

5th Annual

Sheth Distinguished Lecture

Featuring

Dr. Susan A. Allen

Hubert Department of Global Health
Director of the Rwanda Zambia HIV Research Group

“The 800 lb Gorilla: HIV and Genocide in Rwanda”

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Miller-Ward Alumni House



Dr. Susan Allen (Photo: Charity Crabtree/Emeritus College)

The transcript of Dr. Allen's talk follows (including Q & A). If you are interested in viewing the PowerPoint slides from Dr. Allen's talk, please contact Rhonda Dubin (rdubin2@emory.edu).

Dr. Sullivan: Good afternoon. It's my pleasure to introduce our speaker for this afternoon, Dr. Susan Allen. And I'd like to tell you just a little bit about her before she comes up, give you some of the details that she won't give you herself perhaps out of modesty. Dr. Allen received her bachelors in chemistry from Duke University and also attended medical school at Duke. She holds a Diploma in Tropical Medicine and Hygiene from The Liverpool School of Tropical Medicine, did a residency in pathology at The University of California San Francisco and has her Masters in Public Health from The University of California Berkeley. From 1986 through 2004, she held positions as assistant and associate professors both at The University of California San Francisco and The University of Alabama Birmingham. In 2004, I'm happy to say she was recruited by Emory to the School of Public Health where she is a Professor of Global Health with a joint appointment in Epidemiology. And I guess you're known by the company you keep, and Susan will now be in good company with the previous presenters of this lecture here. And I just wanted to say a couple of things about what I think makes her such an inspiring force in public health and HIV research and in sort of her human rights activities. We have the pleasure, and I, as an undergraduate, had the pleasure to learn from many brilliant scientists on the faculty at Emory, and Susan is a brilliant scientist. She began really I would say pushing the envelope in terms of the role of HIV counseling and testing in developing countries. I just came from CDC where in 2006 we really felt like we'd done something very special in highlighting the role of counseling and testing in addressing the HIV epidemic, and this is what Susan was saying 20 years before and it took some others a while to catch up to that point of view. So she really was a thought leader in thinking about how HIV counseling and testing could be HIV prevention, and she'll share some thoughts with you about that. We also have a community at Emory that includes many people who are involved and active and scholarly and advocates in the issues of human rights and ethics. And Susan has also lived through sort of a critical event in the life of Rwanda, which was the genocide. She worked in Rwanda for the eight years before the genocide and has been working in Rwanda for the 14 years since. And she brings her intelligence and passion and Irish fire to the cause of basically bringing war criminals to justice. But I think for those of us who have had the privilege to work with her, even being a great scientist and being a passionate advocate for human rights are important of themselves. But what really makes Susan special is that she doesn't see these things as two boxes or two endeavors. I recently spent a couple of weeks with her in Africa where a couple of things were evident. One is that her genuine affection for and caring for her sort of extended family of her Rwandan colleagues and friends and her Zambian colleagues and friends means that she can see the tragedy of HIV and the tragedy of the genocide as things that affect people that she cares about. And that's really obvious in interacting with her. But also I think it's hard to understand either the HIV epidemic in these countries or the genocide in Rwanda without sort of appreciating how they interact and how when you have an event like the genocide, how that affects the social, underlying social structures, the

healthcare capacity, the infrastructure. And so these two things are really fundamentally related. So as is often true, those that inspire us to move forward our thoughts are those that can see the connections between the boxes, and Susan also does that. So I'm proud to introduce a colleague and a friend, Dr. Susan Allen.

Susan: Thank you. Thank you so much, Patrick. I really am very, very privileged to be invited to speak with you today, and I'd like to thank Jag and Mahdu Sheth for making this event possible and The Emeritus College and Dr. Bianchi for considering me to speak with you today.

So, good thing I can remember my password. So I'm going to, what Patrick didn't say because he's far too diplomatic is I'm a talker, so I'm going to try to get through these slides in the allotted time and so on the left there is a silver back gorilla, that's the papa of the group, and on the right is one of the wives.

So the two countries that I've been working in, and I'll be talking primarily about Rwanda today, but Rwanda is the little tiny dot in the middle of Africa, that's a former Belgian colony, used to be French speaking. Zambia is in Southern Africa, and it is a former English colony, so those two countries will come back again and again in this speech.

