A decade of progress, a decade of promise

This year marks the Elizabeth Glaser Pediatric AIDS Foundation's tenth anniversary. Today, children with HIV who have access to health care are living longer, healthier lives thanks to progress made this past decade. However, the HIV epidemic still rages. In the U.S. and worldwide, new infections are increasing and women and children are the fastest rising group. As we look toward the next decade, we have great hope that the promising work we fund will result in effective treatments and eventually a vaccine to end this deadly epidemic.

This Notecard Program has been generously underwritten by:

TENET.
Tenet Healthcare Foundation

For more information please contact:
Elizabeth Glaser Pediatric AIDS Foundation
2950 31st Street Suite 125 Santa Monica, CA 90405
310-314-1459
http://www.PedAIDS.org
e-mail: info@PedAIDS.org
For credit card donations please call 1-888-499-HOPE

Co-founders - Elizabeth Glaser, Susan DeLaurentis, Susie Zeegen

August 30, 1999

Dear Sandy,

I realized yesterday that I neglected to send you a copy of this letter to Mrs. Clinton, as I had promised.

I'm off to Montreal where we will announce funding for a nevirapine study. We briefed Daniel yesterday so you should have the call to action.

Busy time. See you on Sept. 9.

Regards, Kate

E.G.
O-Ped. AIDS found.

ELIZABETH GLASER PEDIATRIC AIDS FOUNDATION

August 19, 1999

Mrs. Hillary Rodham Clinton
The White House
1600 Pennsylvania Avenue NW
Washington, DC 20500

Dear Hillary,

We were delighted with the Administration's recent announcement of the global AIDS initiative, *Joining Forces for LIFE: Leadership and Investment in Fighting an Epidemic*. This is a strong and important step in impacting the international HIV/AIDS pandemic, and we applaud the administration's efforts.

I recently met with Sandy Thurman, and we spoke about the Leadership Meeting you are planning to discuss global HIV/AIDS prevention and treatment efforts on September 7, 1999. We share your interest in convening key funders from different sectors to discuss a more coordinated effort to fight HIV/AIDS internationally.

We are also in the process of planning a complimentary meeting to bring together key investors from government, foundation, and corporate sectors to discuss the critical need for linking research, implementation, and evaluation to impact global health. Research has recently demonstrated that Nevirapine could be an effective and affordable intervention that could help prevent some of the 1,800 new HIV infections that occur daily in children around the world. Determining how to deliver this intervention and measure its impact will be critical for this to become an effective strategy in blocking mother-to-infant transmission of HIV.

Bridging the wide gap in children's health worldwide will require a more coordinated effort among organizations which perform research and those which implement community-based health care. It is our intention that bringing together such organizations, and the potential for strategic partnerships, could be a catalyzing step in fighting the worldwide HIV/AIDS epidemic.

2950 31st Street, Suite.125, Santa Monica, California 90405 Tel: (310) 314-1459 Fax: (310) 314-1469 www.pedAIDS.org
805 15th Street NW, Suite 500, Washington, DC 20005 Tel: (202) 371-0099 Fax: (202) 371-2044

In collaboration with the Fogarty International Center we are inviting foundations, World Bank, Federal agencies, and UN specialized agencies to participate in this meeting, which will be co-chaired by Gerald Keusch, Director of the Fogarty Center, and Ward Cates, President of Family Health International. We plan to discuss case studies of successful models for disease eradication in an effort to apply what has been learned to diseases for which there is much more work to be done, such as malaria, hepatitis B, and HIV/AIDS.

We are aware of your incredibly busy schedule and many commitments but would be honored to have you participate in this meeting, currently scheduled to be held at the NIH December 14-15, 1999. Your participation would be invaluable.

I understand that your meeting on September 7th may have a more narrow scope but it appears to have a striking relevancy to ours and if you think our participation would be helpful and appropriate, we would welcome the opportunity to attend.

We continue to press on in our work. Our Elizabeth Glaser Scientists, who are some of your biggest fans, will be gathering for our annual think tank at White Oak Plantation in November. We will be sure to advise you of their progress. I thought you would find the attached article describing an effort in Romania compelling. Our small investment will have a major impact.

I look forward to hearing from you about our meeting in December, and to following up about your September meeting. Thank you for your time and for the ongoing consideration and friendship you have always given this Foundation in our effort to bring attention and hope to those battling with HIV/AIDS .

You are in our thoughts often as we follow the progress of your Senate campaign.

Sincerely,

Kate Carr
Chief Executive Officer

Texas Children's Hospital

BAYLOR COLLEGE OF MEDICINE

Department of Pediatrics

Texas Children's Hospital
6621 Fannin St., MC 1-4000
Houston, Texas 77030-2399
TEL: (713) 770-1038
FAX: (713) 770-1281

Mark W. Kline, M.D.
Professor
Associate Program Director
General Clinical Research Center
Associate Director
Housestaff Education

Nancy R. Calles, R.N., B.S.N., A.C.R.N.
Margaret Gwynne Ferris, M.P.H.
Leslie Raneri, L.M.S.W.
Heidi Schwarzwald, M.D.
Cara Simon, R.N., M.S.N., C.P.N.P.

July 7, 1999

Trish Devine
Program Manager
Elizabeth Glaser Pediatric AIDS Foundation
2950 31st Street, Suite 125
Santa Monica, CA 90405

Dear Trish:

One year ago, the Elizabeth Glaser Pediatric AIDS Foundation generously agreed to support the creation of the Romanian-American Pediatric AIDS Training Program (Grant #PS 22065). Your support, in the form of a $9000 Short-Term Scientific Award, has permitted HIV training experiences in Romania for five outstanding U.S. senior pediatric residents. Two other senior pediatric residents will be spending the month of September in Romania under the auspices of the program. The total cost for providing these experiences was $14,000 ($2000/trainee), which was covered by funds from PAF, supplemented by local funds. For this modest sum of money, seven U.S. pediatric residents have had experiences of immeasurable personal and professional benefit, and several have been inspired to pursue careers in the care of HIV-infected children. For these reasons, I very much hope that PAF will be able to renew funding in support of the nine additional senior pediatric residents who have requested the opportunity to participate in this Romanian training experience over the current academic year (July 1-June 30).

I would like to begin by giving you a brief profile of the pediatric residents who have participated in the PAF-supported training program:

Bryan Cannon, M.D., an honor graduate of Southwestern Medical School, worked at the Constanta Municipal Hospital with Dr. Rodica Matusa. He participated in the establishment of a study and treatment program for oral complications of HIV in children. He is a co-author on an abstract and upcoming manuscript describing the findings from this study. Dr. Cannon plans to pursue a career in academic pediatrics after completing a one-year term as Chief Resident in pediatrics at Baylor.

Nancy Dickason, M.D. is an honor graduate of Baylor College of Medicine. She worked at an orphanage for HIV-infected children in Cezieni, Romania. Dr. Dickason will be entering general pediatric practice in Houston. Her experience

in Romania has inspired her to pursue a special interest in the care of international adoptees and the problems of institutionalized children.

Tarsy Dondlinger, M.D., is an honor graduate of the University of Texas Medical School at Houston. Dr. Dondlinger also worked at the orphanage in Cezieni. She will be serving as Chief Resident in pediatrics at Baylor, and plans to create an enduring handbook, "starter kit", bibliography, and directory for pediatric residents interested in international training opportunities. Her ultimate career goals are unclear at this time.

John Vanchiere, M.D., Ph.D. is a graduate of Emory University Medical School, where he studied neurovirology and viral persistence. Dr. Vanchiere worked at the Victor Babes Hospital in Bucharest, the Constanta Municipal Hospital, and the orphanage in Cezieni. Dr. Vanchiere already has authored a research proposal to study the effects of vitamin A supplementation on HIV disease progression. We plan to implement the study in Constanta in September. Dr. Vanchiere also will be collaborating with Dr. Janet Butel, Director of the Baylor Center for AIDS Research, on a study of the role of viral co-infection in HIV encephalopathy of children in Romania. You soon will be receiving an application for funding for this study from Dr. Vanchiere. Dr. Vanchiere will be a postdoctoral fellow in pediatric infectious diseases at Baylor for the next three years. Ultimately, he hopes to work internationally in pediatric HIV.

