VERBATIM

INTERNATIONAL SUBCOMMITTEE OF THE PRESIDENTIAL ADVISORY COUNCIL ON HIV/AIDS

TOWNHALL MEETING ON THE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF

WELCOME AND INTRODUCTION:

ABNER MASON,
CHAIR, INTERNATIONAL SUBCOMMITTEE, PACHA;

LOUIS SULLIVAN, MD, CO-CHAIR, PACHA

OPENING REMARKS:

AMBASSADOR JOHN E. LANGE,
DEUPUTY COORDINATOR,
OFFICE OF THE GLOBAL AIDS COORDINATOR;

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DEPUTY COORDINATOR AND CHIEF MEDICAL OFFICER,
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ABNER MASON: (In progress) – everyone to take their seats we will get started. We have a pretty full agenda. Thank you.

My name is Abner Mason, and as chairman of the International Committee for the Presidential Advisory Council on HIV and AIDS, I want to welcome each of you to this townhall meeting on President Bush's Emergency Plan for AIDS Relief.

I want to first introduce the other members of the International Committee who are here, so starting from my far left, Jim Driscoll, and Nate Nickerson, Cheryl-Ann Hall. And then from my far right, John Galbraith, Edward Green, Karen Ivantic-Doucette. And to my immediate right, Dr. Louis Sullivan.

On behalf of the entire council, I want to thank each of you for taking the time to share your experience and your advice with us and through us to Global AIDS Coordinator, Ambassador Randall Tobias and his team at the State Department, which we're very fortunate is represented here this afternoon by his two deputy coordinators: Ambassador and Deputy Coordinator, John Lange, and Deputy Coordinator and Chief Medical Officer, Dr. Joseph O'Neill. Thank you both for being here. And you'll have an opportunity to hear from them shortly.

For those of you in the audience, your presence here in such large numbers and from such a diverse cross-section of American society is yet further proof of our nation's commitment to fighting HIV and providing treatment and support to those infected and affected by this disease: the greatest threat to human life in history.

I also want to acknowledge our international guests who are here for the important perspective and contribution that you bring. We gather this afternoon with a sense of optimism because in arts of the world hit hardest by HIV, the leadership of President Bush, the bipartisan support of the Congress, and the generosity of the American people has brought a sense of hope to where there was once only despair. We owe it to those in need to get the implementation of the president's plan right. Having the benefit of your experience and advice will be helpful to that end, and I commend Ambassador Tobias and his team for seeking your experience and your advice and I want to thank each of you for being willing to provide it.

With that, let me now introduce Dr. Louis Sullivan, the co-chair of the entire Presidential Advisory Council for some remarks.

Dr. Sullivan.

DR. LOUIS SULLIVAN: Abner, thank you very much. Let me, indeed, join Mr. Mason in welcoming all of you to this afternoon's hearing and thanking you for coming and sharing your perspectives to assist us as we develop recommendations for the president on his global AIDS program.

In addition to the members of the International Committee who are assembled here at the table, we have other members of our Presidential Commission on AIDS who have joined us who are in the audience and I would like to introduce them and ask them to stand as I introduce them so you'll know who they are.

Mrs. Anita Smith, would you please stand? Mr. Joe McIlhaney standing in the rear. Ms. Rashida Jolley, I don't believe she has arrived yet. Mr. Brent Minor. Ms. Sandra McDonald, would you please stand? And Mr. Don Sneed. I'm sure he'll be joining us shortly.

I'd like to emphasize that as we proceed in this process the Presidential Commission on AIDS and HIV is actively seeking additional input on ways we can engage the public in the council's processes, and we would also like to inform you of upcoming meetings of the council to which the public is invited. Those dates are as follows: March 29th – 30th, 2004; June 28th – 29th, 2004; and September 20 – 21, 2004. We welcome your input as all of us work together to improve the picture that confronts all of us as humans with HIV and AIDS. Again, I thank all of you for coming.

MR. MASON: It's now my pleasure to introduce for some comments, Deputy Coordinator of the new office at the State Department, Dr. Joe O'Neill.

JOSEPH O'NEILL, MD: Thank you. I see that John and I have between 1:05 and 1:10, which means that I have two and a half minutes, and that's as it should be because we're here to hear from you, not the other way around.

So a couple of major points to make to you. First, thank you for being here. You ought to look a this meeting as emblematic of Ambassador Tobias and – Tobias's and our office's desire to engage constructively with nongovernmental sector and the community and interested parties, not only in this particular task ahead of us today in developing a strategy, but in the way that we manage and work to bring this program to fruition in months and years ahead.

We approach this – my view is that we need to approach this issue – all of us need to approach this issue with a great deal of humility. Global AIDS is a terrible problem. It's a complicated problem. Anybody who thinks they have the answer is wrong. The answer's out there, but it's going to come from a wide number of people and perspectives. It's going to be a bumpy process on the way getting there. There's so much passion and so much commitment on this issue, in this room, on this committee, in this administration, and around the world, and we need that commitment and we need that passion because that's the only way we're going to get to where we need to go. But at the same time, with that passion and commitment comes – you know, a great deal of

toing and froing and struggling to find the right answer and a lot of disagreement. I'm trying to strike a note here of humility and wanting to work in a constructive way together as we move forward.

There's a huge number of tensions or paradoxes that we need to resolve as we administer this program. We need to respond to an emergency, but we need to do it in a thoughtful and deliberate and considered way, and in a strategic way. We need to bring in new partners, and yet at the same time we need to be able to work effectively with existing organizations that are also doing good work. We need to bring in new ideas and we need to find new ways of doing business. We need to program a tremendous amount of resources. One out of every two dollars spent in the world from the donor community on global HIV come out of the wallets of U.S. taxpayers. We need to be accountable for those dollars. We need to get two million people in treatment by the year 2008 in these countries, and 10 million people given care and palliative care and orphan care for children. We need to prevent seven million infections. We need to do this with a very small staff. We need to do this in an efficient way where resources end up in the hands of people who are actually doing the work.

None of this is easy. We can't do it alone. We're developing our strategic – a strategic plan, which is – I want to close by emphasizing, this strategic plan, which is mandated by Congress and it's due February 20th to Congress, that will – may even be due before we have an appropriation. So I'm making the point here that this is a piece, and only a piece, of a long-term strategic planning process that is going – that should last in any healthy organization, - last for the duration of the time that we're working. Planning is an iterative process. We need to bring new ideas in, new blood in, new – and process and continue to talk to you and talk to community as we move forward.

This plan that we're working on now is the beginning, not the end, of that process. It's going to be an articulation of how we in the administration are approaching the management of this program, what our priorities are, and how we see ourselves moving forward, but I just want to be clear that none of us ought to sort of think, okay, we're done with that part and go home on February 20th. That's actually the beginning. So I look forward to many more of this kind of interaction with affected communities, with people who are involved and concerned. And thank you for being here.

MR. MASON: And now we'll hear form Ambassador and Deputy Coordinator John Lange.

AMB. JOHN E. LANGE: Thank you very much, and I'd like to second the comments of Dr. O'Neill and say how delighted we are to be with you all today and to be hearing your thoughts on our strategy.

As I talked to Ambassador Tobias back in July when he was first named by the president for his intent to nominate Randall Tobias as the U.S. Global AIDS Coordinator, this program has three goals: to reach the individual, the individual, and the individual. Whether it's prevention, care, or treatment, it will not have an impact unless in the end

we reach that individual, and their situations are different in countries all over the world. This is a global program, but from my experience working at our embassies in West Africa, East Africa, and Southern Africa, you really see HIV/AIDS firsthand and realize how critical this is as a pandemic that is tearing away fabric of societies and that must be dealt with and with the strong political and – political commitment as well as resource commitment, the U.S. will be in the lead role on this.

Much of the emphasis of discussions has been on the programmatic aspects of this program, but I would like to bring in one other issue that I hope we get input on, which is the – what we call the diplomatic side of things, because one can easily look at the programs for the 14 focus countries or for the other 75 countries that the U.S. government has HIV/AIDS programs in, but they're – this is really the global problem, and as Ambassador Tobias says, he wasn't nominated by President Bush to be the 14 focus country AIDS coordinator, but to be the Global AIDS Coordinator, so we're working and will be working with governments all over the world on this. To give you an example, because some of you may not have seen the media coverage of this – it was overshadowed by some other events – on the 20th of November, the prime minister of the United Kingdom, Tony Blair, and President Bush spent one hour discussing HIV/AIDS with five ministers of health from five African countries: Ethiopia, Kenya, Nigeria, Zambia, and Uganda. This is – my guess – an unprecedented event to have two leaders such as that spend that much time on HIV/AIDS with some key African leaders who are dealing with this. This is the kind of high-level attention that we expect to continue given President Bush's commitment as well as the high-level interest in other governments of the world, and that is also part of what we look to as our strategy that we need to develop in the months to come to try to gather interest from all over the world, both attention to this issue and resources to be applied to the issue.

I look very much forward today to hearing your comments. Thank you.

MR. MASON: I'd like to thank Ambassador Lange and Dr. O'Neill for being here. Dr. O'Neill has to leave, but before he goes, I just – on behalf of the whole council I want to thank you both for – just to be – an incredible amount of hard work that you have been doing. We – a lot of people are depending on your success, and we want you to know that we support you and we want to help you in any way we can, so thank you.

We are going to begin the public comment. I just wanted to remind you that it's three minutes for each of you, which we're going to try to get to everyone. We're going to start with the agenda as it's laid out, with nongovernmental and community-based organizations. I want to remind you to turn off your cell-phones and any other kinds of electronic devices like that, that would cause a disturbance, and I'm going to call about five people at a time so that we can keep things moving pretty quickly. There is going to be a timekeeper who will have a sign to my right who will remind you when you have one minute left, and then there's another sign that will say stop, and in order for us to hear form everyone, I hope that you will obey his commands over there. So with that, let's start with Terje Anderson, Shari Ayers, Andre Banks, and Marty Bond.

Terje first, if – then why don't we move to Shari Ayers, from Africa Nation. Some people are going to get here late, and we'll allow them to – at the end of this section if they come in. Then is Andre Banks from Africa Nation? Marty Bond from Africare?

Okay, then we'll hear from Clarence Hall. Thank you.

CLARENCE HALL: Good afternoon. My name is Clarence Hall, I'm the deputy director of HIV/AIDS and heath at Africare, and I'd like to make the following statement: on behalf of President Julius Coles and staff members of Africare, I am very pleased to have this opportunity to share the Africare HIV/AIDS experience and give support to the president's Emergency Plan for AIDS Relief and the mission of this body.

Founded in 1970, Africare is the largest African-American owned 501(c)(3) nonprofit development organization in the U.S. We currently have 150 development projects in 26 African countries, with 1,400 employees. Ninety-five percent are in Africa, and 93 percent are African. Africare has provided over $450 million in development assistance to Africa over the last three decades. Africare's mission is to improve the quality of life by assisting African families, communities, and nations with a multisectoral community-based strategy in three principal areas. They are HIV/AIDS health, agriculture, and food security.

Africare's philosophy is to work – to strengthen community-based initiatives, scale up best practices, and provide assistance to make these initiatives sustainable. Africare seeks to promote public-private partnerships to build capacity and infrastructure to mitigate the HIV/AIDS crisis. Africare has supported national efforts in Africa to combat the AIDS epidemic since 1987. I would like to share with you just one or two of our success stories that are in conjunction with the president's – that are very close to the president's initiatives and his emphasis. The adolescent reproductive health program that we have in Southern Africa reveal that Africa has been able to reach over two million youth, the ages – between the ages of 10 and 25 in Southern Africa, and specifically in Malawi, South Africa, Zambia, and Zimbabwe with reproductive health and HIV/AIDS prevention messages that have led to significant behavior change among the target population. Based on these results, Africare received a follow-on grant from the Bill and Linda Gates Foundation to consolidate these accomplishments in the three countries that I mentioned earlier.

A very good demonstration of our effort to scale up our HIV/AIDS programs is the African – is the Africare Disease management Foundation and the Eastern Cape department of health's initiative in South Africa. This five-year program will provide a wide spectrum of HIV/AISD prevention, treatment, and support services to 30,000 people living with AIDS, their families, and affected communities.

Africare is well-positioned to play a leading role in achieving this – these objectives of the president's Emergency Plan for AIDS relief with its 33 years of development experience in Africa, offices in 26 countries, its multisectoral community-

based strategy, and highly motivated and committed staff. We applaud the urgency with which the administration has given this crisis, and we look forward to working with you and our colleagues around the world to make HIV/AIDS a historical event.

Thank you.

MR. MASON: Thank you. Next we'll hear from Sarah Boeski (sp) from Family Health International, and after Sarah, Katherine Brandt, and then Galen Carey.

GRETCHEN BACHMAN: Hi there. I'm Gretchen Bachman, filling in for Sarah Boeski. I'm from Family Health International. FHI, as you probably know, is a non for-profit (sic) organization. We've been working in developing countries for close to two decades on HIV/AIDS prevention and care and we've been generously funded by both U.S. taxpayers and from foundations, and from the work that we've done we've learned some valuable lessons about this pandemic. Not the panacea solution, but some lessons. And I'm going to sum up these lessons learned in the four C's: C for collaboration among all partners; C for community-led and owned; C for comprehensive services; and finally, C for care centered on the family. In our experience, whether it's been through the introduction of anti-retroviral therapy or the establishment of community outreach centers for orphans, these four C's are key. Here are a few examples of how each has guided our approach.

C for collaboration among all partners and C for community-led and owned. FHI does not run programs; we are a catalyst. Sometimes we are a technical advisor, but our programs, or the programs that we support with taxpayer money, are designed, run and owned by local partners. In Rwanda, FHI did not introduce anti-retroviral therapy. We supported the ministry of health and the Catholic mission clinics, home-based and community care clinics, to introduce ART.

It is through this partnership that access to treatment is now widely expanding in Rwanda throughout the wider network of clinical and community-care services under the auspices of the diocese and the government. In another example from Kenya: for the introduction of ART we played a role in introducing home-based care volunteers from a faith-based organization with local PLHA – persons living with HIV/AIDS support groups. Together, they designed treatment, education materials for people living throughout Kenya. It is interesting that the funding for this came from the U.S. government, from the Kenyan government, and from a multinational corporation interested in supporting HIV/AIDS work. Together, these dual partnerships, both international and at the local level, we've ensured the people affected by AIDS throughout Kenya get the information they need to participate in their own care, and these informational materials are designed for them in their own language by their own peers.

C for community owned and led is crucial for all programs. We know that, but no more – I think more so than anything in the support of orphans and other vulnerable children. To give you an example, in Zambia FHI, Care International and a local NGO

called SCOPE (ph) have worked to establish and strengthen community-level committees at the district and subdistrict level. Serving on these community committees are farmers, doctors, businesspeople, teachers, nurses – I mean, everybody is sort of pulled together in these voluntary committees and they do amazing things. They set up community care committees, schools, farms – anything that these children need. And when new resources come in, they vote on whether or not those resources are going to be used and how they're going to support their efforts. This is a long-term problem for orphans; we need a long-term solution. We need to rely on communities.

Finally, since I'm out of time, just two quick more C's. Comprehensive care. Just in a TB clinic in a high-prevalence country where people did not know that you could be TB and HIV co-infected. We need to pull these things together. Comprehensive means we both need the mission hospitals and we need the government hospitals. No one can do it all.

Finally, family-centered care. Let us just remember that we cannot treat just individuals. Mothers will share their drugs with their children if they are both infected. Wives with their husbands, so that's my quick lessons learned: comprehensive, family-centered care, community led and owned, supported by a collaboration of all the partners you see before you.

Thanks.

MR. MASON: Thank you. For people who have not signed up but want to give public comment, you can sign up – we will take walk-ins and as we have time – we will call on you, so you need to go out and sign up and that's the way we'll handle that, for you and any other walk-ins.

MS. : Off mike.

MR. MASON: There's a special sheet out there if you want to give public comment.

KATHERINE BRANDT: Good afternoon. My name is Katherine Brandt. On behalf of the National Hospice and Palliative Care Organization, thank you for sponsoring this townhall meeting and allowing us to contribute to the president's Emergency Plan for AIDS Relief.

NHPCO applauds President Bush's commitment to helping address some of the critical global needs resulting from the HIV/AIDS pandemic.

Fifteen percent of the funds allotted for the president's initiative is intended to address palliative care needs in Southern Africa. As the oldest and largest nonprofit organization dedicated to improving hospice and palliative care in the United States, NHPCO has expertise in a network of professionals well-equipped to offer insights and

practical knowledge regarding the delivery of hospice and palliative care and the role they play on the continuum of care for patients and families.

So what do we mean by palliative care? The health resource administration of the Department of Health and Human Services developed an important definition that reads in part: "palliative care is patient and family-centered care. It optimizes quality of life by active anticipation, prevention, and treatment of suffering. Palliative care addresses the physical, intellectual, emotional, social, and spiritual needs." This relatively simple definition can begin to describe the importance of palliative care services appropriately delivered to those struggling with HIV and AIDS. Relief of pain and symptom control makes other forms of care possible. We know this based on 30 years of care in this nation where hospice and palliative care providers have been helping patients and families live with life-limiting illness free of pain and with dignity and compassion. We know this by the more than 885,000 Americans served by the nation's 3,200 hospice providers in 2002. We know this by the millions of terminally ill Americans who have utilized the hospice Medicare benefit – one of the most valuable benefits provided by a compassionate government. And we know this by the untold number of family members who are able to live beyond the loss of their loved one through the support services bereavement care made available to them.

In less developed countries where symptom control and end-of-life care are not well-developed, there is much to learn from the model of care that lies at the heart of hospices' interdisciplinary philosophy. NHPCO has experience in working with other nations surrounding end-of-life care. We've participated in conferences sponsored by the World Health Organization and other organizations.

More importantly, NHPCO recently hosted a working summit in South Africa that brought together more than 45 participants representing a dozen countries in sub-Saharan Africa, England, and the U.S. This group is working together to write a guide about providing palliative care services to HIV and AIDS populations in Southern Africa.

Palliative care programs provide services which are client-centered and structured around the cultural and social needs of patients and families. These programs strive to bridge the gaps between communities and institutions. By including palliative care services as an integral component of the president's initiative, the care provided to those most in need will be significantly improved. This includes patients, family members, and other loved ones as well as the community at large.

