timely reporting is extremely important to contain the spread among birds and to see if the virus in humans is mutating to become transmissible between human beings. But there are great disincentives to reporting quickly. These poor people often rely on chickens for their personal food, for income, and they fear angering their neighbors who might have their

birds culled if birds dying is reported. One possible solution is to offer to replace culled chickens with vaccinated ones.

While having the ability to respond rapidly to outbreaks and new infections is a critical component of advancing global health, what can be even more challenging is correcting misperceptions about specific health programs, what I sometimes refer to as a "disease of misinformation." If you follow news and information surrounding the global HIV/AIDS crisis, for example, then you may well have heard some of the spirited debate about the best ways to prevent the sexual transmission of HIV.

As we know, the fight against HIV/AIDS is far from over. Despite impressive achievements in the expansion of treatment numbers, four million new infections every year threaten to dwarf the global resources available to meet the treatment requirements in the years ahead. This simple arithmetic fact means that we have no alternative but to scale up significantly and strengthen the prevention of new HIV infections globally. And since the vast majority of new infections occurs through sexual transmission, we must focus particularly on that area. Although opinions can and do diverge regarding the relative importance of various prevention interventions, we must differentiate between legitimate debate and the much more common misinformation so often associated with criticism of the U.S. endorsement of "ABC" – "abstinence or delay of sexual debut," "be faithful and at the very least partner reduction," and "correct and consistent use of condoms."

Some religious conservatives adamantly resist the U.S. promoting the use of condoms, and seem uncomfortable with our work with prostitutes, homosexuals, or injecting drug users. Others, who tend to be on the left, are hostile to or skeptical about encouraging "abstinence" or "being faithful" as behavior approaches helpful in stemming the spread of the disease. There seems to be a fear that this will involve promoting religion, "moralizing," or passing judgment on sexual behavior -- positions, which they argue, is not our place to take, and besides, such efforts, they believe, will almost certainly not work anyway.

In fact, the "ABC" approach is an evidence-based, flexible, and common sense-based strategy, which plays a major role in stemming the tide of the HIV/AIDS pandemic. It is too important to be bogged down in the politics of passion. Too much is at stake, too many lives hang in the balance, and too many children are vulnerable to become orphans if we fail in our prevention efforts.

It should be noted that one way to raise the quality of the discussion of "ABC" prevention interventions is to insist that it take place in the context of gender issues. After all, many of the problems associated with the spread of HIV are intimately connected with the absence of gender equality, the presence of gender-based-violence and coercion typical of transactional and trans-generational sex. For all too many young girls, abstinence is not about being morally conservative, but about having the "right" to abstain. The double standards of men who are not faithful while their wives are is a gender equity issue. In short, "AB"

interventions must be seen as fundamentally linked to gender inequality issues – a topic which can and should unite Left and Right, liberals and conservatives. We need to focus on such common ground.

At the 2006 International AIDS Conference in Toronto, Canada, I hosted a USAID session called *Refining the Prevention Paradigm: Exploring the Evidence and Programmatic Models for Behavior Change*. The discussion provided further acknowledgment that the appropriate mix of A, B, and C is absolutely essential in the fight against AIDS. In particular, the adaptability of this strategy allows responses to be tailored to local epidemic circumstances. For instance, in places like Kenya, Uganda, and Zimbabwe, most new infections result from chains of overlapping sexual partnerships in the general population -- fueling what we call a generalized epidemic. Through community mobilization efforts, education and awareness activities, the data indicates increased adoption of "ABC" behaviors, and points particularly to a reduction in multiple partners.

Furthermore, the data showed associated declines in HIV. By contrast, epidemics such as those in Thailand and Cambodia are primarily associated with commercial sex work or prostitution, and are therefore concentrated in identifiable population groups. In these instances, we also see the utilization of certain "ABC" behaviors -- particularly the B and C portions (correct and consistent condom use, as well as a decline in the proportion of men visiting prostitutes) -- as decreasing the risk of HIV transmission to men and from them to their spouses. In the cases

of Thailand and Cambodia, although it is the C aspect of "ABC" that is the most well known factor, other behavior change as well has clearly led to an associated decline in HIV. In short, sexual behavior change is occurring beyond simply greater use of condoms.

