

PEPFAR: AN ASSESSMENT OF PROGRESS AND CHALLENGES

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PEPFAR: AN ASSESSMENT OF PROGRESS AND CHALLENGES

TUESDAY, APRIL 24, 2007

HOUSE OF REPRESENTATIVES,
COMMITTEE ON FOREIGN AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 11 o'clock a.m. in room 2172, Rayburn House Office Building, Hon. Tom Lantos (chairman of the committee) presiding.

Chairman LANTOS. The committee will come to order.

Before we begin today's hearing, I would like to take care of a housekeeping matter. Last week the House formally appointed the last two members of our committee, Gene Green of Texas and Joe Crowley of New York.

Accordingly, without objection, Mr. Green is appointed to serve on the Subcommittee on Terrorism, Nonproliferation, and Trade and the Subcommittee on the Western Hemisphere, and Mr. Crowley is appointed to serve on the Subcommittee on Terrorism, Nonproliferation, and Trade and the Subcommittee on International Organizations, Human Rights, and Oversight.

Before I begin my statement on the subject of this hearing, I want to express my profound appreciation to my colleagues, Pearl Alice Marsh and Peter Yeo, for the extraordinary job they have done on this very important subject for years.

Four years ago, when this committee produced the landmark legislation we review today, HIV/AIDS was the most urgent public health issue in the world, bar none. It remains so today. More than 40 million people suffer from HIV/AIDS—a number that jumped by 2.5 million over the past 3 years despite all of our collective efforts. This scourge has already stolen nearly 30 million lives, more than any war in human history with the exception of World War II.

But this war will continue without end if we let it. We cannot allow complacency and contentment to slow our steadfast determination to end this disease. AIDS may not be a new phenomenon, but it is as lethal as ever.

The devastation from this virus goes far beyond those who suffer directly from it. It has caused massive upheaval to political, social and cultural structures, including the most important one—the family. As a father and as a grandfather, it disturbs me to no end that more than 15 million children worldwide have been orphaned by AIDS. These are utterly shattered lives.

The cold, sober reality is that no assistance program can ever make them whole, but we can help prevent more children from being added to this long and dreadful list.

So I state today for the record Congress will reauthorize this crucial HIV/AIDS law and will fully fund HIV and AIDS programs in the poorest of countries on our planet.

Four years ago, my friend, Henry Hyde, and I labored long hours—together with many members in this room today, to produce a strong bipartisan bill. It authorized \$15 billion for 15 of the hardest hit nations in Africa and elsewhere, establishing the United States as the world leader in the global battle against AIDS. And those who occasionally complain that we have lost our moral authority better take notice of this figure. There is no nation on the planet which would have made a remotely comparable effort. Our groundbreaking legislation, the United States Leadership against HIV/AIDS, Tuberculosis and Malaria Act, was comprehensive in both scope and scale.

So far we can say that this critically important legislation is working. It has supplied lifesaving antiretroviral therapy to more than 800,000 adults and children, provided invaluable testing and counseling for 19 million, supported essential services to prevent mother-to-child transmission to more than 6 million women and served 4.5 million people with desperately needed care and support. These numbers represent solid progress toward the program's stated 5-year goal of 5 million treated with antiretrovirals, 7 million infections averted and care provided to 10 million patients.

But, my colleagues, there is still a long way to go. The battle against HIV/AIDS is a marathon. It is not a sprint.

Significantly, working with the House, the legislation rightly focused on providing emergency services in the war against HIV/AIDS. We decided to work on an urgent basis with governments and NGOs in the 15 most ravaged countries. But now we must take a step back. We must make sure these countries can sustain the momentum.

That is why the next version of the law will include provisions to transform the program from "emergency" to "enduring." That will necessitate more funding for the target nations and better integration into existing health programs.

As the committee moves to reauthorize this most important program, we will also carefully examine the effectiveness of our HIV/AIDS prevention efforts. When the committee wrote this law, some of our Republican members insisted that at least one-third of total funding for prevention initiatives be used for abstinence-until-marriage education. Despite our strong reservations, this 33 percent requirement was included in the final draft.

A new report from the prestigious Institute of Medicine, however, says that this provision has impeded the prevention arm from achieving its goals. The report says, "The abstinence-until-marriage budget allocation in the . . . Act hampers these efforts and thus [the program's] ability to meet the targets." The Institute of Medicine states that sexual contact accounts for some 80 to 90 percent of new infections in sub-Saharan Africa, yet education on condoms and proper protection gets precious little funding. It seems that the famed ABC prevention mantra—abstinence, be faithful, use condoms—is distorted toward the very beginning of the alphabet.

The non-partisan Government Accountability Office also reports that the 33-percent clause has challenged the country teams' "abil-

ity to integrate the components of the ABC model and respond to local needs, local epidemiology and distinctive social and cultural patterns.”

Clearly we need to and we shall revisit this 33 percent provision as the law comes up for reauthorization. We should take a hard look at the consequences of this funding scheme and consider its wisdom.

Programs to educate, prevent and treat are essential. But any serious discussion about eliminating HIV and AIDS must include the Holy Grail: The potential for a vaccine. It is imperative that we significantly boost funding to research promising experimental vaccines—not only to protect Americans, but to help millions across the globe. The U.S. ought to step up its efforts to help bring this plague to an end once and for all.

So as we look to the future let me assure the people in these disease-wreaked nations: The United States Congress fully understands that there is no work more important, no mission more imperative, than beating HIV and AIDS.

It is now my pleasure to call on my good friend and distinguished colleague, Ileana Ros-Lehtinen, the ranking member of the committee, to make whatever remarks she chooses to make.

Ms. ROS-LEHTINEN. Thank you so much, Mr. Chairman. I would like to welcome back on behalf of our committee a dedicated staff member from our side, Matt Zweig, who has been serving in the Reserves in Iraq, Eastern Baghdad, for the past year. We welcome him back.

He was not able to be here when his wife gave birth to their beautiful baby boy, Ari, so now he has come back to his beautiful wife and 10-month-old Ari and all of his friends and colleagues, so welcome back. A true hero.

[Applause.]

Ms. ROS-LEHTINEN. Thank you, Matt, and so many others, and I would like to thank the chairman for holding this very timely and important hearing on a very troubling subject. I would also like to thank our distinguished witness for coming to share his perspective on the progress made and the challenges that lay ahead for the President’s Emergency Plan for AIDS Relief.

It was just over a few years ago that the President announced his bold, new initiative to fight HIV and AIDS. Since that time, the United States has provided nearly \$13.5 billion through PEPFAR, and we are well on course for exceeding the \$15 billion that was originally pledged for this endeavor.

Our commitment to eradicating this devastating pandemic through PEPFAR is a testament to the compassion and the generosity of the American people, but the challenges are indeed daunting.

According to the Joint United Nations Program on HIV/AIDS, over 39 million people worldwide are infected with HIV/AIDS, and more than 60 percent live in sub-Saharan Africa, as the chairman as pointed out. In Botswana, one of the hardest hit countries, life expectancy has dropped to an astonishing 34 years.

By the year 2010, an estimated 25 million children will have lost one or both parents to HIV/AIDS, and, according to the most recent

Annual Report on PEPFAR, a child who loses a parent to HIV is three times more likely to die than other children.

HIV/AIDS is not merely a public health concern. It is a development concern as well. This terrible disease is killing an entire generation, and that is typically the most productive in developing countries, meaning people who are between the ages of 15 and 24 years of age. These are the workers, the teachers, the parents, the caregivers, the people who keep our economy growing.

It is estimated that by the year 2020, HIV/AIDS will have caused the GDP to drop by more than 20 percent in the hardest hit countries. But the commitment of Congress and this administration is firm. Through PEPFAR, the American people have helped provide care for 2.4 million people infected by HIV/AIDS, in addition to 2 million orphans and vulnerable children.

We have supported the provisions of the antiretroviral treatment for 822,000 people with an estimated 50,000 more people gaining access to treatment each month, and through care and treatment and their moral imperatives which we must continue to support, or we will never win this battle if we cannot prevent new infections from occurring.

In the year 2006 alone, 4.3 million people became infected. An estimated 12 percent of those new infections occurred among children, 90 percent of whom occurred as a result of mother-to-child transactions. These are not mere statistics. These are children, hundreds of thousands of the youngest children who have become infected simply through the act of being born.

As a mother, I cannot accept this as a foregone conclusion. Funding for PEPFAR for fiscal year 2007 is hundreds of millions of dollars higher than the administration's requested level. This extra funding should be directed in such a manner that it saves the most lives possible.

I am eager to hear from our distinguished witness today how he will use those additional funds, and in particular I am eager to hear how he will direct funding to bolster our mother-to-child transmission programs where it is clear from data much more can be done.

I am also interested in discussing accountability and results. The Institute of Medicine recently released its \$4 million congressionally mandated report, as the chairman said. They were specifically tasked with comparing the success rates of various programs and methods used under the strategy to reduce, prevent and treat HIV/AIDS, tuberculosis and malaria.

As medical experts rather than politicians, it was believed that the Institute will be well suited to provide the type of unbiased, scientifically verifiable data that Congress would need in order to make evidence-based decisions when and if it came time to reauthorize PEPFAR.

Unfortunately, the Institute has asserted that it could not provide this data because the program is not mature enough to truly assess its impact, so I would like to ask our panelist today what variables he believes can be used to begin to assess the effectiveness of the PEPFAR strategy and if he believes that the overall strategy as shaped by the Leadership Act needs to be updated or revised.

The PEPFAR program is a positive example of the good that we can accomplish when we work together to solve the most serious of problems. I look forward to finding out and discussing how we in Congress can continue to work with you on this most important issue, and I thank the gentleman again.

Chairman LANTOS. Thank you very much.

I am delighted to call on my friend and colleague, the chairman of the Africa and Global Health Subcommittee, Mr. Payne of New Jersey.

Mr. PAYNE. Thank you very much, Mr. Chairman. I am pleased that you called this very important hearing to assess the progress of the President's Emergency Plan for HIV and AIDS Relief or PEPFAR as we know it.

It has been 4 years since Congress passed the legislation authorizing the program, and while much has been accomplished since that time still, as we have heard already, much more remains to be done.

We have seen a quantum leap in the attitude of this administration. Initially it was difficult to get the administration to move into the area of HIV and AIDS. As a matter of fact, one high-level administration official said that it would make no sense to make drugs available to Africans because they could not tell time.

I am very happy that we have made a quantum leap from that day, when such stereotypes were so prevalent. We now know, because we have seen a tremendous number of lives saved, that Africans can tell time and know how to take medication when available.

According to the Office of Global AIDS Coordinator, over 800,000 people are receiving antiretroviral medication through PEPFAR in the 15 focus countries. Twelve of these countries are in sub-Saharan Africa. Nearly 50,000 new patients join those receiving the life saving therapy each month.

We indeed have come a long way. However, we still face an uphill battle to treat HIV and AIDS and prevent its spread. There are a host of things we need to do better. We need to expand the number of people on antiretrovirals or ARVs. Only 28 percent of Africans needing ARVs are receiving them. Shockingly, 85 percent of African children who need ARVs are not getting them.

We also need to improve our efforts to stop further spread of HIV, which includes the aggressive application of new approaches to prevention once they are demonstrated to be safe. For example, the Center for Disease Control and Prevention released a document last month that stated that the relative risk of HIV infection in circumcised men was 44 percent lower than men who were not circumcised. It is a prevention method that we should try to promote as we move forward in our prevention.

The U.S. and our international partners must expand activities aimed at informing people of their HIV status. A survey conducted in 12 countries with high levels of HIV infection found that 88 percent of men and 90 percent of women have no idea whether or not they have the virus.

Perhaps the saddest statistic I have read is that a mere 11 percent of HIV-positive women who need drugs to prevent mother-to-child transmission during childbirth are getting them. This is a

tragedy which painfully illustrates the fact that despite all of the valiant efforts that we are doing, the international community must do more.

In conclusion, Mr. Chairman, as we prepare to reauthorize PEPFAR we need to take a serious look at considering how to make it more effective. One of the questions I have is about earmarks, which I will ask questions about later, and whether earmarks should be repealed.

This year, even though we are operating under a continuing resolution, one of the few programs that was increased in the continuing resolution was the PEPFAR program.

As we fight terrorism, I think one way that we can really continue to do it is through this program. Everywhere I go in Africa where the program is in effect the people know about it and they praise the United States of America for what it is doing.

I think it is something that we should continue to push because it is saving lives, and it is giving a different face in our international relations.

Thank you, Mr. Chairman.

Chairman LANTOS. Thank you, Chairman Payne.

Let me just echo what you just said. At a time when one of the most popular sports globally is to criticize the United States, it is important to note that in this and in so many other arenas, we are the world's leader.

I am pleased to call on my good friend and distinguished colleague from New Jersey, the ranking member of the Africa and Global Health Subcommittee, Mr. Smith.

Mr. SMITH OF NEW JERSEY. Thank you very much, Mr. Chairman. Mr. Chairman, thank you for calling this important hearing, which is certainly in anticipation of the reauthorization of the President's Emergency Plan for AIDS Relief.

I concur on the importance of examining the extraordinary successes of this program. I welcome Dr. Dybul, who has done an outstanding job with the program, and I also want to thank and make note that it was Henry Hyde and you who led the effort in getting the original PEPFAR legislation passed. This legislation has done a tremendous job in nullifying some of the terrible aspects of this pandemic.

Mr. Chairman, in my travels abroad, particularly in Africa and in Vietnam, which is also a PEPFAR country, as you know, I have seen for myself how the intervention has transformed lives and infused hope in individuals, families and communities affected by HIV/AIDS.

One experience that struck me in particular was in Uganda when I visited there last year. I had the privilege of meeting Mr. John Robert Ongole, who was 29 years old and the first person to benefit from the first treatment program funded by PEPFAR. I was told that when he first started receiving the antiretroviral therapy he looked like a walking skeleton. When I met him, he was healthy and energetic, leading an active life and caring for his family.

I have recently learned that he has almost completed his Bachelor's degree in teaching. He and countless others have experienced and expressed their profound gratitude to President Bush. I couldn't get over how he and others thanked Bush in particular for

this program and then the American people for giving him a new lease on life in the face of this devastating disease.

Although there are numerous issues that I would like to address, and perhaps during the course of this hearing we will, due to time constraints I would like to focus on the most controversial aspect of PEPFAR here in the Congress, the requirement that one-third of prevention funding be expended on abstinence and fidelity programs known as the A and B aspects of the ABC prevention model.