President Bush has shown that the relief of human suffering is a noble goal for a foreign policy. The president's initiative sets the goal of providing two million persons with AIDS with palliative care in 14 countries. We encourage the International Subcommittee of the Presidential Advisory Council on HIV and AIDS to take advantage of what we in this nation understand about the delivery of compassionate, quality, palliative care at the end of life and facilitate the sharing of this valuable information between our nation and others.

Thank you.

MR. MASON: Thank you. Galen Carey and then Sonja Clay (sp) from Planned Parenthood, and then Rachel Cohen from Doctors Without Borders.

GALEN CAREY: Good afternoon. I'm Galen Carey, the director of Policy and former Africa director for World Relief. I'd like to start by commending President Bush for his extraordinary leadership in announcing the HIV/AIDS initiative, and to underline the fact that the progress we have made so far in terms of funding is – while very commendable, is not enough, and I would like to encourage you as a commission to lend your voices to seeking the – at least the full $3 billion in the next budget cycle that had been promised for this initiative. I believe the money is well needed – needed, and can be well invested.

I'd like to briefly comment on the three areas that you asked us to talk about. I won't read my comments, but I want to talk briefly about program planning. World Relief has been involved in community development work for 60 years, and probably the most common mistake that we see made is that outside agencies come in with good ideas and good intentions, but impose their ideas and their money on the local people, and I think that's a – there's a great danger, as Dr. O'Neill has said, that because of the emergency – the fact that lives are at stake – that we will not take the time to have a well planned intervention in each place. And it should look different in different places. So we very much would like to encourage well-conceived and well thought-out community planning processes, especially in the area of prevention. We very much appreciate the focus on prevention through behavior change. I'd like to emphasize that this is a long-term process – something that will take place in a sustainable way over years and not over months. And so we need to be thinking with that in mind.

In the area of partnerships, World Relief has worked very effectively with churches and local faith communities and we'd like to encourage the initiative to look at how churches can be engaged – and other faith communities, in this process, but the caution is that we must not see these local, indigenous institutions as merely vehicles for us to accomplish our purposes, but rather see them as institutions in their own right which need to be respected and need to be dealt with by implementers who understand the unique identity of these faith communities. We'd very much like to encourage that the president's initiative be carried out to the extent that it involves faith communities, by groups and implementers who understand the dynamics and can work effectively and credibly with them.

Finally, in the area of the involvement of people living with HIV/AIDS themselves, I'd just like to share one experience that we've had in our work in Malawi where we've been able to work with churches to form patients' fellowships. These are groups that work together that encourage each other. As one woman said, "you know, I decided rather than just waiting to die, I'm going to go out and help people who are even worse off than me", and I believe that's the spirit we should approach this in.

Thank you very much.

MR. MASON: Thank you. Sonja Clay from Planned Parenthood?

Rachel – sorry. Welcome.

RACHEL COHEN: Thank you. My name is Rachel Cohen. I'm speaking today on behalf of Doctors Without Borders – Medecins sans Frontieres – or MSF. We're an international medical humanitarian organization with field operations in 80 countries, and we're the recipient of the 1999 Nobel Peace Prize.

Today I am speaking only about treatment. MSF is today providing anti-retroviral treatment for approximately 10,000 patients and about 42 projects in 19 countries throughout Africa, Asia, Latin America, and Eastern Europe. Clinical outcomes in our projects are excellent. Patients' CD4 counts are increasing. They're gaining substantial amounts of weight. They're suffering from fewer opportunistic infections. Adherence rates exceed 90 percent. People are returning to work and again becoming productive members of their families and their communities. In short, treatment is really transforming the face of AIDS.

While our ARV treatment programs have had a significant impact on the individuals and the communities with whom we work, they are relatively small scale and we have neither the capacity nor the mandate to provide wide-scale access to treatment at the level that is required – at the level that is so urgently needed. That is in our mind the responsibility of governments. We hope that the lessons we are learning – that we continue to learn about providing anti-retroviral treatment in resource-poor settings are helpful in designing and implementing the president's initiatives and we'd like to highlight at least three areas to draw your attention to, keeping in mind that we've submitted fuller testimony in written form.

I want to stress that there is no single formula, and as Dr. O'Neill said, there is not going to be a magic bullet. If that's what people are hoping for, they'll be disappointed. One of the most important lessons that we have learned is that you must simplify, adapt, and decentralize care and treatment – treatment-monitoring protocols. MSF is in the process of adapting our approach to AIDS treatment to better fit with the real-life conditions faced in developing countries. Our medical teams are using treatments with fewer pills. They're relying less on sophisticated lab tests, taking better advantage of the skills and resources that exist among health professionals in the countries where we work, and decentralizing the point of care to the district and community health-post level.

This is so that we can reach even the poorest and most vulnerable people in the most remote settings, and it's not going – it's so that treatment is not limited to the wealthiest 3 percent.

One of the most important tools that we are using to simplify and adapt treatment are fixed-dose combinations of anti-retrovirals. About 70 percent of our patients are

taking their pills in the form of one pill twice a day. These drugs are available for as little as $140 per person per year, and they are available only from generic manufacturers due to patent barriers.

One other very important lesson is to involve the community. The knowledge and meaningful participation of people living with HIV and AIDS is key to the success of treatment. At our HIV clinics in Kialicha (ph) in South Africa, MSF and grassroots treatment advocates have fostered community-based education programs through carefully designed, patient-centered adherence programs, people on ARVs and MSF programs have the support of their peers and of trained counselors. This community mobilization has already had a positive effect not only on adherence, which is in this project about 95 percent, but has already had a powerful effect on de-stigmatization, reducing discrimination, and strengthening prevention efforts.

One other point is decreasing the price of medicines. The lower the price of medicines, obviously, the larger the number of people that can be treated.

I just want to make one final remark. During the past year there have been several positive developments at the national and international level related to expanding access to care and treatment. If the president's initiative is to meet its stated objectives, it must be designed to work in collaboration with existing mechanisms like the global fund, the WHO three by five initiative, and so on, and with comprehensive national AIDS plans. It must not undermine, duplicate, or complicate these efforts. PEPFAR is just one part of the global U.S. strategy and special efforts must be made to ensure that U.S. policies in general do not contradict or undermine the ability of countries to expand access to care and treatment.

When the U.S. talks of expanding access to treatment on the one hand and then promotes trade policies that will restrict, for example, access to generics on the other, they are in effect giving with one hand and taking with the other. Nothing must get in the way of the goal of providing universal access to treatment – anti-retroviral treatment and other forms of care and support for the millions of people throughout the developing world who will die premature, avoidable deaths without it.

Thank you.

MR. MASON: Thank you. Charles DeBose from Africare; Anna Evans from the World Council of Credit Unions. Peggy – come on up. I'm going to call about five or six people. Could you just line up because I think it will go faster if we do it that way so that we don't lose time with people getting to the podium. Anna Evans, Peggy Harper, Ernest Hopkins from San Francisco AIDS Foundation, and Jodi Jacobson from the Center for Health and Gender Equality.

Thank you.

ANNA EVANS: My name is Anna Evans. I'm commenting on behalf of the World Council of Credit Unions. The World Council of Credit Unions is the international trade association and development agency for credit unions. As a trade association, we represent 118 credit union members in 79 countries. As a development agency we provide technical assistance to strengthen credit unions, primarily with USAID and World Bank funding.

I want to underscore the critical need for PEPFAR to support a multisectoral response to the HIV/AIDS pandemic. First, I'd like to discuss prevention. For meeting a challenge of preventing new infections, it is essential and important to survey the landscape of community-based organizations, not necessarily health service providers, that have a large-scale outreach in rural areas and offer an existing network, an infrastructure, through which messages of prevention and referrals to health service providers can be delivered to vast numbers of people. Credit unions and other member owned community organizations already have the trust of their member clients. To set an example, in Kenya, where credit unions serve 1.5 million members, adding value-added services such as giving referrals to testing centers on savings deposit slips or having an outside health expert offer prevention seminars at already existing member education days offered quarterly could be a lower-cost alternative than extending the operations of a program dedicated exclusively to prevention – extending that program to remote communities where these community-based organizations already exist.

Second, regarding the goal of caring and supporting HIV-infected individuals, I'd like to quote USAID's expanded response to HIV/AIDS report to Congress from June, 2002: the report confirms that HIV/AIDS' – I quote – "most immediate impact is financial" -- loss of income and increased medical expenditure, particularly when the ill family member is the principal breadwinner. A healthcare-only response will not yield optimal results for individuals that are infected as well as affected by HIV/AIDS. AIDS has financial impacts that necessitate households having access to financial services to cope with expenses related to the pandemic.

In African credit unions that we've studied in Botswana, Zambia, South Africa, and Kenya, we've seen members confronted with increased expenses for medical and hospitalization bills, funerals, school fees for additional dependents for orphans that they're being cared for. We have to keep in mind that assuring adequate income in households so that they can be food-secure and provide daily nutritional requirements for HIV/AIDS-infected individuals is an essential component of HIV/AIDS care and support.

Thank you.

PEGGY HARPER: Hi. I'm Peggy Harper from the Foundation for Hospices in sub-Saharan Africa, and I'm coming kind of as a follow-up to Cathy's words earlier about the National Hospice and Palliative Care Organization, but I had some comments that I thought that would be helpful to – that – of lessons that we've learned in our three years in working with the hospice care programs in sub-Saharan Africa.

First, I want to stress that hospice and palliative care, as Cathy indicated, is really a multi-disciplinary approach that is primarily home-based care; that it's – that it needs to be available to children and adults. Primarily it's been – adults have been accessing that care to date and we need to include children. The community-based programs might also include daycare where there could be clinical supervision, and small inpatient units. There's much confusion in thinking that hospices are buildings and I wanted to clarify that.

And that there is a scientific base to a hospice and palliative care, and therefore this isn't just people who are holding hands with people who are dying – not that that's a bad thing to do, but it really is a clinical base to that and therefore it really requires the community caregivers who provide most of the care to have clinical supervision that's appropriate to the country that they're in and how – access to clinical officers. That bereavement, hospice and palliative care has a role in prevention, which is always kind of a surprise to folks, but these are people who were – are in the home and the trust – have gained the trust of the families and therefore can talk about really what they're – what the diagnosis is and what's going on and talk about how it happened that this person was infected and how it can be prevented in other family members. The role of bereavement is critical in the early identification of orphans and their early planning for orphan care.

I think one of the – the experiences in Africa is that some of the countries have hospice and palliative care and other countries are begging for such care when they hear that not all of their people need to die in pain. And so I ask you to be sure to think beyond the country-by-country borders and really think about regional approaches so that those countries that have people who are experiences in providing hospice and palliative care can train other people in other African countries, so a real model of Africans training Africans to provide the care.

I think in addition the importance of not only including anti-retroviral treatment, but also medications and drugs for hospice and palliative care need to be included, such as morphine and other medications for symptom management.

Thank you very much.

MR. MASON: Thank you. Why don't we have Gregory King – go ahead – you can come up. I'm just calling other people. Gregory King from the American Federation of Teachers. Hannah Klaus from Teen Star Program. Kristin Langley (sp) from Plan USA, and Kya Lewis (sp) a former member of the council.

JODI JACOBSON: Good Afternoon. Thank you, all of you, for inviting us to give comment on the program strategy. My name is Jodi Jacobson and I'm founder and executive director of the Center for Health and Gender Equity, an international women's health policy and advocacy organization focused on U.S. international assistance and policy vis-à-vis women's rights and how – We are deeply concerned that the overarching U.S. global AIDS strategy now being developed by the global AIDS coordinator

including, but not limited to, the president's Emergency Plan adequately address the specific vulnerability of women, girls, and other groups to HIV.

I have submitted written comments and I just want to highlight some of the points that I think are of greatest concern. As we're all now aware, an overwhelming body of scientific, medical, and public health data now irrefutably confirms the unique biological, social, cultural, and economic vulnerability of women and girls to HIV/AIDS. In recognition of this evidence, the United States' Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 requires that the president and the global coordinator develop specific strategies to, quote, "meet the unique needs of women and girls including the empowerment of women in interpersonal situations and young people and children including those who are victims of the sex trade, rape, sexual abuse, assault, and exploitation."

I am wanting to offer a few points that I think are critical as we move forwards in the development of the strategy. In short, U.S. global policy to achieve its own goals must, at a minimum, include the following: support for comprehensive HIV prevention strategies that promote scientifically proven, field-tested strategies and best practices to meet the diverse and changing needs of women and young girls throughout the developing world, keeping in mind that in many countries, for example, child marriage or early adolescent marriage is common. Many young girls are married, or 50 percent or more of young girls are married by the time they are age 18, and the rate of new infections is increasing among married women of reproductive age. For these groups, and particularly women for whom their personal situation requires that they are unable to control the frequency or timing of sexual intercourse, abstinence only programs are not a viable option and do not constitute a comprehensive or effective strategy.

The second point is that I wanted to underscore that we need to make sure that we are supporting expanded access to integrated health services. Ambassador Tobias and others have suggested that they will ensure that development assistance and other components of development strategies will be coordinated with the HIV.AIDS program. However, women and adolescent girls need and rely upon a full complement of HIV, STD, and reproductive health information and services, including family planning information and services for sexually active individuals wishing to avoid both infection and unintended pregnancy, as well as for HIV positive women seeking to avoid pregnancy or to safely deliver.

I want to say that I am concerned that our development assistance for international family planning funding is woefully inadequate and is not being well coordinated with the goals of the overall HIV/AIDS agenda. We need to be spending more in this area and we cannot see this area of service apart from where women and girls get their information and how they seek services.

Third, we need strategies to reduce gender violence, sexual coercion, and harmful traditional practices and other barriers to women's health and rights specifically because studies now show that between 50 – 15 to 50 percent of women and girls have

experienced some form of sexual coercion or sexual abuse in their lifetimes throughout the developing world. Other points are already allocated in my written testimony, but I think if we were to pay attention to these basic needs and ensure that women have access to equitable – equitable access to treatment and care, we would be going a long way to resolving the HIV epidemic.

Thank you.

MR. MASON: Thank you.

Fine.

DR. HANNAH KLAUS: I'm Dr. Hannah Klaus. I'm obstetrician gynecologist, now working full time with the Natural Family Planning Center of Washington, D.C., and the Teen Star program, which is an educational program of sexuality for teens which has shown good results in maintaining primary abstinence and the return to secondary abstinence by half of previously sexually active adolescents in the U.S.

We are a health education NGO here, but work mostly with FBOs in developing countries. I'll talk about our programs which are working well. In Uganda, the coordinator also coordinates religious education for the Catholic Bishops Conference in Kampala and their teacher stipends come from the schools in which they work. We're now in seven high schools and we have managed to get the kids to hang in with this. They maintain abstinence. They chart – the girls chart their cycles, which validates their womanhood, increases their self-confidence. And I'm sorry to disagree with the previous speaker – it does work.

In Volovio (ph), the program is most developed in Zimbabwe, the Christian healthcare services now receiving funding from Catholic relief services with 26 teaching sites and 48 active teachers reaching 700 students by last summer with very positive feedback, but they have a very slow approach to the program. They start with a two-hour awareness meeting in the community picking out the leaders, then two weeks later they come with a two and a half day introductory workshop, discuss anatomy, physiology in the local language, indavala (ph) and shuna (ph), and then also talk about parenting, child developing, and – development and counseling. And the last half day is then they have planning and only five says a week – dory, about a month later they give the full teaching program and then go ahead.

So it has to be staged. People have to understand the need for the thing and agree before you do anything else with it. In the course of the training, the teachers learn the Billings ovulation method, which is a natural family planning method which is the basis for fertility awareness training. It enhances monogamy, et cetera. I see my time is getting short. My full thing is on the web, but what I want to stress is that you can't have a one-size fits all for everybody. There are many people who will be very happy with abstinence until marriage and fidelity within marriage. If you insist on making them offer things which are against their philosophy, it's not going to work. And yet, the best

way to prevent HIV transmission is surely abstinence until marriage and fidelity afterwards.

Thank you.

MR. MASON: Thank you.

ERNEST HOPKINS: Hello. Good afternoon. On behalf of the Pangea Global AIDS Foundation, which is the global affiliate of the San Francisco AIDS Foundation, I'd like to thank the Presidential Advisory Council for having this meeting today, and certainly to commend the Bush administration for the presidential Emergency AIDS Initiative and its significant focus on treatment and medical care.

Saving the lives of people with – of people living with AIDS through treatment readiness and access is the focus of Pangea's work in the developing world, and we strongly encourage the administration in its efforts to quickly engage the actual doctors, nurses, health workers, and HIV positive communities in each funded country in order to be successful.

Our experience is that developing close working relationships with these individuals is essential for success. We at Pangea were very pleased that Secretary Thompson, Ambassador Tobias, and their teams were able to visit two sites in Africa where Pangea is actively engaged: Kikiru (ph) Health Center in Kigali, Rwanda, and the Makerere University's Infectious Disease Institute in Kampala, Uganda.

The Kikiru Health Center demonstrates that health quality – that high-quality healthcare can be delivered in very basic primary care settings. The comprehensive services provided at Kikiru include medical care, treatment including ARVs, psychosocial support, and food. The center is very modest, but the care is patient-focused and high-quality, and Pangea commends the initiative's desire to build on the existing infrastructures already in place in countries because we have found that with modest investments significant good can be done.

The second site I mentioned, at Makerere University in Kampala, Uganda, is a partnership with Pfizer Pharmaceuticals, the Academic Alliance for AIDS Care and Prevention, and Pangea. Dr. Hank McKinnell, who is a member of PACHA and Pfizer's support of this project will continue to ensure the excellent training for generations of healthcare providers will be available and high-quality HIV care and treatment will be provided in the new infectious disease institute at – the new – the Infectious Disease Institute facility now close to completion. There has been careful attention to anchoring both the clinical and strong administrative systems for durable, sustainable benefit to the broader region.

One of the most important lessons that we have learned is that systems of care designed in resource-poor settings must reach out and embrace multiple levels of healthcare providers, particularly in light of human resource constraints. When the

proper support and mentorship is provided, nurses and community health workers can deliver very high quality care including monitoring of ARV therapy within existing community-based systems of care. It is this careful attention to the systems for consultation as questions arise, and mechanisms for referral for patients' needs that allows the further evaluations for – by a physician to occur, and that is key to delivering services safely, even in the most remote settings or the poorest – the most resource poor environments.

Finally, Pangea supports the rapid scale-up of treatment in the first round of the R (ph) phase produced by the AIDS coordinator's office. We hope that the country treatment plans to be developed by the 14 U.S. ambassadors of the focus countries with the country representatives are tightly integrated with and informed by each country's existing national AIDS plan. Pangea looks forward to country treatment plans that are consistent, complementary, and well integrated with each country's overall national AIDS plan.

