

**U.S. RESPONSE TO GLOBAL AIDS CRISIS:
A TWO-YEAR REVIEW**

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U.S. RESPONSE TO GLOBAL AIDS CRISIS: A TWO-YEAR REVIEW

WEDNESDAY, APRIL 13, 2005

HOUSE OF REPRESENTATIVES,
COMMITTEE ON INTERNATIONAL RELATIONS,
Washington, DC.

The Committee met, pursuant to notice, at 10:35 a.m. in room 2172, Rayburn House Office Building, Hon. Henry Hyde (Chairman of the Committee) presiding.

Chairman HYDE. This Committee will come to order. Good morning. Welcome to today's hearing.

Two years ago, this Committee championed the "U.S. Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003." Since this landmark legislation, the United States has taken the lead in this global fight urging the world to rally together to stop HIV transmissions and save the lives of those who have AIDS. The U.S. has raised the profile of the emergency and has provided the resources to back it up, \$2.8 billion this year and \$3.2 billion likely next year.

As the President's Coordinator for our country's overall effort to fight AIDS, Ambassador Randall Tobias has demonstrated tremendous leadership and vision for moving forward an extraordinarily difficult and complex program of activities.

Ambassador Tobias is deserving of our highest praise for his accomplishments, even as we in the Congress press him to do more and to do it faster because while much has been done to stem the tide, the AIDS pandemic unfortunately continues to roll forward. It continues to claim millions of lives and devastate countless families, especially in Africa. Indeed, AIDS is proving to be an elusive and moving target, and its defeat will require closing the gaps that arise during the battle.

I would like to highlight three such gaps that have emerged and require our full attention. First, the best defense for preventing HIV transmission is practicing (A) Abstinence and (B) Being mutually faithful to a non-infected partner. This "A" and "B" combined with the "C" of correct Condom use when necessary, form the ABC approach, the essential foundation for HIV prevention.

However, organizations best suited to promote A and B programs, such as faith-based and indigenous organizations, are often not the ones implementing these programs. Instead, organizations long associated with the social marketing of condoms are given much of the funding for AB programs. This must not continue.

I urge the Administration to accelerate the targeting and developing of indigenous and faith-based organizations as the key instruments in our fight to prevent the spread of AIDS.

Second, for many women and girls, having the disease is compounded by knowing that they were infected by an act of violence or exploitation. The protection from AIDS infection associated with the ABC approach evaporates in environments of sexual violence or coercion. For example, a woman who practices abstinence or faithfulness cannot negotiate the terms of her rape.

Similarly, women practicing faithfulness cannot negotiate the terms of their husband's infidelity, nor can girls given to older men in child marriages exercise the option of refusal.

Perhaps most shocking is the infection of children by teachers and authority figures in schools and other places where children congregate. These sickening methods of transmission compromise a significant but vastly underreported portion of new infections that must be eliminated.

We must reverse the trend where women and girls now constitute 60 percent of those living with AIDS in sub-Saharan Africa with girls aged 15 to 19 infected at rates as much as five to seven times higher than boys of their age.

With ABC, we must now include a "D" for Defending the rights of the vulnerable to secure the intended protections resulting from responsible behavior, particularly those derived from practicing abstinence and mutual fidelity.

The tacit acceptance of abuse against women and children is an assault upon the rights of individuals to use personal moral values as the most fundamental instrument in the fight to defeat this disease. We must expand programs to correct or prevent violence and coercive behavior by men, including men as an essential part of the solution, and assist women and children who are or may become victims. Law enforcement and judicial systems must also be bolstered to prevent and respond to these circumstances.

The third issue that I would like to highlight is the severe lack of professional and technical health workers and supporting facilities. This is the single greatest impediment to treating the millions who need it, a far greater bottleneck than the expensive antiretroviral drugs.

We can ship millions of pills to the warehouses of countries devastated by AIDS, but who will conduct the tests, make the diagnoses, perform the labwork, care for those recovering, dispense the prescription, transport the medicines, provide the counseling and monitor adherence to the drug regime?

The World Health Organization notes that Africa has 14 percent of the world's population and 25 percent of the global AIDS burden, but only 1.3 percent of the world's healthcare workers. African countries struggle not only with limited capacity, but also the hemorrhaging of what few professional staff they have to Western countries.

African Governments must take the lead to recruit, train and retain health professionals and build their health infrastructure to help their own people. For our part, we must assist those who have the commitment but lack the resources to do it on their own. Our goal should not be just to have 2 million people on treatment by

2008, but to have 2 million people being treated by their fellow citizens in their own country.

AIDS can only be defeated if we recommit ourselves at every turn and close off every avenue that it may seek to gain new footing. We must especially close the gaps that expose the most vulnerable.

I look forward to hearing from Ambassador Tobias and our other witnesses today, and I am particularly interested in their views on these three areas to which I believe much greater attention must be given.

I turn to my friend, Tom Lantos, the Ranking Democratic Member, for his opening remarks.

Mr. LANTOS. Thank you very much, Mr. Chairman. Before coming to my prepared text, let me pay public tribute to you for your extraordinary leadership on this issue.

Without your passionate commitment to helping the millions who are impacted by HIV/AIDS, this legislation would never have gotten out of this Committee, and I am delighted to acknowledge my gratitude and the gratitude of millions to your leadership.

Chairman HYDE. Thank you.

Mr. LANTOS. Mr. Chairman, thank you for convening this very important hearing to review the strengths and shortcomings of our country's efforts to stop the global spread of AIDS and the virus that causes it, and for your continued leadership on all matters related to HIV/AIDS.

Mr. Chairman, 2 years ago our Committee undertook an enormously challenging enterprise to craft a comprehensive legislative package in support of the President's \$15 billion commitment to battle the scourge of HIV/AIDS in poor countries around the world.

We knew, Mr. Chairman, that in order for this noble enterprise to succeed, both sides of the aisle needed to shelve their partisan and ideological differences. When the House voted 375 to 41 in support of our landmark HIV/AIDS legislation, it was clear that our bipartisan, non-ideological approach was the right one and indeed the only one which offered a hope of success.

Mr. Chairman, with over 8,000 men, women and children around the globe still dying each day of HIV/AIDS, it is imperative that we keep up the overwhelming support shown thus far to fulfill the President's \$15 billion HIV/AIDS promise. To achieve that goal, we must continue to check our partisan and ideological differences on the HIV/AIDS issue at the door.

Together we must support the commonsense ABC approach to slow the transmission of the virus that causes AIDS. We must make extraordinary efforts to increase the availability of low-cost drugs for those infected with this horrendous disease, and we must address the impact on the HIV/AIDS crisis of collapsing healthcare systems in developing countries.

Mr. Chairman, while we are correctly focused on treatment and the amazing hope it brings to millions of sufferers, we must continue to vigorously support prevention programs, particularly those targeted at young adults and high-risk populations.

Despite our differences, Congress accepted the ABC prevention strategy—Abstinence, Being faithful and the effective use of Condoms. While some wanted greater emphasis on C and others

wished to focus on A and B, reason prevailed and we adopted a comprehensive strategy because in the end we all realized that the point was not to fight over ideological differences, but to keep a pandemic from spreading further.

Mr. Chairman, there is mounting evidence that ABC, the complement of the three approaches together, works the best, including in the country where the ABC approach began, the African nation of Uganda.

For the ABC approach to work effectively, U.S. taxpayer dollars should not be going to any organization which actively discourages the use of condoms or for that matter the importance of abstinence and being faithful. We must also choose organizations to carry out our prevention programs which have proven track records, not those which merely pass some moral or ideological litmus test.

Mr. Chairman, the Global Leadership Act approved by our Committee has also increased tremendously the number of HIV/AIDS victims overseas receiving lifesaving pharmaceuticals. The Coordinator reported that 155,000 patients in sub-Saharan Africa are receiving AIDS treatment as a result of our efforts. He also reported the program is on target to reach the 200,000 mark by June of this year.

Impressive as this figure may be, this represents just 8 percent of the 2008 treatment goals of 2 million AIDS victims set by the President and endorsed by Congress. Clearly if we are to meet our own targets and get ahead of this disease, we must uncover the reasons we are reaching so few people with our bilateral programs.

I am particularly concerned that U.S.-funded facilities have reported shortages on HIV/AIDS drugs because FDA approval has not been obtained for some globally acceptable generics. While we must maintain the efficacy of drug stocks available for distribution to U.S.-supported facilities, regulatory delays and other barriers also need to be removed so generic drugs can become more readily available where they are needed. To this end, the Coordinator may need to review the procurement process in order to ensure a quick response when early signs of shortages appear.

Lastly, Mr. Chairman, we must address the declining—or in some instances collapsed—healthcare systems in poor countries affected by HIV/AIDS. The expansion of the number of people in treatment has created major obstacles due to the severe limitations of healthcare systems in developing nations. Strengthening the healthcare infrastructure and increasing the numbers of trained doctors and nurses must remain a major priority for the United States.

Africa faces particularly difficult obstacles of all the regions affected by HIV/AIDS. After independence, most African countries invested heavily in healthcare systems, workforce training and impressively improved the healthcare of their citizens.

With the economic crisis of the 1980s, all this was reversed. In the 42 poorest countries of Africa, spending on healthcare fell by 50 percent during the 1980s. Most African nations also experienced a brain drain of skilled health workers who emigrated to wealthier countries seeking trained doctors and nurses.

For instance, in Ghana between 1982 and 1992 the number of doctors in government healthcare systems dropped from 1,700 to

665. Meanwhile, more than 2,400 nurses from Ghana were licensed to practice in the United Kingdom.

The return of African healthcare professionals is absolutely critical to the reversal of the AIDS pandemic. This will require incentives to stimulate the voluntary return of healthcare professionals and investment in training thousands of paraprofessional workers to extend care to vast underserved rural areas.

Mr. Chairman, the next 3 years will be a critical time in the implementation of our 5-year Global Leadership Act. By working closely with the Global Coordinator's Office we can ensure the effectiveness of prevention programs, significant increases in the distribution of inexpensive and lifesaving HIV/AIDS drugs and new efforts to boost the quality of healthcare delivery systems.

None of this will happen if we fail to maintain bipartisan support for global spending on HIV/AIDS programs. Let us use today's hearing to redouble our collective efforts to work together in a non-ideological fashion to achieve this vital goal.

With people globally dying of AIDS at the rate of 8,000 per day, nearly 700 will be lost to this disease in the next few hours. We have no time to waste.

Thank you, Mr. Chairman.

Chairman HYDE. Thank you, Mr. Lantos.

Normally the Chair does not entertain opening statements beyond the Ranking Democrat and himself. However, Members many times have a great urge to make a statement, and the reason for holding them down is so we can hear the witnesses. We have other opportunities to talk, and the witnesses have a limited window to present us with their views.

In an effort to compromise the situation, the Chair will entertain 1-minute opening statements from those who choose to do so. By unanimous consent, the full statements will be made a part of the record.

I have been asked by two Members, and there may be more as we proceed, so first Mr. Smith of New Jersey is recognized for 1 minute.

Mr. SMITH OF NEW JERSEY. Thank you very much, Mr. Chairman, and I want to especially thank you for your leadership in crafting this legislation.

When you said this Committee crafted this bill, we did all have some input, but you took the lead. It would not have been law without you, so I want to publicly say how grateful we all are that you took the lead on this.

Let me also just say to Ambassador Tobias, and during the Q&A I intend on pursuing this. There is a concern, as you know, Mr. Ambassador, that many of the organizations that are receiving the funding do not take seriously the A and the B of the ABC model.

PSI, for example. I was reading some of the testimony that Martin Ssempe will be presenting later on in this hearing, and he points out that faith-based organizations are being shown the door, are being told that they are not going to be receiving funding because of their emphasis on the abstinence.