This is a recent photo of our staff. Our project in Rwanda is called Project San Francisco because when I moved to Rwanda in 1986 I had just finished my residency at UC San Francisco and HIV was still a very touchy topic in Africa. To have a project with HIV or AIDS in the title just wouldn't work. So I was standing in line to register as an NGO, had no time to think and I just picked Project San Francisco as the name. And now 22 years later, we're stuck with it because everyone knows us by that name.

These are some of our staff. Many of these people are genocide survivors. And our staff, I think out of 67 staff that we had on the day that the genocide began, only 17 survived and returned to Rwanda after the genocide. But we also had a cohort of women that we had followed, we had recruited them from antenatal clinics in 1986 and have followed them since. This is a group who is celebrating the 20 year anniversary of the Project San Francisco which was two summers ago. Many of these women have been HIV positive for more than 20 years and are doing well. Actually only half of that group requires antiretrovirals. So they've provided us with a wonderful opportunity to study natural resistance to HIV infection. And they're wonderful friends. The average age of our cohort was 28 when I enrolled them, which was my age at that time. So now we've been through child rearing and all the different things that life brings, but of course they have suffered more from the genocide. And every time we get together every couple of years we have a party and we catch up.

This is the sign in front of our project in Zambia. Since we started that project a bit more recently we were able to work Emory into the name. So it's the Zambia Emory HIV Research Project.

So just a brief overview of HIV in Africa, the first cases of AIDS were reported in Africa in 1983, just two years after the first cases were reported here in the United States. It was a fatal disease, as it was in the west at that time, but the epidemiology was very different. It was transmitted through heterosexual intercourse rather than between men who have sex with men or through IV drugs, as was true in the west. And the clinical picture was also different. The manifestations of HIV disease and the types of opportunistic infections that Africans got were very different from what we were seeing in San Francisco at that time. The blood test to detect antibodies was developed in 1985 and by that time, when I moved to Rwanda in 1986, upwards of 30% of urban adults had positive test results.

So voluntary counseling and testing, as Patrick mentioned, has been sort of a long standing controversy, even in the United States. There have been and continue to be discussions about whether HIV testing should be mandatory or voluntary, whether confidentiality can be ensured. And I had friends in the late '80s in San Francisco whose HIV test results became known and they lost their jobs and their lodging, and sometimes their friends. So the confidentiality issue was very contentious and important. There was also the problem of cost and I think one of the first states to attempt to do HIV testing as a routine premarital test, as we do in many states with syphilis, was Wisconsin or one of the Midwestern states where there was not a lot of HIV and after a couple of years of it they determined that it cost \$350,000 to identify one HIV infected person. And so of course they discontinued it. And I think for me the take home message is you don't apply a screening tool in a population of very low prevalence and expect to have a cost effective impact. But I think unfortunately the message was taken home by everyone as HIV testing is not helpful. And that was kind of a fly in the ointment.

There was also a lot of debate about the impact of telling people their HIV test results, would it change anything at all? Would it change their behavior, perhaps it would make them more likely to take revenge on others and so forth. So there was a lot of controversy and continues to be.

Now in Africa, evidence of the beneficial impact of voluntary counseling and testing, particularly in couples. So when you figure if 30% of adults are infected and most of those people are married, you're talking about a couple problem. And the beneficial impact of VCT in couples was published very early on, 1991 to '93 by several groups. But in 2001, voluntary counseling and testing was still not available in most of Africa. And fewer than 1% of couples even today have been tested together.

When we first tested the women from antenatal clinics in 1986 in Rwanda, they told us that we were going to have to talk to their husbands. They said you know, it's very nice that you tell us these things and show us how to use condoms and so on, but if you don't speak directly with our husbands, we will make no headway on this. And so we began to have discussions with men and you can see here the kind of lively discussion that ensues when you start talking about condom use and married couples. But it was critical to get that kind of input. So I will just step back again and say cohabiting couples, the reason that we want to add the C to VCT and make it couples voluntary counseling and testing in Africa is because cohabiting couples are the world's largest risk group for HIV, and most new infections are acquired from spouses. The only feasible prevention strategy we've got in the absence of a vaccine or a biomedical intervention, which we are desperately testing but still have not identified, this is the only behavioral intervention that has been shown to work. It's been known for 15 years, but today we still have this problem of very few couples in Africa have been tested for HIV together.