Tim Peters, M.D. is an honor graduate of Yale University School of Medicine. Dr. Peters worked at the Constanta Municipal Hospital, Fundeni Hospital in Bucharest, and the orphanage in Cezieni. Dr. Peters recently has been awarded a Howard Hughes Medical Institute Fellowship to study pediatric infectious diseases at Vanderbilt University.

Elizabeth Campbell, M.D. is an honor graduate of the University of Maryland Medical School. She will be working at the Constanta Municipal Hospital and Fundeni Hospital in September.

Leslie Lace, M.D. is an honor graduate of the University of Texas Medical School at San Antonio. She also will be working at the Constanta Municipal Hospital and Fundeni Hospital in September.

I have attached photographs of the residents working in the Romanian medical institutions. I also have attached a written report by Dr. Peters and an article written by Dr. Vanchiere for the Journal of the International Association of Physicians in AIDS Care, both detailing resident experiences in Romania.

I hope you agree that the funding PAF has provided for this program is money well spent. The experiences these pediatric residents are having are unobtainable in any U.S. center. Current and future generations of HIV-infected children will be the ultimate beneficiaries.

Please let me know if you need any additional information.

With best wishes and warm regards.

Sincerely,

Mark

Mark W. Kline, M.D.
Professor

Clinical Elective in Pediatric AIDS
Timothy R. Peters, M.D.
Romania, June 1999

I would like to express my gratitude for the support that I received through an educational grant from the Pediatric AIDS Foundation which enabled me to participate in the medical evaluation and care of children with HIV disease in Romania. The experience of joining a medical team assembled by Dr. Mark Kline to continue the important work of the Baylor International Pediatric AIDS Initiative was tremendously valuable to me. I am writing to briefly describe this visit to Romania and to share something of what I have learned during this time. I hope in this way to offer some insight into how powerfully I have been affected by this experience.

On June 12, 1999 I flew to Bucharest, Romania with Dr. Mark Kline as part of a medical team assembled to evaluate a cohort of more than 150 HIV infected children. One year ago these children had been enrolled in a prospective longitudinal study of oral complications of HIV infection, and we were to perform full physical and dental evaluations on these children in follow-up. These children are cared for by Dr. Rodica Matusa in Constanta, Romania--a city on the Black Sea that is described as "the world child AIDS capital" in a travel guide that I purchased in the US. Dr. Matusa follows over 1000 HIV infected children in her practice at the Municipal Clinic Hospital in this city of 200,000, and receives referrals from a large part of the surrounding country.

Much of my first week in Romania was spent in Constanta examining over 160 children, many with advanced AIDS, many who have never received antiretroviral medications because of profound lack of funds. Most of these children were orphans, abandoned when they were diagnosed with HIV infection. Most are cared for in orphanages. During the week I was able to visit Casa Speranta which is home for 30 of these children. In addition to the absolutely incredible experience of evaluating these study patients alongside Dr. Kline--a noted pediatric HIV specialist and gifted teacher--I was able to see a large number of additional HIV infected children not in the original cohort. Dr. Matusa took extra time to introduce me to patients that were especially instructive and to discuss her approach to caring for these children without reliable access to antiretroviral medications. Our medical team included Dr. Bruce Carter, a specialist in pediatric dentistry who made special efforts to educate me regarding the oral manifestations of HIV disease.

Our work in Constanta concluded on Friday and we returned to Bucharest by train. That day I was invited to accompany Dr. Kline during a visit to the Institute of Virology in Bucharest, directed by Dr. Constantin Cernescu. Our conversations with Dr. Cernescu included an authoritative and candid discussion of how HIV infection has come to be so prevalent among the children of Romania despite a very low incidence of HIV infection in adults. I learned that in the years preceding 1989, when the communist leader Ceausescu (described by Romanians as one of history's most successful tyrants) was overthrown, physicians who cared for children practiced medicine in an atmosphere of unimaginable isolation and fear. Plans for extraordinary population growth had been laid by the communist government with the goal of a greatly expanded work force. Policies implemented in support of this plan included illegalization of contraception and draconian punishment for abortion. Additionally, each family was required to produce five children, many unwanted by impoverished families. Physicians were punished for infant mortality rates considered excessive, and it was common for fearful physicians to postpone reporting births until children were 4 to 6 months old so as to improve the statistics of their practice. Physicians in Romania for the most part did not have access to the world medical literature. Additionally, laws were made requiring that all medications be given parenterally (IM or IV), based on the assertion that better surveillance of medical serviced could be maintained by the communist regime. Romanian physicians, fearful of government reprisals for infant mortality and isolated from the experience of physicians in other countries, commonly used microtransfusions of blood to treat malnutrition, iron deficiency, poor growth, etc. Dr. Cernescu described physicians moving from patient to patient with a needle and bottle of blood, transfusing one child after another with the same needle. In this tragic setting HIV appeared in the blood

supply. The first cases of AIDS were identified in Romania in the early 1980's, but the government refused to admit its existence until 1987, and made no effective measures to control the re-use of hypodermic needles before the revolution in 1989. Universal precautions were implemented in the years following the revolution, and HIV surveillance now reveals that Romania is the home of more than 80% of all HIV infected children in Europe. An astounding number of impoverished families have responded to HIV infection in their children by abandoning them to the care of orphanages.

My first week in Romania concluded with dinner at the home of Charles and Mary Lewis. Mr. Lewis is an assistant US district attorney now working at the US Embassy in Bucharest, and he has spent the last year developing strategies that will allow the US to participate in combating corruption in the Romanian government. The Romanian government is currently considered to be corrupt at all levels, and this has driven away greatly needed foreign investment. Our conversation with Mr. Lewis offered an extraordinary perspective on the financial circumstances of a government which allocates just 1% of its budget to health care, and an economy marked by 50 years of communism in which after 10 years of "capitalism" only 17% of industry has been privatized.

On June 19 most members of the Baylor medical team returned to Houston and Dr. Kline traveled to Africa to continue his work there. I remained in Bucharest, and that day traveled about 200 km west by train to Caracal. I traveled with Ms. Leigh Hopper, an investigative journalist with the Houston Chronicle, and Mr. Smiley Pool, a photographer with the Chronicle, to visit an orphanage for severely disabled children, located in the small village of Cezieni. The Houston Chronicle has been developing a series of stories on Pediatric AIDS in the US and developing countries since 1996, in cooperation with Dr. Kline's team. We met with a humanitarian aid worker at the train station and spent the day at the home for "irrecoverables." Eighty-five children ages 4 to 18 live in a decrepit hunting lodge there, under conditions of need that defy description. Under the Ceausescu regime these disabled, abandoned children were banished to remote orphanages where they now remain. Those with development levels that allow independent ambulation spend much of their time searching for food, fighting other children to lick empty bowls after meals. The day was warm, and many of the smaller, immobile children were lined up on benches in an outdoor "pen". I discussed the medical care of many of these children with the medical director of this orphanage as we moved through the yard. Many of the children were blind, with cataracts and other physical signs of congenital rubella syndrome and I learned that the children of Romania do not routinely receive that vaccine. Many had severe seizure disorders treated with IM phenobarbitol. Malnutrition, striking dermatologic disease, and severe contractures are common and 3 or 4 children share a bed. The efforts of a philanthropic organization involved in their care allow for a meal with meat one time a week. These discarded children have no medical record, no diagnosis, and no program implemented to improve their conditions beyond often inadequate treatment of acute infections. I met one child with confirmed HIV infections there, on no antiretroviral medications, no prophylaxis for opportunistic infections.

The most extraordinary aspect of examining these disabled, hungry children was the realization of how *not extraordinary* it was. I had read accounts of the conditions endured by disabled children throughout the developing world many times before June 19. I had seen video footage and photographs. It was not enough to make me understand, despite my interest and medical training. I didn't *get* it. As I write I know that I lack the gift that would allow me to assemble the words to describe the suffering of these children. I am left to say that because of this visit, I now *get* it, I understand.