I want to make it very clear and remind my colleagues I wrote the amendment and offered the amendment that provided a conscience clause that is absolutely crystal clear airtight that an orga-

nization that may have some objection, morally and otherwise, can decide not to be a part of a condom distribution plan.

Martin makes the point in his testimony that there is this drive by USAID and by other Western donor countries and agencies to trivialize the whole abstinence and be faithful part of this, and if you look at Uganda—

Chairman HYDE. The gentleman's time has expired.

Mr. SMITH OF NEW JERSEY [continuing]. The numbers have dropped dramatically with an emphasis on abstinence and being faithful.

Chairman HYDE. Mr. Brown of Ohio.

Mr. BROWN. Thank you, Mr. Chairman, and thank you for changing your policy to allow Members to speak for 1 moment.

Welcome, Ambassador Tobias. I look forward to this hearing as a forum to address the successes and the challenges and the opportunities facing you and PEPFAR as we enter its third year.

I want to welcome other witnesses, including Mr. Valenti, and thank him and those at the Global Fund to Fight AIDS, TB and Malaria for their ongoing commitment to this fight.

The AIDS epidemic around the world continues to reach new and staggering heights. Some 40 million people around the world are living with HIV/AIDS. Millions a year, as we know, die from this awful disease.

In the countries targeted by PEPFAR, incidence rates for tuberculosis are up to 5 times the global average, nearly 150 times the incidence rate in the United States. We know that one-half of AIDS deaths in Africa are in fact deaths from tuberculosis.

I look forward to hearing about how our witnesses feel we can address the parallel epidemic of TB infection that is accompanying skyrocketing rates of HIV/AIDS in the 15 targeted countries. We know that around the world the convergence of those two diseases can be catastrophic if we do not act more preemptively than we, as a wealthy nation with a nation of opportunity, can.

Thank you.

Chairman HYDE. Mr. Poe of Texas?

Mr. POE. Thank you, Mr. Chairman. I want to thank all the witnesses for being here today at this important hearing as we try to have oversight on the \$15 billion we authorized last Congress to fight the AIDS epidemic in Africa through treatment and prevention.

However, despite public law and the U.S. policy to promote a balanced ABC model in our AIDS prevention grant, we are getting reports of a very unbalanced dispersal of money to organizations with aggressive condom social marketing campaigns. Meanwhile, groups promoting abstinence and fidelity are severely underfunded.

I understand that one of our witnesses today was denied funding because his organization did not promote open condom marketing. This is unacceptable and clearly breaks the law as it was passed in 2003.

So my concern and my request is, we need an explanation on how the least effective, least popular method of birth control, condoms, is being pushed upon other cultures as their front line of defense against the AIDS epidemic, and I would like an explanation on why groups with a history of criticizing and opposing a

balanced ABC strategy receive the bulk of the AIDS prevention grants.

Chairman HYDE. The gentleman's time has expired.

Mr. POE. Thank you, Mr. Chairman.

Chairman HYDE. The gentlelady from California, Ms. Lee?

Ms. LEE. Thank you, Mr. Chairman. Let me also thank you and our Ranking Member for your leadership and thank Ambassador Tobias and our witnesses for being here. You have an incredibly difficult job.

Let me just say I am one of those who wanted a greater emphasis, of course, on model C. I think when you look at the numbers of women and children now being infected, female condoms, male condoms, we have to have a larger emphasis, a greater emphasis on that in terms of an effective intervention for those who are sexually active.

Let me just say earlier this week I attended in my district the 17th Annual National HIV/AIDS Update Conference, and everyone in the field is concerned about this Administration's, for the most part, abstinence only policy as being the cornerstone of our HIV and AIDS prevention efforts.

I was at the conference in Bangkok, Thailand. Once again, the entire world is concerned about this abstinence only policy and so I think while ABC is the preferred and I support ABC—Abstinence, Be faithful, use Condoms—we have to have an equal comprehensive strategy in terms of funding because groups on the ground in Africa, especially, are telling us and throughout the world that the prevention of the discussion of the distribution of condoms is really a death sentence.

Chairman HYDE. The gentlelady's time has expired.

Ms. LEE. Thank you, Mr. Chairman.

Chairman HYDE. The gentlelady from Minnesota, Ms. McCollum?

Ms. MCCOLLUM. Thank you, Mr. Chair. I look forward to today's hearing, and because I have a lengthy question, I would hope that maybe the Chair would give me an extra minute on my question and I would yield back the time to the Chair.

Chairman HYDE. I thank the gentlelady.

Mr. Crowley of New York?

Mr. CROWLEY. Thank you, Mr. Chairman. Firstly, Mr. Chairman, thank you for holding this hearing today and secondly for supporting my amendment to the Global HIV bill that we passed 2 years ago dealing with gender equity and recognizing the need to teach not only ABC, but the "R" word, Respect of young boys and men toward women in treating them as co-equals.

I have another concern, one that I shared with my colleague, Barbara Lee, and that is the issue of India. She and I had an opportunity to travel there last year to talk about HIV/AIDS and its spread, and the concern that India is not a part of the global HIV/AIDS bill that we passed, it is not one of the PEPFAR countries.

I think it is important in recognizing the development that India is going through right now, the continuing development, that we need to do more in that country as well to help them with their HIV/AIDS crisis that is more than looming. It needs to be addressed in order for India to participate in the way in which we

want them to participate in the future. That is, not as a fledgling democracy, but a strong and vital democracy in that part of the world.

I wholeheartedly support the ABC program. I wholeheartedly support the "R" word, and I think that we need to see that transferred as well not only in Africa, but also at some point, to India as well.

With that, I yield back the balance of my time.

Chairman HYDE. I would like to welcome Ambassador Randall Tobias, the President's Global Coordinator for the Emergency Program for AIDS Relief.

Ambassador Tobias was nominated by the President in July 2003 and confirmed by the Senate that October. Before assuming his position as Coordinator, Ambassador Tobias served on a number of corporate boards and was the President and CEO of Eli Lilly & Company and was named Pharmaceutical CEO of the Year by the Wall Street Transcript in 1995. Before this he was Chairman and CEO of AT&T International.

We are honored to have you, Ambassador Tobias, appear before us, and please proceed with a 5-minute, give or take, summary of your statement. Of course, your full statement will be part of the record.

Ambassador Tobias?

**STATEMENT OF THE HONORABLE RANDALL L. TOBIAS, U.S.
GLOBAL AIDS COORDINATOR, U.S. DEPARTMENT OF STATE**

Ambassador TOBIAS. Mr. Chairman, Mr. Lantos, Members of the Committee, thank you all, first, for your very strong and continuing leadership on this issue, and thank you also for the opportunity to discuss the Emergency Plan for AIDS Relief this morning.

In the 15 months since funds were first appropriated in January 2004, the Emergency Plan has worked throughout the world in more than 100 countries with special focus on 15 of the most severely burdened nations. We believe that dramatic success in these nations, many of them among the world's poorest, will enable us to demonstrate to the entire world what intensive leadership and commitment of resources can indeed do in this fight.

In my view, what the world has most needed in dealing with HIV/AIDS is hope. For there to be hope, it is essential to be able to point to real progress, and I am pleased to report that the Emergency Plan is making progress and is on track to meet its ambitious 5-year prevention, care and treatment goals.

These early achievements are described in detail in our recent first annual report to Congress in the area of treatment. And for perspective, in December 2002, at the time President Bush announced the Emergency Plan in January 2003, an estimated 50,000 people were all that were receiving antiretroviral therapy in all of sub-Saharan Africa.

In the first 8 months of the Emergency Plan we supported treatment for about 155,000 HIV-infected adults and children in the focused nations, and that means that the United States was quickly able to support treatment for three times as many people as had existed before, and we are supporting treatment for more than any other in the developing world.

That data is as of September 30, and the number is now certainly a great deal higher as we have continued to scale up our treatment programs in the months that have followed.

Prevention is another area in which we are making real progress working in support of national strategies. The Emergency Plan reached over 120 million people with targeted prevention messages through media—

[Protestor interruption.]

Mr. LANTOS. We have the message. I think you can sit down now.

Ambassador TOBIAS. The Emergency Plan reached over 120 million people with targeted prevention messages through media and community- and faith-based interventions during the program's initial 8 months. We were also able to reach 1.2 million women with services to prevent the tragedy of mother-to-child transmission of HIV.

We are also committed to care. We have scaled up our programs for orphans and vulnerable children and for palliative care for those HIV-positive people who need it. In the early months, the U.S.-supported care for more than 1.7 million people infected and affected by HIV/AIDS, including over 630,000 orphans and vulnerable children, but there is so much more to do. It is a promising start, but it is only a start.

Counseling and testing are also crucial to the success of our efforts, and the Emergency Plan helped make them available for nearly 1.8 million people in the focus countries in the initial months.

Clearly the U.S. has made great strides in fulfilling our commitment in these first 15 months, and with Congress' support, the Emergency Plan will continue to provide strong results-oriented leadership around the world.

Mr. Chairman, you highlight the importance of partners in our prevention work, including our support for host nations programs to promote the delay of sexual debut and faithfulness for those in monogamous relationships. We are working with many of the indigenous and faith-based partners whose experience and commitment to this work you noted, and we are reaching out for more.

In all of our activities I am committed to ensuring that the partners we work with are, in fact, carrying out the policies set by the Congress and the President. We are in the process of instituting an independent programmatic audit to help us monitor program activities, and that capability will be added to the Emergency Plan in 2005.

You also mentioned the importance of protecting women and girls from HIV infection due to violence or coercion. Of course, you are absolutely right that this is a very serious problem, one that is difficult, but essential to address.

The Emergency Plan has begun to support some innovative programs that focus on that issue, and we recognize the need to do more in the coming years as you suggest.

Chairman HYDE. Ambassador, if you would hold up just for a few minutes?

I wonder if the police could escort our friends from the room?

[Pause.]

Chairman HYDE. I think you can proceed now. Thank you.

Ambassador TOBIAS. Thank you, Mr. Chairman.

Let me close my opening remarks by simply saying that I emphatically agree with you, Mr. Chairman, on the importance of training more indigenous healthcare workers. Building capacity is the key to a sustainable response, and it is and will remain one of our very top priorities. Throughout intensive training efforts we are helping people in our host nations develop the skills to meet their neighbors' needs.

Mr. Chairman, new hope is being borne in places where it has been in very short supply, and this is something of which you and this Committee and all Americans can be justly proud.

I thank you, Mr. Chairman. I ask that my full testimony be included in the record, and I will be happy to respond to questions.

[The prepared statement of Ambassador Tobias follows:]

PREPARED STATEMENT OF THE HONORABLE RANDALL L. TOBIAS, U.S. GLOBAL AIDS
COORDINATOR, U.S. DEPARTMENT OF STATE

Mr. Chairman, Mr. Lantos, and Members of the Committee:

Thank you for this opportunity to discuss President Bush's Emergency Plan for AIDS Relief. As the International Relations Committee has long recognized, global HIV/AIDS is one of the most daunting challenges the world faces—or, indeed, has ever faced.

In my view, what the world has most needed in dealing with HIV/AIDS is hope. For there to be hope, it is essential to be able to point to real progress.

It will be a long journey for us to bring hope under the tragic circumstances of HIV/AIDS. That journey is now, however, well under way.

It began just over two years ago, when the President proposed the largest financial commitment any nation has ever made to an international health initiative dedicated to a single disease. The Emergency Plan is a five-year, \$15 billion dollar commitment—our nation's promise to provide bold leadership and action to a world that faces a desperate emergency.

