August 27, 2009

Dear Friends and Colleagues;

The Global Health Program of the Council on Foreign Relations wishes to convey a brief bit of news. In this update please find:

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**Personnel changes and news from the Council**

Friday, August 28th marks Kammerle Schneider's final day with the Global Health Program. After nearly three years as Research Associate, and then Assistant Director of the Global Health Program, Kamm is moving on to become a policy analyst at the International AIDS Vaccine Initiative. There, Kamm will focus on international policy issues related to HIV vaccine development and use.

Those of you who have had occasion to work directly with the Global Health Program, or attend our various meetings, know that Kammerle is far more than a typical “Research Associate”; in recent months we have co-authored a number of pieces, and Kamm has proven indispensable in liaison work with the Modernizing Foreign Assistance Network, various maternal health programs, advice to Capitol Hill and the AIDS 2031 Project. We wish Kammerle great fortune in her new IAVI job.

We are pleased to announce appointment of El’Haum Alavian, who will fill Kammerle’s shoes. El’Haum will start with the Global Health Program on September 8th. She comes to us with a great deal of international work experience in public health and development. El’Haum did her masters work at the Harvard School of Public Health, with Michael Reich serving as advisor to a powerful thesis on the Bill & Melinda Gates Foundation. Please join us in welcoming El’Haum alavian@cfr.org.

We know that many of you use spam-blockers to keep out unwanted mail, and have set them to allow incoming messages from Kammerle. If you would like to continue receiving these updates, please immediately reset your spam blocker to allow ealavian@cfr.org and dbarker@cfr.org.
(During the transition period you may receive e-mails and other communications from Daniel Barker (dbarker@cfr.org), a NYU graduate who is serving as a temporary RA in Global Health. We thank Dan for his able assistance.)

Peter Navario returned this week from a long stay in Cape Town, dealing with the South African HIV/AIDS crisis. Navario and RA Curran Kennedy will be launching a roundtable series on PEPFAR and the future of U.S. overseas support of HIV programs. If you have strong interests in this area and would like to contribute or participate in the series, please send insights and queries to Curran at c kennedy@cfr.org.

White House H1N1 Report

There was considerable excitement in the scientific community during the Obama transition period as the likes of Harold Varmus, John Holdren and Eric Lander were named to top positions in the White House. After years of Executive Branch skepticism regarding evolution, climate change, basic toxicology and the like, having a cast of Nobel laureates advise the President on scientific matters was, to say the least, refreshing.

The first big test of the President’s Council of Advisors on Science and Technology (aka PCAST) has come far sooner, and with greater urgency, than was imagined last winter when the august group was assembled, amid expected return of the H1N1 “swine flu” virus. This week the PCAST released its recommendations, in the form of the “Report to the President on U.S. Preparations for 2009 H1N1 Influenza,” a well reasoned, sober assessment of U.S. capacity to respond to flu, and the likely scale of this fall’s epidemic. ([www.ostp.gov/cs/pcast](http://www.ostp.gov/cs/pcast))

"As the nation prepares for what could be a challenging fall, it is crucial that our public health decisions are informed by the very best scientific and technological information," said John P. Holdren, Assistant to the President for Science and Technology and a co-chair of PCAST.

Overall, the PCAST concludes that H1N1 is likely to return to the United States (and North America, generally) in September, with the outbreak peaking sometime in mid-October. The vaccine supplies necessary to protect Americans will not be available until after the outbreak has peaked, and both illness rates and hospitalizations will stretch the nation’s response capacity to its limits. Among the PCAST forecasts are:

- **About half the U.S. population will get H1N1 flu this fall/winter season, and 20-40% of the population will have symptomatic influenza.**

- **Although H1N1 is a relatively mild virus, it is extremely contagious, particularly among children and young adults. For this reason, infection will be widespread, and some 300,000 people in the U.S. will be hospitalized.**
• Some 30,000 to 90,000 people in the U.S. will die from their infections. That range is wide, with the bottom figure about what we see in the U.S. from normal seasonal flu, and the top figure representing a 300% increase in the normal annual burden of flu death.