The youngest child whose home is the Cezieni orphanage is now 4 years old, and he has severe scars on his feet and his buttocks--evidence of scald injuries consistent with non-accidental injury. This child was abandoned as an infant and came to live at Cezieni 1 year ago, without explanation, from a large district orphanage for children less than 3 years old. I met this child in a corner of the pen in the yard where he was sharing a crib mattress with 3 children with profound developmental delay. Examination of this boy revealed no dysmorphic features, no microcephaly, no physical signs suggesting organic intellectual impairment. He just stared at the fence and picked at the peeling paint as I examined his scarred feet. I had

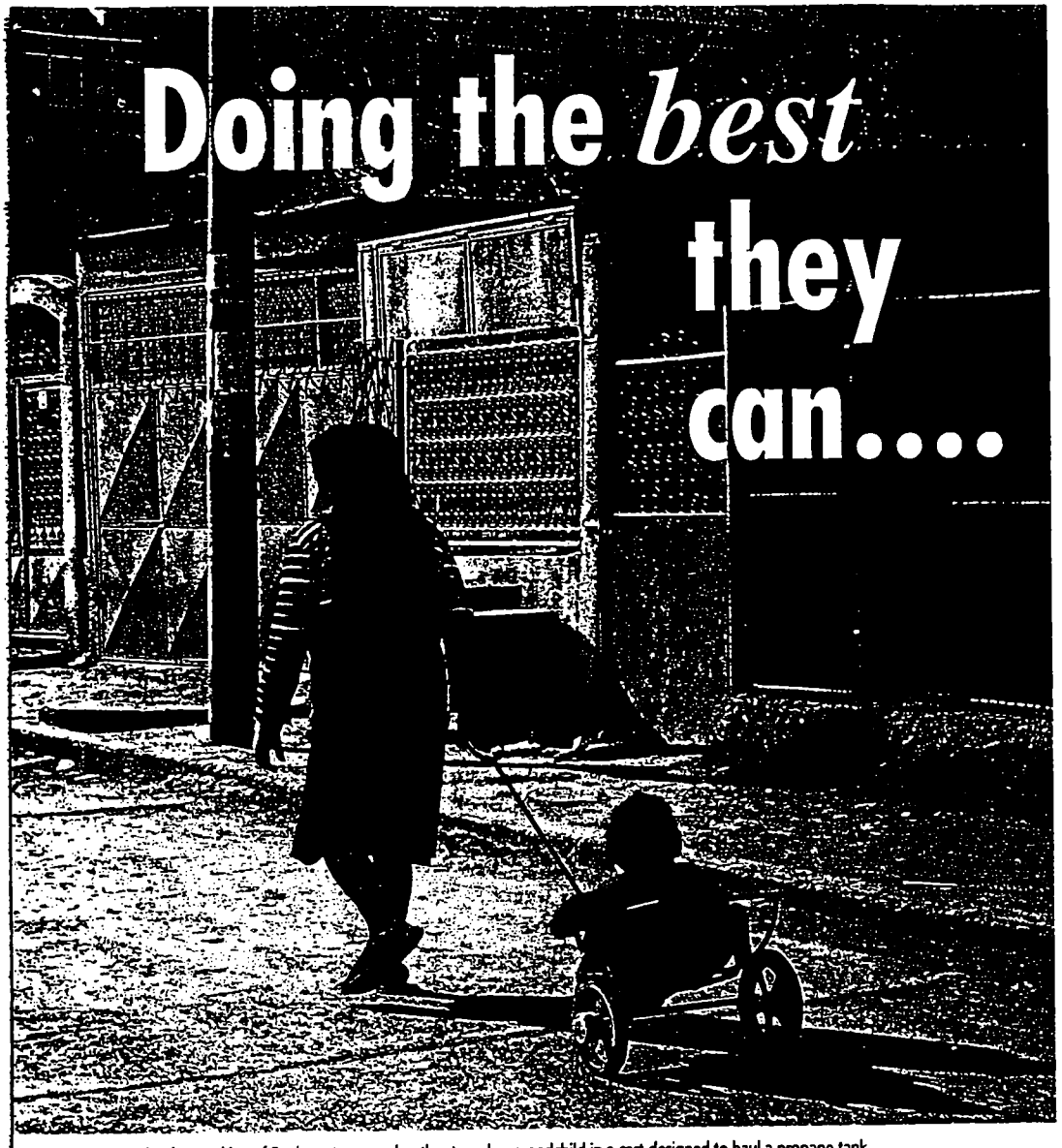
read about how young children need to be held, about the blow that is dealt to the developing mind by neglect and how it withers when it does not know love. But now I understand.

On return to Bucharest I began a week working at Fondeni Hospital where I worked closely with Dr. Constantin Arion, Professor and Chief of Pediatrics and Dr. Bogdan Dinu, Associate Professor of Pediatrics. Fondeni Hospital has more than 1700 beds, 140 of which are dedicated to pediatrics. The pediatric service at Fondeni cares for children with general pediatric problems and serves as a referral center for Hematology and Oncology patients. Additionally, they support a large hemodialysis unit, and can perform diagnostic cardiac catheterization in children with congenital heart disease. This level of sophistication has been maintained in the face of drastically diminished funds. Professor Arion shared that he recently received news that the total allotment of funds for pediatrics next *year* would be roughly $36,000.

I had the opportunity to see many children with extraordinary pathology, including a boy who presented with Burkett's lymphoma and was subsequently found to be infected with HIV. More importantly I was able to work with compassionate, capable pediatricians as they served their patients despite an astounding lack of resources. I am inspired by their selflessness and resolve. On June 24 I was invited to a meeting by the office of the Romanian Minister of Health to discuss my visit. I met with Dr. Daniela Pitigoi, Director of the Preventive Medicine Department. She oversaw the control of a Measles outbreak of 35,000 cases last year, but reports that AIDS and TB control are presently the greatest challenges facing her department. As the week concluded I returned to the United States to begin a fellowship in Pediatric Infectious Diseases at Vanderbilt University School of Medicine.

It is a privilege to care for children, and a greater privilege to know about them. This knowledge is precious, and I am grateful for all that I have learned through three years of residency training in pediatrics. These two weeks in Romania were the most important. Thank you for the financial support that made this possible.

Doing the *best* they can....



On the outskirts of Bucharest, a grandmother tows her grandchild in a cart designed to haul a propane tank.
(All photos courtesy of John A. Vanchiere)

John A. Vanchiere, MD, PhD

We got to the hospital campus at 8:30 a.m., not knowing what to expect. We had heard stories of everything from horse-drawn trailers to delivery trucks, and even cars with the coffins strapped to the top. The Romanians take care of their own. They retrieve their loved ones by whatever means are available. Over and over again I had realized that these people do the absolute best they can with the little they have. This morning we waited two hours wondering who would come to pick up Sami, and with what means. Sami died over the weekend after a long struggle with AIDS; his autopsy was completed two days ago, and his family lives 250 kilometers away. As we waited outside the morgue, Mary told stories of Sami and the multitude of other children who had been in his place before. We played with a cute little puppy that was starving more for attention than for food. We solved virtually all the world's problems in that two-hour wait, not by talking, but by listening to each other's stories and dreams.

A delivery truck arrived with a simple wooden coffin alone in the back of its large cargo bay. The truck had been sent from the hospital near where Sami's family lived. No family had come. I wondered why. Perhaps ignorance, or shame, or fear. Maybe they had mourned the death of Sami months ago when they last visited him in the hospital. Maybe the retrieval and impending funeral were only formalities. Maybe they were out in a field, hand-tilling the winter soil to prepare for spring planting.

My eleventh day in Romania. My first trip out of the US. What a place I had picked to start my travels. I have known for a long time that I have been blessed with many gifts, but I had never known how blessed I was until I spent two weeks in Romania, visiting pediatric HIV clinics in five places—two cities, two towns, and one village. Romania is home to over 50 percent of all European pediatric AIDS cases. Over 90 percent of AIDS cases in Romania are pediatric. The story is well-known. Eight to ten years ago, children were injected intramuscularly with small aliquots of blood from a tainted, unchecked blood supply. Since then, HIV has festered. Like a slow stream of molten lava moving from a volcano, the children with AIDS keep on coming. The flow is unstoppable except by the passage of time. The epidemic wave is near its peak, and the slope on the other side will not be steep. Many more children with AIDS are yet to be identified.