Some have called for the removal of this requirement in favor of what they call an evidence-based approach, free from legislative constraints that takes into account the particular situation of the individual country.

What these people fail to take into account is that the ABC model is evidence-based, and those countries with generalized epidemics have experienced declines in prevalence, and have emphasized behaviors of abstinence and fidelity in relationships between uninfected partners.

I would point out to my colleagues that in *The Lancet*, the prestigious medical journal in the U.K., 160 scientists worldwide plus the President of Uganda wrote in a piece called *The Time Has Come for Common Ground on Preventing Sexual Transmission of HIV*, and I quote in pertinent part:

“Thus, when targeting young people for those who have not started sexual activity the first priority should be to encourage abstinence or delay of sexual onset, hence emphasizing risk avoidance as the best way to prevent HIV and other sexually transmitted infections, as well as unwanted pregnancies. After sexual debut, returning to abstinence or being mutually faithful with an uninfected partner are the most effective ways of avoiding infection.”

In the past I would point out to my colleagues that there are some experts on the ground who have resisted the ABC strategy and have done so robustly. I think that is unfortunate. I met with a number of AID people in my travels who have said they were skeptics, but over the course of time began to see that the ABC model does indeed work, especially the A and the B.

I hope that Dr. Dybul will shed some light on his experience as leader of this important program, and, Mr. Chairman, I yield back the balance of my time.

Chairman LANTOS. Thank you very much, Mr. Smith.

I will be happy to call on all of my colleagues for a 1-minute opening statement should they choose to do so. Mr. Adam Smith of the state of Washington.

Mr. SMITH OF WASHINGTON. I have no further statement except to associate myself with the remarks of the chairman and my colleagues and to thank all of you for your outstanding work on this issue. Thank you.

Chairman LANTOS. Thank you very much.

The gentleman from Colorado, Mr. Tancredo.

Mr. TANCREDO. I have no statement, Mr. Chairman. Thank you.

Chairman LANTOS. Thank you very much.

Ms. Woolsey of California.

Ms. WOOLSEY. Thank you, Mr. Chairman. I have no statement.

Chairman LANTOS. Mr. Fortenberry.

Mr. FORTENBERRY. Thank you, Mr. Chairman, for holding this important hearing.

Let me just say that I would like to affirm what Congressman Smith, the ranking member of the subcommittee, had to say. It is an important element of this and I think will be an ongoing and essential part of our discussion. Thank you so much for holding the hearing today.

Chairman LANTOS. Thank you.

Mr. Crowley of New York.

Mr. CROWLEY. Mr. Chairman, I have an opening statement. I would just add it to the record, and I would just say that I am also looking forward to the testimony of the Ambassador in particular as it pertains to ABC as well and getting his take on the effectiveness of that program.

Thank you.

[The prepared statement of Mr. Crowley follows:]

PREPARED STATEMENT OF THE HONORABLE JOSEPH CROWLEY, A REPRESENTATIVE IN
CONGRESS FROM THE STATE OF NEW YORK

- Mr. Chairman, Ranking Member Ros-Lehtinen, I'm extremely pleased that today's hearing will focus on the U.S. efforts to fight HIV/AIDS under the PEPFAR program.
- The pandemic of HIV/AIDS affects every country on every continent, and every country must be involved.
- That is why I am proud of the results-orientated nature of the Global AIDS Office, particularly in terms of treatment where we have had great success,
- But
- The results-orientated nature of our approach to Global AIDS begs other questions, larger than just this issue that deals with the need for the building of sustainable capacity in these PEPFAR recipient countries.
- There is a concern that our success in treating HIV is leaving gaping holes in the other aspects of health care in developing countries, including primary care services outside the realm of HIV, I will be asking our witness about this issue during the question portion.
- But let me highlight that there are no doubts that the U.S. leadership around the world in fighting Global AIDS has made enormous achievements.
- In addition to PEPFAR and our financial contributions to the Global Fund, I also want to highlight and commend our witness on the good work his agency is undertaking in providing technical support to the Global Fund grantees so that these programs are administered properly and achieve maximum results.
- The "5% set-aside" is working, and is an integral part of our nation's effort to combat HIV/AIDS throughout the world.
- Finally, before I yield back, I would be remiss if I did not highlight the need for greater prevention and education under PEPFAR.
- The ABC campaign mandates that 1/3 of funding be used to teach abstinence, and unfortunately, these programs have been found to be ineffective in preventing the spread of HIV and a waste of American taxpayer dollars.
- I know it was Congress that hoisted this mandate on you, and I will be working with this Committee to bring about more successful and effective prevention programs, including how we administer PEPFAR dollars now, and I will also be asking about ways we could better administer prevention programs to follow up on our successes in treatment.
- I look forward to hearing from our witness today how we can accelerate our efforts and what else has to be done to stop this devastating disease.
- And I thank the Chairman for conducting this important hearing today.

Chairman LANTOS. Thank you.

My friend and colleague from Puerto Rico, Mr. Fortuño.

Mr. FORTUÑO. Thank you, Mr. Chairman, and thank you for holding this hearing today, and thank you, the ranking member from the beautiful state of Florida as well.

I just want to take a minute to pay attention or bring attention to H.R. 848, which is a bill I introduced in this Congress essentially to add a number of island states in the Caribbean region to the number of states that are listed.

As you know, at this present moment we only have Haiti and Guyana covered by this program today, and under H.R. 848 we would certainly be able to cover many of the nation states right here in our backyard in the Caribbean region.

I urge our committee to seriously consider the addition of these nation states when we consider the bill in general terms.

Thank you again.

Chairman LANTOS. Thank you very much.

The gentleman from Georgia, Mr. Scott.

Mr. SCOTT. Mr. Chairman, I have no statement, but I would like to commend you for having this extraordinarily important and timely hearing.

Chairman LANTOS. Thank you very much.

The gentleman from New Jersey, Mr. Sires.

Mr. SIRES. Mr. Chairman, I don't have any comments, but I do want to commend you on having this hearing. This is a very important hearing, and I am looking forward to listening to the Ambassador's comments.

Thank you.

Chairman LANTOS. Thank you very much.

We have the extraordinary pleasure and honor today of hearing from the U.S. Global AIDS Coordinator, Dr. Mark Dybul.

Let me mention parenthetically that later this week he will come out to my congressional district for a major conference on this subject, and we are very much looking forward to having you out in California.

Dr. Mark Dybul has an extensive and most impressive background in HIV and AIDS policy. He served as acting U.S. Global AIDS Coordinator in 2005 and 2006 and held the deputy and assistant positions in that very important assignment earlier. He also led the President's International Prevention of Mother and Child HIV Initiative, and helped plan the program we discussed today.

He has served as the Assistant Director for Medical Affairs at the National Institute of Allergy and Infectious Diseases. As a physician, he helped author the HIV therapy guidelines for both HHS and for the World Health Organization, and he remains as an outstanding leader in the forefront of clinical and basic HIV research.

Dr. Dybul, we look forward to your testimony and to discussing the program you have shepherded into maturity. Please proceed any way you choose.

**STATEMENT OF THE HONORABLE MARK R. DYBUL, U.S.
GLOBAL AIDS COORDINATOR, U.S. DEPARTMENT OF STATE**

Ambassador DYBUL. Thank you, Mr. Chairman, Madam Ranking Member Ros-Lehtinen, members of the committee. Thank you for this opportunity to testify, and thank you for this committee's long-standing bipartisan support of our nation's fight against HIV/AIDS,

which has been an essential component of the success we have had to date.

When the history of global health is written, the launch of the President's Emergency Plan will be remembered as one of the most important events ever. PEPFAR is, however, part of a broader agenda. Not since the Marshall Plan has the world seen such a commitment to development. President Bush, again with strong bipartisan support, has doubled resources for development overall and with his 2008 budget request will have quadrupled them for Africa.

In contrast to the rebuilding of Europe with the Marshall Plan, however, the American people are building life, liberty and opportunity where they have not existed in modern times.

HIV/AIDS is unique. It strikes people in the prime of their life, unlike many other diseases. Since the 1990s, the largest increase in HIV mortality has been among adults age 20 to 49, and communities, as you point out, Mr. Chairman, are losing a whole generation in the prime of their productive and reproductive years.

Parents are dying from HIV/AIDS. In sub-Saharan Africa, the diseases have left more than 11 million orphans, and by 2020 there will be over 15 million. Educators are dying from HIV/AIDS. In Zambia, the equivalent of two-thirds of all newly trained teachers is being lost to HIV/AIDS.

Children who lose parents to HIV/AIDS drop out of school, losing the potential for economic empowerment. They often resort to transactional sex or prostitution to survive and risk becoming infected with HIV themselves.

The pandemic affects business. As you point out, Madam Ranking Member, more than 20 percent of GDP has been lost in the hardest hit countries. The World Bank recently warned that while the global economy is expected to more than double over the next 25 years, Africa is one of the few regions at risk of being left behind.

HIV/AIDS has serious public health implications. An ever-expanding pool of immune suppressed people worldwide can more readily contract disease, including diseases we cannot yet predict. Today we have extremely drug-resistant tuberculosis. Tomorrow it could be avian influenza or something even worse.

In addition, HIV/AIDS poses a threat to national and international security, as Mr. Payne pointed out. It is limiting nations' abilities to protect their own citizens and to provide peacekeepers for conflicts, fueling national and regional instability.

Seventy percent of all military deaths in South Africa are due to HIV/AIDS. By destroying the social fabric caused and leading a generation of orphans, HIV/AIDS is creating a long-term breeding ground for radicalism. General Wald, the former Deputy Commander of the European Command, has called HIV/AIDS the third greatest security risk to our national security behind only weapons of mass destruction and terrorism.

The surest long-term strategy for addressing transnational threats is to promote health, stability and economic well-being, and confronting HIV/AIDS is at the heart of this strategy.

The focus of PEPFAR is HIV/AIDS prevention, treatment and care, and we are on track to meet the President's ambitious goals

in this area. My written testimony reflects the success of PEPFAR to date, and many of you have mentioned it, yet the impact of our programs is not limited to HIV/AIDS.

PEPFAR programs are increasingly linked to important Presidential initiatives in other areas of health and development, and together they represent a renaissance in development. This renaissance rejects the failed donor-recipient approach in favor of an ethic of true partnership. Just a few years ago, the success achieved to date would have been unthinkable, but it is clear now that the power of partnership is transformational, as Secretary Rice would say.

Individuals, communities and nations are taking control of their lives and are beginning to turn the tide against the pandemic. As the Institute of Medicine committee report recently noted, PEPFAR has “demonstrated what many doubted could be done.”

According to the World Health Organization’s most recent report on treatment coverage in the development world, treatment has increased by 54 percent in just 3 years to 2.1 million people. In sub-Saharan Africa, the number of people on treatment has grown from 50,000 people at the beginning of 2003, when President Bush first announced PEPFAR, to 1.3 million at the end of 2006. Mr. Chairman, that is a 26-fold increase in just 4 years.

In order to deepen our understanding of the impact, we have worked with WHO and others to develop a way to estimate years of life added by treatment, so we are not just estimating the number of people receiving treatment.

[Slide.]

Ambassador DYBUL. As this poster shows, our initial estimates predict that our goal of 2 million people on treatment will save an estimated 3.5 million life years through just 2009. That is a remarkable achievement, keeping children from being orphaned, keeping teachers alive, and keeping our social structures intact.

There is no doubt that the support of the American people has been the catalyst for this. The part that is sometimes missed is the broader impact of successful HIV/AIDS interventions because teachers live, workers live and peacekeepers live, and every parent kept alive prevents new orphans.

We have also begun to work with international partners to develop models that quantify the impact of treatment and prevention in preventing orphans created. Our preliminary estimate, which is being worked out with our international partners, is that PEPFAR support for treatment has already averted approximately 230,000 orphans.

Through 2008, as we scale up to 2 million in treatment, we estimate that figure will grow to more than 850,000. As we meet our goal of 7 million infections averted for the first phase of PEPFAR, our preliminary estimate is that support for prevention will save up to 13.5 million children from being orphaned.

A recent study revealed that children who lose a parent to HIV face a three times higher risk of death compared to other children, even if that child is not infected with HIV/AIDS.

As this poster indicates, the flip side of that is when we reach an HIV-positive parent with treatment and care, we keep them alive and healthy, we keep the children from becoming orphans,

and we cut the risk to the child from dying by two-thirds. Truly, preventing orphans is the best way to ensure child survival and health.

From its inception, this effort has focused on meeting the emergency of today while building the capacity for sustainable response for tomorrow. At least one-quarter of PEPFAR's total resources are devoted to capacity building in the public and private health sectors. Health care workforce shortages are a severe problem in the developing world.

To date, PEPFAR has supported the training or retraining of 1.7 million workers. We are working with the World Health Organization on task shifting to expand the available workforce through the use of community health workers and other health professionals, and in 2008 we will triple our allocation for preservice training of health professionals.

In addition, PEPFAR works closely with indigenous, faith and community-based organizations. Eighty-three percent of our partners are local organizations, and when they expand their capacity in order to meet our fiduciary accountability requirements they are in a better position to succeed in the future.

PEPFAR's capacity-building initiatives have positive spillover effects. When a country upgrades its health systems and strengthens the health workforce, it improves overall health care delivery.

As this poster points out, there are recent findings from a study conducted at 30 primary health centers in Rwanda. Twenty-one of 22 basic measures of health service indicators—not HIV indicators, but health service indicators—showed improvement after they began to offer a full package of basic HIV care.

In fact, as we see, we increased family planning. We increased overall health and antenatal sites. We increased syphilis testing. So just by increasing HIV/AIDS programming and by increasing the health capacity, you actually have an impact on overall health, not just HIV/AIDS programs. As the IOM committee chairman, Dr. Jaime Sepulveda, said, "Overall, PEPFAR is contributing to make health systems stronger, not weakening them."

PEPFAR is a dynamic program that is continually being expanded, evaluated and reshaped in real time. The IOM noted, and I quote:

"PEPFAR is a successful learning organization. With each year, PEPFAR is expanding its knowledge base of best practices and lessons learned, sharing them globally and having an impact far beyond PEPFAR programs. We recognize HIV does not exist in a vacuum. It is inextricably linked to other health threats and development, and therefore we are connecting the dots of development."

Today the Emergency Plan is on track to exceed its original commitment of \$15 billion over 5 years, approximating \$18.3 billion with the President's request, and that has been because of the strong bipartisan support of Members of Congress in this committee and others.