• The overall federal response to H1N1 to date has been “very impressive.” The report states: “Overall, the Working Group was deeply impressed by the efforts underway across the Federal Government—including the breadth of issues being anticipated and addressed, the depth of thinking, the overall level of energy being devoted, and the awareness of potential pitfalls. The response is probably the best effort ever mounted against a pandemic, reflecting both past preparedness efforts and the quality and commitment of the people involved.”

• The two tough areas that need planning improvement are in vaccine production and likely use rates on Intensive Care Units (ICUs). “During the [H1N1 epidemic] peak, 1 or 2 out of every 2,000 Americans might be hospitalized. Cases requiring mechanical ventilation or intensive care could reach 10 to 25 per 100,000 population, requiring 50 to 100 percent or more of the total ICU capacity available in the United States [our emphasis] and placing great stress on a system that normally operates at 80 percent of capacity. Because adult ICUs are not prepared to care for pediatric patients, there could be a particular shortage of facilities for sick children. In particular locations, the stress on the health care system could grow even more acute, as large outbreaks occur in prisons, schools, and isolated communities with limited health care access, such as Native American reservations. As awareness of the pandemic spreads, pressure on emergency departments could mount, with long lines and a need for triage of mild cases and non-influenza cases.”

• The epidemic could take an economic toll in the U.S., particularly if its onset is sudden, and it sickens half the American population. “Alongside these health-related burdens, substantial absenteeism from work and school could occur, as sick children stay home, schools with large outbreaks close, and parents are forced to stay home either because of their own illness or to take care of sick children. Key members of the social infrastructure, such as police officers and firefighters, are increasingly home ill.”

• The most plausible scenario reveals that, “By the end of 2009, 60 to 120 million Americans would have experienced symptomatic infection with 2009-H1N1; nearly 1 to 2 million would have been hospitalized, with about 150,000-300,000 cared for in ICUs; and somewhere between 30,000 and 90,000 people would have died, the majority of them under 50 years of age.”

In short, fasten your seatbelt, America – we’re in for a bumpy ride.

Of course the PCAST report is rife with caveats, and the above estimates represent one scenario. The return of H1N1 could look very different; milder or more severe. As Nobel laureate Harold Varmus
explained to TIME Magazine: "There are some people taking the figures too literally. But it's a wake-up call. The public wants to be aware that while these numbers are not predictive, they are certainly well within the realm of possibility."

**Are the scenario numbers realistic?** They are certainly within the ranges generated by numerous computer models and exercises recently. For example, Marya Zilberberg recently published an estimate in *PLoS* ([http://knol.google.com/k/marya-d-ziberberg/swine-origin-influenza-a-h1n2-virus-and/3hti](http://knol.google.com/k/marya-d-ziberberg/swine-origin-influenza-a-h1n2-virus-and/3hti)) that is based on numbers from Mexico this spring, and uses Monte Carlo simulation math to extrapolate for the U.S. this fall. Like PCAST, the Zilberberg study reckons about 46 million people in the U.S. will be infected this fall, and some 2.7 million will be hospitalized. Zilberberg differs with PCAST on death toll, however, because her model finds the U.S. is so deficient in Intensive Care Unit capacity that 200,000 people will die of H1N1, more than half, because they could not get into an ICU.

A summary and bibliography of estimates can be found at: “Mortality and morbidity burden associated with A/H1N1pdm influenza virus.” [http://knol.google.com/k/mark-miller/mortality-and-morbidity-burden/1y43omtho1mv6/3?collectionId=28qm4w0q65e4w.1&position=1#](http://knol.google.com/k/mark-miller/mortality-and-morbidity-burden/1y43omtho1mv6/3?collectionId=28qm4w0q65e4w.1&position=1#)

While this expert briefing avoids adopting specific numbers and forecasts, it does off this chilling, accurate summary of what factors could tip the balance towards far worse rates of illness and death:

> On the negative side, other factors could lead to a worsening situation in the coming months. These include winter-seasonal factors in the Northern Hemisphere, including presence of bacterial pathogens such as S.pneumo and MRSA, who are responsible for a large fraction of influenza-triggered deaths in seasonal epidemics and past pandemics. As discussed previously, viral acquisition of virulence factors by mutation would be unfortunate, as would acquisition of antiviral resistance determinants.