Romania was once the "bread basket" of Europe, and Bucharest, its capital, was the "Paris of Eastern Europe." But these accolades are from long ago, before 50 years of communist rule. Now Romania is a "re-developing" country, struggling economically, only a shadow of its former self. The land of Romania is so rich, but the people and economy are so poor. The Romanian currency has been devalued by nearly 400 percent in the past three years, but salaries have not moved. Millions of acres of beautiful farmland, from horizon to horizon, sit dotted by an occasional person with a hoe or horse pulling a tiller. Tractors are few and far between. Gas is over US$3 per gallon. Liquor costs only a little bit more than gas. Jack Daniels whiskey is cheaper in Romania than in the US. Domestic beer is cheaper than bottled water by nearly 50 percent. Magnificent pastries sell for a fraction of their cost in the US, and a fresh loaf of bread is about 20 cents US. Pediatricians in Romania earn around US$100 per month and a hotel desk clerk I met makes about US$20 per month. Yet many cellular phones can be heard on the streets. Even people who make the equivalent of US$60 per month spend one-third of it on a cellular phone. I guess I just do not understand the extreme of economics. The Romanian economy seems so misaligned, so dysfunctional.

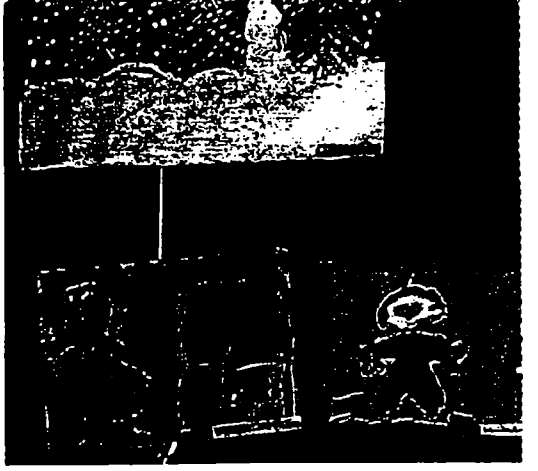
Unfortunately, children take the biggest hit. They are not a priority in an economy spiraling downhill. In Bucharest, thousands of children and adolescents live on

the streets, in sewers and unused subways and abandoned, half-built structures. They are the forgotten first-generation democrats who have few memories of communism. As I looked around the dirty and unkempt streets in Bucharest, I began to see the street children. They were at every major intersection, waiting for the red light to halt a potential benefactor or two. They accepted anything, standing by the driver's window, dirty-faced with hands open. The face of that first little girl is indelibly etched in my memory—an angelic face with big blue eyes, shrouded by a furry white coat. No smile, just a quick check to see if the driver was paying attention to her, then quickly off to try the next captive driver. As we drove, I noticed more of these little ones, standing at corners, huddling in doorways, venturing out with each new traffic signal then returning to the sidewalk. The older girls, barely pubertal, had been pressed into the slavery of prostitution, unable to complete childhood because their survival instincts had already taken over.

Caracal was our first destination outside of Bucharest. The two-hour trip by car was amazing. Through towns and villages we drove, surrounded by once bountiful farmlands. The drive was sad and beautiful at the same time. It was like stepping into the past, back to a quieter and simpler time. After a few encounters with horse-drawn wagons, I realized why they seemed so odd. They had car tires. What an anachronism! What ingenuity! I was beginning to see that Romanians make the best of what they have. We were hosted in Caracal by Father Nicholas Murphy, a Roman Catholic priest from England who had "adopted" a government-funded home for severely handicapped children as his mission.

Murphy had enlisted the Baylor medical team to complete an evaluation of the 85 children who live in a facility in the village of Cezieni. What a place! Once the hunting lodge of a Romanian prince, this now dark and dirty place houses forgotten, discarded children who have no expectation of contribution to society. To say they were severely handicapped would be an understatement. Many of the small ones were bed-bound, two to a crib in cold, damp rooms. A dozen or so of the children had some verbal skills and perhaps a third of the children were independently mobile. Their feet and hands were cold, some scarred by frostbite. Some little fingers had burns from touching the wood-burning heaters which fail miserably in their task. Many of the children rock themselves all day long, bellowing when touched. Others roam the grounds, looking, perhaps searching. In the US, most of these children would still live with their families, supplied with most of the resources required to maximize their potential. In Romania, government support is meager by US standards, and the money is reprioritized by several levels of government before it reaches the children, who eat mostly bread and grains with occasional meat and seasonally available vegetables. These children survive because of the care they receive from the women of Cezieni, who work for about US$5 per month, virtually nothing. These women tend to the children the best they know how, making the most they can of the scant food and resources available. They bathe the children and attempt to keep the crumbling facility clean, but the smell of urine cannot be masked. The front door that doesn't lock is little defense against the winter or the infectious diseases that want to prey on these fragile children. In many ways, these children are handicapped more by the resources and environment than their physical and mental deficits.

Constanta, the famous Black Sea port where Ovid lived hundreds of years ago, is home to over 1000 children with AIDS, many orphaned or abandoned. We were hosted there by Rodica Matusa, MD, who takes care of their medical needs and also has a hand in many of their personal needs. A fortunate 15 to 20 percent are on some type of antiretroviral regimen, but new children with AIDS come to the infectious diseases clinic each week, some near death, others with only minor problems by comparison. Matusa is a member of the International Association of Physicians in AIDS Care (IAPAC), and has been named by the IAPAC Pediatric AIDS Subcommittee on Eastern Europe to serve as director of the Pediatric Health Outpatient Clinic/Pediatric AIDS Clinical Trials Center in Constanta, Romania, when it is constructed. She is also a certified God Bless the Child care provider. Matusa is legal guardian for all of the 30 or so children who live in the hospital. She runs the clinic and the pediatric infectious diseases section of Constanta Municipal Hospital with a loving firmness, knowing how many



Artwork from HIV-infected children at the Pediatric Infectious Diseases Clinic in Constanta.

children count on her. She knows them all by name and knows their course of HIV disease from the beginning of her mission. Her logbook is an impressive diary of the hundreds of children she has cared for, many now dead. What she does not know is how many more will count on her in the years to come.

In some areas of Romania, there are estimates that half of the children born between 1987 and 1991 may be HIV-infected, but no one knows for sure. There are several bright spots in the hospital, like the day clinic adorned with art made by the children and begonias kept by the nursing staff. And there is a colorful playroom with space for drawing and playing. We were even treated to a brief song and dance routine by three boys who have benefited from the skills of a volunteer dance instructor. Some of these children were nearly packed in my suitcase to bring home. I wonder which of the children will still be there when I return.

On my eighth night in Romania, I met some of the street children of Bucharest,

Children with AIDS in the classroom at Victor Babes Hospital.

Bed-bound child with AIDS and severe encephalopathy at Victor Babes Hospital.