Thank you.

MR. MASON: Thank you. Let me ask Marsha Martin to come on up. Marsha Martin from – no you – I'm just calling additional people. Marsha Martin from AIDS Action; Pete McLain (sp) from Voice for Humanity; Jesse Milan (sp) from the Cansella (ph) Group; and Jack Musaali from the Family Research Council.

MR. : Good afternoon. I am speaking on behalf of Kristin Langley who is on your – from Plan USA, but I'm really speaking on behalf of the Hope for Africa Children Initiative, which is a consortium made up of CARE, Worldvision, Plan, Save the Children, The Society of Women and AIDS in Africa, and NAPLAS (ph) which is the National Association of People Living With AIDS in Africa, and we have been working together some three years now. We are community-based. We are holistic. We are African run. What I want to comment – I initially was hesitant to come up at all given the strategic level of these panels' discussion, but I heard someone very early on – it was either you, Dr. Mason, or Dr. Sullivan saying getting things smart – and I want to talk about an operational implication as you go forward.

The first round of procurement under the president's emergency program came out a few weeks ago, and what it tended to do is go just opposite of an approach which we think would make the greatest sense. The greatest sense is for organizations like FHI mentioned earlier on, to work together, to work as a unified group, to subordinate our individual self-interest as organizations for a greater good. But the procurement documentation that came out did not facilitate working together; it facilitated fragmentation, and because the size of each individual procurement was so small and the enormity of the issue is so large, that each organization on its own to compete with each other rather than to unify together, so I just urge you as you are developing not only your strategies, but your operational tactics, to facilitate organizations that come together to put their individual self-interests behind. There will be many consortiums. It won't be just one. There will be many consortiums. There will be individual organizations that

have such a unique niche that they will rightfully want to go on their own and it will make sense, but for the most part of you want effectiveness of impact and you want efficiency in terms of the use of your dollar, you don't want to set up 20, 30, 40, 50 separate parallel structures with all the different overhead and administrative costs associated with it, and that's what you did on your first procurement.

I'm trying to say this as constructively as possible because we all want the president's initiative to work and work well.

Thank you.

(Applause.)

MR. MASON: Thank you. Thank you.

KYA LEWIS: Hi. Good afternoon and good to see everyone. I'm Kya Lewis, senior policy analyst at the National Family Planning and Reproductive Health Association and a former member of the PACHA. I will save some time today by being extremely brief with my comments, but the National Family Planning – NFPRHA – is an organization that represents state health departments, community health centers, and clinics across the country that provide public – publicly funded reproductive health services for low-income people.

And from our experience with our clinics, we know that comprehensive messaging in education and prevention as well as comprehensive integrated care for family planning, STD, and HIVC services work best and that's what we strive to do here domestically. We were concerned about the mandate within the president's initiative that one-third of all prevention funding should go to abstinence until marriage programs, and I just wanted to urge the council to do a few things and think about asking the president to do a couple of things, especially in consideration of the rates of HIV and AIDS we see in women and girls in African and other nations.

First of all, I would urge the council to encourage the global AIDS office and the global AIDS coordinator to make sure that programs – prevention programs are duly coordinated on the ground, that evidence-based prevention methods are used, and that organizations that have been doing prevention work and good HIV work over the years are able to access funds, collaborate with organizations that can do that work with them, and help to solve the problem on the ground.

I would also urge the council to ask the administration to focus on the development of vaginal microbicides to prevent the sexual transmission of HIV, to expand access to integrated services, reproductive health services, and HIV services on the ground. With that, I would say good luck, Godspeed, take care.

MR. MASON: Thank you.

JOSEPH DAVIS: Good afternoon. My name is Joseph Davis and I'm with the American Federation of Teachers. I'm substituting for Gregory King, who had agreed to speak this afternoon, but unfortunately he could not make it.

I would like to share the AFT experience with you and talk about some of the work that we are doing internationally and domestically on the – in dealing with the problem of HIV/AIDS.

As I am sure all of you now, or most of you know, the American Federation of Teachers is a teacher organization – primarily a teacher organization, but we also represent healthcare workers, public sector employees, non-teaching school personnel. The AFT has 1.3 million members across the country, mostly in major urban areas: Baltimore, Chicago, New York, Los Angeles, New Orleans, Dade County in Florida, and in many other locations. We are a political organization and we are involved in the HIV/AIDS effort in two ways. One is through a domestic campaign. We are educating our members throughout the country on the importance of the HIV/AIDS work that needs to be done in Africa. We're trying to build a constituency to support the president's initiative and to support your work and try to encourage Congress to provide more funding for the incredibly important work that you are doing.

The AFT over the years has had a very active international affairs program. That's not our primary responsibility. Our primary responsibility is to represent our members, but our – the focus of our international affairs program is to help develop and support independent, democratic trade unions across the world. We have programs in about 60 countries. We have many programs in Africa, and most recently our president made a commitment to focus – to make HIV/AIDS a high priority. In our programs, we are working with teachers and teacher organizations. We have programs in about five countries now. In those five countries, the organizations that we work with represent over one million teachers.

In the 14 countries targeted by the president's program, there are well over two million teachers, and as you know, and as the minister of education in South Africa says to us over and over again, there's no vaccine for HIV/AIDS – or the only vaccine we have for HIV/AIDS is education. Teachers are central. Teachers are at the epicenter of the problem. They are the people who meet every day with orphans, deal with sick children, deal with children who are traumatized by the problem of HIV/AIDS or the effects of AIDS in their families and their communities and so on. Teachers themselves have a high rate of HIV infection and they're dying in large numbers. Over 1,000 teachers die every year in South Africa for example.

Teachers are also very active in the HIV/AIDS education -- HIV/AIDS program. They are working to support orphans; they're working to support colleagues who are sick. The teacher organizations have a good infrastructure – an excellent infrastructure. Their representation at the national level, at the provincial level, the district level, and they have representatives in every single school, and in – (audio break, tape change) – in your strategy paper, and also keep in mind the importance of teachers, the work they can

do inn reaching out to the community, their importance in the community, but also teacher organizations that can help facilitate your work because they have an existing infrastructure and commitment to good leadership.

Thank you.

MR. MASON: Thank you.

PETE MCLAIN: Good afternoon. My name is Pete McLain. I'm with Voice for Humanity, a relatively new organization that's working on serving as a catalyst for behavioral change through information and education and communication and interventions primarily with oral communicating cultures and that's the point I want to talk on for three minutes.

The over half of Africans that are oral communicators; that is, they take – they may – they're either illiterate or they may be literate, but they primarily taking information visually, orally. In other words, they don't rely on their books or their computers or their handwritten notes or newspapers for information. They rely on what they've stored in their heads or what they get from known and trusted people that they have around them that are repositories of information. So to have—to get information into people's heads, it needs to be in a format that oral communicators can understand, internalize, that will hopefully lead towards behavioral change, so that's stories, that's dramas, it's proverbs, it may be songs, music, that kind of thing. And it's pretty obvious that it's easier to remember a story than it is an outline of eleven points.

We don't memorize outlines of 11 points as literates, we write it down and then that's where we store it. We're not storing that in our heads; but if you're an oral communicator, you're storing that in your head. Or, if you don't do that, then you have people around you that you know and trust that you go to for your information, so when it comes to prevention and awareness, AIDS information, how do you get that across to oral communicators so that they understand it, they retain it, and that they change their behaviors as a result of it? So that's what we're concerned about.

The best way to do that is through person to person, but how – we don't have enough time to do a person-to-person kind of intervention. There's also a problem with person to person because the information can break down over time as you go from one person to the next person to the next person. It breaks down. We've all done that game of telling a story in secret and you go around the room and by the time it comes back to you, it's changed. So what we've been working on is a low-tech – I mean low-cost technology that can provide a consistent message, but in an oral form, so if you think of an MP3 player, we have developed an MP3 player for about a tenth of the cost – it's about $25 – and we can – we're compressing speech up to 125 times, that's part of the reason why we're getting the cost down, so we can put up to 80 hours worth of content on this device, but we built it with a speaker so that you can play it in a small group setting so people can sit around and listen to it, stop it, and have a discussion about it. Interact with it. Maybe it's – there's a drama they reenact. Then you can rewind it and

play it again. It's that kind of learning experience that we think is going to lead to more likely resulting in behavioral change.

Just for my last 10 seconds here I thought I would just demonstrate how this sounds.

(Begin recorded segment.)

"Talking about HIV/AIDS prevention messages from Uganda. Walking in the dark without light to guide you is dangerous. You could easily end up in trouble. Living your life without HIV counseling and testing is like walking in the dark: it is a threat to your life and the lives of loved ones."

(End recorded segment.)

So you get the idea. Thank you.

(Applause.)

MR. MASON: Thank you.

Let me ask Julie Neff from Concerned Women for America. Lucille Perez from the National Medical Association. Cesar Portillo from the AIDS Healthcare Foundation, and Patrick Robinson from the Association of Nurses in AIDS Care to be ready to speak.

JACK MUSAALI: Thank you. My name is Jack Musaali here today from the Family Research Council. As a fellow with a Witherspoon fellowship, I am here to share my experience growing up in Uganda, a country that has been ravaged by HIV/AIDS and has experienced dramatic success in reduction of HIV infections than any other country.

I was born and raised in Uganda and came of age just as the HIV plague was spreading across the nation. During the – when I was nine years old, my teacher came to class one day and said, today we are going to start a new topic. She said she had to teach us about slim (ph). Slim is a local colloquialism about AIDS. That's descriptive of extreme weight loss of a patient after they have gone to full blown AIDS. Ms. Nakami (ph) – that's not her real name – proceeded to teach us about HIV, about the virus, about the methods of prevention, and she said there is no known cure for AIDS, so if you get it, you will die. Sobering words for a nine-year old, but I would not know the significance of what she was trying to tell us until much later.

Unknown to us, Ms. Nakami was dying of AIDS. She still looked healthy and full of life, but on the outside she was surely dying, and before our eyes, as her symptoms of full-blown AIDS became more evident, she was transformed form a beautiful young lady to a haggard skeleton.

During the months and years that followed, a feeling of desperation gripped the country. Reports of people dying from AIDS were too many to count, but too real to ignore. Mothers and fathers, sons and daughters, rich and poor, old and young, no one – not even my teacher – was immune.

A national campaign to educate the young people began in earnest. Each year, the primary school and secondary schools would hold a musical drama competition presenting the message: AIDS kills. There is no known cure for it. It is transmitted mainly through sexual contact, and abstinence is the best choice.

By the time I was 16, I had attended more funerals for AIDS patients than I could count on my hand. Nearly everyone in my school knew a close relative or a friend that had died form AIDS. In 1997, my uncle and then later his wife both died of AIDS, leaving behind six orphans who had to be taken care of by my family. Last year, one of my best friends, an orphan herself, was the last auntie that was taking care of her and her little sister. She now has to raise the rest of her siblings in what is called a child-led household. She cannot complete her education and must grow up and begin to look after her siblings, including a little boy who is HIV positive.

This year as I was leaving to come to the U.S., a close family friend passed away leaving behind a devastated wife, a 10-year old, and a six-year old. There is not one family in Uganda that I know that has not lost at least one relative to HIV/AIDS. My father in his struggle to find a way to teach my brothers and I about sex took us to an annual conference organized by the Uganda Youth Forum and the first lady of Uganda. The conference that year was aptly titled "Not Everyone Is Doing It." In her opening remarks, the first lady of Uganda, Mrs. Musevini (ph) stressed the importance of abstinence as the only viable and preferred method of staying clear of the deadly plague of HIV/AIDS. I attended the annual conference from 1993 to 2000 and during this time I signed the true love waits commitment card, which says believing that true love waits, I make a commitment to God, myself, my family, and my country, my friends, and my future mate to be sexually pure until the day that I give myself to my marriage partner.

Uganda's response to the devastating AIDS epidemic in a resource-constrained setting has been acclaimed as a global model. The focus on Uganda resulted in a 1995 announcement of the declining HIV sero prevailing threats. As we plan for policy interventions in this congressionally mandated five-year strategy – I know my time is up now – to combat this HIV/AIDS, I would like to reiterate that Abstinence and behavior change are possible. If the policies we make do not place significant emphasis on abstinence, they will not be effective in combating this epidemic. I want to testify that behavior change is maybe is still a difficult way, but it is possible and it should be the preferred way of – because it trains the mind to be disciplined and it establishes important qualities of self-control, restraint, and respect for the other person's life.

Leaders should not be timid to support abstinence because, as I can attest, the young people do listen and will abstain.

Thank you very much.

MR. MASON: Thank you. (Applause.)

DR. PATRICK ROBINSON: Good afternoon. I am Dr. Patrick Robinson. I am the president of the Association of Nurses in AIDS Care, known as ANAC. The association is a member organization representing over 2,500 nurses across the United States. I am here today on behalf of the association to urge this International Committee of the Presidential Advisory Council on HIV/AIDS to recommend to the president that nurses be included in all levels of planning, development, and implementation of the president's Emergency Plan for AIDS Relief.

ANAC also urges the council to request of Ambassador Tobias that he recommend to the leadership of the specific countries receiving assistance through EPAR that nurses be included in the planning, development, and implementation of the funding for HIV/AIDS relief. Additionally, that nurses be utilized to educate, train, and empower other nurses and community health workers to provide the care essential to the attainment of the goals of EPAR.

The network model as outlined in the plan is familiar to nurses who work and collaborate across healthcare delivery systems. Nurses are skilled in addressing multiple priorities not only of the systems of care, but also the priority needs of patients and their families. Nurses from the United States and the specific countries must be included in the planning and development of the implementation plan of EPAR and in four domains as outlined. Ensuring that nurses are involved increases the potential of success for EPAR. The foundation of quality healthcare in this country is having highly skilled nurses in all levels of the healthcare delivery. Multiple studies have identified nurses as the critical component of care. When there is inadequate care – nursing care, morbidity and mortality rise. In resource-challenged countries, nurses also are the primary providers of care. Physicians are frequently in short supply, and nurses perform numerous interventions that are usually done by physicians in this country. Additionally, nurses are the primary link to communities and are not only knowledgeable about the needs of the community members, but are trusted by community leadership.

Nursing input is not sought, and non-nurses are deciding what care needs to be provided. If nurses were included in all levels of planning and implementation, more efficient and appropriate programs would be implemented. Worldwide, nurses have been significantly involved in providing the majority of HIV/AIDS care. Their experience and expertise would richly enhance the program planning and implementation processes.

Recently, the World Health Organization announced a need for 100,000 trained providers to implement their plan to have three million people enrolled in anti-retroviral treatment by the year 2005. Nurses undoubtedly will be the majority of these providers. The worldwide plague continues to spread rapidly; we must respond rapidly. Providing anti-retroviral treatment and care will certainly slow the progression of HIV disease, allowing parents to live and raise their children; allowing governments to stabilize

political, economic, educational, and social structures; and to prevent the total destruction of some of the more severely HIV impacted societies. Nurses are ready, able, and committed to participate in this endeavor.

Thank you for providing me this opportunity to speak on behalf of nurses.

MR. MASON: Thank you.

JULIE NEFF: Good afternoon. I come bearing good news. You guys only have 30 minutes till your next break, so that's a good thing I guess. My name's Julie Neff. I'm with Concerned Women for America, and I'd like to thank you for giving us this opportunity today.

Concerned Women for America is a nonprofit women's public policy organization that works both domestically and internationally on vital social and health issues that affect women, men, and their families. Time is short, so I'll be general.

Concerned Women for America and its over 500,000 members stand with the president in his commitment to rescue a continent from destruction by committing U.S. funds to combat AIDS in Africa. The U.S. has an excellent opportunity to combat this pandemic in Africa by learning form the errors we've experienced in our own domestic policies. Therefore, there are three priorities we must exercise in order to achieve a healthy success in preventing the spread of AIDS in Africa. First, we need to provide access to lifesaving drug cocktails for every person who is infected with HIV/AIDS so they can continue to lead their best life possible. Second, we must meet the essential needs of orphans, widows, and others bereft of means of support who are ravaged by this disease. Those essential needs should include basic healthcare services, clean water and good nutrition, and adequate housing. Third, we must also use what works to prevent this disease, and in those prevention activities, we should focus on behavior change as our strategy, eradicating unsafe sex practices such as prostitution, rape, multi-partnering, and fornication. Further, the proper role of condoms in a sensible prevention strategy should be used as a tool to prevent those infected from infecting others.

Compassion demands that we fund what we know will save lives, and based on this premise I respectfully resubmit these comments.

Thank you very much.

MR. MASON: Thank you.

MARSHA MARTIN: Good afternoon. I'm Marsha Martin, executive director of AIDS Action, and I would just like to say thank you for this opportunity to address the subcommittee and also thank you to you, Chairman Mason, for the opportunity to travel with you this summer to Southern Africa, and your colleague, Jim Driscoll.

I would like to share with you some of the observations that AIDS Action as a result of that trip have discussed with our board of directors and would like to share with you what we think we observed that would really help to solidify an effective response given the president's initiative. The opportunity to visit South Africa, Botswana, and Uganda was a unique one for AIDS Action. As many of you know, we are a domestic AIDS service organization. We represent health departments, community-based clinics, AIDS service organizations. We represent individuals and organizations that cover the span of the epidemic from care and treatment to prevention and services. And to be able to see the epidemic outside the country was very important for us and for our membership.

To then be able to be in a position to comment and to provide support where we could in response to the president's initiative. And I would like to just say that this is a unique opportunity to build on an effective response, and effective models that we have seen developed over the years. In South Africa, we saw a serious commitment of the corporate structure and the corporate sector. One of the things that we talked a lot about in the United States in building an effective response was leadership form the private sector, from the corporate sector, from the business community and we saw in South Africa very serious commitments and examples of collaborative programs that have come from the private sector in response to the epidemic when the government was not doing its part, so we want to say that we endorse the role of the corporate sector. We saw large businesses engaged in direct services, engaged in enhancing access to services, and in providing direct care and treatment. Effective models.

We then visited Botswana where we were able to see the role that government has played. There have been some concerns that have been raised about what role can government play – government directly. And we saw in Botswana where the national AIDS coordinating council of the government was engaged in coordinating care in partnership with the private sector as well as with the community, so while we put a lot of focus on the private sector and the corporate sector and we sometimes talk about what government can and cannot do, in Botswana we saw leadership from the very top engaged and knowing and knowledgeable about what was going on, what part they had to play, and how they had a responsibility to come together and coordinate and convene.