The European Centre for Disease Prevention and Control recently surveyed H1N1 epidemiological 2009 data for 28 countries, finding that 51% of all deaths have been among people aged 20-49 years, and only 12% were among people over 60 years of age. This is striking, as it is a near-perfect reverse of normal flu trends, and mirrors what was seen, demographically, in 1918. While the PCAST tried to factor in such trends, it is extremely difficult to know how influenza dynamics, illnesses and death rates may vary if transmission and illness is primarily among young adults.

Officials with the Centers for Disease Control and Prevention have already signaled quiet dispute with the PCAST, insisting to reporters this week that the numbers of hospitalized and dead will be far smaller that the White House reckons, possibly well below seasonal normal flu levels.

A French study of infection and death due to H1N1 in New Caledonia and Mauritius offers stark contrast to the CDC’s optimism. Based on careful assessment of 30,000 reported infections in New Caledonia, and 70,000 in Mauritius, the French find that Acute Respiratory Distress Syndrome (ARDS) occurs far more commonly with the “swine flu” than normal seasonal influenza. Moreover, the researchers conclude that, “lethality due to H1N1pdm to be 1 per 10,000 infections, about 100 times more
than regular seasonal influenza.” The researchers acknowledged that most of these ARDS cases and deaths were due to secondary bacterial infections, but warned that such profound lethality could be the norm for H1N1 in poor countries.

Flu vaccination might significantly reduce such bacterial deaths. Fawziah Marra, of the University of British Columbia, reviews Canada's experience with seasonal flu and secondary bacterial infections in the September 1st issue of Clinical Infectious Diseases. Since 2000 the province of Ontario has urged seasonal vaccination of all residents over 6 months of age, while many other Canadian provinces shun such broad use of immunization. Marra found that: “The broader immunization effort in Ontario was associated with a 64 percent decline in these antibiotic prescriptions compared with the other provinces that maintained targeted vaccination programs. Additionally, influenza-associated mortality fell 39 percent. Flu-related hospitalizations, emergency department use, and doctors’ office visits also fell an average of 52 percent.”

Some flu experts have argued that this fall’s outbreak will, almost by definition, be more virulent than the spring experience, based on historic trends with influenza pandemics. Researchers at the NIAID say this is wrong: There are no inevitabilities with flu.


Can U.S. hospitals cope? The PCAST definitely casts some doubt on hospitals' capacity to handle a surge in influenza cases, underscoring the limited numbers of staffed ICUs nationwide. According to a new study from the California Nurses Association/National Nurses Organizing Committee, registered nurses in eight states are concerned that lack of essential supplies will put their lives in peril. Missing, they say, are isolation facilities for so-called super-spreader patients; proper respiratory gear and masks for healthcare workers and sufficient staffing to cover hospital wards if some healthcare workers either refuse to work, or themselves take ill.

Will healthcare workers get vaccinated? Will anybody? There are two sides to those questions: Will there be vaccine available, and if it is, will healthcare workers accept it? Though some polls show significant numbers of healthcare workers and members of the general public will likely refuse vaccination, the PCAST focused on availability of vaccine. Given production problems in vaccine manufacture, it is clear that no country – including the U.S. – will have significant quantities of product before the northern hemisphere flu season hits, or even when it peaks. Here is how the PCAST sees the vaccine situation:

Although revisions of the schedule are under consideration by DHHS, plans announced in July by the HHS Secretary would provide the first significant quantities of 2009-H1N1 vaccine in mid-October; an effective immune response would take another 2 to 4 weeks to develop after vaccination. [It appears that] the resurgence of the epidemic would start in September and peak in mid-October. If this model is approximately correct with respect to timing, a vaccination campaign would not begin to protect vaccinees until well after the epidemic had peaked.