As the IOM report observed, PEPFAR and its partners have demonstrated that successful programs can be implemented, even

in the most challenging settings, yet the HIV/AIDS pandemic remains an emergency and so many challenges still lie ahead.

We are on a long journey. The American people must continue to stand with our global sisters and brothers, and with the strong support of the President and Congress we will do so.

Mr. Chairman, Members, thank you very much, and I look forward to your questions.

[The prepared statement of Ambassador Dybul follows:]

PREPARED STATEMENT OF THE HONORABLE MARK R. DYBUL, U.S. GLOBAL AIDS
COORDINATOR, U.S. DEPARTMENT OF STATE

Mr. Chairman, Ranking Member Ros-Lehtinen, and Members of the Committee: Thank you for this opportunity to discuss President Bush's Emergency Plan for AIDS Relief, or PEPFAR. We are grateful for this committee's longstanding, bipartisan support of our nation's commitment to fight HIV/AIDS in the developing world.

When the history of global public health is written, the launch of the President's Emergency Plan—both its size as the largest international health initiative in history dedicated to a single disease and its focus on results with ambitious goals for prevention, treatment and care—will be remembered as one of the boldest and most important actions—ever.

But PEPFAR is part of a broad and bold development agenda. Not since the Marshall Plan has the world seen such a massive commitment to international development. President Bush, with strong bipartisan support, has doubled resources for development overall and with his 2008 budget request, will have quadrupled them for Africa. And that does not include massive debt relief and a doubling of trade with Africa—fueling economic development, the ultimate engine for people to lift themselves out of poverty and despair.

In many ways, this new era is more ambitious than the Marshall Plan. Unlike the rebuilding of Europe, the American people are building life, liberty and opportunity where they have never existed in modern times.

Economic Impact of HIV/AIDS

The HIV/AIDS pandemic is unique in human history—not just because it is so widespread and debilitating, but because it strikes at the very heart of the population. Unlike other epidemics, HIV does not attack the oldest, or the youngest, or the weakest—it strikes people in the prime of life. This pattern has worsened in recent years. Since the 1990s, the single largest increase in HIV/AIDS mortality has been among adults aged 20 to 49. In Sub-Saharan Africa, this age group accounted for only 20 percent of all AIDS deaths from 1985 to 1990, but today it accounts for nearly 60 percent.

Communities are being hobbled by the disability and loss of the very segment of the population which is normally the backbone of any society—consumers and workers at the peak of their productive, reproductive, and care giving years. In the most heavily affected areas, communities are losing a whole generation of parents, teachers, laborers, healthcare workers, peacekeepers, and police.

Parents are dying from HIV/AIDS. Around the world, 14 million children under age 15 have lost one or both parents to HIV/AIDS. By 2010, that number is expected to exceed 25 million. In sub-Saharan Africa, the disease has left more than 11 million orphans, and by 2020 there will be 15.7 million.

Educators are dying from HIV/AIDS. Africa is seeing especially high HIV-related mortality rates among teachers and school administrators; in Zambia, the equivalent of two-thirds of all newly trained teachers are being lost to HIV/AIDS.

In HIV-affected households, the family's earned income drops while health costs rise. Extended families and communities are faced with the financial burden of caring for an increasing number of children who have been orphaned by AIDS.

Many children who have lost parents to HIV/AIDS are left entirely on their own. When they drop out of school to fend for themselves and their siblings they lose the potential for economic empowerment that an education can provide. Alone and desperate, they often resort to transactional sex or prostitution just to survive, and risk becoming infected with HIV themselves.

The pandemic also affects the business sector—budgets are being strained by rising health care costs, increased absenteeism, a shrinking workforce, lost expertise, high turnover, and reduced productivity. In 2005 alone, more than three million

workers worldwide were partially or fully unable to work because of HIV-related illness.

The ramifications for national economies are alarming. Between 1992 and 2004, HIV/AIDS caused 43 of the most heavily affected countries to lose 0.3 percent per year in employment growth and 0.5 percent in their annual rate of economic growth.

UNAIDS projects that, by 2020, HIV/AIDS will have caused GDP to drop by more than 20 percent in the hardest-hit countries. The World Bank recently warned that, while the global economy is expected to more than double over the next 25 years, Africa is one of the few regions at risk of being “left behind.”

Public Health Implications of HIV/AIDS

HIV/AIDS has serious public health implications. An ever-expanding pool of immune-suppressed people worldwide can more readily contract and spread disease, including infectious diseases we cannot yet predict.

Take for example the recent rise in Extensively Drug Resistant Tuberculosis (XDR-TB) among HIV-infected people. To date, there has been a significant spread of XDR-TB in sub-Saharan Africa. This should be of great concern to all of us, because XDR-TB is literally untreatable and almost always fatal. In one highly publicized outbreak in South Africa, 52 out of 53 XDR-TB patients in the original report died. Of these, 44 patients had been tested for HIV, and all were positive. In this era of globalization, infectious diseases have no boundaries. Today it is XDR-TB—tomorrow it may be avian flu, or something even worse.

Security Implications of HIV/AIDS

HIV/AIDS is a threat to national and international security. It is limiting nations’ abilities to protect their own citizens and to provide peacekeepers for other conflicts, fueling national and regional instability, because it is taking a high toll on militaries: HIV-related deaths have reduced the size of Malawi’s armed forces by 40 percent. Seventy percent of all military deaths in South Africa are due to HIV/AIDS. In Uganda, more soldiers have died from AIDS than from the nation’s 20-year insurgency.

By destroying the social fabric caused and leaving a generation of orphans HIV/AIDS is creating a long term breeding ground for radicalism. General Wald, the former Deputy Commander, Headquarters U.S. European Command, has called HIV/AIDS the third greatest threat to our national security, behind only weapons of mass destruction and terrorism.

PEPFAR and the Transformational Development Agenda

The surest long-term strategy for addressing transnational threats is to promote the health, stability, and economic well-being of developing nations, and confronting HIV/AIDS is at the heart of this strategy.

The focus of PEPFAR is on prevention, treatment, and care of people living with HIV/AIDS, and I am pleased to report that we are on track to meet the President’s ambitious goals in these areas. Yet the impact of our program is not—and need not be—limited to HIV/AIDS. PEPFAR’s programs are increasingly linked to other important Presidential initiatives in other areas of health and development—the Millennium Challenge Corporation, the President’s Malaria Initiative, the African Education Initiative, the Women’s Justice and Empowerment Initiative and others. Together, they represent a renaissance in development.

Fundamentally, this new philosophy rejects the failed “donor-recipient” approach developed during the Cold War and returns to the vision of the Marshall Plan. It is a philosophy rooted in a hand-shake rather than a hand-out. It is rooted in the power of partnership between people.

Just a few years ago, the success that PEPFAR’s partnerships have achieved would have been unthinkable. It is now clear that this hope and faith was justified—that the power of partnership is “transformational,” as Secretary Rice would say.

Individuals, communities and nations are taking control of their lives and are beginning to turn the tide against the HIV/AIDS pandemic. This new model of partnership is already producing encouraging results and is, as an Institute of Medicine (IOM) committee recently noted in its review of the first two years of PEPFAR, “off to a very good start” and has “demonstrated what many doubted could be done.”

Broader Impacts of HIV/AIDS Interventions

According to the World Health Organization’s most recent report, treatment coverage in the developing world has increased by 54% in just three years, to 2.1 million people. The most dramatic expansion of treatment scale-up has been in sub-Saharan Africa, where the number of people on treatment has grown from 50,000 at the beginning of 2003, when President Bush first announced PEPFAR, to 1.3 million

at the end of 2006. Mr. Chairman that is a *twenty-six-fold increase* in just four years.

There is no doubt that the support of the American people has been the catalyst for this transformation. The part that is sometimes missed is the broader impact of successful HIV/AIDS interventions. People who survive contribute to their society as teachers, workers, and peacekeepers. And one of the most important impacts is that every parent kept alive prevents new orphans.

We have begun work with international partners to develop models that quantify the impact of treatment and prevention in preventing orphaning of children. These are preliminary estimates at this point as we refine the methodology, but there is no doubt that the impact is very great. We estimate that PEPFAR support for treatment has averted the orphaning of 229,000 children to date, and through 2008 as we scale up to our treatment goal of 2 million, we estimate that that figure will grow to roughly 874,000.

Just as treatment of parents can prevent their children from being orphaned, so too can effective prevention. If we meet our goal of 7 million infections averted for this first phase of PEPFAR, our preliminary estimate is that up to 13.5 million children will be saved from orphaning or heightened vulnerability.

Strikingly, a recent study revealed that children who lose a parent to HIV face a three times higher risk of death than other children—and that's true even if the child is not HIV-infected. Truly, preventing orphan hood is the best way to ensure child survival and health—just another remarkable consequence of the rapid growth of effective HIV/AIDS programs.

For children who do become orphaned or vulnerable due to HIV/AIDS, PEPFAR includes services traditionally associated with the Child Survival and Health program. Such services include tuberculosis (TB) and malaria screening; provision of antibiotics; education; and provision of food, nutrition, shelter, protection, and psychosocial support.

Health Workforce and Systems

From its inception, the President's Emergency Plan has been focused on meeting the emergency of today while building capacity for a sustainable response for tomorrow. When we build capacity for HIV/AIDS services, we build the overall health systems of nations for the long term.

At least one quarter of PEPFAR's total resources are devoted to capacity-building in the public and private health sectors—supporting physical infrastructure, health care systems, and workforce development. With support from our Supply Chain Management System (SCMS), focus countries are putting in place transparent and accountable delivery systems that ensure an uninterrupted supply of high-quality and low-cost drugs, lab equipment, testing kits, and other essential medical materials.

As the IOM committee noted, health workforce shortages are a severe problem in the developing world—one we take very seriously. To date, PEPFAR has supported the training or retraining of 1.7 million workers. We are working with the World Health Organization (WHO) on task-shifting, to expand the available workforce through the use of community health workers and other health professionals. Also, in 2008 we will triple our allocation for pre-service training of doctors, nurses and other health professionals.

In addition, PEPFAR works closely with indigenous faith- and community-based organizations—supporting their efforts to grow their capacity to lead their nations' response to HIV/AIDS. Eighty-three percent of our partners are local organizations, and the successes are primarily theirs, not ours. When such organizations expand their capacity in order to meet USG fiduciary accountability requirements, they are in a better position to support them in the future.

PEPFAR's capacity-building initiatives have positive spillover effects: Whenever a country upgrades its health systems and strengthens the health workforce it improves overall healthcare delivery. In a recent study conducted at 30 primary health centers in Rwanda, 21 of 22 measured basic (i.e., non-HIV/AIDS) health service indicators showed improvement after 6 months of offering a full package of basic HIV care. Of the 21 indicators, 17 showed a statistically significant improvement.

As IOM committee Chairman Dr. Jaime Sepulveda said, "[O]f viral, PEPFAR is contributing to make health systems stronger, not weakening them."¹

In addition to strengthening health systems, building infrastructure, expanding health services, increasing capacity and stimulating economic growth, such improve-

¹ From March 30, 2007 IOM Report Press Briefing—Online via National Academies of Science Web cast Archives (Audio location: 57:41) : www.nap.edu/webcast/webcast—detail.php?webcast—id=337

ments enable developing countries to cultivate good governance and build freer and more stable societies.

PEPFAR is a dynamic program that is continually being expanded, evaluated, and reshaped in real time. As the IOM Committee noted, "Beginning with its strategy, PEPFAR has been committed to learning, and the program has displayed many of the characteristics of a successful learning organization." With each year, PEPFAR is expanding its knowledge base of best practices and lessons learned, sharing them globally and having an impact far beyond PEPFAR programs. In fact, long before the IOM committee report was released, we had already taken action to address the issues identified in the report—and we will continue to draw on its input to further strengthen the program.

Now let me offer a brief overview of PEPFAR's progress toward supporting treatment for 2 million HIV-infected people, prevention of 7 million new infections, and care for 10 million people infected with or affected by HIV/AIDS, including orphans and vulnerable children.

Treatment

Through the end of fiscal year 2006, PEPFAR partnered with host nations to support antiretroviral treatment for 822,000 people in the 15 focus nations. By September 2006 in PEPFAR's focus countries, approximately 50,000 more people were being put on life-saving treatment every month. The number of PEPFAR-supported treatment sites increased by 139 percent over 2005, with 93 new sites coming on line each month. Of those for whom PEPFAR provided site-specific treatment support, almost nine percent were children, and approximately 61 percent were women. We also supported training or retraining of approximately 52,000 people in the provision of antiretroviral treatment.

In order to deepen our understanding of the impact of treatment, we have worked with the WHO and other international partners to develop a methodology for estimating years of life added by treatment. We estimate that over 3.4 million life-years will be added by PEPFAR support for treatment as we reach our goal of 2 million people on treatment—and that's just through Fiscal Year 2009. If we were to look beyond that timeframe, of course, the numbers would be far higher.

PEPFAR also has increased the availability of safe, effective, low-cost generic antiretroviral drugs (ARVs) in the developing world. 43 generic ARV formulations have been approved or tentatively approved by the U.S. Department of Health and Human Services/Food and Drug Administration (HHS/FDA) under the expedited review process established in 2004, including eight fixed-dose combination formulations. Three of these are triple-drug combination tablets and ten are double combinations, of which five are co-packaged with a third drug. In addition, eight oral solutions or suspensions appropriate for pediatric use have been approved. In 2006, there was a significant increase in the use of generic products, and in 2007 we will continue to work with partners to utilize the safest, cheapest drugs wherever possible. As a side benefit, the process has also expedited the availability in the United States of six generic versions of ARVs whose U.S. patent protection has expired.

PEPFAR has also achieved significant progress in reducing the cost of ARVs through its Supply Chain Management System, or SCMS. We have determined that SCMS secured better purchase prices on 72 percent of first-line ARVs and 40 percent of second-line ARVs compared with other selected benchmark pricing sources and buyers. SCMS has achieved savings by purchasing generic medicines whenever possible, pooling procurement (such as consolidating multiple orders to buy in larger volumes), and establishing long-term, indefinite quantity contracts (IQCs) with manufacturers, thereby leveraging lower prices through bulk purchases. SCMS has signed IQCs with two producers of the same generic ARV, thereby bringing down prices through competition between the two and ensuring a reliable supply by having more than one supplier. During IQC negotiations, the price of the drug was reduced by 7 percent with one supplier and by 23 percent with the other. SCMS's purchase of Didanosine 200 mg and Efavirenz 200mg, two generic drugs recently approved by HHS/FDA, resulted in cost savings of more than \$46,000 (53 percent) and \$116,000 (52 percent) respectively, compared with the Accelerated Access Initiative (AAI) Unit Price. From January to March 2007, SCMS saved more than \$30 million (70 percent). SCMS has increased its share of ARV purchases that are generics from 72 percent in April to September 2006 to 88 percent (by volume) in January to March 2007.