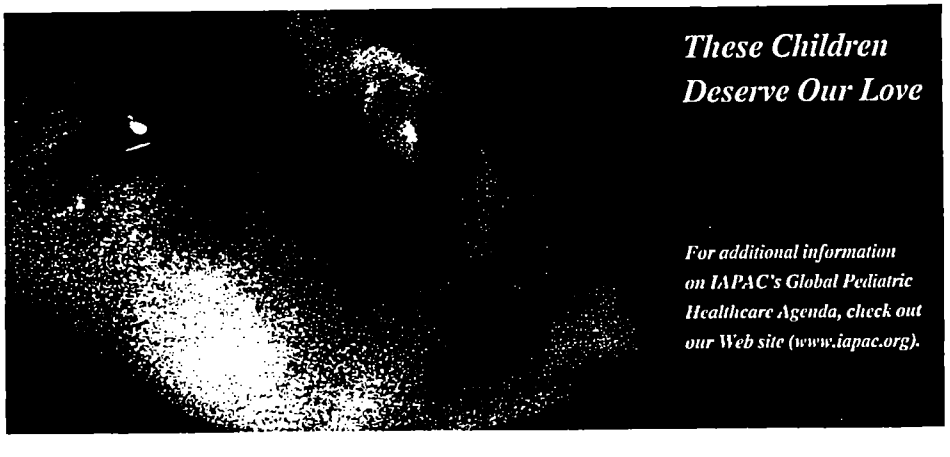
friends of a young Irish teacher and volunteer named Stephen Doyle. As we walked from Piazza Victoria, street kids joined our troop. They all knew or knew of Stephen Doyle. One of them stopped to give some coins to a beggar near a church. I was blown away by that one small act—a homeless child giving coins to a beggar! When we met the mobile medical team, more and more children and adolescents came out to see and touch Stephen Doyle. They hugged him and "high-fived" with him as he caught up on the events of the locals. He represented hope, bringing unconditional love to the disenfranchised children. Huddled around a small fire, young adolescents breathed in on plastic bags with glue inside, desperate to find an escape from another night on the cold streets. Many of the older ones rough-housed on the sidewalk, while Stephen spoke to each of the younger ones to assure their safety. One by one, the children came into the van for care of their injuries and infections. They each left with fresh clothes, some also with medicines from a drawer of mostly outdated donations. Once in a while, I noticed a child with thrush or other stigma of AIDS coming in because of a chronic cough or skin lesion. I had no doubt that HIV and tuberculosis had visited this neighborhood. These villains were silently preying on those with the least to lose. Like most of Romania, the medical team does the best they can with the meager resources they have available. Night after night, they tend the needs of the street children with rarely a word of thanks, opening themselves to whoever comes. And then there is Stephen Doyle. Never before have I experienced someone so giving. That night, none of the children who flocked to his side knew that he would be leaving Bucharest soon, after three and a half years of working in the trenches. With only his return-trip ticket remaining, he would return home hoping to raise more money to fund his work. He hoped to be back in three to six months, but what of the children during his absence.

The Victor Babes Hospital is a campus of hospitals dedicated to infectious diseases in Bucharest, and home to nearly 100 children with AIDS who live in two buildings recently updated by an Italian charity. Hundreds of children with AIDS come to the campus for medical care, and hundreds have died there during the past few years. Despite impressive facilities and many modern medical technologies, HIV cannot be stopped. Like the clinic in Constanta, new children with AIDS come to Victor Babes weekly. They are the lucky ones, who have access to in-hospital school and social services and hot meals daily, and a colorful American social worker named Mary Veal. Mary knows the importance of hugs and candy and being at the side of a dying child. She can tell incredible stories of children helping children to cope with the reality of AIDS. She is one of many saints who have dedicated their lives to these children, despite personal poverty and the recurrent heartbreak of childhood deaths.

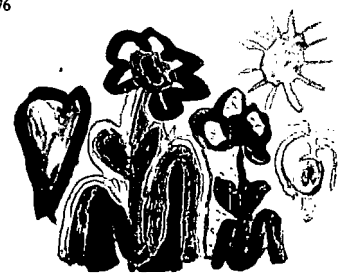
Two weeks in Romania was a long time. A long time to be away from my family, and a long time to spend in pediatric AIDS clinics. I did not miss hamburgers or pizza or other things. I was so well-attended by my host family in Bucharest that it felt like home in many ways. What I really missed was children as a priority in society. Every day I saw children who had no idea of the meaning of home or family. I still cannot fathom that an airline ticket from Romania to the US is nearly six years of wages for an average Romanian. It saddens me to know that many of the brightest Romanians are focused mainly on leaving, and not coming back. To me, it seems the country is in desperate times—economically in turmoil, and socially in disarray. It is an incredibly daunting task to consider what it will take to stabilize Romania. The land is so rich and the people so poor. Ultimately, the stability will have to come from within. The Romanian people must reclaim their past. The strength of the people to make the best of what they have will sustain them. AIDS is one of many vines choking the rosebush, holding back the beauty. I believe Romania will blossom again. ■

John A. Vanchiere, MD, PhD, is a third-year resident in pediatrics at Baylor College of Medicine, who will begin an Infectious Diseases Fellowship in August 1999. His stay in Romania was arranged by Baylor Pediatric AIDS Mentor Program, and funded by the Elizabeth Glaser Pediatric AIDS Foundation.

For a more complete background on IAPAC's work in Romania, go to http://www.iapac.org/about/godbless.html and http://www.iapac.org/about/thesechildren.html. The latter site also describes the work of Rodica Matusa, MD. Further information on Father Nicholas Murphy's program, Saint George's Romania Appeal, can be found on the Web at http://www.nonprofit.net/sgra. Stephen Doyle can be reached at 38 Virginia Park, Finglas South, Dublin 11, Ireland.



T19076



ELIZABETH GLASER PEDIATRIC AIDS FOUNDATION

March 10, 2000

Ms. Sandy Thurman
Director
Office of National AIDS Policy
736 Jackson Place
Washington, DC 20503-0007

Dear Sandy,

I am writing to you today to share exciting news. As a member of our "family" of supporters, I want you to be among the first to learn about a new initiative that we officially announced this week.

For a number of years, we have explored how we could expand our work to more broadly address the need for greater funding for pediatric research. As you know, we established the Foundation to raise monies for pediatric HIV/AIDS research when there were virtually no researchers in this field. Now, more than a decade later, our unwavering efforts have helped bring rapid advances in pediatric HIV/AIDS research, dramatically reduced transmission of HIV from mother to child in the United States, and established a solid community of pediatric HIV/AIDS researchers.

Our more than a decade of work in pediatric HIV/AIDS has taught us that HIV doesn't exist alone, isolated from other diseases. It is part of the whole world of diseases that attack our immune systems. And, what we learn about and from HIV impacts our understanding of other diseases, just as what we learn about other diseases brings insight to our knowledge of HIV. By studying how diseases are interconnected, we hope to accelerate better treatments for children with HIV/AIDS and other serious and life threatening diseases.

Building on this record and knowledge, we are excited to announce the Glaser Pediatric Research Network – a unique pediatric clinical research initiative. Our expanded focus will increase our knowledge about the affects of HIV/AIDS on children, further improve the health of our nation's children and accelerate the discovery of better medical treatments for children.

The Glaser Pediatric Research Network will enable pediatric researchers to catalyze rapid progress on the most promising clinical breakthroughs through an innovative, collaborative approach of supporting research, training and public policy advocacy. In effect, we will help do more for more children.

The Glaser Pediatric Research Network will bring together scientists from world class facilities, including: Children's Hospital-Boston/Harvard Medical School; Children's Medical Center at the University of California, San Francisco; Lucile Packard Children's

(next page, please)

2950 31st Street, Suite 125. Santa Monica. California 90405
Tel: (310) 314-1459 Fax: (310) 314-1469 www.pedAIDS.org

Hospital at Stanford University; Mattel Children's Hospital at UCLA; and Texas Children's Hospital/Baylor College of Medicine.

A goal of the Glaser Pediatric Research Network is to ensure that, as new therapies are developed, physicians learn more quickly about their pediatric applications. Access to larger patient pools, made possible by the Glaser Pediatric Research Network, will lead to faster and more reliable results, and hasten the transfer of research findings into patient treatments and therapies geared expressly for – and tested on – children.

As we discovered with AIDS, new problems can emerge in children that were not previously anticipated. The Glaser Pediatric Research Network will address those pediatric treatments that represent the greatest or newest opportunities to help children: our work will complement, not duplicate, that of others. The Glaser Pediatric Research Network's members are positioned to accomplish more – faster – than by working alone. In addition, the network will help to train the next generation of pediatric clinical investigators through a signature fellowship program, ensuring that new knowledge can be rapidly brought to children while addressing the alarming dearth of clinical scientists in pediatrics. The network will also advocate policies that improve children's health here and around the world.

Research teams will investigate a range of pediatric diseases, including disorders of the immune system, emerging infections, congenital birth defects and genetic diseases – in a lab without walls – and by doing so, accelerate the transfer of research findings to patient treatment.