We thus recommend a “hedged” strategy in which an initial amount of product is packaged “on risk,” assuming a 15 microgram dosage, and the remainder is packaged when dosing and safety information becomes available in mid-September following
the first results of clinical trials conducted by the NIH and industry. The risks of this course of action appear to be relatively low: some vaccine product could be wasted by filling vials at sub-optimal doses. If a somewhat larger dose is required, however, physicians can administer additional vaccine (e.g., a second dose of 15 micrograms to achieve 30 micrograms). The optimal amount of vaccine will need to be determined from immunological responses in clinical tests and an appropriate decision analysis. However, it seems clear that filling and finishing up to 40 million doses could have a substantial effect on the incidence of disease and death in these vulnerable populations.

Flu vaccine opponents variously assert that the Government will force people to be vaccinated; the Government is letting pharmaceutical companies put toxic chemicals in the immunizations, which may cause autism or birth defects or “Gulf War Syndrome”; there is no actual pandemic, merely a vast conspiracy to bring profits to drug companies. If the Administration puts inadequately tested products into use, it risks fueling these fires of opposition.

One obvious way to stretch out vaccine supplies, and conjure more product, faster, would be addition of adjuvants. Some adjuvant products are known to dramatically boost the efficacy of flu vaccines, allowing a finite amount of active antigen to immunize ten times (or more) as many people. European countries have approved such adjuvants, and will be stretching out their vaccine supplies this year. But the PCAST notes that adjuvants are not yet FDA-approved for use in any U.S. vaccines.

Introduction of adjuvants might provoke further outcry regarding vaccine safety, fanning the fires of conspiracy thinking. But the World Health Organization and European Union argue that unless the U.S. stretches out its vaccine supplies, most of the world population will have no vaccine, at all.

Recently, we argued that the U.S. has a moral obligation to the rest of the world to use adjuvants, and share excess vaccine supplies with poor countries. [http://blogs.sciencemag.org/scienceinsider/2009/07/laurie-garrett.html](http://blogs.sciencemag.org/scienceinsider/2009/07/laurie-garrett.html) Tadashi Yamada, Vice President of the Bill & Melinda Gates Foundation, recently argued that the U.S. bears a serious onus to find ways to get vaccine to the rest of the world, though he made no direct mention of adjuvant use. [http://content.nejm.org/cgi/content/full/NEJMp0906972](http://content.nejm.org/cgi/content/full/NEJMp0906972)

The PCAST framed the international equity-of-access question as follows:

There is reason to believe that under-resourced countries may be at special risk during influenza epidemics. For instance, a recent study projected that, if a 1918–19-like pandemic were to happen today, 96 percent of the deaths would occur in the developing world. Given the relatively young demographic profile, the widespread prevalence of co-morbidities such as malnutrition, HIV/AIDS, and tuberculosis, and the fact that many of these countries do not have functional health systems, the 2009-H1N1 pandemic could have a devastating impact on developing nations.

While recognizing that issues with basic health infrastructure in developing countries cannot be remedied in the short run, the availability of materials—including 2009-H1N1 vaccine, antiviral medications, antibiotics, personal protective equipment, and other essential medical materials—may help mitigate the impact of the epidemic. Unfortunately, global supplies of the most important of these items—vaccines and antiviral medications—are expensive and severely constrained; thus, large quantities
are unlikely to be readily available to developing nations. The vast majority of production capacity for 2009-H1N1 vaccine, for instance, already has been reserved by industrialized countries.

Mindful of the urgency of protecting the U.S. population, the Working Group nonetheless believes that the United States can play an important role in efforts to reduce the impact of the 2009-H1N1 pandemic in developing countries, both independently and in collaboration with other countries and WHO. We recognize that the current lack of a U.S. Agency for International Development (USAID) Administrator and a Director of the Office of Global Health Affairs at DHHS has limited the institutional capacity to work on these issues. Nonetheless, we believe these issues should be addressed.