Prevention

Turning to prevention, according to UNAIDS, there were approximately 4.3 million new HIV infections in 2006. There can be no doubt that prevention is the most imperative mission in the global fight against HIV/AIDS. When we prevent an infec-

tion, we keep one person alive and healthy, but we do so much more. We keep that person's spouse from being infected, and his or her children from being orphaned. We keep that person's community intact, and keep a worker in the workforce. Finally, we keep scarce resources from having to be directed to that person's treatment and care. If the number of people newly infected continues to increase, the growing number of people in need of treatment and care will overwhelm the world's ability to respond and to sustain its response.

In recent years, in a growing number of nations, we have seen clear evidence of declining HIV prevalence as a result of changes in sexual behavior. In addition to earlier dramatic declines in HIV infection in Uganda, there is growing evidence of similar trends in other nations, including Botswana, Ethiopia, Haiti, Kenya, Tanzania, Zambia, and Zimbabwe. While the causes for decline of HIV prevalence are undoubtedly complex, these countries have demonstrated broad reductions in sexual risk behavior, suggesting that behavior change can play a key role in reversing the course of HIV/AIDS epidemics.

PEPFAR supports the most comprehensive, evidence-based prevention program in the world, targeting interventions based on the epidemiology of HIV infection in each country. We support prevention activities that focus on sexual transmission, mother-to-child transmission, the transmission of HIV through unsafe blood and medical injections, and greater HIV awareness through counseling and testing.

Long before PEPFAR was initiated, many nations with generalized epidemics had already developed their own national HIV prevention strategies that included the "ABC" approach to behavior change (Abstain, Be faithful, correct and consistent use of Condoms where appropriate). The new data—from time periods that pre-date PEPFAR scale-up—link adoption of all three of the ABC behaviors to reductions in prevalence.

Learning from this evidence, PEPFAR will continue to support all three elements of the evidence-based ABC strategy in ways that are appropriate to the epidemiology and national strategy of each host nation. In focus countries during fiscal year 2006, approximately 61.5 million people were reached by community outreach programs promoting ABC and other related prevention strategies.

The vast majority of focus countries have generalized epidemics, meaning that HIV infection is not concentrated in specific and identifiable groups, but touches the general population. However, PEPFAR also operates in countries with concentrated epidemics where, for example, 90 percent of infections are among persons who participate in prostitution. Hence, the epidemiology in these nations dictates a response more heavily focused on B and C interventions.

The U.S. Government has supplied 1.3 billion condoms from 2004 to 2006, lending support to comprehensive ABC approaches based on the epidemiology of each country. As UNAIDS Executive Director Dr. Peter Piot recently observed, the U.S. is by far the biggest supplier of condoms to the developing world, providing more than all other sources combined.

Prevention of mother-to-child transmission (PMTCT) is a key element of our host nations' prevention strategies, and PEPFAR is supporting their efforts. UNAIDS estimates that in 2006, 12 percent of all new HIV infections occurred among children, and more than 90 percent of these were due to mother-to-child transmission. Since PEPFAR's inception, we have supported PMTCT services for women during more than 6 million pregnancies. Through Fiscal Year 2006, there are 4,863 PEPFAR-supported PMTCT service outlets in the focus countries, and PEPFAR has supported ARV prophylaxis for HIV-positive women during 533,700 pregnancies. This has saved an estimated 101,500 infants from HIV infection.

In addition, by promoting the routine, voluntary offer of HIV testing to women who visit antenatal clinics, host nations have increased the rate of uptake among pregnant women from low levels to around 90 percent at many sites.

There are 3,846 PEPFAR-supported blood safety service outlets, and we have supported training or retraining of 6,600 people in blood safety and 52,100 in medical injection safety.

Last month, in light of compelling evidence that medical male circumcision reduces the risk of heterosexually acquired HIV infection in men by approximately 60 percent, the WHO and UNAIDS recommended that circumcision be included as part of a comprehensive HIV prevention package. Male circumcision does not provide complete protection against HIV infection, and additional research still needs to be conducted, but since WHO and UNAIDS have endorsed and provided normative guidance for it, if any host nations would like to add safe medical male circumcision to their prevention programs, PEPFAR will support their efforts.

In regard to circumcision and any other new prevention methods and technologies—such as an HIV vaccine or topical microbicide—PEPFAR will incorporate

these new approaches, as the evidence is accumulated and normative guidance is provided.

Care

Through Fiscal Year 2006, PEPFAR supported care for nearly 4.5 million people, including two million orphans and vulnerable children (OVCs). PEPFAR has scaled up HIV/AIDS programs for OVCs on a larger scale than had ever been attempted. In fiscal year 2006, PEPFAR also began requiring OVC programs to report on how many of six key services they provide—food/nutrition; shelter and care; protection; health care; psychosocial support; and education.

To date, we have counted both OVC care programs and pediatric AIDS treatment programs toward the Congressional directive that 10 percent of program funds be devoted to programs for OVCs. Beginning in Fiscal Year 2008, we plan to meet the directive with care programs alone, reflecting our deepening knowledge base of best practices for OVC care.

As noted, PEPFAR now covers many services that were traditionally part of Child Survival and Health programs. In Fiscal Year 2003, just prior to PEPFAR, USAID provided \$34.3 million for services for orphans and vulnerable children; \$26.8 million of this came from the Child Survival and Health fund. In Fiscal Year 2006, PEPFAR provided approximately \$213 million to support focus country programs that are providing care for two million orphans and vulnerable children.

PEPFAR also has increased support for national efforts to provide high-quality care for opportunistic infections related to HIV/AIDS, especially TB. I will discuss this in more detail momentarily.

We also have developed ‘preventive care packages’ for HIV-infected children and adults, to help keep them healthy and delay the need for treatment. Care packages can be adapted to local circumstances, and we are working to disseminate them broadly.

Knowing one’s HIV status provides a gateway for critical prevention, treatment, and care. To date, PEPFAR has supported more than 18 million counseling and testing encounters—close to a third of these were with women seeking PMTCT services.

To increase the number of people being tested for HIV, PEPFAR is working with host nations to implement routine, provider-initiated “opt-out” HIV testing, in selected health care settings. We also are supported the use of rapid HIV tests to improve the likelihood that those who are tested will actually receive their results.

In 2006, PEPFAR also supported training or retraining of approximately 143,000 individuals in providing care for orphans and vulnerable children; nearly 94,000 in providing care for people living with HIV/AIDS; and more than 66,000 in providing counseling and testing services.

PEPFAR as a Foundation to “Connect the Dots” of Development

PEPFAR’s prevention, treatment and care results, as important as they are, are only part of the story. At this point, I would like to highlight some specific areas in which PEPFAR is “connecting the dots” of development, leveraging HIV/AIDS investments to achieve a broader, transformational impact.

Fighting Tuberculosis

Since TB is the number one killer of HIV-infected people, it has always been an integral part of PEPFAR and will continue to be an area of increasingly high priority. Before PEPFAR, total U.S. support for bilateral TB and TB/HIV initiatives was approximately \$79 million. In fiscal year 2006, PEPFAR’s support for TB/HIV initiatives increased by 104 percent over 2005, supporting care for 301,600 co-infected people in the focus countries. In fiscal year 2007, we anticipate at least \$120 million for TB/HIV in the focus countries—combined with approximately \$91 million for bilateral TB programs, which is nearly three times the funding for TB just four years ago.

There is growing concern about the advent of drug-resistant strains of TB among people who are HIV-positive. We are working closely with the U.S. Federal TB Task Force to develop a concerted U.S. Government response to TB. We are working with international partners such as the Global Fund and WHO, to strengthen laboratory systems, establish infection-control measures, and expand programs to prevent, diagnose, and manage drug-resistant TB in people living with HIV/AIDS.

Fighting Malaria

PEPFAR continues to partner with the President’s Malaria Initiative (PMI) in countries that are targeted by both programs. In 2008, as PMI expands, 15 countries (7 PEPFAR focus countries and 8 other bilateral) will be jointly sponsored by the two Presidential initiatives. The collaboration of PEPFAR and PMI has already enabled countries to provide comprehensive services for some of the most vulnerable

groups for both diseases, including pregnant women, people living with HIV/AIDS, and orphans and vulnerable children under age five.

Some of the key areas currently being supported through PEPFAR/PMI collaboration include:

- Provision of intermittent presumptive therapy for pregnant women and long lasting insecticide treated nets (ITNs) to pregnant mothers and children under age five as comprehensive components of PMTCT initiatives, OVC care, and palliative care;
- Collaboration in blood safety to ensure a malaria-free pool of voluntary blood donors and to reduce the need for transfusion due to malaria-related anemia;
- Joint funding of surveillance activities; and
- Joint training activities to enhance lab capacity and provision of quality laboratory services.

Finally, through this collaboration, PMI has the opportunity to build on the foundation of community-based structures and programs developed under PEPFAR. For example, in Uganda, PMI plans to deliver ITNs to 1,500 HIV-positive mothers identified through established HIV/AIDS support groups of a PEPFAR-funded partner. In Tanzania, PMI and PEPFAR will collaborate to provide a comprehensive package of palliative care services that includes the provision of ITNs for clients enrolled in HIV home-based care programs. Finally, PMI can build on the work of PEPFAR to strengthen national systems, guidelines, and programs.

Supporting Nutrition

Although addressing the broad issue of food insecurity is beyond the scope of PEPFAR, we do support limited food assistance for specific, highly vulnerable populations. In a pilot program in Kenya, we are supporting a local food manufacturing company in distributing nutrient-dense foods to orphans and vulnerable children; clinically malnourished people living with HIV/AIDS; and HIV-positive pregnant and lactating women in PMTCT programs.

For the most part, however—in order to remain focused on HIV/AIDS—PEPFAR maximizes leverage with other partners that provide food resources. In collaboration with interagency partners, we are engaging on food and nutrition issues with six focus countries in a pilot program. For example, PEPFAR Ethiopia contributes to the World Food Program (WFP), and Food for Peace supports some HIV/AIDS programs. In fiscal year 2006, PEPFAR Ethiopia and the WFP collaborated to provide food resources to more than 20,000 beneficiaries, including orphans and vulnerable children, adult patients on treatment, and care givers. In Haiti, PEPFAR and Food for Peace have begun to develop a conceptual framework to guide their Food and Nutrition Strategy.

Key partners in our Food and Nutrition Strategy include, among others, the USDA's Foreign Agriculture Service, USAID's Food for Peace office, and the World Food Program—a key international partner. In Fiscal Year 2006, PEPFAR allocated \$2.45 million to World Food Program initiatives, and that will increase to \$4.27 million in fiscal year 2007.

Supporting Clean Water

In September 2006, First Lady Laura Bush announced a groundbreaking public-private partnership called the PlayPump Alliance. This \$60 million alliance between PlayPumps International, the Case Foundation, USAID, PEPFAR, and other private sector partners will bring the benefits of clean drinking water to up to 10 million people in sub-Saharan Africa by 2010. The goal is for every USG tax dollar to be matched by five dollars from the private sector. This partnership will improve access to clean drinking water by installing PlayPump water systems throughout the region. The USG, through USAID and the Emergency Plan, will provide a combined \$10 million to the alliance over three years. This investment will directly support the provision and installation of PlayPump water systems in approximately 650 schools, health centers, and HIV-affected communities. In addition, HIV/AIDS messages on PlayPump billboards will spread the word about healthy behaviors.

Supporting Education

Although education *per se* is beyond the scope of PEPFAR's mission, we do support OVC attendance programs which include providing school fees, books and uniforms, as well as HIV prevention and life skills programs. We also leverage our comprehensive OVC care program, to "wrap around" other programs that provide educational access to children who are infected with and affected by HIV/AIDS.

A key example is PEPFAR's coordination with the President's African Education Initiative (AEI), implemented through USAID. Over the next four years, the U.S.

will provide \$400 million for the AEI to train half a million teachers and provide scholarships for 300,000 young people throughout Africa, predominantly girls. This is especially important, since studies show that girls who drop out of school are at significantly higher risk of becoming infected with HIV/AIDS.

Addressing Gender Inequities

Around the world, girls and women are contracting HIV at an alarming rate. The reasons are complex, but they are invariably tied to pervasive, powerful, and often brutal gender inequities. In many of the most heavily affected countries, women and girls are simply powerless to protect themselves against contracting HIV/AIDS.

Because of this, PEPFAR places a priority on gender. Our program is the only major international initiative to require data reporting by gender. We do so to track whether girls and women are receiving the services they need, and we know that girls comprise 51% of the more than 2 million orphans and vulnerable children receiving PEPFAR-supported care.

The authorizing legislation for PEPFAR specifies that we will support five high-priority gender strategies:

- Increasing gender equity in HIV/AIDS activities and services;
- Reducing violence and coercion;
- Addressing male norms and behaviors;
- Increasing women's legal protection; and
- Increasing women's access to income and productive resources.

These five strategies are monitored annually during the Country Operational Plan (COP) review process. In fiscal year 2006, a total of \$442 million supported more than 830 interventions that included one or more of these gender strategies, including \$104 million for activities specifically addressing gender-based violence and sexual coercion.

In addition, last year we convened some 120 experts and stakeholders to discuss the latest findings on gender and HIV/AIDS, and to clarify programming priorities. Two months later, PEPFAR allocated an initial \$8 million in central funding to launch new, gender-specific initiatives in the high-priority areas that had been identified. Beginning in fiscal year 2007, an increased number of programs will seek to change male norms, respond to gender-based violence, and address adolescent vulnerability.

Supporting Technology to Expand Health Workforce and Systems

I have noted PEPFAR's commitment to health workforce and systems development. We are using technology to do more than build health information systems and foster two-way communication with our partners. We recently announced the \$10 million public-private partnership, Phones For Health. It brings together mobile phone operators, handset manufacturers, and technology companies, working closely with Ministries of Health, global health organizations, and other partners to strengthen healthcare services and monitoring systems through mobile phone technology. As with the development of national health information systems, the Phones for Health network will have applications for more than just HIV/AIDS. In the event of an outbreak of bird flu, XDR TB, or any other suddenly arising epidemic, this system and others like it will prove to be invaluable.