So this is one of the signs that we have Ubumi Bwesu in Bemba, at one of our couple's testing centers in the northern part of Zambia. Our procedure is, and I'll just run through some photographs here, we start with a group setting of video followed by a discussion. So we shoot for an average of 20 couples per day at each of our centers. Then each couple goes and speaks with a counselor individually and makes the decision whether to test or not. They have their blood drawn. And these are the rapid HIV tests. I have to say that 1995 was a real breakthrough because prior to that time HIV testing used ELISA technology, which requires a sophisticated laboratory and pretty high level technicians which are of course pretty hard to find in Africa. But in 1995, the first rapid tests, which are very much like pregnancy tests that you would buy at the drug store, became available, and that's what you see here. Once we finish pre-test counseling the couples in any given group, we feed them lunch. And this is an example, when I say lunch, it's not the lunch that you just had here, it's a much simpler. The gentleman in the front is mashing tomatoes, and in the back she's filtering water. We also provide child care because most of the couples that come to us for testing have children and the logistical obstacles are the things that we want to help them overcome. So if they can bring their children to a place that they know will be well cared for, then that's one less concern that they have when they consider spending the day with us. We're pretty low tech. This is one of the portable tents that we take to various locations to provide counseling and testing. And you probably can't see it, but there's a TV set up on the table in the front with a very long extension cord going into the building in the back. And then in the afternoon after all the tests have been run, the couple sits with a counselor and gets their HIV test results and discusses what to do in light of husband's and wives results. So this is a one day program. By the time the couples go home in the afternoon, they have received their test results.

Now it's nice for us to be able to do this as a research center, but it's been very frustrating over the years to know that each time our research funding no longer needs couples if you will, so our research involves HIV discordant couples, where one partner is positive and the other is negative. Those are a very rich source of research potential for everything from pathogenesis to behavioral studies to clinical trials of interventions. But for any given grant which may have a life of five years, there's a time where you've recruited enough couples for whatever your research questions are, and then you have to shut down your couples testing center. Having done this for many years I felt it was sort of surprising to me that the service delivery sector wasn't just naturally picking up the ball. We tried to be more proactive and offer to train the staff in government clinics so that this could be more sustainable and offered on a larger scale. And what we realized is there are there are a lot of obstacles to this. The clinics, government clinics in Africa are highly congested during the week. On any given day the antenatal clinic might see 40 to 80 clients. And it's not a very husband friendly environment. So we propose to do weekend services and that has worked really, really well. We train the clinic staff and provide them with overtime pay because of course they're working a 40 hour week, so if they want to come in on weekends and do some work they need to get paid. We also offset transport costs for the couples that come to us and those that come to the government clinics that we work with, and we try to provide a meal and child care services just across the board wherever we provide these services.

This is an example of one of the antenatal clinics in Rwanda where we have been able to establish weekend couples testing services.

Now this is an example of the reaction that we've gotten from some people, "You're doing this all wrong!" I think many of you have been in the business long enough to have lived through this experience. You fight and fight and fight to get people to acknowledge that your idea is a good one, and then they turn around and tell you that all this time you haven't been doing it right. So the obstacles that we face now, everyone agrees that couples testing is important, everyone is on board with helping to provide it. But the remaining obstacle is that they don't think that we should be paying staff overtime to do it, and they don't think that we should be providing couples with transport reimbursement, or a meal, or any of that. And my contention is that people have very busy lives. If we're going to facilitate having couples come in together and spend the day with us and learn about their HIV test result, in the end, transport and a midday meal and child care is really a minimal investment when you think about it. So we've been pushing very hard to overcome that last hurdle.

I'm sorry, this is a data slide. I really wanted to make this a much more a picture kind of presentation. But let me just say that the middle column, on the left are Zambian men and women and Rwandan men and women. The middle column shows the proportion of infections that are acquired from a spouse. And the far

right column shows the proportion of infections that could potentially be averted by couples testing using a combination of our data and demographic and health survey data. And what you see is that even among Zambian men, who are the second group down who have the lowest percent of new infections acquired from spouses, the vast majority of new infections are acquired within marriage. And by doing joint testing and counseling, which reduces HIV transmission by more than two-thirds, over to the right in Rwanda you could prevent 60 to 65% of new infections, and Zambia somewhere between one-third and two-thirds of new infections, depending on what you choose to look at as your denominator. Are you saying how many infections can be prevented in married couples, or how many infections can I prevent in couples overall? Basically this is very important on an epidemiologic scale, a very important intervention.

