

Watsonian Talk – A Funny Thing Happened on the Way to FHI November 3, 2011

My deepest thanks to my Watsonian colleagues for this opportunity to be with you. What a special treat to re-connect with Tom Frieden and to hear his wonderful tribute to both Dave Sencer and the PHAs. And to have Bill Watson himself with us tonite. Talk about a “can do” approach.

When Bob Kohmesher asked me if I could join you tonight, I jumped at the chance for a reunion. A little over 17 years ago in 1994, I was at this very same annual Watsonian banquet being inducted as an Honorary PHA. I still display the silver tray momento proudly in my NC office today. I asked Bob what would be the best topic to discuss tonite. He said “just reminisce on your life, and its interactions with fellow Watsonians”...then he emphasized NMT 20 minutes max. Hmm, my nearly 40 years at CDC and FHI in 20 minutes = 30 seconds a year!

So here goes...I’ve entitled this talk “A Funny Thing Happened on the Way to FHI” since it also deals with the unique circumstances which got me before you tonight. I adapted it from a presentation with a similar title I gave in 2003 to the ASTDA. In summary, in the early 80s, you welcomed me into your PHA fold as a virtual unknown and then provided a phenomenal and continuous learning opportunity in public health systems management thereafter. Many of you in this room have been mentors, friends and colleagues on a variety of projects over the last two decades – so many in fact that I would use up most of my time if I attempted to name you all. But rest assured I am totally grateful, and offer you my sincerest thanks.

First an admission...my winding up in front of you tonight was largely serendipity, a testimony to the ways in which life’s unplanned vicissitudes can have a happy ending. Thus the title of this talk. It began in 1974 when I joined CDC in hopes of furthering a career in preventive medicine and learning its basic science of epidemiology. The CDC scientific farm system - then and now - is the Epidemic Intelligence Service, a two-year fellowship in applied epidemiology. The EIS officers receive their initial CDC assignments through a system analogous to residency matching. During the match weekend, I listed a variety of positions, any of which I thought would allow optimal development of my epidemiologic skills. I thought I would probably wind up in one of the infectious disease or state health department positions. However, when the match was announced, I had been assigned to the Family Planning Evaluation Division in its Abortion Surveillance Branch. Though somewhat surprised – since I could not distinguish a curette from a toaster – nonetheless, this act of fate provided an amazing career opportunity.

In 1974, the Roe v. Wade Supreme Court decision had just been announced, and the public health impact of legalizing abortion was palpable. Women could terminate their unintended pregnancies in modern health facilities rather than the back alleys, which

allowed much safer choices. Moreover, this “natural experiment” in public policy provided a remarkable opportunity for me as a developing epidemiologist to collect data about the numerators and denominators of a key issue of our time. Together with my then CDC and now FHI colleagues, David Grimes and Ken Schulz, we were fortunate to be in a position to learn more about a single surgical procedure – legally induced abortion – than we know about any other operation. Moreover, because of the visibility of the issue, we were able to translate our epidemiologic findings rapidly into public policy actions. During the 1970s, we directly influenced Supreme Court decisions, Congressional legislation, Presidential Executive Orders and even HHS funding – heady stuff for a small group of three scientists at CDC.

These CDC data clearly established the safety of legal abortion. However, the science did not sit well with those opposed to allowing American women this choice. With the change of political administrations in 1980, from Jimmy Carter to Ronald Reagan, so came my second surprise career opportunity. In 1982, Bill Foege – who was then the Director of CDC and was formerly my PM residency advisor - called me into his office, and we discussed the stark realities. Surgeon General Koop had just been approved by Congress, and I was the Administration’s next target. CDC itself was in a sensitive position, with cutbacks to the Federal budget overall and the Public Health Service in particular. The agency could not afford to fight a controversial battle, no matter how justified its position. Bill offered several career changing directions – the National Clearinghouse for Smoking and Health was moving to CDC, and the Division of VD Control’s Task Force for Kaposi Sarcoma/Opportunistic Infections was seeking more help in its fledgling months. I chose the latter and thus began my history with the Division which housed CDC’s managerial farm system – the PHA Watsonians.

Within months, Paul Weisner announced he was going to the National Center for Environmental Health and the search for a new director of the Division of VD Control was underway. The Search Committee interviewed outsiders and insiders. As a newcomer, I was not initially on any list. Near the end of the process, to provide a totally fresh perspective, Paul asked me to interview. Much to my surprise, to say nothing about that of the rest of the VD field, three days later Mike Lane called and asked me to be the new Director. One slight problem remained however... because of my heritage with abortion and the field of unplanned pregnancies, I had to get clearance at the Department level. This process took over a week – and some still untold negotiations – but in the end, the Administration said okay. Because of these two acts of fate, the EIS match and the Reagan election, I came face-to-face with the PHA legacy. Talk about being fortunate. Better lucky than good.

A few anecdotes exemplify my learning curve with my Watsonian brothers:

- “STD epidemiologists” – Baltimore – the origins of DIS terminology
- Partner notification – NC – the professional approach to interviewing STD clients

By transitioning to STD, I started my intellectual odyssey from a mindset concerned with unintended pregnancy as the priority, to sexually transmitted infections as my focus. Initially this began as trying to merge the two separate cultures. After all, they shared certain similarities. Both conditions are transmitted sexually. Both have a disproportionate effect on women. Both occur at higher levels in young, low-income population, and finally, consistent and correct use of condoms protect against both conditions.