The Council's Global Health Program has long complained of the slow pace of Obama Administration appointments, particularly to USAID and OGHA leadership. At this writing, no names figure prominently in rumored appointment to head either office.

In the absence of leadership at USAID and OGHA, the White House science advisors suggest President Obama immediately name a White House Homeland Security Advisor to lead the U.S. response to H1N1.

Could pharmaceutical companies accelerate production and donate vaccine to poor countries? The pharmaceutical industry is evincing a defense tone of late. This week, for example, the International Federation of Pharmaceutical Manufacturers and Associations (IFPMA) launched a campaign aimed at explaining why it believes it is doing all that it can, and no further pressure on the industry is warranted. In a statement this week the IFPMA agreed that poor countries are likely to bear the brunt of the world’s death toll in any influenza pandemic. But it is unfair, IFPMA says, to demand that the industry share patented technologies, or donate hundreds of millions of vaccine doses, because pharmaceutical companies have already demonstrated global citizenry in other disease arenas:

The pharmaceutical industry has a strong history of helping to address developing world health needs, especially in times of crisis, and the current H1N1 outbreak has been no exception. IFPMA member companies have donated antibiotics, painkillers, nutritional supplements and antivirals, as well as thousands of doses of seasonal influenza and pneumococcal vaccines to countries in need. Companies have also created tiered pricing programs for medicines, so that developing countries can stretch their healthcare resources even further. Industry-developed virus testing technology is facilitating authorities’ monitoring of the outbreak, determining rapidly which of the many clinical samples collected by hospitals and other health facilities contain the pandemic H1N1 influenza strain.
No doubt flu vaccines are difficult to manufacture, and scientists say the H1N1 strains are proving especially hard to grow in large quantities through normal influenza vaccine methods. But the IFPMA’s concerns regarding patent rights and profit protection seem morally dubious in the face of a genuine pandemic. According to the World Health Organization, more than 1 billion vaccine doses have been ordered, and nearly all the “customers” are the governments of the 15 wealthiest nations in the world. This is not a giveaway program: These are top-dollar (Euro, yen, Pound Sterling) paying customers.

On August 4, Glaxo (GSK) received a 96 million dose order, bringing its total H1N1 vaccine orders to 291 million doses – which stock market analysts predicted would bring GSK a $3 billion windfall. That day the GSK stock value jumped 10 points on the New York Stock Exchange. GSK is processing its orders with priority lists, putting the Swiss government in the #1 slot.

The Swiss have also garnered a top slot in orders with Novartis, which has orders from 35 countries, nearly $1 billion worth from the U.S.

Items:

- **Washington Post**, July 1, 2009: Shares of the Rockville-based vaccine maker Novavax surged more than 30 percent on news that the Spanish government plans to use its technology to protect people from the flu.

- **Wall Street Journal**, July 17, 2009: Shares of BioCryst Pharmaceuticals Inc. (BCRX) soared more than 50% in premarket trading after the drug-maker announced positive results on two late-stage studies for its influenza treatment peramivir. Shares were recently trading up 44% to $6.05 on the news. The last time the stock traded above $6 in intraday trading was January 2008.

- Basel, Switzerland (**Reuters**): Tamiflu sales rose more than 200 percent to just over 1 billion francs and Chief Executive Severin Schwan said Roche was able to meet all orders. The group expects similar sales of the drug in the second half. Roche's stock rose 2.7 percent to 158.70 francs by 1001 GMT, versus a DJ Stoxx European health care sector up 0.2 percent.


- **Union-Tribune**, July 30, 2009: Shares of Inovio Biomedical sprang to life yesterday after the company said it has a vaccine that appears effective against H1N1 (swine) flu in animals, though the product would be years from market. The company’s shares, which have traded below $1 for much of the past year, jumped $2.44 yesterday to close at $3.18.
New York Times, July 24, 2009: Sales of the drug Tamiflu have skyrocketed since the outbreak of swine flu in April, bolstering the profits of the drug's maker, Roche. Roche, based in Switzerland, said Thursday that sales of Tamiflu in the first half of 2009 tripled to 1 billion Swiss francs ($931 million), spurred by retail sales and the stockpiling of the drug by governments and corporations. For the second quarter alone, Tamiflu sales reached 609 million francs ($567 million), more than 12 times the level of the second quarter of 2008. The second quarter, from April to June, is not usually a heavy season for flu.