Children are not "small adults." Yet today nearly 80 percent of all drugs prescribed for children have not been tested specifically in infants, children and adolescents, but are prescribed for them through anecdotal information. Recently, we worked with the federal government, advocacy, industry and nonprofit groups to champion the passage of new FDA regulations on drug development for children, requiring pharmaceutical companies to test drugs with applications for children in children.

Of our many legacies, the Foundation's role as an instrument of change and a voice for children will perhaps be the most enduring. Today, our biggest challenge in the quest to find a cure for HIV/AIDS has become the degree of complacency people feel about HIV and AIDS – that it has become viewed as a manageable disease.

The truth is we can only slow the advance of the virus, even as it continues to adapt to new medicines whose long term effectiveness, as well as their toxicity, is still unknown. And keep this in mind, only those in our wealthiest countries can afford these expensive therapies – HIV/AIDS is a ticking time bomb.

Our work is far from over. I am enclosing our expanded mission statement. Your ongoing support and commitment to the goals of the Foundation enable us to continue to move forward to a better future for our children. As we go forward with our work in pediatric HIV/AIDS, our work in bringing progress to developing countries, and now our work in pediatric clinical research, I hope we can count on your continued support to create a better world for our children and children everywhere.

Sincerely,

Paul Glaser
Chairman of the Board

The Elizabeth Glaser Pediatric AIDS Foundation

MISSION STATEMENT

The Elizabeth Glaser Pediatric AIDS Foundation creates a future that offers hope through pediatric research and programs world wide to ensure children are at the forefront of every scientific breakthrough.

Our mission is to identify, fund and conduct critical pediatric research that will lead to better treatments and prevention of HIV infection in infants and children, to reduce and prevent HIV transmission from mother to child and to accelerate the discovery of new treatments for other serious life threatening pediatric diseases.

Through stimulating and catalyzing collaborative and focused scientific research and by better understanding how diseases are interconnected, the Foundation improves the health and lives of children around the world.

The Foundation takes a leadership role in establishing a national pediatric research agenda, as well as promoting global education, awareness and compassion about HIV/AIDS in children.

Meeting to Discuss Collaboration between Programs Working to Prevent MTCT of HIV
April 14, 2000

Meeting Location
Elizabeth Glaser Pediatric AIDS Foundation
805 15th Street, NW, Suite #500
Washington, D.C. 20005
Phone: (202) 371-0099
FAX: (202) 371-2044

8:30 a.m. Welcome and Introductions

8:45 a.m. Guiding Principles for the Forum: Independence, Balance and Collaboration

Meeting co-chairs: Catherine Wilfert, M.D., Scientific Director,
Elizabeth Glaser Pediatric AIDS Foundation
Arthur Ammann, M.D., President,
Global Strategies for HIV Prevention

9:15 a.m. Brief Summary of Current Programs in MTCT Prevention

- CDC – Nathan Shaffer
- USAID – David Stanton
- UNICEF – David Alnwick
- Call to Action Project
  - Elizabeth Glaser Pediatric AIDS Foundation –Catherine Wilfert
  - Global Strategies for HIV Prevention –Arthur Ammann
- Fogarty International Center –Gerald Keusch
- World Health Organization – Winnie Mpanju

10:15 a.m. Break

10:30 a.m. Discussion of comparative advantages to various approaches to implementation

11:30 a.m. Potential areas for interaction and collaboration

- Public/private partnerships for funding
- Building capacity/ infrastructure either within or linked to maternal child health programs
- Development of resource data base of available "infrastructure" in MCH and MTCT through all means of support
- Partnerships for training (NIH/Fogarty, CDC, NGOs, etc)

12:30 p.m. Working lunch

1:00 p.m. Potential areas for interaction and collaboration (continued)

- Partnerships in public health education /agencies/NGO/universities
- Changing public perceptions of disease and interventions
- Partnerships in communication of follow up data, accurate information, updates, technical assistance with antibody testing (maternal diagnosis), virus testing (infant diagnosis)
- Partnerships in bulk purchase of drugs/ diagnostic kits

1:30 p.m. Discussion of implementation and operational research questions

- How does a single pilot site expand to encompass additional populations? (Urban to rural, city or region to country)
- Is ART intervention feasible and potentially beneficial if VCT is accessible in high prevalence area but refused by a large proportion of women?
- Is ART intervention feasible and potentially beneficial if VCT is not yet accessible in high seroprevalence areas?
- When (if ever) is ascertainment of infection in HIV-exposed infants not a part of the implementation program? What long-term follow-up of infant/child mortality can be successfully accomplished?
- What is the role of antibiotic prophylaxis if ART is not available?
- How can laboratory capacity be utilized in a broader geographic area?

2:30 p.m. Emerging issues affecting implementation of programs to prevent MTCT of HIV

- Drug resistance
- Orphans
- Treatment of HIV of the mother
- Misinformation.

3:30 p.m. Conclusions

- Future forum meetings
- Identification of additional resources and collaborations

4:30 p.m. Adjourn

Tentative Invite List - CTA Collaboration Meeting

	First Name	Last Name	Organization				
1.	David	Alnwick	UNICEF	● Yes	○ No	○ TBD	○ Not I
2.	Arthur	Ammann	Global Strategies for HIV	● Yes	○ No	○ TBD	○ Not I
3.	Contrance L.	Blowers	Glaxo Wellcome	● Yes	○ No	○ TBD	○ Not I
4.	Kenneth	Bridbord	Fogarty International Center	● Yes	○ No	○ TBD	○ Not I
5.	Kate	Carr	Elizabeth Glaser Pediatric AIDS	● Yes	○ No	○ TBD	○ Not I
6.	Willard	Cates	Family Health International	○ Yes	● No	○ TBD	○ Not I
7.	Mary Glenn	Fowler	Centers for Disease Control	● Yes	○ No	○ TBD	○ Not I
8.	Helene	Gayle	Centers for Disease Control &	○ Yes	● No	○ TBD	○ Not I
9.	Claudes	Kamenga	Family Health International	● Yes	○ No	○ TBD	○ Not I
10.	Mark	Kane	Bill and Melinda Gates	○ Yes	● No	○ TBD	○ Not I
11.	Trish	Karlin	Elizabeth Glaser	● Yes	○ No	○ TBD	○ Not I
12.	Gerald	Keusch	Fogarty International Center	● Yes	○ No	○ TBD	○ Not I
13.	Michel	Lavollay		○ Yes	○ No	● TBD	○ Not I
14.	Ellen	Marshall	UN Foundation	○ Yes	○ No	● TBD	○ Not I
15.	Eric	Mercier	UNICEF	● Yes	○ No	○ TBD	○ Not I
16.	Lynne	Mofenson	NIH	● Yes	○ No	○ TBD	○ Not I
17.	Neal	Nathanson	Office of AIDS Research	○ Yes	● No	○ TBD	○ Not I
18.	Gordon W.	Perkin	Bill and Melinda Gates	○ Yes	○ No	● TBD	○ Not I
19.	Riku	Rautsola	Boehringer Ingelheim	○ Yes	● No	○ TBD	○ Not I
20.	Joseph	Saba	Axios International Consultants,	○ Yes	● No	○ TBD	○ Not I
21.	Nathan	Shaffer	Centers for Disease Control	● Yes	○ No	○ TBD	○ Not I
22.	James	Sherry	UNAIDS	○ Yes	● No	○ TBD	○ Not I
23.	Janis	Spire	Elizabeth Glaser Pediatric AIDS	● Yes	○ No	○ TBD	○ Not I
24.	David	Stanton	USAID - HIV/AIDS Division	● Yes	○ No	○ TBD	○ Not I
25.	Nelle	Temple	WHO	○ Yes	● No	○ TBD	○ Not I
26.	Sandra	Thurman	White House Office of National	○ Yes	○ No	● TBD	○ Not I
27.	Catherine M.	Wilfert	Elizabeth Glaser Pediatric AIDS	● Yes	○ No	○ TBD	○ Not I
28.	Susie	Zeegen	Elizabeth Glaser Pediatric AIDS	● Yes	○ No	○ TBD	○ Not I

805 15th Street, NW
Suite 500
Washington, DC 20005
Phone: 202/371-0099
Fax: 202/371-2044

The Elizabeth Glaser Pediatric AIDS Foundation

Fax

To: Sandy Thurman From: Prema Kerollis

Fax: (202) 456-2438 Date: 7/27/99

Phone: Pages:

Re: A Night to Unite CC:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

•Comments:

JOIN JAMES CARVILLE AND MARY MATALIN

AND A SURPRISE MUSICAL GUEST

FEATURING A SPECIAL PERFORMANCE BY SANTITA JACKSON AND CHRIS WILLIS

Tuesday, June 22, 1999

SIX-THIRTY RECEPTION FOLLOWED BY SEVEN-THIRTY DINNER

THE NATIONAL BUILDING MUSEUM
WASHINGTON, DC

COCKTAIL ATTIRE VALET PARKING

THIS EVENING'S VIDEO PRESENTATION HAS BEEN GENEROUSLY UNDERWRITTEN BY THE WALT DISNEY COMPANY.