However, the differences between the fields of STD and unintended pregnancy are even more daunting than their similarities. For example, the percent of the population capable of transmitting these conditions, their respective transmission coefficients, as well as the focus for basic science, clinical services, and prevention activities are all different. Moreover, the approach to the clients creates distinctly different attitudes – in family planning clinics, clients are provided with nondirective counseling, allowing them to select among the range of contraceptives available; in an STD clinic, the counseling is much more directive – oriented toward taking medicines as prescribed, not having sex until completing medicines, and making sure that one's partner gets appropriately treated.

Just as I was reconciling some fundamental issues between the fields of family planning and STD, the situation became even more complicated. The discovery of HIV and the awareness of its global importance have dominated public health over the past three decades. This led to the emergence of three cultures, not two, and had an impact on both the field of STD prevention and also that of pregnancy prevention.

The *Newsweek* cover in August 1985 woke Americans up with the realization that one of its idols, Rock Hudson, was dying of AIDS. Moreover, this same *Newsweek* issue, at the time the total number of AIDS cases was just over 12,000, contained a quote which I truly wish had not come so true – “Anyone who has the least ability to look into the future can already see the potential for this disease being much worse than anything mankind has seen before.” My CDC colleagues thought I had crossed the line with my rather excessive hyperbole. Tragically, history has shown my fears to be realized.

In response, the Division was renamed STD/HIV Prevention, and we were dealing with three cultures rather than two. Fortunately, the strategies of these two infectious disease fields grew closer over the years. At first, in the 1980s, the addition of HIV had little impact on the biomedically-driven model of STD control. HIV was focusing on primary prevention, behaviorally-based messages directed toward the highest risk communities. However, by the 1990s, when voluntary testing for HIV had become more widely available, and antiretroviral treatment allowed dramatic prognostic improvement, HIV care began to resemble its STD brethren. At the same time, the field of STD control was taking a more community-oriented approach with its Syphilis Elimination Program. Thus, by the time of the new millennium, the strategies of the two fields had basically

overlapped. In fact, CDC's current HIV prevention approach of targeting and treating those who are infected represents a similar approach undertaken by the STD community during the majority of the 20th century.

Unfortunately, HIV ramped up its international pace during the same interval. The generalized HIV destruction in Africa was recognized, a concentrated HIV fortress in Asia was built, and an emerging HIV foothold in Eastern Europe was established. In 1994, it became time for me to venture outside the confines of Interstate 285, and move to FHI in RTP, NC. This new opportunity both allowed a merging of my two career fields at CDC, and also provided a wonderful chance to impact the global reproductive health and HIV agendas.

At FHI I faced somewhat different challenges than at CDC. For example, my fundraising life changed forever as I quickly suffered the shock of moving from being a funder to a fundee. At CDC, my primary targets for increasing budgets were the HHS hierarchy and Congressional staffers on the Appropriations Committees. At FHI, the tables were turned. We rely on writing proposals (and proposals and proposals...) to our USG and foundation friends to sustain our mission.

At FHI, I also realized that the addition of HIV to the contraceptive field created tradeoff issues for those delivering reproductive health services. Like CDC, during the 1990s and beyond, we struggled with what contraceptives are best to achieve dual protection at both the community and the individual level. At the community level, if HIV/STD prevalence is high, emphasis on those contraceptives which reduce infection risks takes on greater weight. However, if the risks of unintended pregnancy are high (namely, unsafe abortion and dangerous childbirth practices), then those contraceptives with the better record of preventing pregnancy would be emphasized. The same factors, though individualized, operate for the client. They would self assess their risks of HIV/STI, as well as the personal consequences of an unintended pregnancy, to make an informed choice of contraceptive method or methods.

As we entered the new millennium, the PEPFAR program dramatically changed the global health landscape. This initiative increased the level of funding by one log going to GH programs (however siloed). We became able to talk about budgets for GH with the "B" word – billions – rather than mere millions. It also provided career opportunities within CDC and FHI. From 2002 to 2010, our respective PEPFAR-driven in-country organizational programs grew exponentially. At CDC, as Tom emphasized, this required the broad PH management skills of field-tested PHAs. At FHI, I realized the same thing, so we lured Gary West up to NC to help us move forward. It also offered expanded global scientific leadership positions for the generation of EISOs who had entered CDC in the late 80s and 90s, many of whom I was fortunate enough to know. And the PEPFAR experience at CDC helped hone Tim Mastro, who has also joined us at FHI...

And now over the past 3 years, our global health strategies have been guided by the GHI blueprint. This initiative is attempting to build on PEPFAR's HIV/AIDS foundation to strengthen health systems in LMIC by encompassing other primary health conditions, including unintended pregnancies. Thus, in a sense, we've come full circle. Moreover, the current administration has linked the health field itself to broader development goals (the MDGs), as well as defense and diplomacy – the so-called “3 Ds”.

In closing, we Watsonians at CDC are a unique breed. All of us could have joined the commercial world, using our managerial expertise to earn twice our salary. Instead, we chose PH as a career. Our professional gratitude comes from the lives we improve rather than the things we buy. We use an evidence-based approach to implement our multiple programs. In my view, CDC will continue to depend on our terrific blend of science and practice – the EIS and the DIS together – to drive our PH mission. Tom highlighted this in his remarks. This bodes well for CDC's and the Watsonian's future.

Thanks again...