And then we saw in Uganda a very interesting program that showed us that we can provide anti-retroviral treatment in rural areas, clean and safe water, medical services and support, with training of family members and community members in providing care. It seems that there have been times in the past where folks have felt that this is not possible and doable, and in these communities this is what we saw in partnership with community. This is very important to keep in mind that we cannot do this delivery of services without the community, so we believe that a blended leadership model that recognizes all three components is the most effective way to go.

And finally, we will leave you with the words of the ambassador to South Africa. When he greeted us, he said it is time. It is time. It is past time. We must do it now and we cannot wait. The ambassadorial group that is working in response to this epidemic is

exceptional. Many are career civil servants who have been in Foreign Service for a long time. They know the countries in which they work and they are prepared to do their job, so we have the type of blended leadership that we know we need to see.

And on a last note, because we are a domestic agency, we've heard a lot of talk about three and five for the global response. We're going to talk about two and four for the domestic response. We'd like to see $2 billion in the '04 budget.

Thank you very much. (Applause.)

MR. MASON: Thank you. I want to just call a few more people up: Susan Roylance from United Families International, Sharon Rudy from Population Leadership Program, Asia Russell from the Action Group, and Natasha Sakolsky from NASTAD.

CESAR PORTILLO: Good afternoon. Cesar Portillo, chief of Public Affairs with the AIDS Healthcare Foundation. Thank you for the opportunity to speak.

In August of 2001, we launched an anti-retroviral clinic in Durban, South Africa with our local NGO partner, the Network of AIDS Communities in South Africa, or NETCOM. The following year, we launched an ART clinic in the Masaka district of Uganda in a collaborative called Uganda Cares, a partnership with the health ministry of Uganda. And last month we opened a second clinic in that partnership and have an agreement to bring with the ministry up to 10,000 people into anti-retroviral treatment.

In January of this year, we received an invitation from the Episcopal diocese of Honduras to add an ART program to an existing OI clinic in San Pedro Sula (ph). Three months later we launched an ART program with them and we've just signed a memorandum of understanding with the ministry of health to launch two additional clinics.

My comments below, in response to the questions posed in this hearing, are a compilation of input from staff at the local level. In South Africa we responded to the invitation from our local NGO partner, NETCOM. This partnership has been essential in outreach to the community since local communities best understand how to address cultural issues and to help patients negotiate these issues in deciding to initiative ART. This is very important in maintaining adherence. This has been especially important in initiating community-based ART program while the government remained publicly ambivalent about ART.

In Uganda, our staff emphasized that partners, partners, partners makes successful in-country programs possible. Each clinic site has started only after community consultation and mobilization. Criteria for admission was based on WHO and national standards, but decisions on who to admit for treatment must ultimately be a local decision by Ugandans for Ugandans. Local staff and partners conduct needs assessments, which ensure that persons living with HIV and AIDS shape and form the structure of our treatment programs.

And finally, in Honduras the strength of our partner NGO infrastructure has been essential to our success. Our NGO partner, the Episcopal Diocese of Honduras, has a network of local clinics throughout the country. Their experience in hiring and managing medical staff and maintaining medical programs in resource-constrained settings allow us to add quality improvement in their existing HIV program and to layer an ART component on top of their existing program. This combination has allowed us to focus on technical and financial support rather than reinventing the wheel. Together, we're perfecting the ART wheel.

In conclusion, I wanted to echo the statements made by a previous speaker about the recent RFA on treatment. I applaud the administration for moving so quickly to get this funding out to providers, but instead of creating a process by which any willing and qualified provider can tap resources to expand access, an arbitrary threshold of three years experience in three countries is required to apply. Why not two? Why not four?

I would urge that this and other RFAs instead reward innovation and initiative first, to ensure that those in need quickly get access to the best care that we can create.

Thank you.

MR. MASON: Thank you.

LUCILLE PEREZ: Hi. Good afternoon. I am Lucy Perez, past president of the National Medical Association and I thank you for this opportunity to be here and to share with you. For those of you who do not know, Dr. Sullivan, the National Medical Association is the largest and oldest national organization, representing over 37,000 African-American physicians and millions of multi-ethnic patients in the United States and in the Caribbean. Through its membership, professional development, community health education, advocacy, research efforts, and federal and private sector corporations, the National Medical Association is committed to improving the health status and outcome of African-Americans, people of color, and disadvantaged and underserved people throughout the United States.

While throughout its history the National Medical Association has focused primarily on health issues related to African-Americans and the medically underserved, its principal goals and initiatives and philosophy encompasses all sectors of the population. For over 100 years, the National Medical Association has become firmly established in a leadership role in medicine and serves as a catalyst for parity in medicine.

HIV disease is a preventable virulent disease that poses one of the most significant challenges to the global public health and it is for that reason that the National Medical Association is so grateful for this opportunity to come before you. We have learned a lot and personally I have had the opportunity not only to see the epidemic from the standpoint of a government worker and going on a very exciting opportunity for prevention about four years ago, but also had the opportunity to serve as a physician on a

medical mission trip to Kenya in which, for me, I had the opportunity to see what I had to do and where HIV disease, though was part of the differential, was low down on the (low ?).

The National Medical Association has had the opportunity to make a difference where there has not been parity in medicine; where we know that it is important to look at the respect and collaboration of the population in which we are dealing with; where we come with a helping hand, but a hand that is culturally sensitive and culturally appropriate, one in which advocation for diversity is woven into compassion. It is important that the planning strategies, the implementation strategies that you have asked for our input on are done in that manner.

It is imperative that not only the United States, but the world, be sensitive to the womb of civilization and to go into it not as if it is something different, but it is the mere essence of what and who we are. Spirituality is a component of what we do and what we must bring with us when we bring our medicines.

You asked what are the vital aspects of effective partnerships for which the National Medical Association is strengthened and poised to assist in this very comprehensive, though delayed, but very important quest to make a difference, and some of those strengths that we feel are very, very important are strengthening collaborations, medical associations, faith-based organizations, community-based organizations, World Health Organization, Pan-health Medical Association, all of these together working to make a difference.

You asked how – how we were able to effectively in the past bring people together. We were able to take science-based information, take that information, make it culturally sensitive and appropriate, and apply it.

So I thank you for this opportunity. We are grateful for the leadership working to make this initiative move forward. The depth and breadth of our response you have in writing, and I thank you.

MR. MASON: Thank you.

NATASHA SAKOLSKY: Good afternoon and thank you for this opportunity to comment and also to learn from everyone here in the room today. My name is Natasha Sakolsky and I am the director of the Global AIDS technical assistance program at NASTAD. NASTAD is the National Alliance of State and Territorial AIDS Directors here in the U.S.

NASTAD has been funded by the CDC global AIDS program since October of 2000 to provide peer-based technical assistance to national AIDS control programs and national AIDS committees around the world as they plan, implement, and evaluate HIV prevention and care strategies for their countries.

NASTAD applauds the release of a recent joint agency RFP as a part of PEPFAR that focuses on the development of a twinning center, twinning partnerships, and a voluntary healthcare corps. Over the past three years, NASTAD has witnessed firsthand the value of twinning partnerships and peer-to-peer support as we facilitated the transfer and adaptation of lessons learned from state AIDS directors and their programs in the U.S., particularly in the areas of community planning, particularly the involvement of those infected and affected at the local level in that planning; the design and implementation of data systems, including national HIV surveillance systems and the development of epidemiologic profiles that promote the use of data for decision-making; and national strategy development for scaling up the acquisition and distribution of anti-retrovirals particularly in Caribbean countries.

Human capacity building and strengthening of public-sector programs in Nigeria, Ethiopia, Botswana, Brazil, and the Caribbean has benefited greatly form the trust and familiarity that comes with true peer exchange. When real live AIDS program directors and AIDS program staff from one country exchange experiences, frustrations, challenges, and successes with their colleagues from another, this leads itself to success. This human capacity building is vital for scale-up, for innovation, and for sustainability.

A primary lesson learned has been that this relationship has been mutually beneficial and has enabled public health department staff in the – from the U.S. working abroad to bring lessons learned home to their states. For example, a technical assistance provider from Minnesota working in Nigeria returned to her health department with the idea to disaggregate their HIV surveillance data to determine if the increase in HIV infection among blacks in her state were primarily among African-Americans, African born populations, or both. As it turns out, the rise in HIV among those born in Africa was what contributed to the increase in rates she had seen previously and there was actually a decline in rates among African-Americans. This significantly, then, changed their outreach and prevention strategies in the state of Minnesota.

Another example is the technical assistance provider bringing health education materials home form her travels in Ethiopia. Materials that were used in indigenous communities there that she intends to use here in the states with Ethiopian communities at home.

These are two examples. There are many more. Specifically when you look at issues around the air bridge from New York State, Florida, to the Caribbean, the examples are endless, as I'm sure many of you know.

The ANSTAD global program experience has proved that a foundation for effective partnerships is created when colleagues are able to actively come together and learn from one another by sharing tangible lived experiences, both past and present, in the global fight against HIV/AIDS. In addition, we have learned that global AIDS work not only benefits the countries and the people with whom we work, but has a direct benefit in enhancing the U.S. response to the HIV epidemic domestically we well.

What have been the challenges? Our health department staff need permission to travel from their department heads, their secretaries of health, and their governors. In light of state budget cuts, this has become increasingly difficult in recent months. Greater advocacy for the role of U.S. state health department employees as volunteers and as technical assistance providers would be a great asset in all the work we do.

Thank you very much.

MR. MASON: Thank you.

ROBERT WEISSMAN: Hello. My name is Robert Weissman. I'm with Health GAP. I'm here in place of Asia Russell. Health GAP is a U.S. organization founded by AIDS activists and public health experts in 1998 to campaign for access to affordable treatment in resource-poor settings and the resources necessary to sustain such access.

The PEPFAR's objectives were clearly defined in the president's 2003 State of the Union address. Health GAP believes that these important clinical objectives will not be achieved without significant changes in U.S. policy regarding: first, global AIDS funding; second, collaboration with other entities engaged in HIV treatment scale-up efforts; third, intellectual property rights; and fourth, the involvement of communities fighting AIDS in poor countries.

First, on funding, the commitment by the Bush administration to increase AIDS funding by approximately $10 billion to $15 billion total over five years is an important first step, but it's far from enough. The U.S. fair share of global AIDS spending estimated by UN AIDS at 17 – at $15 billion annually by 2007 is much more than has already been promised. In particular, we feel that much more U.S. funding should be devoted to programs that, unlike the PEPFAR, are already operational, accountable, and showing results, such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria.

As a new bilateral bureaucracy, there will be some time lag before the PEPFAR can be expanded – can expand its capacity to spend money on programs needed to save lives. The Global Fund is already operational, but it needs adequate funding. We urge the Bush administration to commit to a level of spending that represents our fair share of the fight against global AIDS: a cumulative total of $30 billion between 2004 and 2008.

Second, collaboration and complementarity. We believe the achievement of the PEPFAR's clinical goals depends on the success of the Global Fund as well as the WHO's three-by-five initiative. The current crisis and resource scarcity means that PEPFAR must prevent wasteful duplication of efforts and must cultivate substantial relationships with the Global Fund as well as the three-by-five emergency field teams. This relationship must involve regular significant contact and collaboration between program coordinators as well as operations staff.

Third, prioritizing access to medicines in U.S. trade policy. Generic competition has dramatically brought down the price of ARVs over the last several years down to

now $140 per person per year. We're pleased that the U.S. government supports the procurement of generic medicines for use inn implementing PEPFAR. However, we're dismayed that the U.S. continues to push trade policies that undermine exactly those objectives. Only yesterday, the USTR completed negotiations of the CAFTA agreement that includes provisions which, if implemented, will undermine the ability of countries in Central America to procure generic medicines. Similar proposals are being sought in the Southern African region.

We call on the administration to halt its pursuit of standards for intellectual property protection that exceed the already high standards set up by the WTO in order to increase generic competition, decrease the cost of medicines, and assure sustainable supplies of lower cost drugs.

Fourth, support procurement of generic fixed-dose combinations of anti-retrovirals. The WHO is moving forward on this front. It is really vital – based on all experience in the field – in making treatment affordable, accessible, and easy. But through trade policy and now we think through questionable clinical justification, the U.S. is questioning the viability of prequalified FDCs, medicines that are only available as the result of generics.

We are calling on the Bush administration to permit procurement of generic FDCs with PEPFAR money and to support the efforts by the WHO for prequalification of quality generic FDCs in order to maximize treatment coverage, simplify treatment regimens, and improve compliance.

Finally, community mobilization and people living with HIV/AIDS. The involvement of people living with HIV/AIDS and HIV treatment scale-up efforts are central to clinical success. Community mobilization is necessary to overcome stigma, develop and implement local principles of equity and community access to ARVs, and to prepare communities for the uptake of ARVs and related interventions. However, PEPFAR is placing a cap of 7 percent on funding for community mobilization efforts. That cap should be removed immediately, and we urge the administration to prioritize the involvement of people living with HIV/AIDS in all planning on the PEPFAR program and to include people with HIV/AIDS and enable them to select their own representatives among stakeholders who coordinate with the U.S. State Department officials in the PEPFAR implementation.

Thank you.

(Applause.)

MR. MASON: Thank you. Kate Schecter from the American International Health Alliance, Chris Torgeson from Doctors Without Borders, Dr. Elaine Wolfson, Global Alliance for Women's Health. If you're here, you can come up. Gregory Carter, Washington AIDS International Foundation, and Louisa Pacheco, Tidewater AIDS Crisis Taskforce. And that completes our NGO community-based organizations section.

DR. ELAINE WOLFSON: Thank you very much for this opportunity. My name is Dr. Elaine Wolfson from the Global Alliance for Women's Health. We are an advocacy and educational organization that's 10 years old. We've been working internationally at the United Nations, at the World Health Organization, and in various countries inn Africa. We have also been developing service programs of palliative care in Burkina Faso with which we work with 14 ambulatory care centers in distributing palliatory care – palliative care, sorry.

We are concerned about the thrust of the program and the context in which we are discussing it. HIV/AIDS is a virus. It's a medical issue. And over two million people are dying each year in sub-Sahara Africa. While we have no – we take no issue with most of the comments made today, there is a question of urgency that I think should be addressed, certainly if we place it next to other epidemics that we have seen in the world and how we respond. In order to get to two million people to be treated with ARVs in the next two years, it would require that 3,000 people ready for anti-retrovirals be – have access to treatment each day and that be aggregated through the years, perhaps my math is wrong. It might even be larger than that. And if we were to take the WHO program – three-by-five – we would have to exceed 3,000 people a day.

Clearly, the structures must be addressed and plans must be made to mobilize treatment. We know prevention is important. We know that in the endgame that will be one of the issues that must be addressed very, very seriously. But if we look a the trajectory of the epidemic, we also know that in the past 10 years in sub-Sahara Africa the epidemiology indicates the epidemic has more than doubled and that we have an opportunity to certainly cut down the deaths, reduce the orphans, reduce the widows, increase the working power of the various people who will die in the next year or who have in two years if we address the treatment problem seriously.

To that end, we have been meeting with diplomats at the United Nations, at the World Health Assembly, at the Economic Commission for Africa. We've held five meetings in the past year. We've had more than 60 countries send delegates, and we have partnered with 11 African countries. Recently, we've been invited to address this issue with African-based NGOs at the African Development Forum in Ethiopia in March, and we look forward to working with you so that we can reach out and work with the Development Forum and the Gender Center in Ethiopia so that we can multiply the demand dimension for treatment. They do seem interested. They have reached out to us, and we would like your support so we can reach out to them.

Thank you.

MR. MASON: Thank you.

DR. LOUISA PACHECO: Good afternoon to all of you. My name is Dr. Louisa Pacheco. I am the president of the National Organization for the Advancement of Hispanics and I also work with the Tidewater AIDS Crisis Taskforce.

We have been working with the Hispanic community for more than 17 years. We are dealing with the HIV/AIDS issue. We have been in collaboration with Central American and South America. One of the things that we had been finding out through the years is prevention really works, and when we're talking about collaboration, we talking about partnership. We're talking about working together. We have been seeing that not all the races they are the same, and as Hispanics we also – we do a lot of multicultural and multisensitivity and when we put programs together, you've got to think about not everybody is the same. Not everybody go with the same culture. Not everybody have the same belief and we have been – every time we get to a country that we have been able to put programs together, basically our program is going towards prevention and education. Our programs go towards, you know, approaching medical staff and requesting them, please, to help these people. That things has been working very good. I mean, that is collaboration. It's not bringing the agenda, your own agenda and your own interests. We don't have enough funds. We don't use no funds, we just use volunteer people all around, even when we go in the countries we use volunteer people.

And one thing that I really want to – for all of you is to think about it, is that here in our backyard we have people that they are dying, all right? I mean, don't forget about those that there have been – that they are in here and they're going to be in here. I have been a doctor for 20 years already dealing with this illness, and I decide just not only to be in here – United States – but to go out of here. And I would say, though, please don't forget about the prevention and educational funds.

Thank you.

MR. MASON: Thank you. We're going to take a break at 3:15 as the schedule – it's about 3:00 now? So we're going to – we're going to make a little headway into the next group, so let me call George Bellmany (sp) from Love For All People International, a faith-based group; Ann Claxton from World Vision; Father Michael Czerny from the African Jesuit AIDS Network.

GREGORY CARTER: Good afternoon ladies and gentlemen and distinguished guests. My name is Gregory Carter. I serve as the co-director of the Washington AIDS International Foundation. Please target the youth.

As I stand before you today, my heart is filled with excitement and inspiration. I give thanks to God that there are people concerned about HIV, such as you and those in this room. I believe that a new day of hope is dawning for all of humanity. Of the more than six billion people that are living in the world today, no one has clear knowledge about the origin of humankind or HIV/AIDS. The origin of these viruses are mysterious and also unclear, but because of the human origin and also our historical process, then the elimination of this virus is also unclear and mysterious. This also carries over into our personal, political, racial, and cultural spheres as well.

Who has a permanent solution? Historically at times we pursue goodness and altruism and at other times evil intentions and selfishness. HIV/AIDS appears in this age as the equal opportunity offender. This virus can either unite us all or kill us all. It has that kind of modern day impact, as you are all aware. It is one of the most lethal equalizers that we'll ever know. It equalizes us in suffering and pain and also, ultimately, in death.