Supporting Systems for Accountability

In order to ensure quality and sustainability of its programs, the Emergency Plan is committed to the strategic collection and use of information for program accountability and improvement. The so-called "burden of reporting" is actually a foundational feature of transformational development. Reporting is one of the principal means of establishing effective systems for transparency and accountability. PEPFAR's rigorous reporting requirements serve a number of purposes. First and foremost, they are building an ever-increasing body of empirical data from which to develop, evaluate, and improve evidence-based HIV/AIDS interventions—and to do it in real time, as we go along, thus creating a culture of accountability that has impact beyond HIV.

Secondly, our reporting system is fostering the establishment of national health information systems in partner countries, many of which had weak or nonexistent systems prior to PEPFAR. Working with UNAIDS, WHO, Health Metrics Network, the World Bank, the Global Fund, and others, PEPFAR is expanding each country's reporting infrastructures and increasing the number of personnel who are trained in the field of strategic information.

Supporting countries as they develop accurate and sustainable reporting systems is not about creating bureaucratic paperwork. It is about enabling these developing

nations to construct a solid framework for a more equitable and transparent society. As one young Namibian told me: “PEPFAR is actually building democracy through its accountability systems focused on country ownership and good governance.” In this and other ways, PEPFAR is serving as a fulcrum for international development. Entire regions of the world that had been devastated by HIV/AIDS are regaining hope and building a foundation for freedom and opportunity—in much the same way the Marshall Plan enabled Europe to revive after the devastation of World War II.

Consistent with the model of accountability, PEPFAR strives to be transparent and forthcoming. We communicate regularly with the American people, through our Annual Report to Congress and the www.PEPFAR.gov website, where users can find everything from individual Country Reports to our program’s legislative guidance. We also keep in touch with our program implementers, through a private “Extranet” website, which provides current research, best practices, reporting guidelines, and other programmatic information on a continually updated basis.

Supporting Public-Private Partnerships

Through PEPFAR’s growing network of public-private partnerships, we are working with businesses to bring their distinctive strengths to the fight. In 2006, PEPFAR invested \$13.25 million in public-private partnerships, leveraging \$59.25 million in additional resources for programs including PlayPumps and Phones for Health, previously mentioned in this testimony. Also in 2006, smaller scale public-private partnerships were developed in the field and launched in Zambia, South Africa, and Kenya. Finally, through a broad consultative group that includes members of the U.S. Government, the private sector, and NGOs, we are moving forward in developing additional public-private partnerships to scale up pediatric HIV treatment. These public-private partnerships make our dollars go further and harness the skills of the private sector making our programs more effective and sustainable. In addition, they can gain further leverage by connecting with other key USG initiatives like the African Education Initiative and the President’s Malaria Initiative.

Conclusion

As we move forward, the ways in which we leverage U.S. investments to address the full range of development issues will be a “growth area” for PEPFAR. In addition to those I have described, other areas on which we intend to focus include supporting micro-enterprise initiatives and addressing neglected tropical diseases.

HIV/AIDS does not exist in a vacuum. It is inextricably tied to other threats to public health, and it has ramifications for a wide range of development-related issues. Thus, PEPFAR’s efforts to “connect the dots” of international development are integral to the larger picture of U.S. foreign affairs. As IOM committee chairman Dr. Sepulveda noted, “The PEPFAR initiative should be seen not only as an important investment in the lives of many individuals and their families, but also as an investment in global security. This is a good example of the kind of health diplomacy needed on a global scale.”

Today, the Emergency Plan is on track to exceed its original commitment of \$15 billion over five years. By the end of fiscal year 2008, the American people will have invested \$18.3 billion in the global fight against HIV/AIDS.

In addition, PEPFAR amplifies the effects of other international HIV interventions by working with and contributing to the Global Fund to Fight AIDS, Tuberculosis and Malaria. PEPFAR is set to more than double its original commitment to the Global Fund, and has provided nearly \$2 billion to date. The U.S. Government is the largest contributor to the Fund, providing approximately one-third of all its resources.

PEPFAR’s other key international partners include the World Bank; United Nations agencies, led by UNAIDS; other national governments; and—with growing commitment—the businesses and foundations of the private sector.

As the IOM committee report observed, PEPFAR and its partners have successfully demonstrated that HIV/AIDS programs can be implemented, even in under-resourced settings. Millions of people are receiving life-saving care in many of the world’s most challenging settings. Hope is being restored through the power of partnerships.

The people of severely affected nations have accomplished so much in their fight against HIV/AIDS, and the American people are privileged to partner with them through PEPFAR. Yet, the HIV/AIDS pandemic remains an emergency, and so many challenges still lie ahead. We are on a long journey. The American people must continue to stand with our global sisters and brothers as they take control of the pandemic and restore hope to individuals, families, communities and nations.

Mr. Chairman, once again, I am deeply grateful for our strong partnership with this Committee. I believe PEPFAR is a truly historic initiative, and one in which every American can take pride. With that, let me turn to your questions.

Chairman LANTOS. Thank you very much, Ambassador Dybul, for a singularly substantive and serious presentation. We are all in your debt.

Let me begin by stating that this committee will again move in a bipartisan fashion to reauthorize this very important program, and I am convinced that our colleagues in the rest of the House will follow our lead.

But I do want to raise some questions about the effectiveness of the distribution of funds that we approved last time. My understanding is that you personally favor the one-third/one-third/one-third approach, and I respect that, but I would be grateful if you would summarize for the benefit of the committee, the views of the critics who would like to either change that ratio or to eliminate it altogether, so if you would begin with that issue I would appreciate it.

Ambassador DYBUL. Certainly, Mr. Chairman. I think this is an area we need to talk about and look at the data and base what we do in the evidence. That is what we have tried to do as a learning organization.

Mr. Chairman and Members, I think, as you know, the data are now becoming overwhelming that a comprehensive ABC approach in a generalized epidemic, which is what we are seeing in sub-Saharan Africa, is the most effective approach because 90 percent of infections are sexually transmitted and so we are fundamentally changing behaviors.

The most at-risk people are young adults and so we need to get to the young adults. In country after country after country where we have data now from demographic health surveys show, for example, in Kenya a 30 percent reduction in prevalence, a 23 percent reduction in Zimbabwe, stabilization or decrease in Namibia, decreases in Ethiopia, decreases in Uganda going back many years, which set the pace, but now we are seeing it everywhere.

The data in each country are almost identical that where we see reductions in prevalence we see an increase in age of first onset of sexual activity. Children are delaying their sexual debut, abstaining for a longer period of time.

Very importantly, we are seeing a massive reduction in young men in their number of partners, 50 percent reductions in casual partnerships among young men in particular, as well as women. We are also seeing some increases in condom use, although not all that much actually. In several of the studies where we have seen decline in prevalence we have seen women increase their condom use, but not men.

We do know that increase in condom use, if they are used consistently and correctly, among people who engage in sexual activity are essential to prevent the spread of infection, so you need to utilize all three approaches.

Our approach has always been to provide information to people we respect and let them make a decision. We are actually privileged today to have Dr. Alex Coutinho, who implements a program

in Uganda that actually does all three pieces, as well as many others who do that in different degrees.

Our approach has always been provide the information, provide the knowledge, and people will make a decision. Should they choose to engage in sexual activity they need condoms, but we need to educate them that there are alternatives, particularly in the context of gender and equality. Young women need to know they don't have to engage in sexual activity, for example, how they can negotiate that. I think it is a very complicated issue.

Now, why a directive? I think first of all we need to be very clear, and the IOM points this out. There is no study—randomized, controlled trial—that would say 33 percent directed toward abstinence-until-marriage is scientifically appropriate. There is no study that will say 10 percent directed to orphans is the right amount.

What we do as policy makers is take the data that tell us how to prevent infections and apply it in a way that we hope will turn the epidemic around; in fact, we know can turn the epidemic around.

Now, historically, and I am sorry for the length of this answer, but it has been raised by so many that I think if I lay some of this groundwork—

Chairman LANTOS. Take all the time you need because this is an important issue. We will have a bipartisan piece of legislation, but this will be one of the issues that members of this committee and others will discuss actively, so please go ahead.

Ambassador DYBUL. So if I could then, and I appreciate that. Many comments talked about this issue, so I think it is important we all think through it together.

I think historically what we saw is the early successes that were reported in prevention were in concentrated epidemics, not in Africa where the most at-risk people are sexually active young people.

What we saw were epidemics in Thailand and Cambodia and Brazil that were heavily concentrated, concentrated in populations and groups, particularly people engaged in prostitution, among the prostitutes themselves, people engaged in prostitution, and their clients or intravenous drugs uses, or other concentrated populations that you could get to.

Now, in the context of a prostitution encounter, a decision has already been made, getting back to people who need to make a decision, and so if you do a lot of condom education you can actually significantly change the epidemic because that is where the epidemic is concentrated.

I think it is also important to point out that the data show very clearly that it was actually both the B and C component; that not only did condom use go way up in prostitution encounters, but the number of men engaged in prostitution dropped precipitously, and the frequency with which they went to prostitutes dropped precipitously, so it was both the B and C component, but that is in the case of a concentrated epidemic.

Now, when you move to a generalized epidemic you can't apply those epidemiologic and intervention data, to a generalized epidemic. That is scientifically unsound. I think what happened is that people saw those data and began to apply them.

They had programs, and many of the same people went to do programming that were in those countries to other countries, and we began to have a practice and approach that looked just like the approach we were doing in concentrated epidemics in a generalized epidemic.

That was a mistake. I can give you a piece of data that still astounds me. If you look at condom use in Botswana from the mid 1990s through 2000, it went up precipitously. In fact, Botswana has one of the highest condom use reports in the world, about 80 percent among sexually active people.

At the same time, the prevalence rate went way up to 30 percent. So you have to have a comprehensive approach to get young people to change behaviors in order to change the epidemic. The purpose of a directive to me at this point is to ensure that we move toward the evidence, that we do have an evidence-based approach. It takes a shift.

It takes a shift in what we were doing, and so over time I think the Institute of Medicine was correct. Over time a directive isn't necessary. I don't know when that will be. I believe we need a directive for orphans, for example, because we haven't gone far enough, and it is actually very difficult to get orphan programs up and started, so it took some time to redirect.

That is the purpose of a directive. It is not that 8 percent is provable by science. Maybe it should be 38 percent. Maybe it should be 30 percent. I don't know. There is no science that will tell you. It is making the rational and policy decision on where the data are in coming up with an approach.

I think we need to work together on what a directive should look like or how we would couch that. I think it is an ongoing discussion and one that needs to occur, but that is the thinking behind it. That doesn't get you to a specific number. It just gets you to where we ought to be thinking and going and so that is my philosophy.

At the same point, I understand completely there are differing views, and that is why we have a wonderful democracy so we can share them and come up with a solution to save lives.

Chairman LANTOS. Well, I appreciate your very thoughtful answer, Ambassador Dybul. I think every member of this committee is fully aware of the fact that the 33 percent formula was not scientifically based, but it was a political compromise among members of the committee and Members of the Congress.

While speaking for myself, there is no intention of totally eliminating any formula. I think the percentages which initially were politically created, not scientifically created, that formula is very much subject to a discussion and will be by members of this committee.

The second issue I would like to raise with you is the progress we have made or are hoping to make vis-à-vis a vaccine in this field.

Ambassador DYBUL. I think it is an extraordinarily important question because in the long-term treatment is essential. It is part of compassion and care. Care for orphans is essential, but in the long-term we want to prevent disease, and the gold ring for prevention is going to be a vaccine.

Let me speak from a personal standpoint as a scientist for a moment. I think it would be important to talk with Dr. Fauci and others who are working in the vaccine area. My own view as I look at the science is the more we learn, the more difficult a vaccine is actually, and we don't have anything in our processes right now that would tell us we are on track to have an effective, preventive vaccine.

A lot of great work has been done. It is not a matter of resources, in my humble opinion. I am speaking personally as a scientist now. I think the issue is technological understanding of the virus and technological understanding of the immune response and that we need a technologic breakthrough to allow us to see things in a different way, and we can't foresee when or how that will occur.

At the same time, there is some very encouraging research for what would be called a therapeutic vaccine who are HIV positive to stimulate their immune system as part of a treatment or care regime so that they can respond more effectively to the virus and perhaps delay or more effectively treat them.

However, in terms of a preventive vaccine, we have some ground to make up. It is not necessarily money or resources. It is very much an understanding of the immune system. If we had the right answers right now we would have a vaccine.

There are other things that we need to look to, however. We can't wait for a vaccine, so, as Mr. Payne pointed out, male circumcision has been demonstrated to be effective in preventing infection. It is a very complicated area, culturally and otherwise.

A lot of the progress that has been made is in behavior change. For example, young men think they are 100 percent protected. That 50 percent reduction in partners might not remain, so a lot of education needs to be included. It is also not a simple procedure, but we do and are working very hard to work with countries and people in country to see how we can implement such a program.

A microbicide would be an important step. Unfortunately, we do not have a microbicide at this point, and the latest data actually showed the one we were hopeful about was less effective and in fact caused more infection than reduced it. There are some studies on preexposure prophylaxis.

So while a vaccine is something we very much want, it is going to be a long time before we have one, and we need to look at every prevention approach and every prevention technology to try to identify where we can go. But I would have to refer you to Dr. Fauci and our friends at NIH for a more in-depth scientific discussion of vaccines.

Chairman LANTOS. We will be talking to them.

Congresswoman Ileana Ros-Lehtinen.

Ms. ROS-LEHTINEN. Thank you so much, Mr. Chairman, and thank you, Mr. Ambassador, for an excellent testimony.

I wanted to ask you about the recommendation of the Institute of Medicine. As you had pointed out, it recently issued an evaluation of PEPFAR which recommends that the initiative begin shifting from an emergency response to a sustainable response.

PEPFAR has done tremendous work, especially supporting projects from incredible organizations based right there on the ground, the community organizations, and in addition PEPFAR has

rolled out the antiretroviral therapy quite quickly, proving that this can be done even in a resource limited capacity and in those settings.

Now the challenge is to make sure that these focus countries begin to take ownership with PEPFAR's efforts in becoming a sustainable part of the overall health system, so I wanted to ask what your response would be to the Institute of Medicine's recommendation and how you see the future of PEPFAR in this context.

What are your plans in making a transition from this emergency response to a sustainable response in PEPFAR focus countries?

Thank you, Mr. Chairman.

Ambassador DYBUL. Thank you very much for that question which is in many ways the crux of the report, how you have a sustainable system.