Indeed, the "ABC" approach to HIV prevention is good public health, based on respect for local culture. It is an African solution, developed in Africa, not in the United States, and has universally adaptable themes. To amplify this point, in May 2006, the Southern Africa Development Community – an alliance of several countries in southern Africa – convened an expert, think-tank meeting to identify and mobilize key regional priorities for HIV prevention. The meeting report characterized multiple and concurrent sexual partnerships as central drivers of the HIV/AIDS epidemic in the Southern Africa region. They recommended that priority be given to interventions that:

- reduce the number of multiple and concurrent partnerships;
- address male involvement and behavior change;
- increase consistent and correct condom use; and
- continue programming around delayed sexual debut.

Clearly, these are African-derived interventions that address "ABC" behaviors. Because it is a remarkably simple and easily translated message, "ABC" is often portrayed as simplistic, and even as a superficial approach to addressing much tougher issues underlying sexual transmission of HIV in a generalized epidemic,

particularly in the developing world. This is simply false. Beyond "ABC," PEPFAR and USAID address gender issues, including power relationships, women's sexual vulnerability, and destructive male sexual behaviors. Indeed, these interventions are intimately connected to the success of often related "ABC" programming.

Critics of the Emergency Plan argue that the "ABC" does not speak to a woman's ability, or inability, to negotiate within a sexual relationship. But, in fact, central to the "ABC" strategy are parallel efforts to address the vulnerability of women and girls. In addition, within the "ABC" strategy there is very specific and growing attention to issues of male behavior, which of course lies at the heart of gender inequality and sexual coercion. In June 2006, there was a particularly interesting article that ran in the *Boston Globe*. The story highlighted the Emergency Plan's significant efforts to target HIV prevention in men. In light of how male behaviors can and often do affect women, particularly the women of sub-Saharan Africa, I will now briefly discuss those efforts.

The Emergency Plan is based on the firm belief that it is impossible to stem the spread of HIV without addressing the unbalanced power relations between men and women. Working with boys and men is and must be an ever greater integral focus of the Emergency Plan's HIV prevention programs, especially since male behavior is a prominent root cause of female vulnerability to HIV/AIDS. Let me highlight a few examples of USAID support through the Emergency Plan:

- In South Africa, the Emergency Plan works with the Institute for Health and Development Communication's Soul City, the most expansive HIV/AIDS communication intervention in the country, reaching more than 80 percent of the population. Soul City emphasizes the role of men in parenting and caring. It challenges social norms around men's perceived right to sex, sexual violence, and intergenerational sex. There is a statistical correlation between exposure to Soul City programming and improved norms and values amongst men.
- Also in South Africa, the Emergency Plan supports a very successful male involvement program known as "Men as Partners." In addition to dealing with HIV/AIDS prevention issues that include masculinity, stigma, and domestic violence, men are encouraged to assume a larger share of responsibilities for family and community care by spending more time with their children, mentoring young boys in the community, and visiting terminally ill AIDS patients.
- In Zambia, the U.S. is working with the Zambian Defense Force to train peer educators and commanding officers to raise awareness among men in the military about the threat posed by HIV/AIDS, and to enlist their support in addressing it. Training workshops cover basic facts about HIV/AIDS and its impact, including transmission, prevention, stigma, sexuality, gender, positive living, counseling and testing, and care.

- In Uganda, the Empowering Africa's Young People Initiative includes a focus on masculinity and gender norms. Community advocacy and sensitization meetings are conducted for both younger and older males. For younger males, the focus is on challenging norms about masculinity, challenging the acceptance of early sexual activity and multiple sexual partners for boys and men, and challenging the dangerous and abusive practice of transactional sex. As for older males, the focus is on supporting counseling, peer education, community interventions, and the ending of the dangerous and abusive practices of transactional and cross-generational sex.
- In Namibia**,** the Lifeline Childline program addresses the root causes of gender violence. It uses age-appropriate messages to teach boys – as well as girls – about HIV/AIDS, sexual abuse, domestic violence, and the resources available to vulnerable children through specialized counseling and other services.

Last September, Peter Piot – Executive Director of UNAIDS, and I co-chaired a two-day consultation in Geneva on the prevention of sexual transmission of HIV. The goal of the expert meeting was to chart a new course beyond the culture wars in which the "ABC" prevention strategy is so often embroiled in this country, and abroad. A key component of this strategy is to integrate programs addressing gender equity, gender-based violence, and male behavior problems (lack of

fidelity, for example) as a way to create an apologetic for "AB" which many can enthusiastically support.