Ladies and gentlemen, this is not the sort of equalization of democracy or fairness that my ancestors cried out for. How about yours? In one sense, this virus epitomizes our global problem. What do I mean by this statement? The answer is simple. We have not completed the basic utilitarianism or the Golden Rule toward each other. We have not been helpful and respectful nearly enough toward each other. Further, we violate sexual contact with each other – proper, healthy, sexual contact. Ninety-nine percent of the HIV/AIDS is preventable by what we think and what we do.

Therein lies the possible cure. We must take what is often called sexual responsibility for ourselves. I applaud your efforts and encourage you all to continue on your journey for universal education; also, my colleagues here who talk about education and prevention. The other 1 percent is contracted through the birth process, contaminated objects, or other blood transmission items. Ladies and gentlemen, we have the cure right here. We have to teach uniqueness, beauty, the values, the potentials, and the importance of every single human being. Further, we have to embrace the value of abstinence for some and the importance of monogamy for others.

Many are already infected and suffering and have died. More still will be victimized while we grapple with technicalities and political correctness. We must care and supply toward the needy. They and we are in a war of viral terrorism. Nevertheless, prevention directed toward the youth should be our greatest concern. Care for those infected, education, and mobilization of the houses of worship is paramount. Investment form the private business sector is a key component and a united global strategy is essential.

I submit that the Ugandan ABC model is the most effective, national, preventative method to date, which combats the scourge plaguing humanity head by head. Please target the youth.

With closer examination of this application, many will see that it has been successful. Lives are saved and people from various groups and perspectives unite together to defeat the virus. I am excited and inspired by this effort. I believe that we here in America have the ability to create a similar united movement.

Ladies and gentlemen, I will do my part. The Washington AIDS International Foundation will do its share of the work. Our work is to stimulate the national and the rational consciousness of all people; to encourage our fellow world citizens to make intelligent choices, both sexual and otherwise; to disseminate truthful information, be it scientific or empirical; to introduce the concept of sexual discipline; to tear down the

walls of cultural barriers and liberate many disadvantaged people, especially in the minority community in America and to encourage them to pursue their dreams and goals. This is our slice of the pie.

The Washington AIDS International Foundation – WAIF – symbolizes an orphan. We are all orphans in some capacity or fashion. Nevertheless, when orphans pull together they create a family. Combining their talents together, they create a community. Uniting these communities together, they create a nation. This nation or movement can effect change in the world. Ultimately, this global change will benefit us all.

Thank you very much for your kind attendance.

MR. MASON: Thank you.

GEORGE BELLMANY: Good evening. My name is George Bellmany and thanks for the opportunity to share. I'm the president of Love For All People International Ministries. I'm also on the board of a local AIDS ministry here in the U.S. that has an outreach to 500 people, and I'm also a volunteer AIDS counselor. I also co-founded a ministry in Nairobi, Kenya. Started a rehabilitation center, and 90 percent of the funds for this ministry I supported – come from my personal funds. That's why I caught the Greyhound bus up here from Altamont Springs, Florida – 17 hours. And I don't recommend that. (Laughter.) And you're all laughing, but I've got to go back tonight. (Laughter.)

Anyway, I would like to address one of the answers that I think that we're supposed to be addressing -- one of the questions, and that is what are some of the valid aspects of effective partnerships? And with only three minutes I'll be very short.

From my experience, or our experience, I think it's imperative – and when you're talking about partnerships, a partnership is no stronger than the weakest partner, and we feel that as a ministry that we want to be a strong partner and we – again, we think it's imperative that those that we're working with and those that – and that's from the head to the grassroots person – that they must have love, respect, and compassion for the person that they're working with. And let me give you an example as a counselor, and I don't want to say I'm all that and a bag of potato chips, okay? But one of the gentlemen that I counsel, and he has been off drugs for medication for two years, his viral load is zero and his T-cell is up past 400. And I'm not saying it's because of me, but I do believe it's because of that relationship, and we understand what it takes for a person to live longer – you know, and we don't want to go through that, but we have to. I think it's imperative. Our seeing people with the wrong attitude, even though we're getting paid, it was a job and – I don't want to go there. Okay.

Also, there must be acceptance and affirmation. In Kenya, there are 42 different tribes, and all the tribes are not the same. If there's anyone here from Kenya, maybe they can amen that. All right. We need to be culturally sensitive; we also have to have some cultural knowledge about what's going on. Okay? Now I've been – I've lived in the

bush. All right? I've also been to all the major slums in Nairobi, and we're just talking about Nairobi, okay? And we're not picking on Nairobi because in the U.S. here we also have some issues and there are some pockets that you can't get into because people are insensitive.

And I'm going to close by saying thank you, God bless you, enjoy your Christmas, and we need some money. (Laughter.)

(Applause.)

MR. MASON: Thank you.

ANN CLAXTON: Thank you very much for this invitation to provide some comments. I'm Ann Claxton from World Vision and World Vision – just to brief introduction for some who might not be aware – World Vision is an international Christian relief and development organization with about 50 years of experience working now in about 90 countries around the world and we partner directly at the community level with churches, community-based organizations, other faith-based organizations, and directly with community leaders and their families.

World Vision's been working in HIV/AIDS programming since about 1988 in Africa and Southeast Asia and Eastern Europe, and in the nine PEPFAR focus countries where World Vision is also active, we are currently reaching about 3.6 million households and support more than 700,000 orphans and vulnerable children through community-based support – care and support programs.

World Vision applauds the presidential initiative. It's a visionary and compassionate one, and we would like to just make a few contributions; hopefully to contribute to the efficiency and effectiveness of the programs. The PEPFAR goals of two million receiving treatment, seven million infections prevented, and 10 million receiving care are all excellent, ambitious, and worthy goals. And I think that they are achievable through the NGO institutional partners and community-based partners that are already experienced and working on the ground. However, what's going to be needed, I think reflecting some of the earlier statements that were made, are some more flexible funding mechanisms. Some of the ones that we've seen coming out so far, we – basically repeat a pattern of rather burdensome and rigid procurement roles, and they need to be modified if we're going to reach the scale that we need to achieve.

Second, all of these goals are equally important and are mutually reinforcing and – so we don't want to get too excited by the great opportunities of the new technology and the anti-retroviral treatments that are available that can save millions of lives and forget about the families and the –especially the children who are especially burdened and impacted by the disease as they watch their parents die and are left behind as orphans. So prevention, orphan care, palliative care, and treatment are all equally important, but we sometimes are hearing more emphasis on the treatment side of things and we want to urge that we remember the families and especially the orphans, because

these are all mutually reinforcing goals and the children who are left behind are the ones who will be the infected adults of the next generation.

A third point is that integrated programs are the most effective, and we've heard this from a few people, so I'll be brief, but through many years of child survival and other types of preventive healthcare programs that are running at the community level we have learned that communities can be linked with the formal healthcare system to expand it to the millions of people who are outside of the catchment areas of these very, very limited healthcare infrastructures, and so the types of community partners who are mobilizing churches and community organizations, who are training community healthcare workers to spread prevention messages, to go into families and care for orphans and care for those who are ill with HIV/AIDS, these are the same volunteers and community organizations that are starting the voluntary counseling and testing centers out in the remote, rural areas and who are able to refer patients for anti-retroviral treatment and for prevention of mother-to-child transmission. Short-course treatment. So it's very important to integrate the community care with the facilities, with the laboratories, and the voluntary counseling and testing systems that are being set up.

Finally, just in terms of partners, which was the question that you asked, the faith-based organizations, the churches and the mosques in the communities have the moral credibility and moral authority – the ear of the community. They have the mandate to reach out with compassionate care. They are sustainable and they're everywhere, so they are excellent partners. They often lack accountability – good strong accountability systems and experience with large grants, and so we need to partner with them through intermediary organizations and I would urge, as we heard before, intermediary organizations who have the trust and credibility of faith-based organizations and share their values and their cultural and religious world views. But together, they can be very, very effective partners with the government in achieving the secular objectives of prevention, care, and treatment.

And one of the things that World Vision is doing with – to involve people who are living with AIDS is to mobilize support groups for clergy who are living with AIDS in Africa, and it's a very, very sensitive subject for them. It's very difficult for them to find the support that they need because of the stigma surrounding it, and yet they are a wonderful role model and a very powerful voice for mobilizing other faith-leaders and their congregations and so World Vision has partnered with faith-leaders to start a group especially for African religious leaders that are living and directly affected by HIV/AIDS called Anorella (ph). And we think that that's going to be a really powerful force in reducing stigma and helping to mobilize faith-leaders and their congregations.

Thank you.

MR. MASON: Thank you.

MICHAEL CZERNY: My name is Father Michael Czerny. I am the coordinator of the African Jesuit AIDS Network, and I thank the Advisory Council for this opportunity.

In 2002, the Jesuit Conference for Africa, facing the aggravating crisis, decided to fortify the earlier efforts that we had already been making and set up this continent-wide network called AJAN, or the African Jesuit AIDS Network. We're about 1,400 Jesuit priests and brothers serving in about 27 countries in Africa, and I think the most significant fact – the most significant starting point is that we are all personally deeply affected, and we recognize that HIV/AIDS is not just a problem out there, it is our problem.

HIV/AIDS is forcing everyone in the church and in society to – (audio break, tape change) – and then to develop appropriate responses. We're trying to pull these responses together into a African-wide network which will enhance the response in the individual countries and that will encourage new forms of accompaniment, care, prevention, resource – (inaudible) – this.

HIV/AIDS in Africa cannot be treated only from a medical point of view. Social ills of poverty and malnutrition, prevalent throughout Africa, set the stage for opportunistic diseases such as malaria and tuberculosis to attack people rendered infinitely more vulnerable by HIV. Anti-retrovirals do little good if HIV positive people lack clean water or a good diet. Just as telling young people to be careful and responsible is practically futile when they see absolutely no future for themselves. In their message on world AIDS day, the bishops of Africa stated their concern that our already fragile economies should be further weakened with much of the trained labor force lost to HIV and AIDS. Poverty, they said, facilitates the transmission of HIV, makes adequate treatment unaffordable, accelerates death from HIV related illness, and multiplies the social cost of the epidemic.

The U.S. administration's $15 billion emergency plan is certainly to be applauded and it will certainly contribute to arresting the rapid spread of HIV and AIDS. It is estimated, however, that anti-retrovirals represent only about 10 percent of the cost of an adequate response to HIV and AIDS. In other words, for every dollar worth of ARVs, another nine dollars is needed for basic health, clean water and sanitation, housing, nourishing food, education, and social services. So I'd like to urge that the just proportion be maintained. One part American, nine parts African. One part ARV, nine parts human development. It is essential that the administration also fund and support these supplementary nine units even if this stretches America's capacities and resources.

Finally, America really needs to listen to Africans rather than impose notions of health and welfare that may be appropriate for this setting, but remain alien to the African reality.

Thank you very much. (Applause.)

MR. MASON: Thank you. Why don't we take a break now? You'll be first up when we come back. And just so we're ready when we come back, Matt Hanley, Catholic Relief Services; Raymond Martin, Christian Connection for International Health; Rabia Mathai from Catholic Medical Mission Board; and Reverend Charles Jurogay (ph) from World Hope Ministries. So we'll take a 10-minute break. Try to stay on schedule. We're a little behind, but not too bad. We're about – probably about 20 minutes behind.

MR. : Yeah. One suggestion: I really crack down on those –

MR. MASON: Okay.

MR. : Really, because you're going to run out of time and –

MR. MASON: Okay.

MR. : And the people who come at the end –

MR. MASON: They're not going to have time.

MR. : Yeah.

MR. MASON: So what I'll do is I'll say we've got to – (audio break).

MR. MASON: – and Rabia Mathai from Catholic Medical Mission Board. Are any of them in the room? And – okay. I think we –

MR. : Why don't we go ahead – (off mike).

MR. MASON: Can I ask someone in the back to close the door and that way we'll keep the conversation in the hall from interrupting us. Okay. You're next. I'm – there was a fellow who was here, but we'll take him when he comes backing the room, so if you want to come on up.

MR. : Even without the full panel, huh?

MR. MASON: Let's see. I think every –

MR. : Be nice for Ted to be here. I believe that would be nice.

MR. MASON: Well, okay. I hear you. If we can get – I think Josephine is going to go out and grab our members.

Just, yeah, could you get Ted Green? Because I – just so that – I just want to share that the committee is going to take all of the public comment – there's a transcriber – we will get it transcribed. We're going to take the transcript of the public comment in

addition to the written comment and try to put it into – do a summary and try to capture the themes that we have been hearing and that are a part of your written testimony and then we will provide that to Ambassador Tobias and Ambassador Lange and Dr. O'Neill and their team, so just so you know, you're – both your oral comments and your written comments will be sort of gathered together, consolidated in a form, and then passed to Ambassador Tobias and his team for them to incorporate into their thinking, so again we want to thank you for doing this and thank you for your patience.

Yes?

MR. : Okay. Thank you very much.

MR. MASON: Sure.

MR. : Thanks for –

MATT HANLEY: My name is Matt Hanley. I'm a technical advisor with Catholic Relief Services, which is the official relief and development agency for the U.S. Conference of Catholic Bishops. We're most pleased and welcome the increasing recognition on the role that faith-based organizations play in responding to HIV/AIDS around the world in both care and prevention. The Catholic Church is the single largest provider of care to people living with AIDS around the world, and also provides approximately – or up to 60 percent of all healthcare in many sub-Saharan African nations.

The church also has an extensive network of schools, presenting an ideal infrastructure through which to introduce value based HIV/AIDS preventive education and life-skills education. The dioceses structure itself, with its network of parishes, youth groups, and women's groups, and other community mechanisms, also represents a powerful local resource that has remained largely untapped and underutilized.

Recently, SECAM, or the Symposium of Episcopal Conferences for Africa and Madagascar, also called on every African bishop to place HIV/AIDS on their personal agenda, which will further open up the doors to all the pastoral, administrative, human and health resources of every dioceses within Africa. CRS works a lot with the local church, but other faith-based groups, other community-based groups, ministries of health and governments, in its response to HIV/AIDS primarily consists of home-based care, palliative care, orphan support, and prevention.

CRS believes in a holistic response to HIV/AIDS – believe that's necessary, especially as there's no panacea at the present time for our response to HIV/AIDS. And CRS further recognizes the tension and dilemmas inherent in making difficult decisions regarding the allocation of limited resources to a crisis of such magnitude. However, accumulating and well-documented evidence suggests that prevention, and specifically primary behavior change, needs to be urgently prioritized even more than it presently is. We're all well aware of the encouraging examples of successful locally owned and

developed prevention campaigns that have achieved real changes in sexual behavior and subsequent declines in HIV prevalence.

As a result of Uganda's success, which was eloquently addressed earlier by Jack, Uganda is faced with treating and caring for approximately 5 percent of its population today as opposed to 20 to 30 percent of its population if those changes in behavior had not occurred. Outside of Uganda, there's also evidence. For instance, a rigorous UN AIDS multi-country study concluded that the only two behavioral determinants associated with the decline in HIV/AIDS prevalence are a reduction in the number of sexual partners and a delayed onset of sexual debut – essentially, our abstinence and fidelity messages. And I think this is a critical point in our discussions on policy and strategy that you've graciously invited us to today. In fact, it's – I just think we all need to keep that in mind, is where risk-avoidance – and what I mean by risk-avoidance is abstaining or being mutually faithful. When those risk-avoidance behaviors have not occurred, we have not seen declines in the epidemic even with infusions of resources, counseling, and sophisticated – other sophisticated technical interventions, as important as they are. So that is really a critical piece for all of us to keep in mind, both short-term and long-term.

There are other implications for that. Many are aware of the new variant famine in Southern Africa, which is attributed in large part to the onset of HIV/AIDS. The onset of the famine is attributed to HIV/AIDS, which has killed many of the laborers themselves, so that just is another very compelling reason why we really need to prioritize primary behavior change. So – and Catholics and other faith-based groups are well-positioned to continue promoting those risk avoidant – risk avoiding types of behavior which are essential to achieving the impact that we all need to see.

So if we are to use wisely the administration's generous allocation of resources, and are serious about achieving a maximum possible impact, we must decrease the overall toll HIV/AIDS exacts on communities and countries by reducing its persistent transmission.

I would also in closing –

MR. MASON: We're going to have to stick to –

(Cross talk.)

MR. HENLEY: Okay, thank you.

MR. : Please, we have a lot of people here. We don't want to be fair to those who have yet to testify by using up all of the time, so if you'd please respect the time constraints.

MR. HENLEY: Thank you very much.

MR. MASON: Thank you.

RAYMOND MARTIN: My name is Ray Martin. I'm the director of Christian Connections for International Health. CCIH is a membership association of individuals and 40 organizations promoting international health and wholeness from a Christian perspective through field-oriented information sharing, networking, research, and partnership building. Our network relates to nearly 2,000 organizations and individuals in 100 countries.

I would like to make two points. First, priorities in the implementation of the president's plan should be determined by public health and social science evidence of what has worked. CCIH interaction with church-related people throughout Africa and elsewhere convinces us that they recognize that defeating AIDS is largely a challenge of changing behaviors. Even though many political leaders and traditional public health organizations may be more comfortable with strategies focusing on medical solutions, we must learn from success stories such as Uganda and Senegal which emphasized mobilizing faith-based organizations and other institutions to reduce high-risk sexual behaviors.

As we scale-up to implement whatever we are able to do medically and financially to treat HIV-infected individuals, let us be careful not to be distracted from the paramount importance of preventing new infections. To extinguish or dampen the raging fires of the global AIDS pandemic, we must aim our fire extinguisher at the base of the flames. Churches and other religious institutions need to be empowered to scale-up their capacity to promote delay of sexual debut and reduction of sexual partners as well as any other effective means of prevention that they are comfortable with.

My second point has to do with moving from rhetoric to reality in engaging with faith-based organizations. When you look beyond the rhetoric, the actual level of resources allocated to faith-based organizations by major donors is still very small. One example: only 4 percent of Global Fund grants go to FBOs, even though in many countries a quarter to a half of medical and social services are run by FBOs. This suggests an inefficiency in deployment of resources that should be corrected as we move to implementation of the president's Emergency Plan.

Thank you.

(Applause.)

MR. MASON: Thank you. Why don't we – come on up: Reverend Jurogay from World Hope Ministries, Jacob Fein from American Jewish World Service, Alan Saunders from the Interreligious and International Federation for World Peace.