In the time since funds were first appropriated in January 2004, the Emergency Plan has worked throughout the world, with a special focus on 15 severely burdened nations, including 12 in sub-Saharan Africa, two in the Caribbean, and one in Asia. We believe that dramatic success in these nations, many of them among the world's poorest, will enable us to demonstrate to the entire world what intensive leadership and commitment of resources can do in this fight.

I am pleased to report that the U.S. has begun to do what we must to bring hope to the hopeless: we are getting results. As our recent Annual Report to Congress makes clear, the Emergency Plan is on track to meet the ambitious five-year prevention, care, and treatment goals the President set for it.

Let me give an example of these results in the area of treatment. To put them in perspective, in December 2002, one month before President Bush announced the Emergency Plan, an estimated 50,000 people were receiving antiretroviral therapy in all of sub-Saharan Africa.

In its first eight months, the Emergency Plan worked under national strategies in the 15 focus countries to support treatment for nearly 155,000 HIV-infected adults and children.

And that data is as of September 30th. The number is now certainly much higher, as we have continued to scale up treatment programs.

Prevention is another area in which it is essential for us to work in support of national strategies. Our approach must be based very specifically on what works for the culture and circumstances of each place we are working, with the individuals and groups we are targeting. Our prevention strategies are informed by the remarkable experience of Uganda, and implementation is being developed in consultation with the people and governments of our host nations.

I'm pleased to report that the Emergency Plan reached over 120 million people with targeted prevention messages through media and community-based interventions during the program's initial eight months. One example of targeted outreach is the Emergency Plan's initiative to reach out to men and boys, helping them keep themselves and their loved ones safe from HIV. In South Africa, a U.S.-supported

workshop offered lifesaving prevention information, getting men involved in fighting HIV/AIDS.

Another key prevention strategy involves preventing transmission of HIV from mothers to children. Last year, we were able to reach 1.2 million women with services to prevent that tragedy. Once again, that number is as of six months ago, so the figure is much higher today. In Guyana, for example, Emergency Plan support helped a clinic reach more than 25 percent of all pregnant women in the nation, offering testing and, as needed, antiretroviral prophylaxis.

In addition, we are pursuing other prevention strategies, described at length in the Report to Congress.

We also remain committed to care. We have scaled up our programs under national strategies for orphans and vulnerable children, and for palliative care for those HIV-positive people who need it.

In the early months of implementation, the U.S. supported care for more than 1.7 million people infected and affected by HIV/AIDS, including over 630,000 orphans and vulnerable children. Speak for the Child, a community-based program in Kenya, offers an example of the activity the U.S. is supporting for children. The program focuses on young children, who are especially vulnerable to disease, malnutrition, and psychosocial harm when their families are affected by AIDS. With dramatically increased support thanks to the Emergency Plan, Speak for the Child was able to expand from serving 400 children in March 2004 to 3,300 by the end of September.

When people see that those who are infected with HIV, or who lose parents to AIDS, are well cared for, that too brings hope. There's so much more to do, but it is a promising start.

As we look forward, one of the biggest challenges we face, along with other donors, is the need to sharply increase the rate of counseling and testing. I believe that the paradigm of "provider-initiated testing," in which testing is increasingly integrated into the health care system, is very promising. In the Emergency Plan's early months, we supported counseling and testing for nearly 1.8 million people in the focus countries. Once again, those are numbers we plan to drive much higher in the coming years.

So the U.S. has not just taken a single step, but has made great strides in fulfilling our commitment. Based on our results to date, I believe we are on track to meet the President's goals, and to save a steadily increasing number of lives.

I am deeply grateful to this Committee, and to Congress as a whole, for the support we have received for the first two years of the Emergency Plan. In Fiscal Year 2004, our funding level was nearly \$2.4 billion, and it rose to \$2.8 billion for the current fiscal year. The President's request for nearly \$3.2 billion in 2006, therefore, represents the third year of steadily increasing funding toward the President's commitment of \$15 billion in five years.

From the outset, the President intended that funding for this initiative be increased over time. This approach is consistent with sound public health practice. His Fiscal Year 2006 request for nearly \$3.2 billion is what is needed for us to keep the Emergency Plan on track to fulfill our commitment of \$15 billion over 5 years, and to reach our goals of preventing 7 million new infections, supporting treatment for 2 million people, and caring for 10 million people, including orphans and vulnerable children.

We support programs in many nations where the capacity to deliver health care is severely limited by a history of poverty and neglect. At the risk of stating the obvious, our ability to put resources to work in a nation is constrained by its health care infrastructure and supply of trained health workers.

This is why we have invested so much effort in expanding that capacity in nations hard-hit by HIV/AIDS. The initial success we have been able to achieve gives us confidence that we can put steadily increasing resources to effective use.

Of course, our capacity-building work is not primarily about making it possible for the United States to do more in the future. Rather, the Emergency Plan is building local and host-nation capacity so that national programs can achieve results, monitor and evaluate their activities, and sustain their responses for the long term.

Without local capacity, nations cannot fully "own" the fight they must lead against HIV/AIDS. For that reason, a statistic I find most encouraging from the early months of our work is this one: fully 80 percent of our more than 1,200 partners working on the ground were indigenous organizations including faith- and community-based partners.

In the early days of the Emergency Plan, we have made tremendous strides in helping host nations develop their capacity to respond. Our recent Report to Congress provides detailed information on these achievements, so I will only briefly summarize them here.

As you know, infrastructure is a major challenge. In the early days of the Emergency Plan, the U.S. has been able to promote the expansion of existing health care networks and the development of new public and private network systems to enhance the delivery of HIV/AIDS services in remote areas.

For those networks to be effective, they require trained personnel. Responding to the critical shortage of trained health workers at all levels, the Emergency Plan has supported training that covers a broad range of services, from prevention—including mother-to-child prevention—to antiretroviral treatment, to palliative care, to counseling and testing, to orphan care. The American people, through the Emergency Plan, are helping people in our host nations develop the skills to meet their neighbors' needs.

The Emergency Plan has also fostered indigenous leadership in the fight against the HIV/AIDS pandemic. The U.S. has provided technical assistance for appropriate policy development, including policies protecting women and girls, and for strengthening local institutions and organizations, including organizations of persons living with HIV/AIDS.

Other components of local capacity on which we have focused include surveillance, reporting, evaluation, and strategic information. These tools allow us to maintain the accountability which is a cornerstone of the Emergency Plan, and to adjust our programming based on what works. Even more importantly, these tools allow host nations to monitor and adjust their national responses.

Our host nations have warmly welcomed our commitment to partnership with them, and our support for their national responses. At this early stage, U.S. support is still needed—in fact, it is indispensable. Our support is essential to allowing host nations that have recently been able to begin antiretroviral therapy on a broad scale to maintain and expand that work. We can help to ensure that the gains we have made are not allowed to slip away, but are built upon.

The Emergency Plan is also providing essential support to our international partners, working with them to build capacity. Under the “Three Ones” agreement, we are cooperating intensively with international donors in support of our host nations' strategies. For example, we support the Global Fund to Fight AIDS, Tuberculosis, and Malaria in two ways: through our direct financial contributions, which continue to far exceed those of any other donor government, and through our efforts to build the capacity on which their programs often rely.

Ever-increasing accountability and transparency will continue to be areas of emphasis throughout 2005. From the beginning, Congress has shared the President's vision of the Emergency Plan as a new way of doing business, one focused on the bottom line—saving lives. We have made an unprecedented commitment to strategic information, monitoring and evaluation, and we have made substantial progress on that front, as described in the Report to Congress.

I am committed to ensuring that the partners we work with are in fact carrying out the policies set by Congress and the President. We are in the process of instituting an independent, programmatic audit to help us monitor partner activities, and that capability will be added to the Emergency Plan in 2005. I am also aware of the need for a user-friendly Emergency Plan website to offer Congress and the public access to information. Such a website is currently under development.

If I may step back and look at the big picture for a moment, the Emergency Plan is part of our nation's broad effort to offer leadership on international development. I think the Emergency Plan embodies the President's approach, emphasizing partnership with host nations, capacity building, and accountability. These are increasingly among the hallmarks of America's development strategy.

Results, of course, are the test of any strategy. In just eight months, the United States was able to put more people in the developing world on drug treatment than any other donor. That's a powerful fact. With Congress' support, the Emergency Plan will continue to provide that kind of strong, results-oriented leadership around the world.

Thanks to the commitment of the American people and Congress, along with the courageous people of our host nations, new hope is being born in places where it has been in short supply. This is something of which all Americans can be proud.

Mr. Chairman I ask that my full testimony be included in the record. I would be happy to address your questions.

Chairman HYDE. Without objection. It shall be made a part of the record, and we will now proceed with questions.

Mr. Lantos?

Mr. LANTOS. Thank you, Mr. Chairman. I want to commend Mr. Tobias not only on his statement, but on his very effective and non-ideological performance, a very difficult responsibility.

I want to apologize in advance if I dash out, but I am in another Committee, and a vote is pending. I may have to leave.

Mr. Tobias, I would like reassurance from you, if I may, that any group receiving abstinence-only funds from your office is not allowed to provide medically inaccurate information about condoms.

For instance, I would like to ask you whether you would grant funds to an organization in Uganda which would use our taxpayer dollars to inform young people that condoms do not protect them from HIV/AIDS and an organization which engages in public burning of condoms.

Ambassador TOBIAS. Mr. Lantos, as has been pointed out, it is part of the legislation that created the Emergency Plan, and it is certainly the policy and practice as we are implementing the Emergency Plan that this is a results-based/data-based implementation program.

Therefore, with our prevention—the heart of our prevention program being our A and B and C—organizations are expected not to provide or put out information that is simply not factually correct about A, or about B, or about C. That is our policy, and we are doing our best to implement that.

Mr. LANTOS. With all due respect, Mr. Tobias, you did not answer my question.

If an organization publicly announces that condoms do not protect young people from HIV/AIDS and demonstrably engages in the public burning of condoms, would such actions make them ineligible for U.S. taxpayer funds?

Ambassador TOBIAS. Based on the facts as you have represented them, I would think it would.

Mr. LANTOS. So you would deny funds to such an organization?

Ambassador TOBIAS. Based on those facts.

Mr. LANTOS. Based on those facts.

Ambassador TOBIAS. I think that would be the case.

Mr. LANTOS. I appreciate it very much.

The second question I have relates to India. It is our projection that in 5 years' time, India may have over 20 million cases of HIV/AIDS, and I would like to make a strong recommendation that India be included in the list of focus countries because certainly while on a percentage basis, given the size of India's population, the HIV/AIDS problem may appear to some to be negligible, we are talking about millions and soon tens of millions of people.

I would be grateful if you would respond.

Ambassador TOBIAS. Mr. Lantos, the focus of the Emergency Plan is really to bring together all United States Government HIV/AIDS activities around the world, and we have programs in about 100—a little more than 100—countries around the world.

The large focus in particularly launching the Emergency Plan has been on the 15 so-called focus countries. Our working definition of a focus country is one that is engaged in a national scale-up of prevention, treatment and care activities and where the United States is committing the resources and the assistance and the involvement to help support that national scale-up.

At the same time, we are also deeply engaged in a number of other places, India being an example. We increased our commitment to fighting HIV/AIDS in India by nearly 25 percent from 2003 until 2004, and in fact India has, and I think quite appropriately, the largest bilateral U.S. support outside of the 15 focus countries, and in fact it is larger than the financial support for some of the focus countries. It was about \$36 million in 2004.

In addition to that, because the Global Fund is such an important part of our overall strategy and we are providing a third of the funding for the Global Fund and the Global Fund is also very active in India, we are providing a good deal of support that way.

I think as time goes on we will need to find ways to do more because, as you point out, India is a very, very important source of HIV/AIDS spread in the world and within the country.