Financial Times, July 20 2009: Some of the world's leading pharmaceutical companies are reaping billions of dollars in extra revenue amid global concern about the spread of swine flu. Analysts expect to see a boost in sales from GlaxoSmithKline, Roche and Sanofi-Aventis when the companies report first-half earnings lifted by government contracts for flu vaccines and antiviral medicines. A report last week from JPMorgan, the investment bank, estimated that governments had ordered nearly 600m doses of pandemic vaccine and adjuvant – a chemical that boosts its efficacy – worth $4.3bn (€3bn, £2.6bn) in sales, and there was potential for 342m more doses worth $2.6bn. It forecast that fresh antiviral sales could boost sales for GSK and Roche by another $1.8bn in the developed world, and potentially up to $1.2bn from the developing world.

It is difficult to share the industry’s concerns about patents and profits amid such enormous surges in revenues and stock market values.

Influenza Zoonosis

All of the PCAST projections are rendered useless if H1N1 manages to reassort with a more virulent influenza: Under such circumstances, the 90,000 high end death estimate is meaningless. But how probable is such an event?

Daniel Perez and his College Park colleagues recently published the results of experimentally co-infecting ferrets with H1N1 and other circulating flu viruses (“Fitness of Pandemic H1N1 and Seasonal influenza A viruses during Co-infection,” PLoSCurrents. Rather than reassorting, the “swine flu” H1N1 strain had such a powerful fitness advantage over other H1 and H3 strains that it crowded them out and completely dominated all experimental infections. The College Park team concludes that this signals a very low probability of reassortment occurring.

The ferret experiment mirrors what was seen, epidemiologically, with H1N1 human outbreaks in Mexico, New Zealand, Australia and the U.S. – in all cases the circulating seasonal flu strains disappeared from clinical significance, and all human flu illnesses were soon caused by H1N1.
But the College Park team did not work with H5N1, the extremely lethal, highly virulent “bird flu”. And they did not try to induce coinfection in pigs, poultry or wild ducks.

As the possibility of a H5N1/H1N1 reassortment presents a genuinely nightmarish scenario, far exceeding the scale of the 1918 influenza, attention must be paid to any event that seems to increase the likelihood that a given human or animal might be infected with both viruses at the same time. In recent weeks human cases of H5N1, and separately H1N1 have been confirmed in China, Vietnam, Russia, Indonesia and Egypt, and reported but unconfirmed in two other Southeast Asian countries. The H5N1 virus is now in circulation in pigs over a wide swath of Asia and Siberia. This is worrying, but not significantly so, as human H5N1 infection is an extremely rare event, and human-to-human transmission has only been reported in a handful of cases since 1997.

A greater concern would entail co-infection of pigs or domestic fowl.

It is, therefore, disturbing to learn that H1N1 “swine flu” has appeared in commercial turkey farms located outside the port city of Valparaiso, Chile. Clearly, H1N1 has found a way to infect birds, and spread among them.

Given H5N1 is a rapid transmitter among poultry, this is a problem. But Chilean authorities insist they have stopped the turkey outbreak, and that there are no indications of further spread to people or pigs in the area.

We wonder how the turkeys got infected in the first place, and whether the farms’ proximity to one of Latin America’s largest shipping ports is related to H1N1 introduction in birds. It would be a concern if the index case for the Chilean turkey outbreak were a flocked of infected birds shipped from Asia, where H5N1 infection is a common fowl event.

Chilean authorities believe the turkeys got H1N1 from their human handlers, though to date no evidence of such transmission has been published. There have been at least three documented cases since April of human-to-swine transmission of H1N1, demonstrating that the strain is promiscuous in its zoonotic activity.