RABIA MATHAI: Thank you for this opportunity. I'm Dr. Rabia Mathai representing the CMMB, the Catholic Medical Mission Board, a faith-based leader and a catalyst. We call it a best-kept secret engaged in exclusively in the international

healthcare since 1928. My organization has 75 years of global experience having worked with 350 faith—based partners in over 100 countries. Our experience spans providing medicines and medical supplies; building capacities of in-country, front-line, primary healthcare workers through training programs; and most importantly, providing long-term and short-term U.S. medical and public health professionals training in over 100 countries including our HIV/AIDS programs.

CMMB's two major HIV/AIDS initiatives from which I am going to draw lessons learned are: Choose to Care, a community-based HIV/AIDS intervention for prevention, care, and support with Southern African bishops conference and the Bristol-Myers Squibb Foundation with 144 projects on the ground in its fourth year in five countries: South Africa, Botswana, Namibia, Lesotho, and Swaziland.

A second initiative is called Born to Live. It's a global initiative for prevention of mother-to-child transmission for HIV/AIDS in South Africa, Haiti, Zambia, Nigeria, to name a few, and going to scale in Kenya with 60 faith-based sites.

The lessons learned that I'd like to share with you are: first lesson is that we have learned that in partnering with umbrella, in-country, faith-based organizations, it helps and facilitates a lot in rapid scale-up through the healthcare, parish, and educational networks. Second lesson is – that we have learned is that since up to 50 percent of the healthcare in the focused 14 countries is provided by FBOs, our catalytic role in building their capacity has helped us in carving a space for the FBOs on the main table with the government for HIV/AIDS national policy and strategy issues. Much more help is needed with this from a group like yours.

Our PMTC sites now have a critical mass of HIV-positive women needing and ready for chronic ARV treatment. This will contribute towards gender equity, for strengthening household units at the community level, for health treatment. In both programs, we have many, many HIV-positive people, especially women and youth. They have found a new sense of hope and they have support networks. They are not afraid of revealing their status and have become community advocates.

Lastly, two important points that we have learned. HIV/AIDS programs cannot be vertical programs, but have to be integrated into the existing maternal and child health and other multisectoral programs. Our HIV/AIDS work in Asia and Pacific, in China, India, and Papua New Guinea informs us that if we do not begin focusing and addressing that region in these early stages, it will mimic the current pandemic and – or even dwarf it in comparison.

Thank you very much.

MR. MASON: Thank you.

CHARLES JUROGAY: Good afternoon. My name is Reverend Charles Jurogay and I'm representative on a project called Aid of World Hope Ministries, a ministry that

works with HIV/AIDS orphans down in Kenya and Tanzania. And the most basic thing that I see the need – the most pressing need we have – is the need for the pastors and other faith-based organization leaders, because they lack training. So training is one of the handicaps that we face in combating the HIV/AIDS.

The next thing we truly need is kind of support from other networks in order to have proper strategies in order to combat the AIDS. And then the next thing – I'm sorry, I would like to keep it very briefly just to pressing needs – is support. We lack support because we don't have adequate funding. Support for the orphans.

And the next thing is the training for the caregivers. And as you know, the caregivers are – where they come from probably is not so many people would like to be affiliated with the people who have AIDS, so technically training is basically needed in order to accept people living with AIDS among the community they are from because what kills the most is to be rejected.

Also, the other thing is about the other organization – the government and other sectoral organizations – if we could strengthen to train this pastors and other social and community leaders in order to deal with the stigma of AIDS, this will probably reduce the pain and other – and actually other affiliated suffering with the disease.

Nutrition is one of the most, most necessary things, but as you know, once the kids get infected and they don't have proper – proper feeding, the treatment will actually do nothing, so without proper nutrition even if you give – even if we get the AIDS vaccine right now and we don't have food, still it won't work. So in accordance with the treatment, nutrition is also very necessary.

Actually, funding for all these other organizations would be very good if we get adequate funding with a faith-based organizations because what it comes to be is that governments try to fund other sectoral organizations – secular organizations and – like me; I'm a project coordinator of some 20 churches with 500 apiece. If all these people are now trained and taught about the effects of HIV/AIDS, this will be a tremendous groove on stopping the AIDS.

And thank you for listening to my needs with the African accent.

MR. MASON: Thank you.

MR. JUROGAY: Truly appreciate it. Thank you.

(Applause.)

MR. MASON: Thank you.

JACOB FEIN: Good afternoon. My name is Jacob Fein. I work for the American Jewish World Service, which is a not-for-profit organization founded to help

alleviate poverty, hunger, and disease among the peoples of the world regardless of race, religion, or nationality. Though we draw our inspiration from Jewish tradition, most of our project partners work in communities and countries where there are no Jewish communities.

The American Jewish World Service funds the work of our partners, which are local NGOs and community-based organizations offering a full range of help to individuals and communities coping with the effects of the HIV/AIDS pandemic. Our funding and technical support is always driven by the needs of these communities as they articulate them.

In our experience, the most successful projects link development and advocacy efforts, demonstrate the ability to manage funding, promote community leadership and local participation, empower the disenfranchised, are both replicable and sustainable, and have a high rate of social return.

This year, the American Jewish World Service supported 47 projects in 21 countries. And particularly, we have worked to develop relationships with groups that integrate comprehensive community-based prevention, home-based orphan care, support for people living with HIV and AIDS, and advocacy – specifically, efforts to enhance treatment access and preparedness.

Through our work, we have come to the following conclusions that we hope will offer some help in developing and implementing the president's Emergency Plan for AIDS relief. Sustained and multi-year hands-on support is necessary for success. Community and home-based programs for orphan care must be prioritized. Orphanages only increase stigma. Organizations are capable of reporting responsibly on the usage of funds and the success of programs. Complex reporting requirements for programmatic and financial oversight only hinder results. There is a generation of experts in community-based prevention and care programs and existing pilot programs to offer ARVs. While delegates at the recent ECASA (ph) conference were talking about how to create home-based palliative care programs, our project partners were meeting and telling each other how to sustain and expand the programs they already run.

We will not succeed in turning back the tide of this pandemic without learning from the lessons of these community leaders through peer education and I think that's by far the most important point that I could possibly make is that the expertise is there. We need to make sure that we share that expertise through peer education and that outside experts are most useful when they're brought in specifically for their knowledge of country-wide scale-up, but not for actual implementation on the ground.

So thank you very much for an opportunity to share our thoughts with you.

(Applause.)

MR. MASON: Thank you. Alan Saunders from the Interreligous and International Federation for World Peace, Carl Stecker (ph), Catholic Charities Relief, Daniel Tolan (ph), Global Health Services Ministries. Okay, then Troy Lewis (sp), Baptist Mission of Zambia and Laura van Vuuren, World Relief, both of whom were here. If not, then we'll move on to – okay.

DR. DANIEL TOLAN: Dr. Daniel Tolan from Global Health Services.

The AIDS epidemic can be beaten. I've heard some say because of AIDS that it is too late for Africa, but based on my almost 20 years experience in Africa as a missionary doctor, I want to state unequivocally that this epidemic – this scourge – can be beaten. The question is how.

The AIDS epidemic can be beaten by the right people. A Masai man, an educated man, a research assistant, a man with AIDS and overwhelming TB, I invited him to speak about living with AIDS to a hospital chaplain training program – to 12 students from East and Southern Africa. He was scheduled for two hours. He left after three days of incredible impact in those students' lives. The best people to teach are those already infected.

The AIDS epidemic can be beaten by the right message. It is not a matter of information or encouraging certain behaviors, it is a matter of changing world views and beliefs which decide behavior. I will never forget an old Masai man telling me the men – the way we men have valued our women is the problem. That is why we have forced them to have sex with people in our own age group, and if we change how we see women – how we see women, we will begin to treat them differently.

The AIDS epidemic can be beaten by the right partnership and the right leadership. Today I represent 14,000 members of the Christian Medical and Dental Associations. Five hundred of our member physicians and nurses are giving their lives to a career in another culture outside the U.S. – outside the U.S.A. I also speak for thousands of international members, especially in Africa, who are caring in their own culture. These people are experienced in dealing with issues of worldview and belief systems. They know the language and the culture, and they realize that the agenda must be set by the community people themselves if we are going to beat this disease. These physicians and others have the influence that only long-term presence within a community can bring.

I've heard Dr. O'Neill speak about the importance of the church and mosque in Africa in this disease, and the leadership that the church must take. It is these physicians and healthcare workers who are often looked to by the church for leadership in issues like AIDS. We must bridge to this community of medical leaders and national churches to give them the best chance to beat this disease.

The right people, the right message, the right partnerships. The AIDS epidemic can be beaten. A young Masai boy died in my arms of overwhelming infection from a

simple wound by a stick. 1984, a mission hospital, 300 inpatients, one surgeon, one physician, and myself – a scared fourth-year medical student. I held his lifeless body in my arms and I cried. I gave mouth to mouth resuscitation. In retrospect, the clinical picture likely was AIDS. The boy's face has never left my mind. When I feel like quitting in the fight – and I have felt that – I see his face. We have an opportunity to help breathe life into the suffering of Africa and elsewhere. Let's breathe, work, partner, and hope together.

I know – just as a note of thank you from the children of Africa, I know that President Bush has taken a strong stance that can only be supported by those close to him, and I'm sure Mrs. Bush is standing solidly with him in this, and as a thank you to President Bush, to Ambassador Tobias, Dr. Joe O'Neill, Mr. Abner Mason, comes this thank you from the children of Africa: a Masia shuka (ph), a blanket work by the warriors of Africa. Wrap up in it at Camp David, take it to a picnic, to – in a car to ballgames, but always fight like a warrior.

Thank you.

(Applause.)

MR. MASON: I thank you very much. That's very kind. Thank you.

MR. : By the way, Mrs. Bush gets first dibs.

MR. MASON: Thank you. (Laughter.) Thank you.

TROY LEWIS: Good afternoon. My name is Troy Lewis. I'm with the Baptist Mission of Zambia and we live and work in Zambia dealing with this HIV/AIDS problem and I serve in that capacity there as program developer for that group.

We also work side-by-side with a number of other African brothers and sisters bringing together as far as other faiths and other denominations, particularly the expanded church response in Zambia, which I serve as an officer for, where we work bringing umbrella bodies together of Christians of all denominations and forging a Christian – a united Christian response to HIV/AIDS and the PACANET – the pan-African Christian AIDS Network, which I serve on as well doing the same thing at a continental level.

In addition to trying to work at a systems level dealing with these issues, I'm doing work – doing much work – or we're doing much work on the ground. And part of my hope here and in these few points that I want to share is to try to be a voice for those that are in the rural areas and the villages that don't have a voice and aren't here today. And some of this echoes some of what has been shared already.

In representing faith-based, I also want to thank you for the acknowledgement that this administration and that we're seeing from the UN and others with regards to

recognizing faith-based organizations which are in every village, in every urban compound. And right now, with these efforts and with this help we're creating synergy bringing together the faith-based, working with other sectors and institutions.

The four points I just want to touch on briefly as far as about them, I hope that these resources can be used for – in fact I believe that it is imperative. One is, in Africa, there some of the infrastructures that we take for granted here in the U.S. do not exist, and one of the things that happens repeatedly is that initiatives and (helps ?) they come and they reach the city capitals, but they fail to make it out to the rural areas and the villages. And so if we think about it as that – we think about Africa has some major arteries, what is needed is that money needs to be dedicated towards building capillaries to get the resources – to get the resources, knowledge, and monies out to those areas, out to those villages. And faith-based institutions form a connect – form a – places a presence to be able to form this connectivity from the capitals down to every rural area and village.

The other, we need to be careful in strategic and the use of these monies. And for example, what I mean about how is it that we do staffing strategically, but not to some of the extremes that I've seen. Working in Zambia with the Global Fund and the World Bank, for example, they said that these monies cannot be used for staff. Well, some of the things that we're trying to do in Africa has not existed before, particularly some of these connectivity issues and if we need quality people working in some of these areas, we're going to have to pay them and some monies have to be devoted strategically to staffing.

But on the other hand, we have to be careful about setting dangerous precedents. For example, where an NGO comes in and doing a community-based school and they end up paying all their staff people. Well, we have churches and others doing these – that have been doing these for years, but in terms of with volunteers. Well, this NGO can serve this one particular area, but what happens that it sets a precedent for those that are working with volunteers and it destroys 500 other initiatives for this one that is started.

The third one is about representation, as was shared before, about listening to the voices that are on the ground and just as we have representation from persons living with HIV/AIDS and representation for women, it's imperative – particularly I wanted to encourage the Presidential Advisory Council that we have the voice of people from Africa. Not just those that can afford their own plane fare over here, but those that are from the rural areas and working in the villages. And also representing – a need for representing these voices that I think is underrepresented is that there are – is that while everyone – people are talking about advocates for ARVs, they're an incredible need and what I'm seeing people dying from are opportunistic infections.

I just have this one picture here of the lady that we're working with, Mrs. Peery (ph). And what happened to her – one of the sadder cases I went to going to her home and she's laying there on a pallet in the corner as we so often see – in the corner of her little hut in her little home. And what happens is that she's only been able to lay in two

positions because she has bedsores all over her body, and what they were saying is that – and what happened whole churches want to get involved in doing home-based care, but they don't even have antiseptic. They don't have pain medicines. They don't have anything to be able to give this lady here. And so, yes, while we pay attention to ARVs, if we can do something to help people to survive from opportunistic infection to opportunistic infection until the ARVs reach those communities.

Thank you very much.

(Applause.)

MR. MASON: Thank you.

LAURA VAN VUUREN: Hello. My name's Laura van Vuuren and I serve on World Relief's HIV/AIDS technical team. I'm really the only member that's not living at the epicenter – in sub-Saharan Africa at the epicenter of the pandemic.

World Relief first addressed AIDS in 1992 in Swaziland and Malawi where I was actually a country director, and it was prompted by just a chilling awareness that something both colossal and terrible was happening in these communities where we were working to alleviate poverty, empower women, and help children live beyond their fifth birthday. We've continued since then with very limited resources and we, though, are thankful for that because it's made us more resourceful and more careful about what will make a difference, but we do rejoice at this new allocation and – but at the same time we worry that if we don't leave our egos and self-interests at the door, we could focus on trying to make a big impression and doing things too fast at the expense of these very carefully planned and implemented programs when resources were very scarce.

We – regarding partnerships – you asked us to speak about that – we partner with the church and we've learned that to construct a solid community-based program takes time. For it to be sustainable we have to listen, we have to ask questions, we have to work with local leadership and respect them before we set any strategy or proceed with the plan. I think a key challenge for us is that we have to channel support to the community-level players who are already responding to HIV/AIDS with their own resources.

World Relief has worked steadily to equip and build local congregations to plan and implement and monitor their own programs. Our goal is really to fuel a grassroots movement that gains momentum over time and will continue long after we're gone. Effective partnerships are based really on mutual respect and building on natural competencies and allowing each player to do what it does best. For example, we accept that ARVT is necessary to prevent parent-to-child transmission of AIDS, but for the treatment to reach its full potential we need to build – to be holistic about out approach. And – oh dear. And we have to break down stigma and fear and create an enabling environment, and the church does that very well. So we don't teach them to give verapine (ph); we teach them to counsel and break down stigma and fear.

I'd like to also talk about program integration and multisectoral collaboration. From the start, World Relief has tried to integrate both prevention, care, and counseling, and economic strengthening with the common foundation of family, church, and community. But we've also worked hard to integrate AIDS into our micro-enterprise development program, into our maternal child health program, and our youth programs because we feel we'll have greater impact and more efficient use of our resources.

We've also tried to encourage collaboration within our sectors. I'm very privileged to be the facilitator of a working group on HIV/AIDS for the micro-enterprise development practitioner peer learning group, and one of our projects right now is to come up with some alternatives for the groups that HIV/AIDS NGOs are struggling with – to have some safe and sound practices that they can use, so we are encouraging this cross-sectoral dialogue as well.

Thank you very much.

MR. MASON: Thank you. We're going to move to the next group. Jennifer Cooke from CSIS, Cynthia Davis from Charles Drew University of Medicine, Andy Fisher, Population Council, and Gus Gill from Charles Drew University. You folks could come up.

JENNIFER COOKE: Hi. I'm Jennifer Cooke. I'm dreading that orange sign. (Laughter.) I'm Jennifer Cooke with the CSIS Africa program, the Africa program of the Center for Strategic and International Studies. I work with Steve Morrison who directs the CSIS task force on HIV/AIDS, an initiative that's bipartisan, chaired by Bill Frist and Senator Russ Feingold and funded by the Gates Foundation. We're very grateful to Dr. Sullivan for his frequent input and leadership as a member of the task force.

The task force also brings to Washington front-line leaders in the fight against HIV/AIDS to ensure that their perspectives are incorporated into U.S. policy thinking. Last month, we held a conference on Botswana and Botswana's strategy to fight HIV/AIDS. President Festus Mogae led a senior delegation of nongovernmental and governmental experts. The purpose of the conference was to profile for a U.S. audience Botswana's achievements in fighting HIV/AIDS, the enduring challenges that it faces, and how these might inform U.S. policy efforts, particularly the president's initiative.

Botswana's experience with HIV/AIDS is a conundrum, and I think for that reason it's a fascinating case study. It enjoys democratic governance, a well run economy, very strong leadership on HIV/AIDS, but what the conference highlighted for us was that despite these factors, the enduring challenges of gender, stigma, and human capacity persist.

The Botswana case highlights that if women are not empowered legally, culturally, economically – there's the sign – to negotiate the terms of sex, prevention efforts will fail. Similarly, if messages of abstinence, condom use, and fidelity do not

reach men, prevention efforts will fail. And finally, if appropriately trained personnel, from doctors to community leaders to community care providers, are not available, it will be difficult to bring to scale any programs no matter how well designed.

Despite these challenges, Botswana has taken bold steps through a number of public-private partnerships to fight the disease. Among these, the ACHAP, a partnership with Merck company, Gates Foundation, that's strengthening capacity institutionally and at the grassroots supporting an effort to provide anti-retrovirals through the public sector.

A number of other promising partnerships that are really building enduring capacity and I think importantly are helping encourage additional new partnerships within Botswana and across the region. Botswana may not be – the model may not be replicable in all its details elsewhere in Africa, but I think this idea of building on comparative strengths of the corporate, the public sector, and most importantly harnessing the energies of the people most affected is something that can be replicated elsewhere in Africa and worldwide.

Thank you.

MR. MASON: Thank you.