So why isn't it happening more? Well, historically policy makers and funding agencies just have not prioritized couples. HIV has been one of those diseases that has been well, you have to worry about the young, you have to worry about sex workers, and truck drivers and so forth. And somehow the largest at risk group has gotten left out. As a result, VCT service providers haven't, until recently, figured out how to cater to couples. It is trickier if you have husband and wife in the room with you when you're giving results compared to dealing with individuals, so that's a new set of skills. And communities and their local leaders haven't really been aware of the importance of couples testing in part because there's a misconception that HIV is very efficiently and rapidly transmitted. If you're in a marriage, the assumption is within weeks of marrying someone with HIV of course you, too, will be HIV positive. In fact that's not the case. It turns out that HIV is not that efficiently transmitted and in most capital cities in sub-Saharan Africa somewhere between 10 and 25% of married couples will have one positive and one negative partner. So it's very important to identify them.

We got an NIH grant to promote sustainable couples testing, and the first thing we did was to go to the leadership of the two countries we were working in. This is a consensus conference on couples VCT, President Paul Kagame of Rwanda is sitting in the middle and helped to launch this. In fact, he brought his entire cabinet to the opening of this conference to show his commitment. And similarly, the first lady, Maureen Mwanawasa in Zambia, launched our couples VCT conference in 2003. We also went to leaders in the community, influential people, and trained them to go out and promote couples testing in the community.

So this graph shows, in the back, the blue and red bars show the number of couples that come to our centers who report having previously been tested. Now the blue bars show the proportion that was previously tested, both the man and the woman said that they had been previously tested. And the yellow bar shows the subset of those that had been tested together. So one of the controversies that continues to go on is does it make any difference if the husband and wife are in the room together when you give them their results versus if you test the wife one

day and the husband the next. Now, I would say intuitively most of us are married and we would say it's better if you're both together. You don't have to go through this whole business of disclosing and then trying to muddle through to some sort of a solution that's specific to your situation without the help of a professional. We really stand by the joint procedure. We've been promoting it, and as a result, in Rwanda what you can see in 2007 is that almost a quarter of the couples that come to see us have been previously tested together, and that's a direct result of the promotional activities that we began right after that consensus conference with President Kagame in 2003.

Now in Zambia we've had a more muted impact. Here in 2007, we still only have 5% of couples that have been jointly tested and 15% of couples where both partners have been tested. So we still have a ways to go, but we're getting there.

This is one of my favorite slides. I'm sorry, in the back you probably can't see this. But sometimes you're trying to get on the plane and the lions are in the shade of the wing. You just have to wait until those lions are ready to move. We've definitely made some progress. We have a procedure manual, which our group funded by The National Institutes of Mental Health and The Centers for Disease Control, along with The Liverpool School of Tropical Medicine, jointly developed for procedures of how to test and counsel couples. We also, I'm happy to say, have some funding from CDC now to roll out couples testing in Southern Zambia and in the capital city in Rwanda. The other thing, of course, from the academic point of view, is publish or perish. For a long time couples testing in Africa was so controversial I couldn't get papers accepted. I just got a paper accepted last year that I had first submitted 10 years ago. The data did not change. It was just that people were more receptive to the idea. So I think that's definitely a plus. And so what we still have to do, we don't have funding for couples testing in the North of Zambia where the copper mines are and where it's very densely populated, so we're still pursuing that. Nor do we have funding to roll out couples testing beyond the capital city in Rwanda, so we're still pursuing that. Then of course there are all the other countries in sub-Saharan Africa that we would like to help launch this intervention in.

So I'm going to transition now, it takes a second for this DVD to load. Does anyone have any questions about HIV? I don't know generally whether you have question and answer in the middle of this. Yes?

Male: That's fine.

Q: On that rapid testing, how accurate is it?

Susan: Thanks for asking that. We use three different kinds of rapid test in sequence. So the first test is a screening test, it's designed to be very sensitive at the expense, of course, of specificity. And then we do a confirmatory test for people who are

positive or people who are married to someone who is positive with the first test. And if either of those tests disagree, there's a third test. So if you use a three test algorithm, it's pretty good.