I think one of the things the report pointed out is we actually are developing sustainable programs as we are trying to do in emergency response, and that is the difficulty. We are not out of the emergency. Tremendous progress has been made, but we are not out of the global emergency.

Treatment has expanded, increasing 54 percent, a 26-fold increase over the recent era, but still only about 25 percent of people in sub-Saharan Africa who need treatment have access to treatment. Still we see many new infections per year, 5 million new infections per year. Much better in Africa, but difficulties in other regions, so we are still in an emergency.

The trick really is how you respond to an emergency and at the same time develop sustainable systems and move as quickly as you can in countries that make enough progress from an emergency to sustainable response.

The solution there in our view goes back to the Monterey Consensus, which was a very historic document in development that basically laid out four principles for how you do sustainable development.

Country ownership. Country ownership first and foremost. You can't have a sustainable program unless it is led by, directed by, and engaged by people like Dr. Coutinho who are in the country expanding their own programs, so it has to be country owned at every level.

There has to be a results-based approach so that the money is used to good effect and you can demonstrate that effect. The results base is not just to be accountable to the American taxpayer and others who are providing the resources. It is because as you learn about your programs through accountability measures you can actually improve your programs and so that results base allows for a sustainable approach that will be adaptive over time and be even more effective.

The third piece is a multisectoral approach. Sometimes people hear country ownership and assume it is just government. A fundamental principle of the Monterey Consensus is for sustainable approaches you need a multisectoral approach, which means non-governmental organizations, faith and community-based organizations, the private sector.

Everyone needs to be engaged in country ownership to have a sustainable system that is owned by the local people so it will con-

tinue and to bring in their resources as well from the government and nongovernmental sectors for more sustainability.

I think those key principles are what is the basis of sustainable, so what we are doing about that, which is why I emphasize that 83 percent of our partners are local organizations, is building that in-country capacity, training people but also now increasing what would be called the pretraining.

If you are going to have community health workers, you need nurses and doctors to oversee them and building a network and a system. That is not the sole responsibility of PEPFAR. That is not even the sole responsibility of the U.S. Government, but there are many other international partners that will help get us there, so I think you have to build the workforce within that country ownership so that you can have a sustainable system.

You need increased investment in the country itself. Many countries have increased their own resources. South Africa this year is contributing around \$750 million for HIV/AIDS. Botswana is around \$160 million now. Namibia has increased their contribution. India just announced a big proposal.

That is how we are going to get to sustainability. We can lead and join and partner, but ultimately we are going to need increased resources from the countries, as well as those other systems that were created in Monterey.

I have to say here no one has all the answers, and we don't even have all the questions, but it is something we need to constantly focus on and think together about how you build those sustainability markers.

Most importantly, you need to work with the people in the country and ask them how we develop sustainable systems and work with them for that country ownership.

Ms. ROS-LEHTINEN. Thank you very much.

Chairman LANTOS. Thank you very much.

Mr. Payne.

Mr. PAYNE. Thank you very much, Ambassador, and let me commend you for your depth of knowledge and your commitment to this cause.

One of the problems that we of course know exists is that many developing countries lack adequate departments of health, or ministries of health that can work effectively.

Have you worked with the individual countries where the program is existing to try to attempt to help create a health delivery system that would be sustained over time?

Ambassador DYBUL. Yes. Absolutely. In fact, that is one of the principal things we do under the sustainability marker is to work with countries to build those systems and build them in a way that works in an African context and also works in this country. It is called the pyramid or task shifting system, where doctors oversee nurses who oversee community health workers and help to build systems throughout the country.

One of the insights and important things about focus countries is that we are really supporting national scale up. You can do pilot projects, which we are doing a lot in development, without building local systems. You can send in Americans and you can send in Eu-

ropeans. You don't need a supply system, and you don't need logistics systems because you are bringing everything in.

When you get to a national scale up, all those systems have to be developed. So we are putting an enormous amount of investment and time toward country ownership to build sustainable systems both in government and nongovernmental sectors.

For example, in some countries like Kenya, 40 to 50 percent of the health care is provided by faith-based organizations. So you build both the faith-based institutions, but also the governmental institutions because they are both half.

You build them nationally with workforce, with supply systems, logistics systems, human resource systems, and waste disposal systems. Some things you don't even think about when you are thinking about scaling up health care systems. Those are the systems we are investing in.

About a quarter of our resources go directly to those systems, but ultimately the results are what prove the systems are being built. You can't get to 40, 50, 70, 80 percent coverage for treatment, for example, without a national system, and that is what we are supporting.

About 20 percent of our partners are governments. We work directly with governments. We work through NGOs that build governments. We also build the NGO sector, so it gets to that multi-sectoral approach in building the capacity in-country, but it is an essential approach, and it goes back to the question from the ranking member. That is how you are going to get the sustainable systems by building those systems.

I would point out again that Dr. Sepulveda, the chair of the IOM report, said emphatically when asked that we are in fact strengthening health systems overall. The key is to ensure we continue to do that for the future, stay attuned to what is going on and learn from it and build those systems.

Mr. PAYNE. Have we been able to deal with TB? We had a hearing on it recently, but especially the drug-resistant strain in South Africa. Fifty-two or fifty-three people who contracted it died.

I understand there is a lack of laboratories that can detect TB. What is being done in that area?

Ambassador DYBUL. Yes. Thank you very much, and thank you for holding the hearing because it really did help us as a government come together. In fact, later this afternoon we are coming together as a government to meet again on how we can in an inter-agency way address the global threat of tuberculosis.

Our particular piece of it is the HIV/TB piece of it, but in sub-Saharan Africa TB is a leading cause of death. So TB is very much within the aspect of what we need to be doing for HIV/AIDS. In fact, it is probably HIV/AIDS that has allowed extremely drug-resistant tuberculosis to flourish in some places, so it is very much something we need to address.

Much is being done. As you know, we increased our resources by \$50 million this year to deal with tuberculosis, getting up to \$210 million, which is a threefold increase from just a few years ago, and we are focusing on laboratories.

In each of our focus countries we are actually working to build reference laboratories for tuberculosis because it is necessary for

HIV/AIDS. Those reference laboratories can then be used to identify extremely drug-resistant tuberculosis.

Ultimately, identifying it isn't going to get rid of it. What we need are the programs to ensure that people who are TB positive are tested for HIV, because we know it is a great risk to them, and to ensure that everyone who is HIV positive is evaluated for tuberculosis and treated effectively. You get to extremely drug-resistant tuberculosis when you are not treated effectively and so prevention involves building those systems and programs.

Some great successes so far. Rwanda and Kenya are doing extremely well integrating TB and HIV/AIDS, and we actually brought some folks together on an international basis with the World Health Organization to see how we can take those successful models and scale them in other countries by having country representatives to begin to look at all that.

So we are putting the resources to bear, but we are also using our technical experience and programmatic experience after a couple of years to ensure that we scale these programs as rapidly as we can.

Mr. PAYNE. Thank you.

Chairman LANTOS. Thank you very much.

Mr. Smith.

Mr. SMITH OF NEW JERSEY. Thank you very much, Mr. Chairman.

Dr. Dybul, thank you again for your extraordinary testimony and leadership.

As you know, the genesis of the PEPFAR percentages across the board were to ensure a balanced approach to the pandemic. For example, on the treatment side, the 55 percent. In the prior years we did next to nothing. On palliative care, 15 percent. We did next to nothing. On orphans, next to nothing, if nothing at all. On the prevention side, the 20 percent, one-third of which is for abstinence, during the 1990s and prior to that next to nothing on abstinence, and that is without a doubt.

I think we need to be looking forward, and I wonder whether or not we have done enough on abstinence especially in light of the growing body of evidence that people's behaviors can be molded. People can defer. They can abstain, again leading to a healthier person who is free of HIV/AIDS.

I would hope that you would work with us. There are some people who just want to jettison the percentages, but frankly had we not had them in the law my sense is that whether it be palliative care or treatment, we would not have gotten any of those things for which we were looking. They served a very, very useful purpose and continue to do so.

Let me ask you a couple of questions, to which you might want to respond. I commend the administration on the faith-based, New Partners Initiative. As you may know, 40 percent of all of the health care in Africa is run by the Catholic Church, and yet the Global Fund, as we know, provides next to nothing to their infrastructure to reach this pandemic. Thankfully the administration is reaching out to partners of all kinds, including faith-based. Would you like to address that?

Safe blood. I chaired a hearing last year on safe blood, and I think your point about when you beef up some aspects of health care policy to mitigate the problems of HIV/AIDS you help everything. In your written testimony you point out that there is a significant increase in the number of pints available, as well as those individuals who are being trained in safe blood.

We know that if there is sufficient safe blood available in Africa, in excess of 40 percent of maternal mortality goes away, so you are doing a tremendous job when you fight HIV/AIDS in trying to mitigate maternal mortality.

Finally on the issue of sex trafficking and prostitution, during the markup I had offered an amendment that passed committee. The amendment, however, was challenged in court but was recently upheld by the United States Court of Appeals for the District of Columbia on February 27 ruling that we can differentiate between those organizations that are trying to help women who are perhaps in brothels with condom distribution while we do not partner with those brothel owners.

The intent behind that amendment when I offered it, and it remains the intent of the author to this day, is to try to ensure that we do not become enablers of prostitution and sex trafficking. We ought to be looking to enable those women to escape and find a life free of that kind of degrading treatment, but regrettably some of the partners that we had financed in the past went to court because they did not want to adhere to that policy.

Would you like to shed any light on your views on that as well?

Ambassador DYBUL. Thank you very much, Congressman, and I appreciate all those points because I think they are very important aspects of the program.

I do believe you are correct that the purpose of directives is to direct into areas we have not gone before, and I think as I mentioned it was very true of the abstinence directives, the orphan directive, the treatment directive, and I think you have to look over time at them and see where we are.

As I said, I think related to orphans in particular and our prevention program we need a little more time with some direction.

I think you are quite right. We don't do enough abstinence, we don't do enough fidelity, and we don't do enough condom overall. We don't do enough of anything yet. We are still in the scale-up phase, getting back to the issue that was raised by the ranking member. We are not out of the emergency yet and so everything needs to grow.

I think fundamentally we are going to need the rest of the world to grow their contributions as well. Currently the American people are providing as much as everyone else in the world combined in terms of developed countries.

As long as we are in that position, there will not be enough of anything, and we need more behavior change of every respect. We need more prevention programs, more prevention of mother-to-child transmission. We need more of everything. We are still in the scale-up phase.

In terms of faith-based organizations, as you know we have advocated strongly for the use of faith-based organizations, and the reason is we won't achieve the results, we will not get national scale-

up, unless we use faith-based organizations because they provide so much of the health care in-country.

There is not very much difficulty in Africa. When, for example, Namibia or Kenya or Botswana designs their national health scale-up for antiretroviral therapy, for example, they incorporate the faith-based hospitals into their scale-up plans, and they do that because they understand that they are there, they do good work and they can't actually succeed in their national goals without incorporating those institutions.

So it is an essential thing that we need to keep pushing. It is essential not only for our own program, but all programs doing work, and I think the World Health Organization's recent report has gone a long way to encourage others to do what we are doing, which is recognizing you can't achieve your goals unless you include these institutions.

Safe blood is an important issue, of course, and it is something that is part of our prevention program. We are not just doing behavior change. Safe blood has many aspects to it. Relative to an HIV aspect, it is a relatively small contributor to HIV infection in Africa but nonetheless is there and so we are engaged in programs. As you say, there are effects that go beyond PEPFAR because of those activities.

In terms of prostitution, there is no question, as we talked about earlier, that prostitution can drive the epidemic in countries. It is also very difficult. Gender equality is one of the principal issues we need to deal with if we are going to turn this epidemic around in many places, and prostitution and a culture of prostitution actually damages your ability to reverse and create gender equality.

So we think relative to HIV/AIDS on multiple fronts we need to address this and deal with it, and I think it is quite right we need to ensure that we are not promoting or encouraging those activities because that is going to make dealing with the epidemic all the more difficult.

At the same time, as you and as the law have pointed out, that doesn't mean from a compassionate basis and from an epidemic basis you don't actually deal with persons engaged in prostitution.

Most people don't choose this as a profession. They are there because of socioeconomic and cultural issues that drive them into it, and part of a compassionate response is engaging them, caring from them, treating them, helping them prevent the spread of infection to themselves and to others.

So that is a very important part of what we do, and we probably have more programs working with prostitutes than anyone in the world because it is part of a compassionate response.

At the same time, you don't want to do things that encourage that activity because it will lead to spread of the infection both directly, but also by encouraging gender inequality.

Mr. PAYNE [presiding]. Mr. Carnahan.

Mr. CARNAHAN. Thank you, Mr. Chairman, and, Ambassador, thank you again for being here.

I just wanted to express my concern with I guess the overall strategy and in terms of the restrictions with regard to abstinence only. In the global gag rule, I think it limits an overall comprehensive approach, especially when we see statistics like the fact that

most children living with HIV acquire it through mother-to-child transmission.

Again, I think it would be helpful if we could tailor that funding to local communities and countries where the statistics vary, so I think having those artificial formulas, it raises an issue when two of the congressionally mandated studies from the Institute of Medicine and the GAO have expressed those concerns as well.

In fact, the IOM study stated, and I quote, "The budget allocations have made spending money in a particular way an end in itself rather than a means to an end." I continue, "Congress should remove the budget allocations." The GAO report reached some very similar conclusions.

Again, I think it gives us reason to seriously look at those limitations and that there may be positive benefit in terms of our overall strategy by having some more flexibility and less of an artificial formula on how to spend the dollars and would ask you to comment.

Ambassador DYBUL. Again, I think this is a very important issue, and I think flexibility is important. This is one of the things the IOM, not directly in the study, but afterwards in conversations, said, which we agree with completely.

Vietnam ought to have a much different prevention program than Kenya. In fact, that is precisely what we have because we don't apply directives to individual countries. It is an overall approach so that we do have markedly different programs from country to country.

It differs not only by the epidemic; it differs by what other partners are doing, so if other partners are engaged heavily in certain activities we don't need to be engaged in those activities as much so it is sharing in activities so there is a lot of flexibility.

We actually allow countries to explain why they wouldn't meet any directives, and we have yet to not accept such a reason for why they wouldn't meet an objective, so there is enormous flexibility in the system already, and we are applying it in a very flexible way to ensure that we are responding effectively to the epidemic.

Transmission. Mother-to-child transmission is absolutely the leading cause of HIV among young children. It is a relatively small contribution to overall HIV and so our efforts in mother-to-child are balanced in an overall prevention program, but we have massive programs in mother-to-child transmission and are also pushing for national scale-up of prevention of mother-to-child transmission.