Mr. LANTOS. Thank you, Ambassador. Thank you, Mr. Chairman. Chairman HYDE. Mr. Smith of New Jersey?

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

Mr. Ambassador, I referenced earlier some of the testimony that a man by the name of Martin Ssempe will be providing later on. He makes the point, and I would ask you if you could respond to it, in talking about money that had been given to Population Service International—a condom social marketing firm—as the primary abstinence provider and calls that a joke, that lives are at stake. He is concerned that for kids it is a ticket to death.

He points out that PSI turns away faith-based groups. One of the managers informed him, and I quote Mr. Ssempe: “If we are going to work together, we have to include condoms as a component of our prevention program,” which is absolutely contrary to the legislation, because I know—I offered the amendment, and it passed the House, passed the Senate, was signed by President Bush into law, and you know the clear language.

What is done to PSI now, if this is true, to ensure that that kind of illegality is stopped dead in its tracks?

Secondly, a group which also receives a significant amount of money from our Government, Family Health International, which is headed by Dr. Willard Case, and I would just point out, parenthetically, to my colleagues that back in 1976 he gave a paper, and I have a copy of it, and I say this parenthetically because it is not exactly on point, but it shows, I think, a mindset that I find extremely disturbing. He said that pregnancy is the second most prevalent sexually-transmitted disease. A natural occurring, life-affirming, life-giving state that a woman finds herself in when she is with child—pregnancy—is called a disease. He is now head of Family Health International.

His organization, and I would ask you if you could respond to this, makes the point when they are talking about abstinence to young people, and this is apparently black and white their definition of what is included in an abstinence definition. It includes massage, body rubbing, kissing, masturbation and mutual masturbation.

Now, is that a message that you tell young people in Africa or anywhere else constitutes abstinence, and what do we do in terms of our definition of what abstinence is? Is it just simply a lack of sexual intercourse? Or are oral sex and a whole host of other non-

pregnancy producing or potentially HIV-enhancing activities what we are talking about? If you could respond specifically to their definition of abstinence, I would appreciate it.

Finally, on the local front, Commission Cleet is going to be holding a 4-week or so meeting and asked a number of questions of our personnel over there in Geneva, where is the money going in the Global Fund?

I supported President Bush. I supported Henry Hyde, was a co-sponsor of this legislation, but who we give this money to does matter. It has to be transparent, and I find a lack of transparency when it comes to the Global Fund and exactly what it is that they are doing on the ground with this money.

PSI, like I said. If you could respond to those three questions, I would appreciate it.

Ambassador TOBIAS. Mr. Smith, when the President announced the creation of the Emergency Plan and then when this Committee initiated legislation, including the amendment that you referred to, it was very clear that ABC was the heart of our prevention strategy.

We spelled that out in some detail then in the early part of 2004 when we produced a strategy, and then in January of this year we produced for the field some far more detailed guidance for the implementation of ABC. What is contained in those documents and particularly the guidance to the field, I think, would be the answers to the definitional questions.

Let me say that everything we are doing, we are doing with very careful consideration of what I have learned since joining the government are very complex procurement and contracting laws and regulations. We are very careful to follow that.

Once organizations are funded, they understand that in receiving the funding they have to comply with the programs and policy guidance that we provide them based on that strategy and based on the guidance to the field I mentioned.

We are engaging now, and I think it is very timely to do so, program auditors, external program auditors, who will be evaluating the adherence to that guidance and those policies in the program implementation because we want to ensure that the money we are investing is going into things that are going to work and going to produce results. Any specific instances of deviation from the policies and guidance will be reviewed when they are identified and appropriate action will be taken, whatever that may be.

Mr. SMITH OF NEW JERSEY. What is appropriate action?

Ambassador TOBIAS. Appropriate action could include terminating the awards if in fact under the law that is the appropriate thing to do, but we will have to see what instances are identified during this process and then what the appropriate steps are to do.

At the same time we are working hard to expand the pool of partners to implement the programs. Part of our annual review process of the country operating plans includes reviewing the progress that has been made in each country and bringing in new partners, the degree to which we are increasingly utilizing indigenous partners and the utilization of faith-based organizations.

We have made progress. Particularly with indigenous partners. I am pleased that 80 percent of the total partners in the program

who will receive funding in 2005 are indigenous organizations. There was an increase in faith-based partners from 20 percent to 23 percent in 2004 to 2005.

We are also in the final stages of finalizing a new partners initiative that will be designed to provide technical support to organizations who want to do business with the government but need training in order to gain the techniques in order to do business with the government.

Implementation of the Emergency Plan involves changes in the magnitude that everybody has recognized here this morning. The magnitude of the challenge is very consistent with my own experience in running an international company in the private sector with operations in 132 countries.

It is one thing for the head of the organization to announce from the CEO's office that this is our policy. It is not then surprising to me, in going around the remote corners of the world, that not everybody is doing everything perfectly the first time. I think we are making progress, but clearly there is much, much more to be done.

Chairman HYDE. The gentlelady from California, Ms. Lee?

Ms. LEE. Thank you, Mr. Chairman. Let me just follow up in terms of the issue of following procurement laws. It has come to my attention that last year, around November 1, you approved funding for an HIV/AIDS prevention grant in Uganda the Technical Review Committee deemed not suitable for funding.

Now, this grant was never announced to the public. I thought that the technical review process had to be completed and adhered to in terms of a recommendation. There was no public announcement on this grant. I believe it was the Children's Aid Fund organization run by Ms. Anita Smith and Shepherd Smith.

I am trying to get a handle on this because I do know that they have close ties with the Bush Administration, but again we need all of the information. I would like to ask you for all of the information on the review of this grant, including the contacts with the White House and just how this actually happened following up with what Mr. Smith said.

I mean, you indicated transparency. This one clearly did not meet that test.

Ambassador TOBIAS. Well, Ms. Lee, this particular grant involves a unique opportunity to replicate the success in Uganda where HIV prevalence has declined from 15 percent to 5 percent in other nations that are battling generalized HIV/AIDS epidemics.

The First Lady of Uganda, Janet Museveni, is credited in many places with placing a significant role in developing Uganda's highly successful ABC approach. The Children's Aid Fund proposal provides the U.S. Government with a unique opportunity to work directly with the First Lady of Uganda and her Uganda Youth Forum in AIDS prevention activities.

As the technical panel that you referred to noted, the Uganda Youth Forum is a pioneer in abstinence and faithfulness messages. Based on those reasons, the USAID Administrator recommended that the Global AIDS Coordinator approve funding for the Children's Aid Fund proposal subject to certain determinations.

That recommendation was consistent with USAID's grant-making policies when such a selection is based on an adequate justification, as it was in this case.

Ms. LEE. Mr. Ambassador, okay. So when a technical review panel indicates it is not suitable for funding, you have the authority to use other means to go on and fund it that give you the confidence that it is suitable for funding?

Ambassador TOBIAS. That is right.

Ms. LEE. Okay.

Ambassador TOBIAS. For all of these reasons, the USAID Administrator recommended that funding be approved. I approved that recommendation and asked that USAID fund the proposal subject to a determination that they meet USAID's financial management requirements.

Ms. LEE. Okay. Would you be so kind as to release the information that you can release to us for our review with regard to that grant, please?

Ambassador TOBIAS. I believe that whatever information can be released subject to the privacy requirements around the procurement process—

Ms. LEE. Sure. I understand.

Ambassador TOBIAS [continuing]. Has been. I will check when I go back to my office—

Ms. LEE. Would you double-check? Okay.

Ambassador TOBIAS [continuing]. To determine that.

Ms. LEE. The second question I want to ask you is, I am very concerned now about the denial of funds to those organizations that work with sex workers. You all have decided that you require organizations to have a public policy opposing prostitution.

Now, you know, that issue is a very important issue for women especially, and let me just say I visited Zambia and talked to many of the sex workers at truck stops. One hundred percent of them said if they had a job, if they had other means to support themselves, they would.

Why in the world would you deny organizations who try to work with these sex workers, who try to find them jobs, who try to help them understand how to protect themselves? Why would you deny funding to one of those organizations and allow this policy in addition to the whole issue of First Amendment rights that these organizations have? What is going on?

Ambassador TOBIAS. Ms. Lee, the facts are not quite as I think they may have been reported to you.

The fact is that the legislation passed by the Congress directs to me that no funds may be made available to carry out the act by providing assistance to any group or organization that does not have a policy explicitly opposing prostitution and sex trafficking, and so we are implementing that provision in the legislation.

Quite simply, it is our responsibility to comply with the provisions of the act, and I think it is an important provision of the law. In fulfilling our responsibilities it is our intent to fight the disease and the spread of the disease and the people who promote the spread of the disease, but it is not our intent to fight the people who live with the disease.

Ms. LEE. Mr. Chairman?

Ambassador TOBIAS. As emphasized in the funding restrictions, we have no policy and no intent to exclude any group of persons from services who need these services, and in fact I have visited programs that we are funding where we are trying to provide job skills, for example, to get prostitutes out of such work.

Ms. LEE. Mr. Chairman, I just think, given the huge numbers now in terms of women being infected with HIV and AIDS, we need to first repeal that policy.

Secondly, immediately ask USAID to stop doing this because I know many organizations that are being denied funding if in fact they are trying to work with these sex workers.

Chairman HYDE. I thank the gentlelady.

Mr. Poe of Texas?

Mr. POE. Thank you, Mr. Chairman.

I have two rather short questions, Mr. Ambassador. First, we have an ABC model. What is the percentage for A, the percentage for B, and percentage for C that the funds go to? And which countries other than Uganda have shown a decrease in AIDS in their country?

Ambassador TOBIAS. The benchmarks or the earmarks in the legislation direct that 20 percent of the funding be spent on prevention and that 33 percent of prevention expenditures be spent on abstinence.

Now, in actually implementing this in the field, and I think most public health professionals would agree with this, it is important to couple the A messages and the B messages except for young children, and so when we talk to people about abstinence, about delaying the age at which they become sexually active, we also then talk to them about what to do when they enter into a marriage relationship and the importance of knowing their status and their partner's status and being faithful within that relationship.

In 2004, 34 percent of the funding in the focus countries was spent on all prevention. That would be prevention not only of sexual transmission of HIV, but also prevention through safe blood, safe injections, preventing mother-to-child transmission and so forth. AB spending was 27 percent of that 34 percent. Now, if we look only at the expenditure in 2004 of prevention for sexual transmission of HIV, then AB spending was 56 percent of that portion of prevention.

The numbers do kind of funny things here because if, instead of having spent 34 percent in 2004 on prevention, we had spent the same amount on AB but had only spent 20 percent of the money in the focus countries on prevention, then the AB spending would have been 41 percent.

As we go out into the future I am confident that we will be meeting the earmarks that the Congress has established. As the money goes up, it will go up in larger proportions in treatment because we will be adding more people in treatment and acquiring drugs and training, healthcare workers, and that sort of thing as these programs expand. That will change the size of the base, and if you do the math and all of that, it makes the percentages go up.

Those are the earmark requirements, and that is exactly what we are attempting to do. Part of our programming effort involves setting targets in each of the countries when they put their annual

plans together, and those earmarks are the targets that they are expected to work toward.

Mr. POE. So my question is: How much are we spending on A, how much are we spending on B, and how much are we spending on C percentage-wise, please?

Ambassador TOBIAS. It is difficult for me to break out A from B, but the A and B together, as I indicated, depending on which base you use, is either 27 percent or 56 percent of the prevention expenditure.

Mr. POE. And so the vast majority is going on C? Would you agree with that?

Ambassador TOBIAS. No, I would not agree with that.

Mr. POE. But you cannot give me a percentage for each one of them?

Ambassador TOBIAS. Well, I can, and I will be happy to lay this out for you in some detail.