CYNTHIA DAVIS: Good afternoon. My name is Cynthia Davis and I'm an assistant professor in the department of family medicine at Charles Drew University of Medicine and Science. I have developed health education and prevention programs for the last 20 years on a local and national level targeting high-risk populations, but since 1995 I have been directly involved in several international projects focusing on advocacy and the provision of direct services targeting at-risk populations in sub-Saharan Africa.

In 2000, after attending the international AIDS conference in Durban, South Africa, I decided to try to visit as many sub-Saharan African countries on my way home to learn directly from people who are working in the field what their experiences were. I traveled throughout South Africa, Zimbabwe, Uganda, Nigeria, and Senegal and some of the lessons learned – that I learned from people who were doing the work at the grassroots level included the implementation of broad-based community mobilization efforts including all sectors of the public and private sectors; involvement of persons living with HIV and AIDS and are impacted by HIV and AIDS in all aspects of planning, implementation, and evaluation of proposed projects; the enhancement of educational support and mentoring programs whose goals are to empower women so as to improve the standard of living for girls and women who are being severely impacted by the pandemic due to their low socio-economic status as well as cultural practices which discriminate against women; transparency at all levels of program planning, implementation, and evaluation; protection of human subjects when research projects are being developed and implemented; and the development of social marketing campaigns that speak to the needs of people and the realities of their lives whereby messages are not sugar-coated but reflect the stark realities of HIV/AIDS' impact on families, communities, and societies at large.

The vital aspects of effective partnerships that were shared with me include: ongoing, open communication whereby there is a level playing field and all parties share equally in decision-making and problem-solving; involvement of trained professionals and laypersons who have a passion for their work, have experience in working with the populations targeted for intervention, who are respected and trusted by the community, and are knowledgeable of the cultural norms, beliefs, and attitudes of the individuals and communities being targeted for interventions; and most importantly, strategic planning that clearly delineates a development of financial mechanisms to sustain the collaborative in order to ensure its long-term viability.

Since I have less than a minute, again I want to thank you for giving me the opportunity to come and share with you some of my – the work that I've done on an individual basis. Thank you.

(Applause.)

MR. MASON: Thank you. Dr. Kathleen Kurtz with the International Center for Research on Women, and Cherreka Montgomery from the same institution, and Charles Dugu (sp) from the McCormack Graduate School of Policy Studies.

JOHANNES VAN DAM: Good afternoon. My name is Johannes van Dam. I am deputy director of the Horizons program of the Population Council. I'm speaking on behalf of Dr. Andrew Fisher.

Thank you for the opportunity to comment on the president's Emergency Plan for AIDS Relief. In the next few minutes I will make a case for allocating a relatively small percentage of the total budget available to operations research as an essential programmatic activity to ensure that money spent is indeed well spent.

The history of HIV/AIDS programs resembles that of many other public health and development programs. Large numbers of successful pilot programs offer promise, but few examples of large-scale, nationwide implementation deliver on that promise. Attempts to implement what we know to be successful in one location often fail when those programs are introduced in other cultural settings or in settings with a different resource-base.

Operations research offers the means to turn this around. It does this by diagnosing and evaluating the potential and problems of programs and interventions and by comparing one service delivery option with another in terms of impact, cost effectiveness, quality, and client acceptability.

Let me give you just two examples of how applied operations research has made a difference in program planning and implementation. In the United States, mother-to-child transmission is almost nonexistent, but every day in the developing world 2,000 babies and newborn infants are infected with HIV. Short course Anti-retroviral therapy is

now available in many developing countries to help prevent mother-to-child transmission, but where such programs exist, few women have taken advantage of them. Operations research conducted in Zambia and Kenya documented acceptability, operational barriers, cost, and the impact of pilot MTCT programs. Materials developed for operations research were adopted in the scale-up process in those countries and include needs assessment materials and training curriculum.

Second, the HIV.AIDS epidemic is leaving in its wake a huge number of orphans, overwhelming existing support systems. Operations research was used to test and develop an approach to improve the chances of successful survival and social integration of orphans in Uganda. The program involves families early, before parents die, in planning for their children's future. Because of operations research, will writing, memory books, succession planning, and identification of guardians now are accepted as a best practice in many programs.

We encourage the president's Emergency Plan for AIDS Relief to allocate funds under the plan for operations research to ensure that United States leadership in the campaign against HIV/AIDS results in optimal use of available resources, and we modestly suggest that of the funds allocated to programs, 2 to 3 percent be allocated specifically to operations research.

Thank you.

MR. MASON: Thank you.

CHERREKA MONTGOMERY: Hi. Good afternoon. My name is Cherreka Montgomery and I'm the policy advocate with the International Center for Research on Women. ICRW, or the International Center for Research on Women, was founded in 1976 to really conduct research on women's economic and health status, particularly in developing countries.

I would like to share with you today some of our important research that we've conducted regarding cross-generational sex and its impact in increasing adolescent girls' vulnerability to HIV infection in sub-Saharan Africa.

What is cross-generational sex? We define it as when an adult man has a sexual relationship with a female partner age 15 to 19, and this relationship leaves the young women powerless to negotiate safer sex. And we find that this is a large contributor to the spread of HIV/AIDS in sub-Saharan Africa. For example, among girls age 15 to 19 in Uganda, the risk of HIV infection doubles for those with male partners 10 or more years older. And in Zimbabwe the risk increases for each age of – for each year of age difference. So what we know is that as the age difference increases, the power imbalance also increases, making girls more vulnerable to HIV infection.

Why should we care about this? Well, the UN estimates that adolescent girls have the fastest growing rate of HIV infection. We know that girls are up to six times more likely to be infected with HIV/AIDS than boys.

What's driving this phenomenon of cross-generational sex in sub-Saharan Africa? We know that, for example, in sub-Saharan Africa many older men seek relationships – these sexual relationships for pleasure and that because they have this perceived notion that sex with young girls enhances their prestige and that such girls are free of HIV infection. On the other hand, adolescent girls' sexual behavior is motivated mainly by the desire for gifts or for money to increase their social status. Both older men and girls accept this as a social norm.

So we also find that marriage does not protect against HIV transmission, particularly for girls and young women. Our research shows that many married men engage in sexual relations with multiple partners. Sometimes they are already infected with HIV when they enter marriage. The other key point is that power imbalances play a particularly strong role in increasing the infection among young women. The threat of violence and coercion within these sexual relationships further increases girls' vulnerability to HIV infection. We have studies that show that men tend to control the conditions of sexual intercourse, including condom and contraceptive use and the use of violence. And that we know that without condoms for protection during sexual intercourse, girls who have sex with these older men are at extremely high risk of HIV infection. Lacking adequate and accurate reproductive health information, many girls do not even perceive that they are at risk of HIV infection, making them even less prone to protect themselves in sexual relationships with older men.

Quickly, I want to just leave you some points, but we do want to be engaged in further dialogue with you and Ambassador Tobias, and I'll sum them up as this: we need to create an enabling environment by working with youth, parents, and teachers, and traditional authorities, and other key stakeholders to make young people smart about the reproductive health decisions and avoid sexual – risky sexual behavior including cross-generational sex. We need to develop comprehensive education programs that teach women and girls, and information and skills about HIV infection, including reproductive health.

The other thing I want to mention is we've got to create peer networks to support and encourage safe sexual behavior, but I also want to leave you that men must be equally involved and that we've got to support efforts and encourage men to be more responsible in their sexual behavior including being faithful and also using condoms.

Thank you.

(Applause.)

MR. MASON: Thank you. We're going to try to – we're running behind about 20 minutes. We've got to stick to the three-minute – okay.

GUS GILL: My name is Gus Gill. I'm from Drew University of Medicine and Science and I'm head of our international health institute. I didn't plan to talk today; I just came here to learn and I've learned a lot. I'm speaking on behalf of Dr. Eric Bing, who just got in from Angola last night so he wasn't able to make it today, and you'll receive his written statement later.

We have a unique program that was funded by the Department of Defense, and this program was to train the military in Angola about HIV prevention and as a consequence of that we have the soldiers putting down their weapons and fighting another kind of war in the local communities.

Dr. Bing and members of our faculty have learned Portuguese as a sign of respect for the country that they are dealing in. We've brought Angolans here and they've taken courses at UC San Diego and UCLA as well as Drew.

My personal feelings are God has given America everything. We have everything. It's much more important rather than just being mighty, we can be great. And being great means you've been given a lot, it's our responsibility to give a lot. And I wanted to tell Dr. Louis Sullivan – because I want to personally thank President Bush for putting emphasis on this dredge to humanity.

Our program was on on PBS, or one of those channels. I'm getting senile now in my old age. But he had Bill Frist – whatever his name is – speak on that program about what we're doing in Angola. We have programs throughout the world, but that's just one.

Thank you.

MR. MASON: Thank you.

I'm Audrey O'Donnell (sp), McCormack Graduate School of Policy Studies, University of Massachusetts, Boston. We are a land-grant university. We have a mandate to work in the community.

I'm going to talk about a mechanism that we have developed to deliver services and programs to individuals in the rural areas of Africa. The McCormack Graduate School in Mass, Boston, and its African partners have established university-based community resource centers, or CRCs, in Senegal and Kenya by building the infrastructure to combine ICT access and delivery of health services in programs with more traditional, local, economic and social development mechanisms.

In the 48 countries of sub-Saharan Africa, there are approximately 131 universities. Kenya has five public universities with about 16 campuses. Senegal has two. All are underutilized and undervalued as agents for development. University-based community resource centers have great potential for development and delivery of health

services because the universities are able to provide good organizational and operational support and they are a link to learning opportunities, a bridge to the community, and have a revenue basis.

Accessing technology for the CRCs has been central to the development and sustainability of our initiatives in Africa. This could not have been accomplished without the CRCs receiving their IT access from the university whether it be through a landline or wireless. Even as our CRC in Senegal was under construction, impact was already being felt. The proximity of our site in rural northern Senegal a short distance from the Mauritanian border to national and international traffic reaped a good deal of attention from other regional initiatives including NGOs and donor agencies seeking to link up with our CRC to combine services and programs and to develop a databank, or indeed to replicate it elsewhere.

Before McCormack's project began at Egerton University in Kenya there was no organized plan to work with the community, usually ad hoc without any sustainability. Since our partnership began a little more than 14 months ago, and a framework was developed for Egerton to work with the community surrounding the university, community tensions and conflicts that existed between the university and the community have subsided. The (varsity ?) management and the community leaders have seized the opportunity to promote and enhance a university community nexus. The university management sees it as an opportunity to not only educate the community, but to address their most challenging problems together, including HIV/AIDS and drug abuse issues in the rural Nekora (ph) region.

There are about 340,000 inhabitants and 20,000 out-of-school and at-risk youth in that community surrounding Egerton University. The tools, infrastructure, and technology for the empowerment of the rural poor in the LDC's are possible. The challenge, however, continues.

MR. MASON: Thank you. And Peg Willingham, from the International AIDS Vaccine Initiative, and Lea Acord from Marquette.

CHARLES DUMO: Good afternoon. My name is Charles Dumo, and I'm a Kenyan Ph.D. student at U. Mass, Boston, and I'm also their program director for Kenyan programs at the John W. McCormack Graduate School of Policy Studies. The McCormack school at the U. Mass, Boston, in alliance with the office of the Kenya's first lady and Egerton University in Kenya has developed a university-based, community resource center, or what I'm calling a CRC, initiative that's addressing in a comprehensive and multifaceted manner the high levels of HIV/AIDS in communities surrounding the university in Akuru (ph), western Kenya.

CRCs enable the partners to address HIV/AIDS through a diverse array of programs that are aimed at prevention and mitigation of the disease. For the infected, programs include peer mentoring and counseling on behavior change, and for the infected programs include provision of ARVs through the Kenyan government-monitored VZT

(ph) centers; guidance and counseling attention to orphans, which is a much overlooked segment of our Kenyan population; and provision of nutritional supplements and other income generating projects.

Because a diverse array of programs are housed in the CRCs, including the government-monitored VZT centers, the stigma of those who visit testing centers is reduced. An individual could be visiting other programs in the CRC and not necessarily the HIV testing.

Eighty percent of Kenya's population lives in the rural areas. Most health services and programs do not reach them. Using CRCs based at or near universities, most of which are located in the interior of the country, enables services and program to reach these populations. It is also possible to tailor the programs to a specific community, reflecting its language, circumstances, and culture.

Egerton University has donated land where the CRC is housed and provides experts to work at the CRC in services such as IT access. With these resources emanating from the university and its income-generating activities, the CRC is able to sustain itself.

In conclusion, university-based community resource centers have distinct advantages whereby they are able to comprehensively mitigate and prevent the spread of HIV/AIDS. Kenya's – our Kenyan president has also asked for the Egerton project to be used as a prototype for a countrywide initiative.

I'd like to thank you and thank the president and everybody who is working on HIV/AIDS. Thank you.

MR. MASON: Thank you. Why don't we also – Konji Sebati from Pfizer, William Shild (ph) from Pfizer, Rolf Campbell from Land o' Lakes, and William Courtney from Computer Sciences Corp get ready.

PEG WILLINGHAM: Thank you. Ladies and gentlemen, I appreciate this opportunity to discuss today what is needed to accelerate finding a vaccine to prevent HIV and AIDS. My name is Peg Willingham and I'm here today to represent the International AIDS Vaccine Initiative – IAVI. My written testimony tells you who we are and what we do, but today I'd like to focus on what we hope you will do.

The president's Emergency Plan for AIDS Relief is an unprecedented step in the expansion of prevention and access to treatment and care for AIDS. As the administration moves forward to implement your strategic plan, we hope you will also incorporate actions necessary to accelerate the search for a vaccine to prevent AIDS. That will be the true endgame in the struggle to eradicate AIDS.

With new HIV infections occurring at a rate of five million per year, an AIDS vaccine is more urgently needed than ever. A vaccine that shields people from HIV

infection before it strikes, complemented by education and treatment, is our best hope to end this terrible epidemic. An AIDS vaccine is within reach, but only if the world mobilizes a concerted effort to push promising candidates from the lab into clinical trials and takes the necessary steps to ensure global access to a vaccine once it becomes available.

The United States is leading the world in providing treatment to people who desperately need it. We hope the United States will also now make finding an AIDS vaccine a top priority and commit to significantly increasing funding for AIDS vaccine research as well as overall AIDS research in general.

The U.S. government has provided an array of incentives to marshal the biotech and pharmaceutical companies' expertise to meet the threat of bioterror. Certainly none of us wants to get anthrax or smallpox, especially those of us living in Washington, DC – we worry about that. But similar incentives are needed to encourage research and industry involvement for an AISD vaccine and other preventive technologies like microbicides.

The United States should also commit to ensuring that an AIDS vaccine is available globally by creating legally binding precommitments or contracts to purchase an AISD vaccine for international use. Important synergies can also be found between PEPFAR programs and AIDS vaccines clinical trials. Communities who are participating in research that has a potential to benefit the entire world should get first in line and receive priority in the provision of comprehensive AIDS services, including anti-retroviral therapy.

The administration should include scale-up of AIDS services associated with clinical trials as an objective of your strategic plan. The plan should also lay the groundwork for eventual delivery of vaccines through existing PEPFAR programs and channels, and the U.S. should also seek coordination between AIDS vaccine trials and the Global Fund.

The United States has the power to achieve the greatest hope of our time: a world without AIDS. We look forward to working with you and the other groups represented here to achieve that vision. Thank you.

MR. MASON: Thank you.

LEA ACORD: Good afternoon. My name is Lea Acord, and I am dean of the College of Nursing at Marquette University in Milwaukee, Wisconsin. Thank you for this opportunity.

In September, 2002, two nurse faculty members, one, Karen – (audio break, tape change) – we'd like to share with you.

The global nursing shortage is affecting the healthcare infrastructure in Africa. There are not enough well-educated nurses to serve the populations in Africa, especially in light of this very serious epidemic. Secondly, there is a perception that the nurses in Africa are leaving for jobs in other countries. Unfortunately, the way the African countries seem to be addressing these issues is to lower the standards for nursing education. For example, Zambia plans to increase the number of, quote, "enrolled nurses." These are nurses educated in six to 12 months post-secondary school.

Nigeria is in the process of reducing their nursing education standards, believing that doing so will mean that their nurses are less likely to be recruited to other countries. These solutions are unconscionable given the complexities of the healthcare systems, the gravity of the healthcare issue Africa faces, and the dependence on nurses as frontline caregivers. In fact, a recent large-scale study in the United States confirmed the need for better, not less, educated nurses. Furthermore, educating nurses at a lower level has major implications for the nurses themselves. With little training and no protection from injury, nurses increase their own risk of infection on the job, and death if untreated after occupational exposure.

In Kenya, two to three nurses are dying of AIDS monthly according to Elizabeth Oyer (ph) from the Ministry of Health. This statistic could be turned around if nurses were well-educated and knew how to better protect themselves and others and had the resources to do so.

Let me conclude by telling you that Jesuit – that Marquette as a Jesuit institution is committed to service and supports the college of nursing in our efforts to enhance the quality of healthcare to persons with HIV and AIDS, and we're working with other Jesuit institutions. We would also like to take advantage of government opportunities, but we're often finding that the timeline is very short to respond to your RFAs, and if you want comprehensive responses we respectfully request that the format be less cumbersome and the timeline be longer.

Thank you.

MR. MASON: Thank you.

ROLF CAMPBELL: Good afternoon. I'm Rolf Campbell. I'm with Land O' Lakes International Development.

Good nutrition is an essential treatment for people with HIV/AIDS. There's a proven role for nutrition in effective drug therapy and palliative care for people with HIV/AIDS. In the successful care and the growth of orphans, nutrition holds a central position. During each phase of HIV/AIDS there are stresses on the body that have crucial implications for the quality of nutrition needed and the body's capacity to ingest, absorb, and utilize nutrients effectively. As HIV infection progresses into AIDS disease, hypermetabolic responses, malabsorption of nutrients in the gut, diarrhea, and anorexia

all contribute to severe challenges to intake and maintenance of adequate nutrition, protein, energy, and micronutrients.

Quoting Mr. Paul Harvey from his 2003 HIV/AIDS literature review: "In the early stages of HIV infection, adequate nutrition can help to slow the progression to AIDS, and diets rich in protein, energy, and micronutrients are likely to help build immune resistance to opportunistic infections." This has led to calls for food relief rations to be revised to reflect the needs of people living with HIV/AIDS. Good nutrition can change their life, reduces the cost of medical care, reduces complications and hospitalizations, shortens the duration of hospital stays, improves effectiveness and tolerance to medications and treatments, increases productivity and independence, and increases the ability to remain at home.