Q: Is Emory involved in the efforts to offer circumcision to men in Africa _____?

Susan: Our group is counseling couples about the impact of male circumcision. We're not doing any clinical trials in that regard. I'm not sure if there are others at Emory who are, I'm sure there are people providing technical assistance to some of the places in Africa. But now that the two or three definitive clinical trials have been done, that's pretty much being handed over to the public health sector. What I will say is that unfortunately it's another example of kind of a bumpy transition between the research question and implementation because the two cities that I work in right now, male circumcision is being rolled out for all men, not just HIV negative men. And unfortunately, only HIV negative men benefit. And in fact, HIV positive men have problems with healing and so forth. So there's still a little bit of a disconnect.

Q: When the spouse gets infected second, one is infected, the other isn't, the second one isn't infected, how do you know it came from the spouse and not from someone else?

Susan: Ah, very good. Well, that's why I married Eric Hunter, in addition to his lovely blue eyes. He is virologist, and his lab and his research team do sequence the virus and make sure, because it's true, if you're going to study a transmission event you have to know the donor and the recipients. And in 85% of cases where transmission does happen in discordant couples, they have acquired it from the spouse if you look at the viruses. Sort of like a paternity test.

Q: Of the couples you test, what percentage would be both negative or both positive?

Susan: It depends on the city. In Rwanda, 80% are both negative about 11%, one is positive and the other is negative, and 9% both are positive. In Lusaka, the prevalence is much higher, 25% of couples have two positive partners, 23% have one positive and one negative, and the remainder are both negative.

Q: Are we assuming that there's some kind of natural immunity in couples where there's one and one?

Susan: Well, that's one of the areas of active research is what are the determinants of transmission or the lack thereof in discordant couples? Is it contagion in the positive partner? Is it partial resistance in the negative partner? Is it both? Is it the virus? Is it the host? So there are a number of different research questions still being addressed in this.

- Q: How cost effective is the rapid testing? _____
- Susan: That's an excellent question. In our experience using the model that we have the cost per infection prevented is about \$85 per infection prevented.
- Q: \$85, that's expensive for that part of the world.
- Susan: It is. Although if you look at the cost of treating someone once they have HIV, which in that same city in Zambia for example is \$500 a year, I think it's worth the initial investment.
- Q: Is anybody testing this in countries with polygamy?
- Susan: That would be primarily West Africa, and I had a Fulbright fellow who was a doctor from the Abidjan who was going to go back to Ivory Coast and set up couples testing and then Ivory Coast politically blew up. So we're ready to help if you know someone. One more.
- Q: I had a question, it just happened my reading group read the book written about Ethiopia, the woman who lives near CDC wrote about an orphanage. But her, one of her contentions was that there's very little money coming from the United States in view of gross national product or how many people per capita that there isn't much coming, and that also American companies are not cutting the costs where in India there is someone who has cut the cost way down. So I don't know, maybe that's too practical a question, but will the United States pay for condoms?
- Susan: They do. I think the problem is if everyone in Africa who needed a condom every time they had sex had a condom, that would be really expensive. And so right now there's just not enough condoms going in. And what we advocate for in the context of couples testing is focus the condoms on the people who need them most. Because if you have a concordant negative couple who are both faithful you could argue that they don't need those condoms as much as say the discordant couples. Okay, now I don't want to keep you because I know many of you have to rush, so I'm sorry.
- Q: Why was Rwanda selected? Is it more prevalent there or just coincidence?
- Susan: Actually, it happened that the first physician from Belgium to describe the first cases of AIDS in Africa went to Rwanda. So it was just the fact that he was the first person to bring it to the world's attention that made Rwanda a country of interest. Later, of course, lots of countries in Africa began to participate.
- So I'm going to switch gears a bit now and show you a five minute, what we call a trailer of a documentary that we are producing. It's about the genocide in

Rwanda. I'll warn you, it's a bit firm and graphic, so I hope that, close your eyes if it's going to bother you. Let me see.

[Video playing]

Susan: So we are trying to raise funds to finish this documentary, and I apologize for the sound. I know some of you may have had some difficulty hearing that. But I have copies of this if anyone would like a copy we're happy to share it with you.

This is a memorial plaque at our Project San Francisco in Rwanda commemorating the names of the people who worked with us who were killed.