ELIZABETH GLASER PEDIATRIC AIDS FOUNDATION

A Night to Unite

Elizabeth Glaser Pediatric AIDS Foundation

The Elizabeth Glaser Pediatric AIDS Foundation is the leading national non-profit foundation dedicated to identifying, funding and conducting critical pediatric AIDS research worldwide. Co-founded by Elizabeth Glaser, Susan DeLaurentis and Susie Zeegen, the Foundation is committed to reaching its goals while maintaining the lowest possible administrative overhead, which is currently less than 6%

This year, as we commemorate the Foundation's tenth anniversary with the message, "A Decade of Progress, A Decade of Promise", it is natural to look back at where we started and measure how far we have come We have made important progress — developing an entire research community dedicated to pediatric HIV/AIDS where none existed before, raising more than $75 million to fund pediatric AIDS research and programs, securing new treatments to improve quality of life and life expectancy of infected children, and working to ensure that more drugs that are available to adults are becoming available to children

Around the world each day 1,600 children are infected with HIV/AIDS and no affordable treatment is yet available in developing countries In the United States new infections are increasing among women and adolescents. While these statistics are daunting, research breakthroughs bring tremendous hope The Foundation believes that with your support, a generation of children free of HIV/AIDS is an achievable goal

Senator Orrin G. Hatch

and

Senator Barbara Boxer

REQUEST THE PLEASURE OF YOUR COMPANY AT A SUMMER DINNER

CELEBRATING

A Decade of Progress, A Decade of Promise

HONORARY CO-CHAIRS

President & Mrs. William J. Clinton
President & Mrs. Gerald Ford
President & Mrs. Ronald Reagan
Mrs. Lyndon B. Johnson

HONORARY COMMITTEE

Honorable Bruce Babbitt
Honorable Dan Glickman
Honorable Donna Shalala

Honorable Spencer Abraham
Honorable Daniel K. Akaka
Honorable John Ashcroft
Honorable Max Baucus
Honorable Evan Bayh
Honorable Robert F. Bennett
Honorable Joseph R. Biden, Jr.
Honorable Jeff Bingaman
Honorable John Breaux
Honorable Sam Brownback
Honorable Conrad Burns
Honorable John H. Chafee
Honorable Max Cleland
Honorable Thad Cochran

Honorable Susan M. Collins
Honorable Kent Conrad
Honorable Paul Coverdell
Honorable Larry E. Craig
Honorable Michael D. Crapo
Honorable Tom Daschle
Honorable Mike DeWine
Honorable Christopher J. Dodd
Honorable Richard J. Durbin
Honorable John Edwards
Honorable Dianne Feinstein
Honorable Peter G. Fitzgerald
Honorable Bill Frist
Honorable Slade Gorton
Honorable Bob Graham

Honorable Charles E. Grassley
Honorable Judd Gregg
Honorable Chuck Hagel
Honorable Tom Harkin
Honorable Jesse Helms
Honorable Ernest F. Hollings
Honorable Tim Hutchinson
Honorable James M. Inhofe
Honorable Daniel K. Inouye
Honorable James M. Jeffords
Honorable Tim Johnson
Honorable Edward M. Kennedy
Honorable J. Robert Kerrey
Honorable John F. Kerry
Honorable Herb Kohl

Honorable Mary L. Landrieu
Honorable Frank R. Lautenberg
Honorable Patrick J. Leahy
Honorable Carl Levin
Honorable Joseph I. Lieberman
Honorable Trent Lott
Honorable Richard G. Lugar
Honorable Connie Mack
Honorable John McCain
Honorable Barbara A. Mikulski
Honorable Patty Murray
Honorable Don Nickles
Honorable Jack Reed
Honorable Harry Reid
Honorable Charles S. Robb

Honorable Pat Roberts
Honorable William V. Roth
Honorable Rick Santorum
Honorable Paul S. Sarbanes
Honorable Charles E. Schumer
Honorable Richard C. Shelby
Honorable Gordon Smith
Honorable Olympia J. Snowe
Honorable Arlen Specter
Honorable Ted Stevens
Honorable Craig Thomas
Honorable Robert G. Torricelli
Honorable Paul Wellstone
Honorable Ron Wyden

A Night To Unite

A special 'Thank You' to our underwriters

Bell Atlantic Corporation
GTE

Their generous support ensures that all proceeds from this event will benefit the research and educational programs of the Elizabeth Glaser Pediatric AIDS Foundation

Our heartfelt thanks are extended to the following supporters for their generous contributions.

ANGELS

Abbott Labs
Amgen
America Online
AT&T
Glaser Family Foundation
Glaxo Wellcome
Novell, Inc
Pfizer
Philip Morris Companies, Inc
The Barksdale Group, LLC
Warner Lambert

BENEFACTORS

Bristol-Myers Squibb Company
Joseph E. Seagram & Sons, Inc
Schering-Plough Corporation

PATRONS

American Express Company
Harmon Family Fund
SBC Communications, Inc.
Starwood
The Anschutz Foundation

FRIENDS

AIG
American Airlines
American Hospital Association
Amerigroup Corporation
Amdahl Corporation
Baxter
Cisco Systems
Daimler Chrysler Fund
Delta Airlines
Ernest Gallo
Global Crossing
Hill & Knowlton
Hotel Employees & Restaurant Employees International Union
Mass Mutual
The TJX Companies, Inc
United Airlines
Viacom

A Night To Unite

- ☐ YES, I/WE WOULD LIKE TO BE AN ANGEL $100,000
  4 tables of 10, most preferred seating at gala. Recognition from the podium by the Master of Ceremonies and in the evening's speaking program. 20 invitations to VIP reception prior to gala. Recognition in press releases, media events and all printed materials.
- ☐ YES, I/WE WOULD LIKE TO BE A BENEFACTOR $50,000
  2 tables of 10, preferred seating at gala. Recognition in the evening's speaking program. 10 invitations to VIP reception prior to gala. Recognition in printed materials.
- ☐ YES, I/ WE WOULD LIKE TO BE A PATRON $25,000
  2 tables of 10 at gala. Recognition in the evening - speaking program. 4 invitations to VIP reception prior to gala. Recognition in printed materials.
- ☐ YES, I/WE WOULD LIKE TO BE A FRIEND $10,000
  1 table of ten at gala. 2 invitations to VIP reception prior to gala. Recognition in printed materials.
- ☐ Please reserve _____individual ticker(s) at $1,500 per ticker
- ☐ I/We are unable to participate in any of the above but wish to contribute $ _____

PLEASE MAKE CHECKS PAYABLE TO: Elizabeth Glaser Pediatric AIDS Foundation
We also accept VISA and Mastercard. For more information call 202/371-0099

$105 per individual ticket is not tax deductible. The Foundation is a 501 (c) (3) non profit organization.

Meeting to Discuss Collaboration between Programs Working to Prevent MTCT of HIV
April 14, 2000

Meeting Notes

On April 14, 2000 the Elizabeth Glaser Pediatric AIDS Foundation convened a meeting among leading funders of programs seeking to prevent mother-to-child transmission (MTCT) of HIV in developing countries. The goal of the meeting was to discuss current and future programs and opportunities for synergy and collaboration among the groups who were present. The forum was guided by principles that acknowledged the need for independence, balance, and collaboration among the various programs. The meeting was co-chaired by Dr. Catherine Wilfert, Scientific Director of the Elizabeth Glaser Pediatric AIDS Foundation, and by Dr. Arthur Ammann, President of Global Strategies for HIV Prevention.