Chairman HYDE. The gentleman's time has expired.

Mr. POE. Thank you, Mr. Chairman.

Chairman HYDE. The gentlelady from Minnesota, Ms. McCollum?

Ms. MCCOLLUM. Thank you, Mr. Chair.

There are three countries in southern Africa that are not focus countries in the President's Emergency Plan, but they are facing disaster. In fact, your leading global AIDS expert has said Malawi, Lesotho, and Swaziland are facing extinction. Each of these countries is surrounded by a PEPFAR country, which makes them islands of infection.

Malawi, Lesotho, and Swaziland have a combined population of 15 million people, and together the life expectancy for a woman in any of these countries is 37 years old. For a man, it is less than 35. That means a teenager who is 17 years old has reached middle age.

Females age 15 to 24 in Swaziland have an HIV prevalence rate of 39.5 percent. In Lesotho it is 38.1 percent. In Malawi it is 15 percent. By 2010, these three small countries will have one million AIDS orphans.

Now, I have no idea why these frightening deadly statistics do not qualify as an emergency under PEPFAR and why these three small nations which are literally dying due to AIDS and HIV are not included in the President's Initiative.

I strongly supported their inclusion, and I know many of my colleagues did as well. Unfortunately, these islands of infection have the appearance of providing a tragic baseline study for data in PEPFAR country reports.

Mr. Ambassador, my question is: Does the AIDS crisis in Malawi, Swaziland, and Lesotho qualify as an emergency, and are you and the Bush Administration willing to work with Congress to add these three devastated countries to the current list of focus countries receiving support?

Mr. Chair, seeing as I did waive my 1-minute, I do have another question.

Hearing your testimony last year in the House Foreign Relations Subcommittee, you made reference to a study on condoms by the London School of Hygiene and Tropical Medicine. One of the study's recommendations called for the increased investment on

condom promotion distribution and strengthen logistics as current supplies are inadequate.

It has come to my attention in calendar year 2004, 103 million condoms were shipped to the Emergency Plan focus countries. This is a 60 percent decrease—a 60 percent decrease—in condoms from the previous year, which I find troubling and irresponsible; negligent, in fact, if this is true.

Since we know that abstinence does not protect girls and women from rape, coercive sex, child marriage with an untested or infected partner, and we also know that faithfulness in marriage to a partner who is untested and HIV-positive is a death sentence, especially in countries in Uganda where the average age for marriage of a woman—or should I say a girl—is 17 years old.

My second question then: Why has PEPFAR decreased the supply of condoms to 60 percent when we know that 95 percent of the sexually active population are untested? They do not know their status. If you do not know your status or the status of your partner and you are having unprotected sex, this becomes high-risk sex. Even having sex in a faithful marriage relationship without knowing your status puts you in high risk. Why was there a 60 percent decrease?

Ambassador TOBIAS. Ms. McCollum, I do not have the numbers with me. I will get them and get them to you, but my impression is we actually purchased more condoms in 2004 than in 2003. I do not know the source of your numbers, but with the scale-up of the program I think that is my understanding.

Let me also say that it is an ABC program. Abstinence works. Being faithful works. Condoms work. They all have a role in the mix, and I will be happy to talk about the details of that if you would like.

With respect to the three countries that you mentioned, and going back to the comments I made earlier about the fact that we are not just a 15-country program, but a program really focusing on more than 100 countries around the world. In 2005, we will provide funding in Malawi for almost \$15 million, \$14.99 million, and in Lesotho and Swaziland, they will both receive something in the range of \$6.5 million.

We are also working in Lesotho and Swaziland to coordinate our efforts there with the United States teams on the ground in both of those countries, and the team in South Africa because of the geographic proximity, and we will be doing some of that with respect to Malawi.

These are all three countries that have been very hard hit by the HIV/AIDS pandemic, and they certainly deserve our attention, and we are trying to give them that.

Chairman HYDE. Mr. McCaul of Texas?

Mr. MCCAUL. Thank you, Mr. Chairman. I appreciate your leadership on this issue and Congressman Lantos as well.

I just have two short questions. One, the Uganda model seems to be an unqualified success, and it is stressing primarily the A and B of the ABC. How can we replicate that success not only on the African Continent, but worldwide? That is the first question.

The second one addresses the level of funding. We spent \$2.8 billion this year, and I think \$3.2 billion will be appropriated next

year to prevent the transmission of HIV worldwide. The Continent of Africa obviously is the major focus.

What percentage is going to the African Continent on this issue, and can you also address the level of funding, whether this is an appropriate amount of funding or whether it is either too less or too much?

Ambassador TOBIAS. Let me address the funding issue initially. I think when this Committee and the Congress responded to the President's State of the Union address and created the legislation that created this program, I think both the title, the President's Emergency Plan for AIDS Relief, and the funding were both totally appropriate. It is an emergency. Eight thousand people are dying every day, and we have to have a greater sense of urgency than we have.

I think as the Chairman said in his opening remarks, one of the biggest roadblocks that I have been dealing with as we scale up these programs is the lack of infrastructure, the lack of trained healthcare workers on the ground, and so there have been some absorptive issues as we have gone forward.

I might note that if you look at the \$15 billion commitment initially, and look at the \$2.4 billion that was appropriated in the first year, the \$2.8 billion in 2005, the \$3.2 billion that we have requested next year, add those three numbers together and subtract them from \$15 billion. That would leave an average of \$3.3 billion in each of the last 2 years in order to meet \$15 billion, so we are pretty much at a steady state.

I think the time will come soon when we need to think about where do we go after this 5-year program, after 2008? And I am beginning to think about how all of us working together ought to be talking about that.

In addition, what we desperately need to do—desperately need to do—is to get the rest of the world engaged in the same way that this Congress and this President have been engaged. We, the United States Government on behalf of the American people, are providing more funding than the rest of the world's donor governments combined.

Last year I was left sitting with \$88 million in my hand that the Congress appropriated for the Global Fund that, because of the very appropriate 33 percent ceiling on our contributions to the Global Fund relative to the total contributions, I was unable to give to the Global Fund because the rest of the world had not stepped up for their support to the Global Fund. So we need to get the rest of the world engaged.

To your other point, a very, very big and important element of the Emergency Plan is to use what we are doing and what we are learning in the 15 focus countries as the basis for then extending those lessons learned to other countries in the world.

As we have begun to get our hands around the focus countries and extending our efforts beyond that, we will be doing more of that kind of activity.

Mr. MCCAUL. I want to thank the Ambassador for his testimony and his leadership in helping to save lives against this terrible disease. Thank you very much for being here.

Ambassador TOBIAS. Thank you.

Chairman HYDE. Ms. Watson of California?

Ms. WATSON. Thank you so much, Mr. Chairman, and thank you Ambassador Tobias.

I just recently returned from India. We went to the area devastated since the earthquake and tsunami, and in discussions with the Prime Minister, AIDS is a tremendous concern and not only an epidemic but, we know, a pandemic.

I understand that there is or has been some discussion that it is such a huge country. I think they have over a billion people and they have money so we are not going to make them a recipient, but I think we should. I think we should. The \$15 million ought to go and hold their government responsible for its most effective use.

I would hope that we have some way of evaluating. I had missed most of the discussion, but you might want to comment as to how we evaluate the uses of our money. That is number one.

Also, I am concerned about how we distribute the funds on the Continent of Africa. Because the continent is composed of 54 countries and because there are 22,000 tribes speaking 16,000 languages, we cannot use the cookie cutter approach.

I know there was a lot of support for the Uganda model, and we know they have had success, but given the fact that there are different beliefs, there are different kinds of customs and cultures, we ought to have some way of shaping our program to fit the needs of the various countries and the various areas in a country, so I would like you to comment on what we are doing along those lines as well.

Ambassador TOBIAS. Ms. Watson, a very important principle of the way in which we are implementing the Emergency Plan is to do so hand-in-hand with the host country government.

About a year ago, in partnership with U.N. aides, the U.K., and several other donors, we helped to put in place a kind of a global strategy called "the three ones" which is having every donor encouraging every country to have one strategy for the country, to have a coordinating mechanism within the country that can help coordinate everything that goes on in that recipient country and to embrace a single monitoring and evaluation, a results measurement system in each country so that we are all working together and we are doing so on a country-specific strategy, so that is a very important part of what we are doing.

Not very long ago I was in the southern part of South Africa and spent almost half a day with a group of traditional healers. These are women—generally women—who are really the first line of primary healthcare, if you will, for many people, particularly in rural Africa.

When someone goes to a Western doctor and gets tested and they find they are HIV-positive, the first thing they do in many cases, particularly in the rural areas, is go to the traditional healer hoping to get a different opinion. And so because of that culture, we are funding programs to work with these traditional healers who are very receptive to what we are doing, to give them the knowledge and the skills to provide the right messages, messages about A and B and C, and messages about the importance of adhering to treatment and nutrition and other aspects of what we are doing.

That is just one example of something that would not be an appropriate way to do it in some countries, but there are 400,000 traditional healers in South Africa alone.

Ms. WATSON. Would you yield for a moment? When you said the one/one/one strategy, are you saying that they need to have one way of dealing with the AIDS epidemic in a country, or is that one strategy to work in various areas and regions of the country so the kind of activities and programs and services that are provided fit and are customized to meet the needs of the people in that area? I just want you to clarify what your one strategy means.

Ambassador TOBIAS. You know, one of the great Members of this body famously said that all politics are local. I have concluded all healthcare is local.

It is not just having a single cookie cutter approach even in a single country, but it is important that the nation have a strategy as to how they are going to approach the implementation of HIV/AIDS in that country. It may have different parts to that strategy that focus on different areas of the country.

It is also important as more and more donors step up—the United States Government, the Global Fund, other bilateral donors, philanthropists such as the Bill and Melinda Gates Foundation—that we are not stepping on each other and that we are closely coordinating all of our activities on the ground with the host country and consistent with the host country's strategy for approaching this, and that is really what we are making every effort to do.

Chairman HYDE. The gentlelady's time has expired.

We have three more questioners. We have two more panels and so I would appreciate any brevity, succinctness, even terseness.

Mr. Fortenberry?

Mr. FORTENBERRY. Thank you, Mr. Chairman. I will be brief.

Thank you, Mr. Ambassador, for your service and for your important work in this most difficult task of combatting the spread of HIV.

I would like to follow up to an earlier question. You suggested that funding would be denied groups who have demonstrated opposition to condom distribution. Conversely, would you also withhold funding from groups who by their demonstrated mission have opposed the abstinence and faithfulness message?

Ambassador TOBIAS. We have been very clear about what is in the law. We have been very clear about our policies in implementing the law, and very clear in the agreements that we have struck with people that we are funding of our expectation that they adhere to the law and to the policies.

So if people are not doing that and, again, consistent with the procurement and contracting laws and so forth, I would expect to take whatever action is appropriate, and that certainly could be up to and including terminating funding if people are not doing what they have agreed to do with the money.

Mr. FORTENBERRY. Thank you.

Chairman HYDE. Mr. Payne of New Jersey?

Mr. PAYNE. Thank you very much. Thank you. It is good to see you again. I am very impressed with the interest that you took this responsibility on.

Just on the \$15 billion, and I missed your testimony. I am just wondering. Of the \$15 billion that was supposed to be allocated over the 5 years, about how much of it have we actually spent?

Ambassador TOBIAS. It is \$2.4 billion plus \$2.8 billion in 2004 and 2005, plus we have asked for \$3.2 billion in the 2006 budget, so that is 8-point-whatever billion dollars that adds up to.

Mr. PAYNE. Okay.

Ambassador TOBIAS. \$8.4 billion, I think.