Quoting Dr. Heinrich Friess (sp) of the United Nations Subcommittee on Nutrition: "The potential for micronutrient deficiencies to act as co-factors in HIV transmission and progression is most obvious in poor populations with adequate dietary – inadequate dietary intake and high infectious disease burden."

There are four factors showing how good nutrition must be considered an essential treatment for people in Africa with HIV/AIDS. One, good nutrition is essential to meet physiological needs of people with H – with AIDS disease, including their hunger and metabolic responses to drug therapies. Two, the nutrition status of a large percentage of HIV-positive Africans including orphans, African children, is already depleted. They are not starting off well and if they're fortunate enough to receive diagnosis and formal medical care, they're starting at a position where they're already depleted. Their nutrition intake is inadequate. Number three, access to nutritionally dense affordable supplemental foods is crucial to maintaining health. An essential input to drug treatments for effective recovery from debilitating HIV/AIDS conditions. And lastly, private African and U.S. food industry, in alliance with NGOs and institutions, are in a position to deliver nutritionally dense foods to people with HIV/AIDS disease and to orphans. And I've included three concrete examples in my written remarks of Kenyan – or, not of Kenyan – of African businesses engaged in exactly that.

Thank you.

MR. MASON: Thank you. As Konji's coming up, can we have Renee Fiorentino from Synergy Project, Gary Hinnenger (ph) from Becton Dickinson, and David Oxley from OraSure get ready.

KONJI SEBATI: Thank you. Good afternoon. I'm Konji Sebati, Pfizer's medical director for global HIV/AIDS philanthropic programs. I will talk about our flagship program, the Diflukan Partnership Program, which is a donational diflucan and antifungal medicine for the treatment of AIDS-associated opportunistic infections. The medicine is donated free of charge with no limit to cost and time to all developing countries with a prevalence rate of 1 percent and above.

The program also provides training for healthcare workers on the treatment of opportunistic infections. It is now operational in 21 countries and we have learned a lot of lessons. The ones that stand out and have continued to inform us as we expand the program worldwide are the following. For a successful program, it is important that the beneficiaries be governments, people living with AIDS, nongovernmental organizations, or CBOs. They should have shared decision-making, shared responsibilities as well as accountability. It is not for the donor to dictate what needs to be done and how it will be done.

Second, it is important to understand the local context, beliefs, and just how things are done in a country. Even though some may look and feel odd to Westerners, it is important to understand how people do things. Ensure that programs are integrated in already existing and successful programs. Identify what works well in the country, what has been working well, improve on those that are not working well, and adapt – do not reinvent the wheel.

Building capacity is absolutely important and transferring skills is imperative. The days of signing checks or sending a cargo load of medicines or sending Western experts for short periods of time are over. It is important to build local capacity, improve infrastructure, and ensure sustainability. All these lessons learned, if addressed early and appropriately, make for good partnerships.

Thank you.

(Applause.)

MR. MASON: Thank you.

MICHAEL SHELL: Good afternoon, Mr. Chairman, Mr. Ambassador, ladies, and gentlemen. I am Michael Shell, not from Pfizer, but a professor of medicine from the University of Virginia and the immediate past president of the Infectious Diseases Society of America, or IDSA. Today I represent the Academic Alliance for AIDS Care and Prevention in Africa as one of its founding members.

The Academic Alliance is a unique private-public partnership between prominent academicians from North America and Africa; the pharmaceutical industry; the IDSA; the AIDS Support Organization ORTASA (ph), the largest NGO in Africa; and many other partners which we have listed in our written testimony. That was launched in June 2001.

Our core mission is very direct: to enhance the care and prevention of HIV and AIDS in Africa through training and research. You have before you our written testimony which lists the founding members of the Academic Alliance as well as some of our initiatives and accomplishments to date. Within the timeframe available, I'd like to highlight only two of these: clinical care and capacity-building.

Malago (ph) hospital is a national hospital of Uganda and a major teaching facility of the Makerere University Faculty of Medicine. When the Academic Alliance was formed, the AIDS clinic was operational only one day per week. We have now renovated space and have expanded the clinic to five days per week with more than 500 patient visits per week and now care for a cohort of over 3,000 HIV-infected patients. Currently, over 600 of these receive anti-retroviral therapy.

A major new initiative, the Infectious Disease Institute of the Academic Alliance is under construction. This facility, comprising approximately 25,000 square feet, will open in March of next year. It is the first large-scale facility to be constructed on the grounds of Makarere University in over 30 years. The clinical facility resources are listed in our written testimony, but this facility also will house the finest state of the art laboratory and training center in sub-Saharan Africa. The IDI will support care of at least 10,000 patients annually with HIV/AIDS, and with support as many as 7,500 could be on the anti-retroviral therapy by the end of 2005 if resources for drugs and laboratory tests become available. In addition, infrastructure and the delivery of excellent care and prevention services, building capacity for the future is vital to combating the AIDS epidemic in sub-Saharan Africa.

We have developed a curriculum for the education of African physicians in the state of the art HIV/AIDS care. Selection committees for trainees as well as trainers are multinational and there are more than 20 to 25 applicants for every position that can be filled.

The AIDS training program is facilitated by trainers selected by the membership of the IDSA, but 50 percent or more of the training is already done by Ugandan physicians. The training program started in April, 2002, and since then we have trained more than 150 physicians from 13 sub-Saharan African countries and have completed this intensive one-month course. The trainees are now training others throughout the continent.

We developed the first AIDS treatment information center to provide up-to-date, essential, clinical information to physicians in real time, as well as a newsletter to stay in touch with our trainees and monitor the success of the training program and improve patient outcome.

Expansion of the training program to other countries as well as the nurses and clinical officers will be initiated next summer. Time does not permit the discussion of our operational research, clinical community outreach, or prevention activities; nevertheless, the Academic Alliance has achieved a great deal in the last two and a half years and wishes to partner with you and facilitate our mutual and shared mission.

I'd like to commend you on your commitment to this important, complex problem and we look forward to working with you in the future. Thank you very much.

MR. MASON: Thank you.

RENEE FIORENTINO: Good afternoon. My name is Renee Fiorentino. I'm a monitoring and evaluations specialist with the Synergy Project. The Synergy Project is a contract held by Social and Scientific Systems and we provide support to the Office of HIV/AIDS within USAID.

My message today is about partner coordination and strengthening of information systems. In response to the Presidential Advisory Council's request for lessons learned regarding planning, implementation, and outcome measurement strategies that have worked best, I would like to share some of the synergies work in the area of implementation monitoring.

As part of a framework referred to as APDIME, which stands for assessment, planning, design, implementation, monitoring, and evaluation, Synergy has devoted significant resources to improving and building consensus around standards for implementation monitoring. Logistically, Synergy has achieved this through our mandate to serve as secretariat for the Implementation Working Group, the collection of 50-plus agencies and organizations implementing HIV/AIDS program with USAID funds.

Substantively, our work in implementation monitoring has included the establishment and promotion through a participatory consultative process of a categorization system for HIV/AIDS programs and a set of core program output indicators organized according to the category structure. Implementation of this category and output data collection system through an HMIS called the HIV/AIDS programmatic database, has allowed us to look at coverage and effectiveness of HIV/AIDS programs. Coverage and effectiveness being the questions that inevitably arise from outcome analysis. And the system has allowed us to look at these things across USAID's portfolio.

Looking at program-level data in this aggregate, standardized way has not typically been done in the past, but coordination of implementation agencies and donors, including the multilateral agencies, around this approach has already increased capacity for broad-level planning with – which with strengthened communication and bi-directional information-sharing systems in place could lead to the improved local planning and eventually leading to improved outcomes.

In our work, remaining challenges include the development of improved tools for decentralized data collection and tools to facilitate the interaction of diverse management information systems, but our experience tell us that in this era of increased resources and increased need for coordination collecting and looking at program-level data in this standardized way is incredibly useful.

Thank you.

MR. MASON: Thank you. And while you're coming up, can we have Beth Shehy (sp) from Land O'Lakes, if she's here; Mike Trainum from Shell Book Publications System; Chris Wright from John Snow; and Paul Meyer from Voxiva.

GARY HENNIGER: My name is Gary Henniger. Got all this time waiting and now I can't get it out. Isn't that great? (Laughter.)

My name is Gary Henniger. I am the director of Product Development for Syringe Reuse Prevention Devices at BD – Becton Dickinson. I'm here on behalf of my company to discuss our experiences in helping to prevent the spread of HIV/AIDS in Africa and the developing world.

For those of you who do not know BD, we are a medical technology company that serves healthcare institutions, life-science researchers, clinical laboratories, industry, and the general public throughout the world. We manufacture and sell a broad range of medical supplies, devices, laboratory equipment, and diagnostic products.

One of the questions that we are often asked regarding HIV/AIDS is, what are the issues driving HIV/AIDS problem in Africa? While the role of unsafe sex in the spread of HIV/AIDS is well documented, international health studies indicate that the reuse of medical devices in Africa and developing world is also a contributing factor to the spread of HIV/AIDS and other blood-borne diseases. The World Health Organization and Centers for Disease Control have reported as many as 40 percent of all injections in the developing world are administered with reused, unsterile medical devices. In the year 2000 alone, WHO estimates indicate that 500,000 new HIV infections, two million hepatitis-C infections, and 21 million hepatitis-B infections resulted from the reuse of injection devices.

Other recent studies argue that a third or more of all new HIV infections in the developing world might have been caused by injection device reuse. The data from the WHO also indicates that unsafe medical practice, including device reuse, is among the causes of preventable HIV/AIDS spread in the developing world. Many concerned parties, including BD, have been dedicated to addressing this issue for many years. Even though a vast majority of injection devices utilized and reused in the developing world are not manufactured by our company, our commitment to this issue has (manifest results ?) in many ways. We have developed low-cost technologies specifically designed to prevent reuse, collaborated with international agencies in the development of appropriate safe injection policies, and made substantial philanthropic commitments to support of international vaccine efforts utilizing safe injection technology for deadly diseases such as tetanus and measles.

As a result of leadership of international agencies such – and organizations such as WHO, UNICEF, GAVI (ph), USAID, American Red Cross among others, and the work of all manufacturers of safe injection devices it is estimated that 75 percent of childhood immunizations in Africa today are administered with syringes and needles that physically lock after a single use.

But efforts to prevent the spread of HIV/AIDS in Africa and the developing world cannot stop with immunization efforts because immunization accounts for only 10 percent. There are many more important priority – there are many important priority areas – I'm going to respect the time.

Thank you very much.

MR. MASON: Thank you. Thank you.

Yes? And then Paul.

CHRIS WRIGHT: Thank you. My name is Chris Wright. I'm with John Snow Incorporated.

An investment in health logistics, improvements will improve program impact, is cost effective, and saves lives. John Snow incorporated has been working in health logistics for the last 15 – 18 years. We have a phrase called no product, no program. IF you have no ARVs, you have no ARTs. Public health and international assistance programs – organizations cannot successfully address the HIV/AIDS pandemic unless the right products for preventing and treatment of the disease are delivered in the right quantities, in the right condition, to the right place, at the right time, and for the right cost.

This is the role of health logistics; a role often underemphasized and underfunded in the planning of public health initiatives in the developing world. For programs to function efficiently, and one day independently, HIV/AIDS assistance programs must be balanced between directly providing commodities and services and reinforcing the infrastructure.

Logistic systems must be strengthened if they are to manage appropriately and avoid wasting the coming surge of HIV/AIDS commodities promised by multiple new funding mechanisms and initiatives, not least of which is the president's initiative. A comprehensive HIV/AIDS program requires more than 1020 distinct products to be managed effectively, including anti-retroviral drugs, HIV tests and laboratory reagents, medicines for treating essentially – sexually transmitted infections and opportunistic infections, condoms, contraceptives, and consumable laboratory and medical supplies.

But many existing distribution systems, particularly in Africa, are unable to provide even the most essential medicines to hospitals, clinics, and other service delivery points with any consistency or reliability. Stronger logistic systems will save lives. Securing a dependable and regular supply of HIV/AIDS commodities to service delivery points is especially critical to the success of ARV treatment programs because any interruption in those supplies will endanger the lives of the patients and – due to the risk of drug resistance – jeopardize the treatment program itself.

Do we wait for distribution systems to be set up on the scale of UPS in Timbuktu? No. But we want to make sure that the near-term solutions are also transferable – transferable and evolve into long-term solutions.

I'll stop there, but please remember: no product, no program.

MR. MASON: Thank you.

Yes?

MIKE TRAINUM: Thanks for listening to us today. I'm Mike Trainum, CEO of Shell Book Publishing Systems. In the 1980s, my family and I lived and worked among the Klo-whai-wasai (ph) people of Papua, New Guinea. We helped as much as possible with community development, literacy, and the diffusion of life-crucial information.

One summer when many babies were dying from diarrhea in the mountains all around us, a nurse traveled up from the nearest government station to explain to others that they must use rehydration fluid to save their babies. Her exhortation was in the local trade language – pidgin – and she explained very clearly, at least to us, how to make life-saving rehydration fluid by adding sugar and salt to boiled water. After she left, though, we overheard some of the local women laughing and talking about how stupid she was. Of course, because everyone knew that you withheld fluids from someone with diarrhea. After all, like begets like, doesn't it? Why would you give more water to someone who obviously had too much already? After more investigation, we worked with the local people to develop a small booklet based on a cultural analogy that had emerged from communities – the discussion and validation – cultural validation of the crucial concepts involved, and I want to emphasize, not translation. Community process, cultural validation, community ownership, oral, written – it's important.

This shell book – shells are a traditional unit of value in that – the mountains of Papau, New Guinea – compared a severe diarrhea victim's limp skin with the leaves of a common plant the Klo-whai-wasai would irrigate when it grew limp from drought. It worked. Many babies were saved and that shell book has since been localized by communities in several hundred Papua, New Guinea languages.

The lesson I've learned is that people rarely, if ever, act on information that they cannot understand and have no way of validating in terms of their own language and cultural perspective. Until new life-crucial information is understood, validated, and accepted by local communities, it will miss the mark more than – often than not.

The implications for PEPFAR success are: there are 400 million people in PEPFAR countries. These people speak 1,082 languages; over two-thirds live in rural areas and are the least likely to have functional fluency in the national or regional languages most commonly used for HIV/AIDS information. That's 250 million of the target – over two-thirds of the target population don't – will not have a clue that PEPFAR occurred. Now, this sounds daunting but our – over the process – over the last 14 years

we've developed this resource in local communities. It's not rocket science, but it's got to be done properly. And in Papua, New Guinea, now, 435 languages use – the communities are used, and for grades one, two, and three curriculum, and then they transition into the national language. This can be done and you need our help. Read our paper.

MR. MASON: Thank you very much. And our last speaker, Paul Meyer from Voxiva.

PAUL MEYER: Mr. Chairman, thank you. All protocols observed. My name is Paul Meyer. I'm the CEO of Voxiva, an information technology company that builds technology applications for public health in developing countries.

I want to just share a couple lessons that we've learned in deploying systems in a lot of countries. I'm actually glad to have spoken after john Snow, who really focused, I think, on the logistical challenges of this undertaking, which is really tremendous. This is an enormous undertaking this initiative is driving and I think that unless information technology is really leveraged effectively to find out where the problem is, to manage resources, to track distribution, it's almost inevitable that it will fail.

I want to just repaint a mental image for the committee of information flows in developing countries, and I've now seen this in country after country after country. There's a ministry of health in a country and then there's the sort of constellation of programs – the WHO, CDC, and NGOs, and donors, and so forth – and in each country then there are programs. There's the HIV/AIDS program, the TB program, the PCT program – the PMTC program, polio, malaria, and so forth. They all have their own information flows and right now in most of the developing world those information flows are paper-based.

What does that mean for the doctor in the field? It means the doctor in the field has a form to fill out for the TB program, a form to fill out for the polio program, for the malaria program, and it's absolutely paralyzing for that health worker in the field. The thing that terrifies me, and this I'm speaking as a technologist, because all those programs have their own budgets, their own – different people at the top of them, different donors that impose their own requirements in terms of M&E and others, that each of those programs get technologied over separately. So I have a nightmare vision that some poor doctor or poor health worker in a village in Africa or Latin America or India will end up having a Palm Pilot from the TB program, a laptop from the HIV/AIDS program, 36 different passwords, and will be paralyzed by technology.

I think that obviously given the resources, that the president's initiative is directing towards HIV/AIDS there's an incredible opportunity to actually deploy appropriate technology systems to really manage the critical information flows that are absolutely necessary to tackle this huge challenge. If done right, the possibilities are beautiful. One could put systems in place starting with HIV/AIDS that are architected and designed in such a way that they can then be extended to do TB and malaria and

polio. And at the end of this initiative, one will actually leave strengthened infrastructure in place and public health systems that actually work and manage it effectively.

One – so, again, two just points I'd like to leave in your minds. One, just classic problem is this stovepiping is purpose-built systems that don't work across programs. The second one that I want to dwell on is actually this tendency on the part of donors' initiatives to put monitoring and evaluation systems in place – to basically extract information from people in the field. The potential of information technology if done appropriately is to actually introduce technology into the operational flow of programs, tracking things like distribution, new cases, and so forth. If you do it the right way, M&E is just a byproduct of a well-flowing information flow and the whole system will be strengthened more effectively.

Thank you.

MR. MASON: Thank you.

I want to just before we close ask Ambassador Lange if he has some closing comments.

AMB. LANGE: Just a very brief comment to thank everyone for coming. I found this to be very, very helpful input and we will be giving a full report to Ambassador Randall Tobias and hope to be working with you all in the future.

Thank you.

MR. MASON: I want to thank you, Ambassador Lange. Thank you for staying. I want to thank all of you and – for coming. I think Reverend Bellamy may get the award. Seventeen hours each way on Greyhound – but all of you – I want to thank all of you. We really appreciate this. And I want to thank the committee members as well for taking time, and I want to thank the staff of PACHA: Josephine Robinson, Elizabeth Onjoro, Dana Ceasar, and all the staff. They put this together under a very tight timeframe. It's been wonderful.

Your oral comments and your written comments will be on the PACHA website by February 1st of next year, and that's www.pacha.gov. Thank you and we look forward to working with you in the future.

(Applause.)

MR. MASON: Not too bad. We're five minutes late. That's not too bad.

MR. : Thank you very much.

MR. MASON: Absolutely. Thank you. Thank you. Look forward to working with you.

(END)