German researchers have identified an experimental means by which H5N1 transforms into a rapid transmitter and disease-causer in mammals, working with lab mice (Gabriel G, Klingel K, Planz O, Bier K, Herwig A, Sauter M, Klenk H-D: Spread of Infection and Lymphocyte Depletion in Mice Depends on Polymerase of Influenza Virus. Am J Pathol 2009 175:1178-1186). They discovered that H5N1 adapted to mouse infection thru a set of mutations in the gene sequence coding for viral polymerase. Once this adaptation was completed, H5N1 produced immune system collapse and whole organ failure in the animals, and infected higher regions of the mouse respiratory tract, allowing spread from mouse to mouse.
The sorts of ecologies in which a zoonotic/reassortment event might occur are typified by Dhaka, Bangladesh, where 12 million people are crowded into a small, water-bound space, 3.4 million of whom are slum dwellers. Chickens and other livestock freely roam among the densely packed homes and shacks of Dhaka, wild birds and ducks land on the river and tributaries, and the local health and veterinary systems are utterly incapable of handling even the routine needs of the populace and its agricultural sector. Bangladesh is widely believed to have both H5N1 and H1N1 circulating in the country right now, but the H1N1 is isolated to humans (in this Muslim country swine infection is insignificant), and H5N1 has circulated in poultry for three years. If a poultry-infectious strain of H1N1 got into that environment, rapid spread and H5N1/H1N1 co-infection would be probable in birds.

(Photo by Garrett, Dhaka chicken market, 2008)

Gayle, HIV, White House and Appointments

This week the White House announced that Dr. Helene Gayle, CEO of CARE, will serve as a Special Advisor to the President on HIV/AIDS. Gayle brings an extraordinary background and depth of experience to the appointment. For Gayle, serving the President will be additive to her already full plate, running CARE and chairing the CSIS Smart Global Health Commission.

Un fortunately, this signals that Gayle is out of the running for other critically important positions in the Administration, including heading USAID and OGHA. At this time, we are VERY sad to report, both of those slots remain unfilled, with no clear contenders under known discussion.
Happily, another critical health position has been filled – Dr. Francis Collins is now heading up the National Institutes of Health. The former head of the Human Genome Project and an admired scientific leader, Collins is on the record favoring an elevation of the importance and scope of the NIH’s global health portfolio. In a statement posted on the Fogarty website Collins explains: "The ability of NIH to play a major role in U.S. soft power seems like an opportunity we should not pass up," a chance to be "more of a doctor to the world" than a "soldier to the world" by helping control both infectious and non-communicable diseases. "And we should, in the process of doing so, make sure we’re focusing not just on doing research in those countries but helping them develop their own research capacity for the longer term."

**Foreign Assistance bill and feedback**

The struggle within the Obama Administration and on Capitol Hill to redefine the strategic mission and political architecture of U.S. foreign assistance (including PEPFAR, PMI, MCC and a range of global health initiatives) continues.

Earlier this month, the House Foreign Affairs Committee issued a three-page concept paper that outlines a plan to overhaul U.S. foreign aid. The concept paper recommends "giving the administration greater flexibility to control aid in exchange for greater public oversight and a performance- and need-driven allocation system." The paper suggests reorganizing aid programs around seven purposes, including ‘reducing poverty and alleviating human suffering,’ ‘advancing child survival and maternal health,’ ‘improving delivery of basic health care’ and ‘enhancing access to safe water, sanitation and shelter.’ The House committee concept paper also suggests elevating and strengthening the role of USAID, by giving it a seat at the National Security Council and supervision of the Office of the Global AIDS Coordinator and Millennium Challenge Corporation.


Also CFR Global Health Fellow, Peter Navario, authored an article, “PEPFAR’s biggest success is also its largest liability,” in the July 18th issue of *The Lancet*: [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)61312-X/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)61312-X/fulltext)
HAPPY TRAILS, KAMMERLE, IN YOUR NEW JOB.

As always, the Global Health Program will endeavor to keep you informed about these and other developments in the field.

Sincerely,

[Laurie Garrett's signature]

Laurie Garrett