Mr. PAYNE. All right. Has there been any work with your group? You were talking about the 33 percent of the Global Fund, and I personally believe that is the best way to expend the funds because the Global AIDS Fund has a lot of infrastructure and countries with a lot of organizations working together and U.N.-related organizations, and I think it is usually better run. However, there are restrictions that we do have.

Has there been any advocacy on your part trying to talk to some of your counterparts in other countries, to talk about them perhaps having more focus on funding the Global AIDS Fund so that the overall amount contributed can increase what the U.S. is able to participate?

Ambassador TOBIAS. Well, Mr. Payne, certainly our strategy in the Administration is one of implementing both the bilateral programs that we have talked so much about, but also in encouraging support for the Global Fund. The Global Fund is a very important part of our strategy. We are providing about a third of the funding of the Global Fund.

I am about to go on the Board of Directors of the Global Fund, replacing former Secretary Tommy Thompson, who will be actually stepping down as Chair of the Global Fund at the upcoming April meeting, but I think we need a multilateral vehicle out there that can attract funding from other sources and particularly those who are not in a position to have bilateral programs.

Then it is important that we are all working closely together, and so we are putting more emphasis in our bilateral programs in countries, for example, where the Global Fund money has been slow in getting implemented.

In many cases the problems are on the ground. There are technical things that need to be done on the ground, and we need to be providing technical support so that that money can flow. We are trying to work very closely together with other donors and the host countries to address those issues.

Mr. PAYNE. Thank you very much. This is my last point. In a meeting about 2 months ago with the President, he asked me what programs did I think were more beneficial, going through the Global AIDS Fund or bilateral? And I still contend that the global approach is the most thorough even though, bilaterally, I do not think we should not do that. But I think that if we strengthen the Global Fund, strengthen their organization, I think at the end of the day it would probably be a better, more precise organization to work for.

I appreciate what you are doing, and keep up the good work.

Ambassador TOBIAS. Thank you, Mr. Payne.

Chairman HYDE. Mr. Sherman of California?

Mr. SHERMAN. I will be very brief, Mr. Chairman. Thank you very much for holding these hearings.

For the last 3 years I have tried to increase our spending on AIDS. I realize that our foreign aid dollars are scarce, and I would like to see us spend more on foreign aid in general, and AIDS in particular, but assuming our Committee will not be allowed to do that I have, and Secretary Powell sat in that chair and praised an amendment that I hope that we will be able to pass this year. That is, to give the President the right to take money that would otherwise go to the World Bank away from the World Bank and instead use it for combatting AIDS around the world, at least to the extent that the World Bank is sending money to the Government of Tehran, which last I checked, is one of the two remaining axis of evil.

So I know at least Secretary Powell has supported that move. I hope the Administration will support that move. I hope, Ambassador, that you will, and I hope to have support on this Committee.

If we cannot increase the amount we spend on international aid, the least we can do is make sure it is going to the right place and the right causes.

I yield back.

Chairman HYDE. Thank you, Mr. Sherman.

Ambassador TOBIAS. Mr. Sherman, could I make just a brief comment, and that is that the support that I have received now most recently from Secretary Rice on a continuing basis on this program has been essential, and I think the Committee will be interested to know I have had two conversations in the last 2 weeks with former Secretary Powell, who is still engaged in helping with this effort.

Chairman HYDE. Thank you very much, Ambassador. We commend you for your dedication, your productivity and your endurance. Thank you.

Ambassador TOBIAS. Thank you very much, Mr. Chairman.

Chairman HYDE. Our next witness is Jack Valenti, and I would like to welcome Mr. Valenti, who is a friend to the Committee, the President, as well as everybody he knows. He is President of the Friends of the Global Advocacy Group for the work of the Global Fund. For almost four decades, Mr. Valenti served as President and CEO of the Motion Picture Association of America before beginning his long and very distinguished career in the movie industry; in 1966, he served as a special assistant to President Lyndon Johnson.

It is with great pleasure that I welcome you to our Committee, Jack, and let me be the first, or the last, to thank you for your tireless work to fight the AIDS pandemic. If you don't mind encapsulating your speech to 5 minutes, the full statement will be made a part of the record. Mr. Valenti.

STATEMENT OF MR. JACK VALENTI, PRESIDENT OF FRIENDS OF THE GLOBAL FIGHT (FORMER PRESIDENT AND CEO OF THE MOTION PICTURE ASSOCIATION)

Mr. VALENTI. I am not ready for the digital age, Mr. Chairman. I want to thank you, Mr. Chairman, and the Ranking Member, Mr. Lantos, and I want to thank you because of what you and this

Committee are doing. I think that it is one of the great tributes to American leadership.

You are earning the gratitude of millions of desperately poor and desperately sick people all over this globe. So I think that is a laurel wreath that you and this Committee can wear with great honor. And I would also like to endorse and applaud the work of Ambassador Tobias. His valiant efforts are becoming more apparent to the American people. I count him to be a man whose skill, diplomacy, and urgency is getting things done that need to be done; and I count him an heroic warrior in the struggle against these pandemics. He is working in very close harmony with Dr. Richard Feachem, the Executive Director of the Global Fund.

Now, I have been President of the Friends of the Global Fight Against AIDS, TB and Malaria for, well just recently. Our mission is to do everything we can to sustain and enlarge all the work of PEPFAR and the Global Fund, and all other critical groups out there that are fighting this grotesque intrusion on peoples' lives. AIDS, malaria and TB kill 6 million people every year.

Now, Mr. Chairman, let me put that in graphic language. It is the equivalent of: Forty-six 747s crashing fully loaded every day; it is the equivalent of an Asian tsunami hitting us every 2 weeks; it is the equivalent, and this is the worst part, of New York City being totally populated today by orphans, little children. Now, what is unacceptably tragic is that we have the resources, we have in place that which can prevent and treat these diseases and, in the case of malaria and TB, cure them. So we have the tools, we have the resources, we have the knowledge. Why this delay? Why don't we do more?

Well, I think you, Mr. Chairman, I think Mr. Lantos pointed out two challenges which face us. One, of course, is the exodus from these countries stricken with these diseases, the exodus of doctors and nurses and volunteer workers. They are going someplace else, or they are falling ill to the diseases themselves; and this is something that the Global Fund is looking into as well as PEPFAR, but it is not easy to solve.

I know that the Global Fund, in the last couple of years, has trained 385,000 people in these life-saving techniques. They are not doctors, and they are not registered nurses, but they are people who can go into the remote areas, who can go into these villages and do good work. So that is what we have to do.

Now, let me offer to you something I think that has to be put into perspective about how little it takes. For the cost of a Sunday newspaper, Mr. Chairman, for the cost of a Sunday newspaper, a woman can prevent the transmission of HIV to her unborn child; for the cost of a sandwich and soda, a woman can be cured of tuberculosis; for the cost of a cup of coffee, you can provide a bed net that is impregnated with an anti-mosquito treatment and that child can sleep safely for 5 years; and for less than the cost of a subway ride, you can cure a child of malaria in 3 days.

Now that, to me, shows that so much needs to be done in the way of both volunteer forces and funding. Now, what has the Global Fund done along with PEPFAR? It has committed \$3.2 billion in 310 programs, in 127 countries, for prevention and treatment. Along with PEPFAR, it has treated almost a quarter of a million

people with AIDS drugs; it has given HIV counseling and messages about attitude changing to over a million people; it has distributed 1.4 million bed nets, bed nets which keep you from getting malaria; it has delivered, and this is a key point, 300,000 doses of a strikingly effective malaria medicine, the best the world has ever seen. It is called "ACTs." And this year, they are going to be delivering 30 million doses of this extraordinarily effective drug.

But the Global Fund needs more, Mr. Chairman, just to extend these successful programs in these 127 countries. And by the way, I haven't even talked about what needs to be done in China and Russia and in India, as has been explained here by the questions that you have asked. The National Intelligence Council says that, unchecked, AIDS will reach 35 million people in India and those three countries, 20 million in India alone.

The Global Fund needs money; it needs just to continue these successful programs; it needs \$2.4 billion, of which \$800 million would come from the U.S., one-third. Now, I know we have budget problems, and I know we are all constricted, but how much is a life worth? And the Global Fund is the only multi-lateral organization out there working very closely, I might add, with PEPFAR. They are partners in this.

And my final point, Mr. Chairman, is this: The heaviest pain is being borne by little children, in whom the ceremony of innocence has been drowned. These children, all alone, do not understand why they are alone, their parents dead. When they go to sleep at night, if they sleep, they are doubtless praying for somebody, someone to come and be with them. Now, if no one comes, Mr. Chairman, what then do we say to them?

I don't have to go on any more. This Committee knows better than anyone in Congress about what is going on, what needs to be done. And, as I said, we have all the tools and resources at hand. What is needed is more people in the field, going into the remote areas, into the villages, not into the chanceries of the world, or the prime minister's or the President's office, but out where the people live and die. I am kind of mesmerized by what I am saying up here, Mr. Chairman, but I think I will stop at this time.

[The prepared statement of Mr. Valenti follows:]

PREPARED STATEMENT OF MR. JACK VALENTI, PRESIDENT OF FRIENDS OF THE GLOBAL FIGHT (FORMER PRESIDENT AND CEO OF THE MOTION PICTURE ASSOCIATION)

" . . . you can almost hear little innocent children, their parents dead, now alone, pray for someone to be there for them. If no one comes, what then can we say to them?"

First I choose, on behalf of the "Friends of the Global Fight against AIDS, and Tuberculosis (TB) and Malaria," to applaud and endorse the valiant labors of Ambassador Randall Tobias, who guides the forward journey of President Bush's Emergency Plan for AIDS Relief, otherwise known as PEPFAR. Ambassador Tobias understands with mounting clarity what needs to be done, and with skill, diplomacy and urgency is moving to the future with indispensable action. He is a heroic warrior in this worldwide struggle, working in close harmony with Dr. Richard Feachem, Executive Director of the Global Fund.

We at the Friends of the Global Fight have enlisted in this war on grotesque pandemics. Our mission is to sustain and enlarge the work of PEPFAR, the Global Fund and other critical partners. We are all too dismally aware of the collision between medical science/in-the-field forces and a contagion gone berserk. There sweeps across the planet a trio of terrifying shroud-covered messengers of death: AIDS, ma-

alaria and TB. They are literally decimating civilizations, more fearsome than the Black Death that almost destroyed Europe in the Middle Ages.

Six million human beings die every year from these diseases. Let me put it more graphically.

That death toll is the equivalent of 46,747s fully loaded crashing *every day of the year*.

It is the equivalent of an Asian tsunami hitting us *every two weeks*.

It is the equivalent of New York City totally populated by *orphans*.

What is unacceptably tragic is that these diseases are treatable and preventable, with life-extending drugs and attitude-changes, and in the instance of malaria and TB, curable.

We have the knowledge. We have the tools. We are equipped to attack this trio of death-dealers head-on with safe and effective medicines that work and with effective prevention techniques.

If that is so, why can't we do more? Why the delay? The challenges are many, but a few stand out above the crowd.

Firstly, there is a shortage of foot soldiers to wage this fight. The doctors and nurses who are so critical to delivering life-saving aid are themselves succumbing to these diseases or leaving their home countries to accept more lucrative jobs. We must turn our sights to this difficult problem. PEPFAR and the Global Fund are leading the way. Already, Global Fund programs have trained 385,000 passionate people in techniques to fight these diseases.

Our battle plans must also focus on those who are bearing the brunt of this onslaught, women. A broad range of tactics must be deployed to help all women, from young school girls to married mothers, protect themselves from these diseases. The Global Fund is attuned to this need. It has many programs around the globe employing those critical tactics. In Kenya, for example, a remarkable group of women from the Kenyan Network of Women Living with HIV/AIDS are spreading compassion and empowerment to women throughout the country with the help of the Global Fund.