Many of you know this, but I'll just remind you, the genocide took place from April to July of '94, one million people were killed in about 100 days, mostly people of the Tutsi ethnic group, and people of the majority Hutu ethnic group who were moderate and who did not want to participate in the killing were themselves killed. It was entirely organized by the then government with help from the military, the paramilitary, civil service, basically everyone was involved. The genocide was stopped by rebel forces who were made up of largely people who had, the children of people who had survived previous genocides in the late '50s early '60s and again in the '70s.

Since 1994, the president of Rwanda, Paul Kagame, who was the leader of the rebels that stopped the genocide, has now presided over just a spectacular rebound, economically and every other way. Half of the parliament members in Rwanda are women, which I think is unique in the world. Identity cards have now been purged of ethnic identity, so you can't tell if someone is Hutu and Tutsi by looking at their ID card. About 150,000 perpetrators who were arrested as the rebels came through and stopped the killing have now been released in something like a truth and reconciliation commission type of process, although just to put some comparison on this, out of 10,000 applicants for the South African Truth and Reconciliation Commission, I'm told that fewer than 300 were actually granted amnesty. So the South African model is much more stringent. In Rwanda, basically they have released everyone as long as they confessed, named who they killed, named who they killed with, and who gave them orders.

Today the population of Rwanda is about eight million. Based on the confessions that have been gathered in the course of this truth and reconciliation process, the U.S. State Department estimates that the number of people who participated in the killing is almost 900,000, so that's an almost one to one ratio of perpetrator to victim. And that corresponds to some two-thirds of Hutu men at that time. So it was almost like mass insanity. At least 8,000 of these people who perpetrated the killings were planners and organizers, most of who escaped. And this is the focus of our work, as shown in the video. So one thing that, for those of you who are familiar with Rwanda, you often here what amazing progress has been made there

with reconciliation and how people are reaching out to forgive those who perpetrated atrocities. But I think that's a nice delusion on the part of the West. I think we'd all like to ignore the fact that we abdicated responsibility in '94 when this was happening. In fact you have to remember that unless we bring to justice the people who organized this thing, it's very difficult to have true reconciliation. Right now people who lost entire families are living side by side with those who killed them. The survivors are outnumbered by the perpetrators, and the perpetrators really have no remorse. They would do it again tomorrow. The genocide organizers are trying to make that happen, and they're living very comfortably in exile, many of them here in the United States. The UN International Criminal Tribunal, which was the only mechanism that was set up to bring any of these folks to justice, spent \$1.2 billion in 12 years to prosecute 30. It was a symbolic gesture, but really what it served to do was to reinforce the impunity and the confidence of the many thousands who are quite confident that they will go free. This is one of the reasons that the ICTR costs so much money. Everything is done in very high style, and here is Jean-Paul Akayesu, one of the first three arrested in Zambia after the death threats to our project, you saw him in the video, with his very high priced lawyers. They didn't do any good, he was convicted, but still. This is a map of Rwanda; every dot corresponds to a massacre. That gives you some idea of how many people there are that need to be brought to justice.

Now what we can do here, and I can tell you honestly that this is one of the things where individuals really matter. The whereabouts are known for more than a dozen genocidal organizers in the U.S. Homeland Security, Justice, and State need help. We are working with them, but they need our help, and they need a push to make this a priority and to keep it a priority. They need help from seasoned investigators in Rwanda because that's where the evidence is in order to bring the perpetrators to court. African Rights is a human rights organization that we've been working with. They're the only human rights organization with experience investigating genocide perpetrators in Rwanda. This is an example of a success story. This man was arrested here in the United States and handed over to Rwanda, so Homeland Security was able to pursue this man based on information provided by African Rights.

And this is a failure. This gentleman, who is a Presbyterian minister, very high level one, who until recently was in Zambia and African Rights conducted a very detailed investigation, this is the first page of a 50 page report that is absolutely blood curdling reading. Despite the fact that this report was made available, both to the U.S. Embassy in Zambia and to the Homeland Security folks here, he got into the U.S., so he's in America now.

So I think that it's in everybody's interest to bring these perpetrators to justice because Darfur and other places like it will continue. If we don't take a situation like Rwanda where the good guys won, where no one has any political investment

in protecting the bad guys, and the only reason the bad guys go free is laziness and lack of commitment, if we don't seize this opportunity, then all these other much more complex situations like Darfur can simply not be solved.