In an effort to spend the majority of our time discussing opportunities to work together, a minimum amount of time was spent on a review of ongoing programs. Brief summaries of programs from the following groups were provided, and materials describing the programs were sent to participants in advance of the meting. Additional copies of these materials are available upon request.

- CDC
- USAID
- UNICEF
- Elizabeth Glaser Pediatric AIDS Foundation
- Global Strategies for HIV Prevention
- Fogarty International Center
- World Health Organization
- Family Health International

A review of the programs led to a discussion of comparative advantages to various approaches to implementation. Each participating organization was recognized as having a particular strength which could be mobilized towards the successful implementation of programs to reduce MTCT, particularly in resource-limited developing countries with a high prevalence HIV vertical transmission.

- The **CDC** provides technical expertise including resources to assist with HIV testing, assistance with obtaining surveillance data, and helping countries to obtain Ministry of Health endorsement of policies or approval of new technologies including antiretroviral drugs. The LIFE initiative provides some resources specifically for interventions to diminish mother-to-child transmission which allows the CDC to expand their epidemiological research to operational research assisting in implementation.
- **UNICEF** has offices in more than 160 countries. UNICEF has pilot projects to prevent perinatal transmission of HIV which provide technical assistance, the support to the implementation, the monitoring, and the evaluation in selected sites in nearly 20 countries. The pilot projects are providing data on the successes and problems in implementation.

- **USAID** -Resources from the LIFE project are available to implement prevention programs including MTCT. USAID has experience in implementation including obtaining laboratory test supplies, therapeutic agents and is established in sites in many countries.
- **UNAIDS** guided the perinatal clinical trial collaborative sharing of information. UNAIDS has served to help to collect surveillance data and to establish policy and has excellent contacts in many countries.
- **EGPAF**, in collaboration with **Global Strategies for HIV Prevention**, has flexibility as an NGO to act quickly. As a grant-making organization with designated resources, EGPAF can support MTCT implementation projects.
- **Fogarty International Center** has strengths in training and research capacity strengthening in developing countries including training investigators from developing nations, training investigators in the developed world to work in the developing world, creating infrastructure for research, and has knowledge of existing research capacity in developing countries.
- **WHO** works together with its UN partners (UNICEF, UNFPA and UNAIDS secretariat) in the global initiative to reduce the MTCT of HIV (established in 1998). The Inter Agency Task Team (IATT) for the reduction of MTCT of HIV has adopted the following three-pronged strategy: 1) Primary prevention of HIV among parents to be; 2) Prevention of unwanted pregnancies; and 3) Prevention of transmission from HIV-positive women to their offspring. Within the IATT, WHO is responsible for: 1) Technical support to research, local capacity building and monitoring and evaluation of MTCT interventions; 2) Development of technical norms and standards; 3) Promoting the integration of interventions within health systems; 4) Strengthening global surveillance; and 5) Updating drug policies and strategies.
- **FHI** offers technical assistance, support for monitoring and evaluation, and contributes to capacity building of local institutions through its headquarters and in-country staff.
- **UN Foundation** has ability to make grants to UN agencies (applications are due in September). They already have child-survival projects initiated in Madagascar, Zimbabwe, Zambia, Nigeria, Tanzania, Malawi, Mali, and Senegal.

There are several challenges that we face in the implementation of programs to prevent MTCT of HIV. By stressing our comparative advantages, we may be able to address these challenges more effectively. The challenges include:

- How does a single pilot site expand to encompass additional populations? (Urban to rural, city or region to country)
- In the transition from a successful intervention to implementation of the intervention what questions must be addressed by "operational research"?
- Is ART intervention feasible and potentially beneficial if VCT is accessible in high prevalence area but refused by a large proportion of women?
- Is ART intervention feasible and potentially beneficial if VCT is not yet accessible in high seroprevalence areas?
- When is ascertainment of infection in HIV-exposed infants not a part of the implementation program?
- Can child survival with a successful intervention be assessed?
- How can laboratory capacity be utilized in a broader geographic area?
- How do we fight misinformation?

- What can be done to increase uptake of testing? Can fear of diagnosis be diminished? Will a successful intervention change the perceived risk of diagnosis or enhance the need to know mom's HIV status? Can we change the public perceptions of disease and interventions?
- How do we promote regionalization and best practice sharing?

Potential areas for interaction and collaboration include:

- ***Streamlining counseling and testing to reach the maximum number of women.*** Routine testing with right of refusal should be considered for high prevalence areas. Lengthy, individual counseling is not optimal. We need to develop better models of VCT, perhaps incorporating other important conditions during pregnancy e.g. anemia, malaria, syphilis, and vitamins. Materials are needed to facilitate incorporating testing into routine antenatal care. We should consider one page counseling handouts or videos (different for nevirapine or zidovudine).
- ***Health education at all levels*** (agencies/NGO/universities, community - outside of health center) ***to change perception of MTCT programs.*** FHI and USAID have begun such programs. Involvement of key NGOs and community-based organizations is critical.
- ***Training of future in-country leaders to direct MTCT programs.*** Collaboration between groups (NIH/Fogarty, CDC, NGOs, EGPAF) could enhance training efforts. Create leadership training in country. Leaders need knowledge of legislative function, advocacy, and sociocutureal circumstances. EGPAF is exploring the development of such a program.
- ***Integration of capacity and infrastructure for MTCT prevention programs into maternal-child health programs*** (child survival, prevention, and community programs).
- ***Public/private funding partnerships.***
- ***Development of resource data base of available "infrastructure" in MCH and MTCT*** through all means of support in countries where we will attempt to implement MTCT programs. This should include overall MTCT activities including training and technical assistance (antibody testing, maternal diagnosis, virus testing, infant diagnosis, etc.) on a country-by-country basis from all participating organizations. FIC can contribute to this immediately, as Dr. Bridbord (FIC) and Dr. Reck (OAR) have begun this for NIH.
- ***Bulk purchase of drugs/ diagnostic kits.***
- ***Combined effort to negotiate and interact with governments.***
- ***Reference laboratory development and expansion of services***
- ***Rapid test registration, distribution and technical assistance***

Next steps:

- Forum should meet again in 6 months.
- Try to identify a country where all of us are working together and attempt countrywide implementation.
- Malawi: Attempt to link UNICEF site with CDC for technical assistance. EGPAF and Doris Duke Foundation both cultivating proposals there which should be coordinated if possible.
- Kenya: Leadership and networks exist in Kenya, but there is a lack of political will to implement comprehensive programs. Try to enhance coordination between CDC, FIC, USAID, EGPAF, and FHI programs. We should try to encourage a dialogue between Kenya and Uganda, where programs have been successful. Relationships with Minister of Health are needed immediately.

- Rwanda: Explore ways to link CDC, USAID, FHI, and EGPAF efforts there.
- Uganda: Need resources and coordination of plans. MRC, EGPAF, Doris Duke, and CDC all have programs there. Need to explore areas of collaboration.
- Botswana: - There was agreement that HIV seroprevalence makes MTCT prevention programs an emergency. The country has a committed and has resources. Need to consider Nevirapine to those refusing testing and/or presenting late in pregnancy. Can EGPAF help CDC and UNICEF in this effort?
- India: INCLEN Fellows are trained and in place. They could be an in-country resource. EGPAF will contact David Fraser and Chad Gardner for names.
- Haiti: UNICEF and EGPAF should consider a joint site visit. FHI also has programs there.
- Ivory Coast: French have initiated treatment program. Could it be linked with MTCT program through UNICEF or the LIFE initiative?
- Nigeria: Send EGPAF/CTA application to Nathan Shafer and Bill Blattner for help. FHI also has programs there.
- Work to place antiretrovirals to prevent MTCT on list of essential drugs from WHO.
- Include regulatory bodies (FDA, etc) in these discussions as we try to scale-up implementation.
- Attempt to create e-mail dialogue with existing programs including missions.
- Involve the faith-based community in the next round of talks.