Our crusade lacks another essential: More funds.

Again, to put it in clear easy-to-understand language—

For the cost of a Sunday newspaper, a mother can prevent the spread of HIV to her unborn child.

For the cost of a movie ticket and popcorn, thirty AIDS patients can receive a day of life-extending drug treatment.

For the cost of a sandwich and soda, six months of medicine can cure a woman of TB.

For the cost of a cup of coffee, a child can sleep safe from malaria for 5 years under a bed net with anti-mosquito impregnation.

For the cost of a subway trip, a little girl can receive the world's best malaria medicine to cure her of the disease in 3 days.

The United States is one of the founders of the Global Fund, the progeny of the G8 countries. The US contributes one-third of the Global Fund's total income, with all other countries contributing two-thirds. In 2004, the Fund received some \$1.6 billion. In the interest of candor and fact, that is not enough for the Global Fund to continue current programs to expand its life-giving work in the year ahead and to take on new challenges that will not go away.

The Global Fund and PEPFAR are strengthening their collaboration at the individual country level, where the actual treatment takes place. There are specific plans in the 15 countries where PEPFAR operates and teams from PEPFAR and the Global Fund make sure that duplication is eliminated, and joint efforts are given new urgency. In fact, because the Global Fund operates 310 programs in 127 countries, the Fund is the multi-lateral arm of PEPFAR, complementing the work of US bilateral programs around the world.

This collaboration arrives at the right moment. The pandemics are rushing into India, Russia and China with hurricane-swiftness, and growing rapidly. In these countries, the Global Fund is the channel for 60 percent of total US funding to combat AIDS, extending the reach of bilateral programs. Especially important is the Fund's role as the action vehicle for US investment in TB and malaria control, two diseases that together kill as many as die from AIDS. Results in malaria control have been rapid and impressive.

In the beginning of its fifth year, the Global Fund has now committed more than \$3.2 billion to prevention and treatment in 127 countries throughout the world. It releases fund only upon proven performance.

What are the wide sweeping results of the Global Fund at the end of 2004? Together with PEPFAR, the Fund has provisioned 240,000 sick people with life-extending AIDS drugs, driving an uplift of 70% in treatment access globally in 2004.

It has made HIV counseling and testing services available to over one million people.

It has distributed nearly 1.4 million insecticide-treated bed nets to protect families from malaria.

It has distributed 300,000 doses of the most strikingly effective malaria medicines (artemisinin-combination therapies) more readily known as "ACTs." By shifting to the more powerful ACTs to defeat malaria, the Fund is now ready to provide more than 30 million ACT treatments each year, compared to under one million previously.

It has treated nearly 400,000 TB patients.

It has had cheerful, confirmed successes in Zambia, the Lubombo Region (100,000 square kilometers across South Africa, Swaziland and Mozambique), and Haiti

In Zambia, where the AIDS rate is 16% of adults in the country, where 1,000,000 children are now orphans, the Fund has distributed more than \$120 million to counter-attack these diseases. It is allied with the Churches Health Association of Zambia (CHAZ), which in turn works with 250 faith-based organizations all over the country. These programs have supported and cared for 52,000 orphans, and have reached 270,000 people with behavior change messages. PEPFAR and the Global Fund are in intimate cooperation in Zambia.

In the Lubombo Region, the Fund's support for a program created by private corporations has enabled the Fund to reduce malaria infections by 90%. The principal weaponry has been ACT medicines and the spraying of the interiors of lodgings with DDT.

Haiti has the highest HIV infection rate in the Western Hemisphere. Despite frustrating political turmoil over the past year, the Fund provided 2,300 people with ARV treatment, tested 85,000 for HIV and reached nearly 1,000,000 at-risk youths with effective prevention messages.

What then is our plea?

The Global Fund has urgent funding requirements if it is to attack unceasingly the pandemics across a wide landscape in all parts of the world. In fiscal year 2006, it needs \$2.4 billion just to extend its existing successful programs. The U.S. share of that crucial funding would be \$800 million. If the funds are not there what happens? The Fund may surely have to discontinue effective life-saving programs and the life-extending medications of AIDS patients would be in jeopardy. The board of directors of the Fund (whose chairman for the past two years was HHS Secretary Tommy Thompson) has launched a new round of grants, which will require \$1 billion more, \$300 million from the U.S. This would amount to a total of roughly \$1.1 billion in fiscal year 2006. Other donor countries are primed to provide their share. Already other donor countries have pledged enough funding to fully match the U.S. FY 2005 appropriation of \$435 million on a two-to-one basis. The Global Fund has launched a new replenishment process to raise funds from other donors for the next two years. It is confident the process will raise enough money to match a U.S. appropriation of at least \$800 million in FY 2006.

These pandemics move with indifferent regard for the misery and death they inflict. I dare any observer to gaze into the hopeless, fearful, wondering eyes of little children. Children with no parents, whose innocence is drowned because of a savage intrusion over which they had no control Children who don't understand why there are alone and when they sleep, if they do, you can almost hear them pray for someone to be there for them. If no one comes, what then can we say to them?

Chairman HYDE. Well, thank you, Jack. You are equal to the task of fighting AIDS and you do a brilliant job. I would like to get to the third panel, however. If someone insists on asking a question, I will certainly yield. I rarely do. Mr. Lantos, who seldom interjects himself.

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

I can see why Lyndon Baines Johnson was so incredibly effective because you were running his public-diplomacy program, Jack. We are deeply in your debt. You are clearly the most effective public citizen the United States is fortunate in having, and I think HIV/AIDS is very fortunate to have you assume this responsibility.

I have a very simple question. For four decades, you have led the Motion Picture Association with incredible attractiveness. What would be your suggestion to involve private corporations in this enormously important battle?

Mr. VALENTI. Mr. Lantos, I think it is very important. As you know, there is a group, I think it is called—it is Public-Corporation Coalition. It is led by some very dedicated people. They are going to corporations now and enlisting their contributions to fight AIDS, malaria and TB in those areas where they do business around the world.

So they have a personal interest, a corporate interest in doing this, but I think a lot more needs to be done. I think we need to enlist far more corporations than we have now. I think there are about 190 who are involved in this public coalition. We probably ought to have four times that many, and I do believe that we have to enlist other foundations. The Gates Foundation has done extraordinary work in this, the generosity is massive.

But more needs to be done. It is an area, as you quite rightly point out, that needs to be really artfully explored.

Mr. LANTOS. Well, we are deeply in your debt and we salute you for your continuing work on behalf of the people of the world.

Mr. VALENTI. Thank you, Mr. Lantos.

Chairman HYDE. Mr. Smith?

Mr. SMITH OF NEW JERSEY. Thank you, I will be very brief as well. And I am going to say that was brilliant testimony, very encouraging. You covered every base, and I think your focus on the fact that with the right kind of drug, for a very modest amount of money, the mother, the child, the transmission of AIDS from mother to child, especially during the birthing of a child, can be prevented, and that is a message that needs to be gotten out everywhere.

And secondly, beginning in 2006, as I know you know, 10 percent of the money in Mr. Hyde's bill will be used for orphans, or supposedly is going to be used for orphans who have been left behind. But again, that was outstanding testimony.

Mr. VALENTI. Thank you.

Chairman HYDE. Ms. Lee?

Ms. LEE. Thank you very much. Thank you, Mr. Chairman.

Let me just also commend you, Mr. Valenti, for the very compassionate and dedicated work that you are doing. I think the plea that you made to us this morning reaffirms my belief that, quite frankly, I don't think we need this limit in terms of U.S. contributions, in terms of waiting until the international community comes forward because of the numbers of people who are dying and who are infected.

If you remember, it was myself and Congressman Keach, with the help of Ron Dellums, who established the framework for the Global Fund with the Global AIDS and Tuberculosis Relief Act of 2000. We really never envisioned this limitation on U.S. contributions. You heard Ambassador Tobias talk about the fact that there were \$88 million, I think he said, that couldn't be used because the international community didn't step up to the plate.

I just wonder in terms of how you see this? Do we need to hold back our money, given the nature of the pandemic, as you so eloquently described, or how do we address his concern with regard to the international community? I know Dr. Feachem very well and I know that he is committed to doing that. But why in the world

should the United States hold back, given the nature of the problem and the fact that we do have the resources to do this?

Mr. VALENTI. Good question. Ms. Lee, I think the law says that the U.S. can give up to one-third of the total amount of money contributed by other donors.

Ms. LEE. That is what the law says. Some of us didn't agree to that. That came later after we set up the fund.

Mr. VALENTI. But, as it is now, that is the canopy under which we live. But I believe, and I know that Canada, the U.K., and other countries, are increasing their donations, as is Italy.

If we could appropriate \$800 million, we are throwing down a gauntlet to the world, saying: "We are ready to commit. Where are you?" I think this would have a real surging affect on these other countries. As a matter of fact, people within the Global Fund, who are in more intimate contact with the leaders of other countries, tell me that is absolutely so.

So I say that is why I think the U.S., always in the lead, has to continue in the lead. The appropriation of this \$800 million, I think, would stimulate an immense outpouring from other countries, which means that we would have \$1.6 billion coming from other donors. It would be what we need, what the Global Fund needs, to continue these programs.

Ms. LEE. I agree, Mr. Valenti, and I certainly support what you are saying. But it sounds like we are in a Catch-22, the chicken-and-the-egg situation. It is kind of like we are withholding money until we see other countries come forward. Yet if we do throw down the gauntlet and say: "This is what we are willing to do," I agree that more countries will respond. So how do we convince the Administration, and those who are opposed to this, to do that and the money would follow?

Mr. VALENTI. Well, there are a lot of people in Congress who believe this is the way to go; and I think this is a question of persuasion, of making other Members understand what the stakes are here. Entire civilizations are being decimated and we can't stand aloof from that.

Therefore, I believe that some of this antagonism—maybe I shouldn't call it that, this opposition will begin to defuse and melt away. I really do. I have been an optimist all my life, Ms. Lee, and I am not going to stop now.

Chairman HYDE. Thank you.

Do you have a question, Ms. Watson?

Ms. WATSON. Thank you, Mr. Chairman.

And I want to wish Mr. Valenti all the best. I have watched you over decades and I admire your ability to be persuasive.

As we try to implement our contribution program, can you suggest to us what it is that we need to do here in Congress? As you so rightfully described, this pandemic can wipe out this globe. No doubt about it. So what would you suggest and recommend that we can do? And with your influence and persuasion, you can assist us here in Congress to improve the way we are delivering needs.

Mr. VALENTI. Ms. Watson, you have been a good friend and I am grateful to you.

I do believe that Congress' essential task is to provide the funds. I mean you can't get out and actually do the work, but those funds

are absolutely indispensable for it to be done. When I cite you the minuscule amounts to save one child's life, and to save one mother's life, then you can multiply it, but the U.S. has to come forward with those funds.

If we appropriate the \$800 million, it will really send a ringing message around the world. I think the last appropriation was what, \$457 million? I am hopeful that the White House will find this suitable to their aims; I hope that other Members of Congress will too; and I think that we just have to do a lot of persuasion, and to offer up the prospect of hope among those without hope, and offer a little better tomorrow for the desperate around the world today.

And I repeat again: It seems like a long ways away to India and China and Russia and sub-Saharan Africa, but this is a small planet these days and we cannot live alone on it. That is the best persuasion I think that I can offer.

Mr. Chairman, I thank you so very much for allowing me to spend some time with you. Thank you.