Thank you very much. And actually before I'd like to thank Ray Schinazi and his wife Lynn who is here now because they have very kindly offered to set up a foundation for prevention of genocide through justice and are making the very first generous contribution. So if anyone has ideas to help us fundraise, please let me know. Thank you very much.

Male: Thank you very much. Do we have time for just a couple of more questions? Is that okay?

Susan: I certainly do. I don't know if –

Male: Do we, I think we have maybe five or ten minutes.

Q: Are you looking at the next generation of your infected couples to see, for evidence of genetic transmission because whether it's getting into the DNA and then what it does there, whether it could be active or inactive. The RNA virus is very, this is an important model. Are you looking at it?

Susan: Transmission from mother to infant, is that what you mean? Yeah, of HIV.

Q: It's a genetic problem, it's where the RNA gets into the DNA and it's transmitted that way.

Susan: Well, there is transmission from mother to infant. We actually don't do research on that, but many people do.

Q: But you've got an important model for couples.

Susan: We do, but the problem is that we're –

Q: _____ ones that are resisting the disease, they could be getting it into the RNA and DNA transmissions.

Susan: Well, where it's really important to be if you want to study transmission from mother to baby is in the labor and delivery wards, that's where the research is done. Our couples testing centers are community based, we don't have labor and delivery wards. But there is a lot of research, and there are several people here I think who are much expert about this than I am, so I'd have to refer you to them.

Q: I thought maybe you were cooperating with Fred Hutch (?) because in Seattle he mentioned that because they're doing it.

- Susan: Yes, many people are doing prenatal transmission research. But our focus is on heterosexual transmission.
- Q: You don't have to look in the newborn period, you can look other times in families, and you've got that cohort, which is very important.
- Q: Sue, I appreciate this initiative with the genocide and fully supportive and I have a son who is a philosopher and one is a lawyer and I just want to bring up another aspect of this that has bothered me as one who has been involved with the national and international aspects of HIV since the early '80s, and that is the reverse aspect. You kill with the genocide quickly. You allow people to develop HIV and AIDS, you allow millions and millions of orphans to now get AIDS who are going to suffer and be the next generation vulnerable for passing AIDS on. And I think there's an ethical public health problem here that's got to be addressed. There are leaders who allow millions and millions of their people to die when they could have done otherwise. And we don't have to cite any country, we know them as the world's _____ there are many, many, not only in Africa, but in other parts of the world, including some of our states. So I just wanted to bring that open to our ethicists here and philosophers and lawyers, shouldn't there be something done also about leaders who allow millions or thousands and thousands of children and adults to die of a disease that is slow progressing, causes a lot more suffering than being killed by _____. I don't say I'm against genocide, but I'm against sociocide because I think we've got to address the issue of the ethical aspects of allowing people to die in your own country or in other countries. Could you address that from your perspective _____?
- Susan: Well, I agree. I think, and you have to be a pretty loud voice to get that message across because a lot of the machinery that moves public health forward and decision making and so on really isn't accountable. It's not accountable to the populations that it's supposed to serve, and it's not accountable to being evidence based, at least in my experience. So I completely agree.
- Q: Is there any kind of a public/private partnership approach to managing this problem as it has been with other very major social issues where the private sector approaches to an NGO problem _____ cooperating, is it happening in this area?
- Susan: Well, I think both in HIV and in genocide prevention that is the case. The public/private partnerships in HIV have revolved around keeping the work forces healthy and making diagnostics and therapeutics more affordable. And that's been actually very successful. Now in genocide prevention, a lot of people think that this is a government problem; only governments can deal with criminals. But actually the business sector has an awful lot to offer in this case because these guys that get into the United States are the high level guys. These are the doctors and the lawyers and the teachers, and they get jobs. It's people who give them

jobs, whether it's universities or businesses who are not exercising due diligence in looking into their background. So we have encouraged actually a reference check process where, and I get calls informally all the time from people who have heard about me and who say hey, I just got an application from this guy, he says he's from Rwanda, what can you tell me about him. He says he's a doctor. Well, maybe he's a doctor and maybe he's not, maybe he killed and maybe he didn't. But it's, I think it's the responsibility of any employer or any university to ask that question. I mean in this day and age you can actually find out the answer. There was a time where immigration authorities and all these folks, they didn't have the internet, they didn't have easy communication. But now I would say I think it's a responsibility, I think it's another ethical responsibility of business and everyone who isn't government.