Ideally we don't just want to do prevention of mother-to-child transmission. We want to keep the mother alive too. We want to prevent the transmission to the child, but we also want to prevent the mother from dying so the family unit stays intact and we prevent an orphan.

That is where prevention and treatment are very closely linked. As in this country where we went from short course therapy in mother-to-child transmission, which was very effective, it wasn't until we had full antiretroviral therapy that we saw the full drops in transmission from mother-to-children, and that is what we are pushing for.

With national scale-up of treatment targeting pregnant women, as well as everyone else, we will actually do a much better job at

prevention of mother-to-child transmission, but also keep the kids from becoming orphans. We do have very significant programs, \$100 million a year or more, targeted to prevention of mother-to-child transmission for exactly these issues.

I think the issues of the directives and flexibility is an important one. As I mentioned, we do have great flexibility, even with the general directives. We do not apply them to individual countries. I think it is important to point out that the GAO did not recommend removing the directives, but recommended that we look at them and ensure that we have a flexibility system underneath it, and that is what we have tried to do and I think we have done fairly well.

I am sure we could do better at that, as we could do better at everything that we are doing. I think the broader issue is the one Chairman Lantos raised and Mr. Smith and others have raised of how we ensure that we are having a comprehensive program, and really what the directive tried to do is ensure we have a comprehensive program and weren't skewed toward one or the other and how we do that most effectively. I think that is something that we all need to work on and consider.

Mr. CARNAHAN. Well, I appreciate this dialogue, and I compliment the initiative and the funding, but again I think everybody wants to see this succeed, to really grow our partners and the effectiveness of the program, so we will be promoting that discussion here to see how we can be sure we have the flexibility and effectiveness to really fight this epidemic, so thank you.

Mr. PAYNE. Mr. Fortenberry.

Mr. FORTENBERRY. Thank you, Mr. Chairman.

Thank you, Mr. Ambassador, for appearing today. Given your strong and I believe appropriate emphasis on trying to reduce high risk behaviors that can be so destructive in the transmission of the disease and wreck havoc not only on individual lives, but on entire populations, how has that emphasis been met in the host countries?

In other words, does it reinforce cultural and social norms in existence that can lead to healthier outcomes?

Ambassador DYBUL. It is an excellent question and one I think we haven't discussed enough here because the national strategies of every country that has them around prevention in Africa has an ABC strategy. That is their strategy. ABC was designed in Africa. It is a part of where they see the evidence base and a cultural response to how they can most effectively reduce their epidemics.

So what we are doing, getting back to the question of the ranking member, is supporting the national strategy for country ownership. It is something we need to do.

The Minister of Health of Namibia actually responded to the GAO report by saying you missed it. That is not Africa. What I need is someone who will support the AB pieces because no one else in the world is doing it right now, so I can't have a comprehensive ABC approach unless you all are doing a fair amount of AB because no one else is doing it.

I think it is important to recognize that to support the national strategies and national approaches it is essential to have a comprehensive ABC program, and it needs to be a balanced program.

The evidence is there. The evidence and the data are there, and that is why the countries have national strategies for ABC, and that is why we support ABC, so I think that is a very important point because it is part of what goes on.

I think it is also important to understand ABC is a very important catch phrase, and it is a very important approach, but there is a lot that goes on beneath there, and a lot of that is self-respect and what we call life skills. It is actually teaching kids to respect themselves, to respect each other, to value themselves and to therefore avoid practices that increase your risk of being unhealthy or that are not respectful.

It does wonder for gender rights, for example, to teach kids to be respectful, and those types of messages feed into the ability to implement the ABCs so it is part of a much bigger approach.

Mr. FORTENBERRY. And that dovetails nicely into existing social societal structures that cannot only reinforce that, but create synergy in that regard.

Ambassador DYBUL. Absolutely. Absolutely.

Mr. FORTENBERRY. Thank you.

Mr. PAYNE. Thank you very much.

Mr. Engel.

Mr. ENGEL. Thank you, Mr. Chairman.

Ambassador Dybul, thank you for your testimony. I am the chief sponsor of the Stop Tuberculosis Now Act of 2007, and I have been long concerned about the global threat of tuberculosis.

Following up on some of the remarks that Mr. Payne made before, the emergence of extensive drug-resistant tuberculosis in particular has really exposed the dire need for laboratory capacity in sub-Saharan Africa.

South Africa, as you know, has confirmed several hundred cases of XDR-TB, which is virtually incurable, heavily lethal and closely linked to HIV/AIDS. XDR-TB and its precursor, MDR-TB, which is resistant to at least the two most powerful TB drugs, are closely linked to HIV, and its unchecked spread undermines the investment the U.S. has made to fight HIV and AIDS.

We can reasonably presume that XDR-TB exists in other countries, including focus countries throughout the region, but they don't have anything resembling the laboratory capacity to test for drug resistance and carry out surveillance. The World Health Organization has said that South Africa has more lab capacity to carry out TB drug resistance than the rest of sub-Saharan Africa put together.

With that in mind, with the new funding for TB/HIV made available from the continuing resolution for fiscal year 2007, how much of this money is going to be used to strengthen laboratories and what is your timeline for getting the funding to countries to boost lab capacity?

Ambassador DYBUL. Thank you. As I mentioned with Mr. Payne, we very much appreciate that hearing, and it helped highlight and focus on an issue.

I don't have at my fingertips the amount total of the \$210 million that goes for laboratory. We can get that for you. It is quite a bit actually, and the continuing resolution resources allowed us to increase, but it is something that we have been doing for quite a

while because laboratory infrastructure building is an important part of what we do.

Plans have existed and money has been moving to build reference laboratories for tuberculosis, to get tuberculosis screening into HIV facilities, to get HIV patients tested for tuberculosis and to expand care and treatment for people who are HIV/TB positive because that is how we will ultimately deal with extremely drug-resistant tuberculosis; not by diagnosing it, but preventing it through effective tuberculosis treatment, particularly in HIV-positive patients.

We can get you the precise dollar amount, but a fair amount of what we do is actually building laboratory capacity, which is part of HIV care.

Mr. ENGEL. Thank you. If you could get that to me, I would appreciate it.

[The information referred to follows:]

WRITTEN RESPONSE RECEIVED FROM THE HONORABLE MARK R. DYBUL TO QUESTION
ASKED DURING THE HEARING BY THE HONORABLE ELIOT L. ENGEL

In fiscal year 2007, an additional \$50.2 million was allocated to TB/HIV activities above the planned funding levels for the 15 focus countries. Of this amount, approximately \$15.2 million or 30.4 percent has been allocated to TB/HIV activities that increase lab capacity. The additional resources will bring the total funding for TB/HIV in fiscal year 2007 to approximately \$120 million.

Mr. ENGEL. You know, again I want to emphasize building laboratory capacity.

Let me ask you this: Important disease-specific programs like PEPFAR and the President's Malaria Initiative draw from local health systems. What should OGIC do to increase the supply of health professionals to meet country health workforce needs without draining scarce health workers away from the public and primary care providers?

Ambassador DYBUL. Yes. I think that is a very important issue, and again going back to Dr. Sepulveda, the chair of the IOM, we are actually strengthening health care systems at this point.

The trick is to make sure we continue to strengthen them and don't draw from other sources. We are seeing that impact, as I have pointed out, as health overall is actually increasing where HIV expands.

In terms of health care workforce, which is a piece of the health system—it is not the whole piece, but it is an important piece of it—there are a couple things we have been doing and will continue to do. One is training and retraining for 1.7 million already. That is in just 3 years.

Also, importantly, working with countries on practices and policies to most efficiently use the available workforce, which is called task shifting. We are actually working closely with the World Health Organization to establish policies, practices, credentials and protocols to allow for expected task shifting.

The reason you need task shifting is very much the same reason we use task shifting in this country. It is not secondary health care or second class health care. It is efficient use of health care resources.

For example, in Mozambique, a country with 600 doctors for 19 million people—that is not just AIDS doctors; that is doctors—you

can't have a physician dominated health system. You need a task shifted system where physicians oversee nurses oversee medical officers oversee community health workers to get that reach.

We are supporting the training in that pyramid. We are supporting the policy work in that pyramid so we can build those health care system pyramids for HIV/AIDS care to effectively use the systems.

So we do training at the bottom of the pyramid. We also do training at the top of the pyramid. We have always had what is called preservice or that top-of-the-pyramid training in our program, but we have actually tripled going from 2007 to 2008 the amount of resources countries have to use on that preservice.

We also need to work with others. This is not something in terms of health workforce we can do alone, so we are working with other bilateral and multilateral and local governments and countries to see how you build a full system that actually uses what has happened so far, these programs directed at diseases to expand health systems, to ensure that continues.

So a lot is going on in this area, and we will continue to do it because it is an essential piece, but it is not the only piece of health systems, and we are working on the other pieces as well.

Mr. ENGEL. Let me just ask you. I know my time has expired, but will this fully fill our program needs without draining the local systems?

Ambassador DYBUL. At the moment it is. At the moment it absolutely is.

I go back to the IOM report. I go back. There are only two data points I know of, actual data on what is happening in terms of health systems, not only the IOM review that says we are in fact strengthening health systems overall.

One is the study I quote, a study that actually evaluated what was the impact on increasing AIDS programs, including resources and other program activities, on 21 other health indicators, including family planning, antenatal care, general health care, general laboratory evaluations, screening for sexually transmitted diseases. Twenty-one of twenty-two went up significantly as HIV/AIDS expanded, non-HIV indicators, and a number of them were directly associated with the expansion of the AIDS care.

To be honest, this isn't a very big surprise to me. We have numerous studies over the years that show that people who participate in clinical trials have better health in general than people who don't, even when they get placebo, and the reason for that is they are part of a high-quality system where the people providing the care are well trained and the people engaged in the health care are well informed.

So as you are expanding HIV/AIDS services, are you actually strengthening the health systems, as the IOM pointed out, that has these effects on overall health? The only data actually suggests that we have increased general health care, that we haven't drained from the health care system. We have increased it.

The trick is going forward to make sure we do the same, and that is where looking carefully at workforce, looking at systems is important, to make sure over time the positive effect on health actually continues.

Mr. ENGEL. Thank you. Thank you, Mr. Chairman.

Mr. PAYNE. Thank you.

Mr. McCaul.

Mr. MCCAUL. Thank you, Mr. Chairman.

Ambassador, thank you for being here, and let me say thank you for the work that you and your colleague are doing. This is, as you stated, probably the greatest crisis of our generation, and it is truly God's work.

I want to touch on something you mentioned in your opening statement, and that is as we view this global health threat there is also a national security concern component to that.

As we try to galvanize support in the Congress in terms of funding on this issue, I find that that point tends to be persuasive, and I wanted you to expand upon that if you may, and then a second point is the funding issue itself.

In 2004 to 2006 we provided \$8.67 billion to this effort and yet more than 39 million people worldwide are infected; 4.3 million new infections occurred in 2006. By 2010, we will have 25 million children who will have lost one or both of their parents, and by 2020 it will cause the GDP in the hardest hit countries to drop by 20 percent.

Can you compare what we are appropriating in this country, in the United States, relative to the rest of the global community and what we need to do to be more persuasive to get other developed nations to step up to the plate?

Ambassador DYBUL. Perhaps, Congressman, the two issues might be related.

In terms of the security issue, I think we do need to talk more about it. The reason we acted, both the bipartisan Congress and President, was a humanitarian concern, but beneath all those lives that were being lost there is an impact on society and an impact on security.

This is why General Wald called HIV/AIDS the third greatest risk to security for the American people besides weapons of mass destruction and terrorism. That is a pretty powerful statement from a four-star general; not a public health official, but a four-star commander, the deputy of the European command responsible for Africa.

So why does he say that? Why did the U.N. Security Council identify HIV/AIDS as a principal security threat? Why did the U.N. General Assembly deal with HIV/AIDS, the only time they have ever dealt with any health issue? Why did Secretary of State Powell, a pretty good military expert, list HIV/AIDS as a security threat?

Well, there are really two reasons. One is immediate, and one is more long term, but very much there. The immediate one is on the direct impact on peacekeepers. The Africa Union in Africa provides about 37 percent of all peacekeepers for the United Nations. Thirty-seven percent. That is likely to go up as conflicts occur around the world.

HIV/AIDS is decimating the ability to maintain peacekeepers. It is the leading cause of death among most militaries in sub-Saharan Africa. It is not war and conflict that is killing soldiers. It is HIV/AIDS.

In a recent effort to field battalions of peacekeepers in South Africa, they couldn't field a single fully healthy battalion because of HIV/AIDS. They couldn't field a single HIV-negative battalion.

So the impact on our ability to have peacekeepers to keep the peace in Africa is directly impacted by HIV/AIDS, and one of the cruel ironies of this is not only can you field fewer peacekeepers and more effective peacekeepers, but when you go on peacekeeping missions you are more likely to get infected because you are away from home and may engage in unsafe practices.

So not only do you have difficulty fielding peacekeepers; once you get them there they are going to get infected more and not only bring the infection home, but further decimate your ability to maintain peacekeeping forces.

So that is the immediate effect. The longer term effect is this rending of the social fabric that we are seeing, the creation of a generation of orphans, the preferential killing of teachers and people in the most reproductive years of their lives, the killing of 15- to 40-year-olds.

When you look at the deaths in Africa, it is frightening how we have shifted from most people dying in their 70s to most people dying in their 20s and 30s because of AIDS, cutting life expectancy in half in some places.

That loss of the most productive and reproductive people in society means your parents are dying so you don't have anyone to take care of the orphans. Your teachers are dying so you don't have anyone to educate them. Your peacekeepers are dying. The people who will generate an economy are dying and so this long-term destruction of the social fabric is a perfect environment for radicalism.

Of course, with half of Africa being Muslim we have many other opportunities for radicalism to intervene, so it is a long-term threat as well, and this is why our four-star generals have identified HIV/AIDS as one of our most significant security threats, particularly in Africa.

I think it is something we do need to talk about. We need to recognize that this is a humanitarian issue, but the loss of that many millions of people and the cutting in half of life expectancy in countries is actually going to have longer term and immediate consequences beyond the simple loss of life, which is in and of itself a reason to act.

In terms of funding, you point out something we actually address a lot because I think it is an issue. All this money has gone in, tremendous results are seen, but yet when you look at, for example, the data from USAID you have the same number of new infections and the same number of deaths this past year as the year before.