In laying out his vision of results and sustainability for global health, Director of U.S. Foreign Assistance Randall Tobias often cites the example of Dr. Peter Mugyenyi, the leader of the Joint Clinical Research Center in Uganda. Calling him one of the most inspiring, creative, and effective leaders in the fight against HIV/AIDS on the African continent, Ambassador Tobias tells the story of a meeting in Ethiopia, where Dr. Mugyenyi made a keen observation. To paraphrase, he said that it is neither practical nor moral for the people of Africa to expect that the rest of the world will take care of their problems forever.

He explained that it is not practical because it means their own destiny will be at the mercy of changing political priorities in nations far beyond their control. And it is not moral, because the people of his continent have many of the tools they need to meet their own needs, and those they do not have they can and must develop. Dr. Mugyenyi has made incredible progress through his own organization in making drug treatment available in Uganda. In one largely rural district, his organization has now succeeded in providing access to antiretroviral therapy to 100 percent of those who need it, with a locally-designed strategy they can be sustained in the future.

To be clear, for now Dr. Mugyenyi is working in close partnership with the President's Emergency Plan for AIDS Relief, utilizing the extensive financial

support we are providing. Indeed, at this point, USG support is indispensable. But he is already developing capabilities and resources so that a time will come when he will no longer depend on us.

As Ambassador Tobias puts it, Dr. Mugyenyi totally understands what is required for the long-term sustainability of his very important work. And "sustainability" must be the operative word.

In the book *Millions Saved: Proven Success in Global Health*, by Ruth Levine and Molly Kinder, we see time and time again that major successful public health interventions often draw on the combined resources of multilateral and bilateral donors. Coordinated partnerships of international donor resources are not only essential, they are the gold standard by which we should measure our commitment to alleviating poverty and human suffering. In the end, advancing global health means sharing a united goal. It means filling gaps where needed and complementing resources. It means responding quickly when on the brink of crisis, and -- as we've seen with the advent of unprecedented global health programs -- it often means doing what has never been done before. One fact is certain: what we can accomplish together is considerably greater than the sum total of what we can all do as individual countries. And this matters, because added effectiveness translates into less death and suffering, and into a far healthier global community – goals which motivate us all.

Let me make just two final points – specifically addressed to you at Messiah College.

First, I am hopeful that a number of you will consider careers in development – global health, economic development, promoting democracy, or humanitarian assistance. We need your compassion, your expertise, and your dedication. Faith communities are important places in which to cultivate such commitment and preparation for service. Life is short, and it is a great privilege, and much more interesting, to do something that really matters. Development, helping people, matters. It is a wonderful way to do good and to put one's Christian faith into action.

Second, a liberal arts education is a perfect preparation for development work. I trust you understand that there are many roads into development work. To be sure there is preparation specifically designed to equip one for public health service, international development, the Foreign Service etc., but any liberal arts major is wonderfully useful.

Today, most people have several careers during their lifetime. Their major in college or graduate school will certainly help them get started, but they will likely evolve and move into new areas as well. A liberal arts education, precisely because it focuses on broad, interdisciplinary training, and the "how" of learning and communicating, is the ideal grounding for navigating diverse assignments.

My own background was as a college history professor, a human rights and religious freedom NGO executive, a college president, and for the past five and a half years an international development administrator focusing first on the former Soviet Union and Eastern Europe more broadly and now on health issues globally. It was precisely that broad liberal arts background, and then the diverse jobs I have held over several decades, that prepared me for the policy, management, and communication challenges of my present position.

There are people in this audience who may find that they have unique skills to offer in "retirement," to NGOs like World Vision for example, where one can volunteer as doctors, nurses, businesspersons, teachers etc. to do some good in a place which desperately needs what you have to offer.

In short, I am hopeful that some of you will consider a career in international development, while others I hope will at least have the opportunity to spend some time during your career or in retirement in helping in some tangible way abroad. Further, I would hope that all of you will support both our government's commitment to international development, but the even larger commitment of the religious and private sector to helping alleviate the suffering in the world. And global health is a great place to make such a contribution!

Thanks again for the invitation to be with you at Messiah College and thanks for coming tonight.