Q: I have one more question _____. I have one question.

Q: Yes, I would like you to comment on Samantha Power and her recent genocide Pulitzer Prize novel to her appointment as foreign policy advisor and how we can get good women who are bright to continue to go on in situations like this when the news media said that she was too academic and that all academicians have a tendency not to be able to speak lower, at a lower level. That just burned me up.

Susan: Well, Samantha Power, a lot of the books that have been written about Rwanda are pitched towards people who know a lot about Rwanda. So it's very hard to come to a Samantha Power book knowing nothing about what previously happened. It's almost as though her book, you have to read a couple of books beforehand to be prepared. So I think maybe that is what they meant by that. But on the other hand, I mean I agree with you that basically the information needs to be out there at whatever level people need to make them understand. I mean I would bet you anything if you alerted Americans that right down the street could be a Rwandan war criminal, you'd get a reaction. People just don't know. So I think that this is one of the reasons we need to get this documentary made and one of the reasons we need to get more of these guys arrested and sent back to Rwanda so that people see that the problem is there.

Q: It's been my experience that there are three reasons why people do or don't do things, the noble reason, the public reason, and the real reason. What would you judge as the real reason for the genocide?

Susan: Money. The guys who were in power didn't want to lose power. The Western countries were forcing multi-party democracy on them. They didn't want elections; they knew they'd lose, so they created this as a diversion.

Q: What is the public reason?

Susan: Oh, it's a little bit like holocaust revisionism, the Jews deserved it, or if they hadn't been stealing everybody's money people wouldn't have hated them so much and they wouldn't have had to kill them. There are all kinds of excuses that people will bring up in any genocide, and in Rwanda, that's what you hear. The Tutsi are responsible for their own extermination.

Q: There is no noble reason.

Susan: Oh, no. Well, I think your extremist Hutu to the core feels that the Tutsi are a scourge on the planet and deserve to be eliminated. So they feel noble about what they did. The only thing they regret is they didn't finish the job. But I don't think that there's any noble reason to have done what they did. There's certainly a noble reason to nail them for it though. And a practical one.

Q: There's an increasing influence of China in Africa, and my forecast is that the life largest non-Chinese Chinese speaking continent will be Africans and Latin Americans second, they've been tracking for the amount of Chinese language _____. Any influence of China in this area at all _____ sidelines?

Susan: I think the oil fields in Darfur, which is really what everybody's fighting about there, have, a number of Western countries have decided not to participate in building up those oil fields, although from what I gather, President Bush the elder, his first job as CIA Chief in the '70s was to go to Darfur and get oil fields for Amoco or someone. I grew up in the Middle East, so I would hear these things as I was growing up. China is being asked to disinvest in the Darfur situation, and I'm not sure where they are with that. But I think that basically genocide is bad business. Stability is what you need in order to be able to do anything that is income generating. I think really it's in everybody's interest, and it will ultimately be in the Chinese interest to participate in neutralizing the current Sudan government.

Q: You refer to guys, are there any women among these war criminals? Obviously there were some victims, we saw victims and heard your person speak, but were the women out _____?

Susan: Yes. There's actually a book put out by African Rights about women who killed. There were actually frighteningly quite a few. In fact, I heard about one, she was the minister of justice in the transitional government right after the genocide, the transitional government. And the way I found out that she was in Zambia, that she had fled to Zambia when the genocidal government was overthrown was that my bodyguard lived next door to her bodyguard. After we got these death threats, the police gave me a bodyguard. And we were chatting, and he said oh yeah, this Rwanda problem, you know, my neighbor also is protecting a Rwandan. And I said oh yeah, who's that? And he told me the name, which I recognized and I got the book out and showed him she was in the book of women who killed and her

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photograph was in there. And I said take this book to your neighbor and ask if this is the woman he's protecting because he should know who he's dealing with.

Q: What happened?

Susan: She had to flee because she realized that the Zambians had caught on to her and she was going to get arrested. So she scooted, but she's in jail in Rwanda now.

Male: Let me just thank Susan Allen again for a really excellent and stimulating presentation that leaves us with many thoughts. I just also want to thank the Alumni Association for providing these excellent facilities for us; they cooperate with us on many of our programs. So let's all give Susan Allen another round of applause.

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