Buried beneath those larger numbers there is what is happening in different regions. Africa has actually seen a reduction or stabilization of infection in most places, while other places are making up for that success, eastern Europe and other parts of the world, so it is a tradeoff. While we are seeing huge success in Africa, we are seeing tradeoffs.

Also, even though we have done massive and rapid expansion of treatment, it is still 25 percent of those in need, so still many people are dying. One of the problems, as I mentioned, is we as a country, the American people, are providing as many resources as

the rest of the developed world combined, and as long as that is the case we will not tackle the broader issues.

So how to get more people engaged? Probably address it as a security issues as well as a humanitarian issue and also do what we have been spending a lot of time doing, which is just getting in there and encouraging and providing information on the impact overall of AIDS programs on general health, on other activities, and to work with our partners more so that we fill pieces.

A lot more needs to be done in that regard. We are working on it, and suggestions people have for how to do better we are very open to.

Mr. McCAUL. Thank you, Ambassador. Thank you, Mr. Chairman.

Mr. PAYNE. Thank you.

Ms. Jackson Lee.

Ms. JACKSON LEE. Let me say thank you very much, Mr. Ambassador, to the chairman of the subcommittee and to this committee in general. This is important oversight work.

Mr. Ambassador, I probably will submit my questions for the record and simply make these points. My first experience with malaria was a professor at Yale University who taught me who had experienced and done work in Africa, and the one thing that they made point of is that malaria you live with all of the time.

I cite that because I know that we are talking about PEPFAR and HIV/AIDS and tuberculosis. What I am saying is that I think one of the greatest aspects of diplomacy is, one, the ability to cure diseases to save people's lives. HIV/AIDS, tuberculosis, these diseases you either live with or you die with.

I am concerned basically on the structure of PEPFAR, 15 countries and then the nonfocus countries. I will be submitting a question that asks why we are not expanding the 15 countries and why we are not expanding the nonfocused because another experience I had was to walk into a hut and see a dying man on the floor, the dirt floor, and a 4-year-old was attending to him. He had HIV/AIDS and tuberculosis. We don't know how long he would last, but obviously the 4-year-old was the only "healthy" person left in that family to care for the dying.

We can do great things by expanding, encouraging capacity, as you have said, but not doing this on the cheap. I don't suggest that \$1.5 billion is something to sneeze at, but if we could understand what it means when we send PEPFAR dollars, when we send Peace Corps individuals, when we engage in diplomacy in developing nations, we would be able to focus on what is important, and that is solving the world's health problems, encouraging capacity and really having the United States reclaim its moral high ground around the world.

Those are my concluding remarks, and I will submit my questions for the record. I yield back.

Mr. PAYNE. Thank you very much for the gentlelady's comments.

If the ranking member of the full committee or the ranking member of the Africa Subcommittee would like to ask any questions?

Mr. SMITH OF NEW JERSEY. Just one final question if I could.

Dr. Dybul, on the whole issue of palliative care, I remember before we marked up this legislation I met with a priest and a nun

from South Africa who were taking the lessons of hospice, which obviously couldn't be replicated with ease in Africa, but they had taken those lessons and were teaching people how to deal with death and with a dying individual.

As you know, and as a matter of fact, I actually offered an amendment during markup to emphasize palliative care, believing that everyone should have the dignity of dying in a way that respects them, and when they take their last breath they die with some peace and are surrounded by loved ones.

Could you elaborate for the committee what PEPFAR is doing vis-à-vis palliative care and with the hospice component attached to it? I understand this is not hospice as we know it where you go to a place, and so many of us have had loved ones that have gone to hospices.

I had it in the case of my own mother, and it is a way of dealing with a terminal illness that is humane, and again it provides a certain dignity, but it seems to me that we can do more so that these individuals are not put away, shunted aside and left to die, only compounding their misery.

Ambassador DYBUL. Congressman, I think there are many extraordinary things about PEPFAR, but one of them was an emphasis on palliative care where it didn't exist before.

One of the remarkable things is palliative care has radically changed because of treatment. One of the most complicated things right now for hospice directors and hospice associations, and I have spoken with many of them, is what to call themselves because they were a hospice where people with AIDS came to die, and now with treatment they are not dying. They are actually care centers, and they don't know what to call them anymore. It is so radically different because of treatment.

One of the most exciting things I have personally seen is within 6 months of PEPFAR we funded pretty much out of the box a palliative care hospice in South Africa in the beginning of the year when the first appropriation was passed, and by that next World AIDS Day they always had a World AIDS Day to commemorate everyone who had died in the hospice.

That first World AIDS Day in 2004 they had a day of celebration to celebrate how many people were alive because of treatment, and that is actually almost a conundrum for the hospice people right now is what do they do because they are not a hospice anymore.

At the same time, we do need to continue palliative care, and we have actually had a fairly expansive definition of palliative care. Care is for people from the moment of diagnosis to the moment of death, and there is compassionate and essential services that must be provided throughout someone's life.

Many people don't need treatment. There is much care you can provide before you get to the point of needing treatment, and so we have actually designed through an evidence-based approach a care package, a palliative care package to make people's lives better from the beginning to the end, and it is actually rolling and scaling up nationally.

Unfortunately, some people do still die and so we are continuing to support what we would understand as palliative care and hospices. We support the African Palliative Care Association, the hos-

pice association, to bring their lessons and knowledge throughout sub-Saharan Africa because it is not something that existed in many places, as you point out.

A health care network around palliative care didn't exist, so we are trying to expand and deliver those important basic approaches to palliative care and hospices throughout the subcontinent while we are expanding individual services and countries.

I think it is one of the remarkable things that occurred, and that is what you see in that 2.4 million people receiving care. There is lots of palliative care going on there.

In the end, I think the most important thing we have done for palliative care is gotten rid of it by treating people effectively so they live a regular life and don't have to die.

Mr. PAYNE. Great. Thank you very much.

Let me ask you one final question also. The question of nutrition. How are we working with the USDA and Food for Peace and World Food Program. I talked with Tony Hall, the recent head of FAO and former Congresswoman Eva Clayton, and their concern of course was that without nutritional food the medication is very difficult to take.

So how much emphasis is on that? Also with clean water, which as you know is still a continuing problem. They are all together. What focus do we have on those issues?

Ambassador DYBUL. If I could address nutrition first, and there are multiple pieces of nutrition. There is nutrition and food as part of orphan care, and actually we have identified internationally six basic services that orphans need to receive, and one of them is food and nutrition, so we have fairly significant programs to ensure that children have access to food and nutrition within the orphan care program.

It is also very important for pregnant women to have access to food and nutrition during their pregnancy, and HIV-positive women perhaps more importantly, so our guidance is actually very permissive on the use of food and food supplementation for pregnant women and for orphans and vulnerable children, and we are doing quite a bit of it.

On the issue of HIV-positive people for care and treatment, it is a different issue, an important issue. I think here we are operating somewhat in a data free zone, although there are some data now indicating that there are certainly people, and we have all seen them, for whom the drugs will be less effective if there isn't access to food and nutrition.

So what we have mostly supported so far is basically what is called therapeutic food and nutrition programs, so that is a clinical determination of who receiving antiretroviral therapy or in care needs the food and nutrition for a clinical purpose because, as you know, we are working in areas that are basically food insecure.

There are many people who are hungry, and it is not just HIV-positive people. If you go into an HIV-positive home and ask them their biggest problem, they will probably say food and nutrition. If you go to the next home where there isn't HIV and ask them what their biggest problem is, they will probably say food and nutrition.

Fortunately, very few people actually die from the food and nutrition issues whereas they will die from the HIV/AIDS disease if

they don't get treatment and so it is putting all those pieces together in the most comprehensive and effective way you can, leveraging the World Food Program, leveraging Food for Peace, leveraging what we are doing with our other programs, including the agricultural allowances and the great programs the Department of Agriculture has to ensure that we have the best system we can.

We actually made an awful lot of progress in coordinating in a way that is most effective. Ultimately what you want is sustainable food programs, just like you want sustainable health care systems. Ultimately giving food packages isn't going to solve the problem and so we are also working to build sustainable food programs for HIV-positive people and working with Food for Peace, for example, to ensure that there is a national approach.

There are also some huge foundations who are interested in this who we are talking to as well because ultimately for an HIV-positive person you want to teach them how to grow their own food or have gardens associated with clinics and hospitals and other programs that we are supporting so that there is a sustainable food approach there.

In terms of water, it is very much the same. Clean water is a huge problem in Africa. It is not something that we in PEPFAR can handle, but we can do pieces. I think one of the greatest examples of that is the public/private partnership Mrs. Bush announced to basically bring clean water to 10 million people in Africa.

Our program is part of it because clinics and people with HIV need access to clean water through PlayPumps, an extraordinary thing. Kids play on merry-go-rounds, and they pump water up.

USAID is very engaged both in the education and other sectors to bring clean water, so both USAID and we put in resources for this clean water program, and then the private sector through the Case Foundation and others are going to leverage \$50 million to match our \$10 million to bring clean water to 10 million people.

That is the kind of innovative thing we need to do, getting back to the Monterey Consensus. How do you involve all sectors to have an effective response that ultimately is owned by the country and is effective and leads to results?

I think those are examples of things we are trying to do to ensure that our programs continue, as I said, to build health overall and don't detract from health, but build other systems.

Mr. PAYNE. Well, let me thank you very much for this very comprehensive testimony. We still have a lot of work to do, as you have indicated. We have to get other countries to step up to the plate.

We are happy that we do have private individuals and pharmaceutical companies that are really doing a lot more these days. Many of the pharmaceutical companies from New Jersey—Merck and Bristol-Myers Squibb and others—are doing tremendous bilateral programs.

We are also pleased that the Bill Clinton Foundation and the Melinda and Bill Gates Foundation and others are really stepping up to the plate. It is going to take all of us together. It is going to take corporations. It is going to take companies. It is going to take our national bodies like our Congress and foreign countries to also step up to the plate.

I am glad that African countries are devoting more of their own resources, though meager in many instances, to this fight. I think if we all come together hopefully we will be able to defeat the scourge of HIV/AIDS.

Thank you very much for the great work that you do.

The meeting stands adjourned.

[Whereupon, at 12:45 p.m. the committee was adjourned.]

A P P E N D I X

MATERIAL SUBMITTED FOR THE HEARING RECORD

PREPARED STATEMENT OF THE HONORABLE SHEILA JACKSON LEE, A REPRESENTATIVE
IN CONGRESS FROM THE STATE OF TEXAS

Thank you, Mr. Chairman, for convening this hearing on this ongoing health crisis. I would also like to thank the ranking member, and to welcome our witness, the Honorable Mark R. Dybul, U.S. Global AIDS Coordinator, from the Department of State.

Seventeen years after the first cases were diagnosed, AIDS remains the most relentless and indiscriminate killer of our time, with 39.5 million people worldwide now living with HIV or AIDS. Despite pouring billions and billions of private and federal dollars into drug research and development to treat and “manage” infections, HIV strains persist as a global health threat by virtue of their complex life cycle and mutation rates. 24.7 million of those infected, or about 63%, live in Sub-Saharan Africa, a region with just 11% of the world’s population. 61% of those infected in this region are women. Though Africa, and even more specifically African women, bears the brunt of the AIDS pandemic, Americans should be reminded that HIV/AIDS does not discriminate, with well over a million people in our own country currently living with HIV or AIDS.

Africa’s astronomical rate of HIV infection can be attributed to a range of different factors. Poverty, women’s frequent lack of empowerment, and high rates of male worker migration combined with the limited resources, facilities, and expertise of many national health systems have left this region particularly vulnerable to the disease. Sub-Saharan Africa also faces a wide range of social and economic consequences as a result of its high HIV/AIDS rates, including a decline in economic productivity due to sharp life expectancy reductions, the loss of skilled workers, and an estimated 12.3 million AIDS orphans facing increased risks of malnutrition and a lack of access to education.

During my time in office, I have fully and eagerly supported legislation giving increased attention to this disease, both domestically and globally. I have worked to declare HIV/AIDS a state of emergency among the African American community, which faces an infection rate nearly eleven times that of white Americans. Internationally, I am proud to co-sponsor H.R. 1713, introduced by my colleague Ms. Lee of California. This bill targets the needs of women and girls in developing countries, recognizing that women are particularly hard hit by the global AIDS pandemic, and it requires US policy to emphasize their needs. This bill would eliminate the restriction that 1/3 of all AIDS prevention funds be used for abstinence-only programs, allowing for more balanced funding for HIV prevention initiatives.

The U.S. government’s commitment of \$15 billion dollars over five years (2004–8) has great promise to make a substantial contribution if fully funded. Top scientists from around the world are committed to vaccine development, which remains one of the greatest hopes the world has for preventing transmission of the virus. Clinical trials are now ongoing in several countries, including the United States. Still, more work must be done.

Though the drugs we currently have are effective in managing infections and reducing mortality by slowing the progression to AIDS in an individual, they do little to reduce disease prevalence and prevent new infections. For this reason, the prevention programs are perhaps the most critical aspect of any initiative to combat global HIV/AIDS. The current restrictions on PEPFAR mandating that 1/3 of all prevention funds be used on abstinence-only education neglect the real needs of populations both in America and abroad. These stipulations hurt the ability of PEPFAR to adapt its activities in accordance with local HIV transmission patterns, and they impair efforts to coordinate with national health plans. Though AIDS is clearly a

global problem, it does not affect every nation equally or in the same manner. Removing these stipulations would allow PEPFAR to better address the requirements of each country, making more efficient and effective use of taxpayer dollars in serving the millions affected by this disease.

AIDS has proven a stubborn and persistent health crisis. Among our tasks here must be to work to transition from emergency response programs to a long-term and sustainable approach to this ongoing threat. In addition to the removal of constraints on US policies, there is an ongoing need for coordination between US and international agencies. In addition, local health infrastructure must be strengthened, and every effort must be made to increase numbers of qualified health workers in Sub-Saharan Africa.

If we are to turn the tide of turmoil and tragedy that HIV/AIDS causes to millions around the world, and hundreds of thousands right here in our backyard, it is imperative that we continue to fund and expand medical research and education and outreach programs. However, the only cure we currently have for HIV/AIDS is prevention. While we must continue efforts to develop advanced treatment options, it is crucial that those efforts are accompanied by dramatic increases in public health education and prevention measures. Investments in education, research and outreach programs continue to be a crucial part of tackling and eliminating this devastating disease.

As Americans, we have a strong history, through science and innovation, of detecting, conquering and defeating many illnesses. We must and we will continue to fight HIV/AIDS until the battle is won.