Chairman HYDE. Our third panel is now to come forward. Dr. Geeta Rao Gupta is President of the International Center for Research on Women (ICRW), a leading global authority on women's role and development, women's empowerment and human rights. She has been at ICRW since 1988 and President since 1998. Dr. Rao Gupta led a number of groundbreaking studies documenting the factors fueling the spread of HIV/AIDS among women. She also serves on the boards of Interaction, the Ms. Foundation, and the Moriah Fund, and is an advisor to the U.N. Global Coalition on Women and AIDS, and co-Chairs the U.N.'s Millennium Project's Task Force on promoting gender equality and empowering women. Welcome, Dr. Gupta.

Mr. Martin Ssempea comes to us from Uganda where he is the Founder and Director of the Campus Alliance to Wipeout AIDS, a faith-based organization with Makeverre University in Kampala, where he specializes in AIDS prevention. Mr. Ssempea is a long-time activist against AIDS in Uganda, advocating the merits of abstinence and be-faithful programs, and has been an adviser to Uganda's First Lady and her efforts to fight HIV/AIDS. We welcome you, Mr. Ssempea.

Holly Burkhalter is the U.S. Policy Director of Physicians for Human Rights, headquartered in Boston, specializing in medical, scientific and forensic investigations of violations of internationally recognized human rights. Before her current position, she spent 14 years at Human Rights Watch, including Director of its Washington office. She worked for then-Representative Tom Harkin of Iowa; she also was a staffer on this Committee at the time working on the Subcommittee on Human Rights and International Organizations. So we welcome you back, Ms. Burkhalter.

It is pleasure to have you three here today and we look forward to your insights on these important issues. We ask that you proceed in the order that you were introduced, providing a 5-minute summary of your written statements; and, needless to say, your full statement will be made a part of the record.

And so, Dr. Gupta.

**STATEMENT OF GEETA RAO GUPTA, PH.D., PRESIDENT,
INTERNATIONAL CENTER FOR RESEARCH ON WOMEN**

Ms. GUPTA. Thank you very much. I would like to thank you, Mr. Chairman, and other Members of this Committee for scheduling this important hearing.

As you have been hearing all morning, we are in the midst of a relentless epidemic, the HIV/AIDS epidemic that is taking countless lives worldwide, and there are only two points I want to make today. The first is that increasingly large numbers of those who are infected are women, particularly young women, and the second is that our current strategies for prevention are not sufficient to meet the needs of women and girls.

U.N. AIDS statistics have shown that, since 2002, the number of women living with HIV has risen in every region of the world. In sub-Saharan Africa, as we heard earlier today, out of every 10 infected persons, 6 are now women, and infection rates among young women are especially high. In the African region as a whole, three out of every four infected 15- to 20-year-olds are now women.

This inexorable rise in infections among women demands special attention and immediate action, action that must go beyond the ABC approach, the approach that refers to Abstention, Be faithful, and using Condoms. That approach, while necessary to contain the AIDS epidemic, is not sufficient to address the underlying vulnerabilities that contribute to women's risk of infection.

And I would like, today, to draw your attention to three specific vulnerabilities that women in the developing world face that prove that the ABC approach is not sufficient and which underscore the need for that additional "D" that you talked about, for women to be able to Defend themselves against infection.

The first of these is with regard to marriage. For many women around the world, marriage poses a risk of infection that they have very little ability to control or reduce. The ABC approach for these women is not a realistic strategy for prevention because abstinence within marriage is not a viable option because their husband is typically their only sexual partner, and the use of a condom is dependent on their husband's cooperation and is often stymied by the need for a child.

The risk of infection is often greatest when a woman gets married at a young age. We have data from Kenya and Zambia that show that HIV infection levels among married girls, 15 to 19 years of age, were 10 percent higher than for unmarried, sexually active girls of the same age.

When the age difference between spouses is 10 years or more, the risk of HIV infection for the wife doubles, as compared to an age difference of 4 years or less. Marriage for such young women does not offer any protection because older husbands are more likely to have been exposed to the virus before marriage and, therefore, are more likely to enter the marriage with HIV infection, sometimes not knowing their status.

Young brides also have much less social and economic power than their husbands and, therefore, have very little leverage to negotiate protection or fidelity. And because newly married couples in most cultures have to prove their fertility by having children, it

makes it very difficult for them to use condoms, which, you know, are also contraceptive.

This issue of child marriage is particularly important because it is not a small problem. Recent data show that 51 million adolescents are currently married, and it is predicted that 100 million more will be married over the next decade, and I am talking about countries all over the globe. Research also shows that it is poverty, lack of education, and a lack of viable economic alternatives for young women that makes child marriage so prevalent. It is not just culture.

Our research in India shows that when laws prohibiting child marriage are combined with community education on the risks of child marriage, and when community interventions include the participation of both parents and young people, the age of marriage can, in fact, be increased.

I would like to suggest some actions that can be taken within the President's Initiative for AIDS Relief, and the first of these is an investment in female-controlled methods of prevention, such as the female condom or microbicides. Microbicides are substances that women can use to prevent sexually-transmitted infections. The female condom is currently too expensive and, as a result, is not accessible to women in poor countries. And microbicides urgently need financial support to accelerate research and development. The U.S. has played, and should continue to play, a leadership role in this regard by including microbicides as part of a comprehensive response to the HIV/AIDS pandemic.

The second recommendation I would like to make is to invest in interventions to increase the age of marriage and reduce the incidence of child marriage in developing countries and respond to the unmet needs of young married girls by investing in their access to secondary schools, which they are often denied because they are married; by their access to reproductive health services and information; and to nonexploitative and safe economic opportunities. In addition, we need community education initiatives on the risks of child marriage that can protect girls and allow them to be healthy, to complete their education, and to benefit from economic opportunities.

I would like to urge you, Mr. Chairman, especially, to consider holding a hearing on this important issue of child marriage and its implications for the HIV/AIDS epidemic.

The second vulnerability I would like to talk about is violence against women, both physical and sexual. Violence against women, both directly and indirectly, increases their risk of infection to HIV and greatly constrains their ability to seek testing or treatment or look after loved ones who are sick or dying. Statistics from WHO, the World Health Organization, show that anywhere between 10 to 69 percent of women report physical abuse at the hands of an intimate partner at least once in their lives, and between 7 to 48 percent of girls between 10 to 24 years of age report that their first sexual encounter is coerced.

Just as there is an AIDS epidemic, Mr. Chairman, there is an epidemic of violence against women that we have been ignoring, despite the fact that it has enormous health and economic consequences for women and for the societies in which they live.

Forced or coercive sex presents a direct risk of HIV infection for women that cannot be prevented by any of the strategies currently promoted, A, B, or C, and, additionally, fear of violence and the threat of abandonment pose significant risks as well because they significantly limit women's ability to negotiate protection, leave a risky relationship, discuss fidelity, or access testing or treatment services.

Women's economic vulnerability and dependency on men makes the threat of violence or abandonment a much more immediate danger to them than the possible risk of infection and death 5 to 7 years later. The link between violence against women and HIV is so strong that a study in Tanzania found that the experience of violence was, in fact, a predictor of HIV status. Young, HIV-positive women were almost 10 times more likely to report partner violence than similarly aged HIV-negative women.

So, to address the issue of violence against women, I would like to suggest that the President's Initiative for AIDS Relief invest in the provision of post-exposure prophylaxis, which is antiretrovirals for all victims of rape, and this must be made mandatory in all programs immediately upon the occurrence of rape in all programs funded by the U.S.; second, that communication programs be invested in that challenge prevailing beliefs about the acceptability of violence against women. There are several such successful communications efforts, such as the Soul City Program in South Africa, that can be replicated, and they have successfully decreased the tolerance of violence against women.

And, third, we would like to see an investment in a coordinated, health sector response to violence against women because women exposed to violence are most likely to seek help at a health facility. Voluntary counseling and testing facilities, for example, should have the ability to identify women who are at risk of violence upon disclosure of their status and should be able to provide those women with the necessary counseling and mediate disclosure sessions with partners as a potential way to reduce tension and the adverse consequences.

The third issue on vulnerability that I would like to bring up is property inheritance rights. Women's economic dependency and vulnerability underlies much of their vulnerability in this epidemic because without economic leverage, women cannot insist on protection or fidelity in their marriage or other relationships; nor can they leave a relationship that they know to be risky.

Access to economic assets, such as land and housing, much more than just income, provides women an important way to assure themselves some economic security, as well as a means of livelihood and shelter, all of which are important ways to gain economic leverage. Land and property can also serve as collateral for loans in times of crisis. Yet there are many countries in the world where women still do not have the right to own or inherit property and land, and even when such laws exist, they are often poorly enforced.

As a result, women are not guaranteed the most basic economic protection when faced with the death of a spouse or father and can be left destitute and homeless when they most need support and solace. The lack of economic security at such a time also greatly in-

creases the probability that women will sell sex for money in order to survive and to feed their children.

Research in Karala, India, found that 49 percent of women with no property also reported physical violence, whereas only 7 percent of women with property reported physical violence. So there is a link between property rights and violence against women.

I would like to recommend some actions that the President's Initiative for AIDS Relief can take. The first is to make sure that property and inheritance rights for girls and women are a cornerstone of the AIDS prevention and care intervention supported by this initiative. The initiative must support legal literacy programs for women that make them aware of their rights to own property in countries where this right is enshrined in the law. And the initiative should invest in paralegal services to help families affected by AIDS write wills and create the legal documentation that makes property grabbing from widows less likely.

There are several in-country organizations, women's groups, in particular, that are already engaged in such activities that desperately need to be funded and need all of the technical support we can provide them.

In conclusion, let me reiterate that the increase in women's HIV infections should serve as a wakeup call to alter the current U.S. approach to AIDS prevention, treatment, and care. To expand it beyond the ABC approach to what I call an "ABC-plus approach" that includes investments in programs to increase the age of marriage, provide services to allow women, as well as their spouses, to be safe within marriage, reduce violence against women, and assure women's ownership and control of economic assets, such as land and housing.

Just asserting the need to abstain, be faithful, and use condoms is not enough to protect women and girls from the ravages of this epidemic. We need more, and we need it now, and we need these things in order to ensure that the President's Initiative's targets are, in fact, met. Thank you very much.

[The prepared statement of Ms. Gupta follows:]

PREPARED STATEMENT OF GEETA RAO GUPTA, PH.D., PRESIDENT, INTERNATIONAL CENTER FOR RESEARCH ON WOMEN

Thank you for this opportunity. As you all know, we are in the midst of a relentless epidemic—the HIV and AIDS epidemic—that is taking countless lives worldwide. The two points that I would like to make today are first, that increasingly large numbers of those infected are women, particularly young women, and second, that our current strategies for prevention are not sufficient to meet the needs of women and girls.

UNAIDS statistics show that since 2002 the number of women living with HIV has risen in every region of the world. In sub-Saharan Africa, out of every 10 infected persons nearly 6 are women. And infection rates among young women are especially high. In Kenya, for example, for every 20 young men with HIV (15–24 years of age), there are 45 young women with the virus—more than double. In the African region as a whole, three out of every four infected 15–24 year olds are women (UNAIDS and WHO 2004).

This inexorable rise in infections among women demands special attention and immediate action—action that must go beyond the ABC (abstain, be faithful, and use condoms) approach to prevention. That approach, while necessary to contain the AIDS epidemic, is not sufficient to address the underlying vulnerabilities that contribute to women's risk of infection. I would like to draw your attention to three specific vulnerabilities that women in the developing world face that prove that the ABC approach is not sufficient and that underscore the need for additional strate-

gies. Each of these vulnerabilities occurs because of fundamental economic and social inequalities between women and men that must be addressed if we are to succeed in containing the spread of AIDS.

Marriage: For many women around the world, marriage poses a risk of infection that they have very little ability to control or reduce. The ABC approach for these women is not a realistic strategy for prevention because abstinence within marriage is not a viable option; their husband is typically their only sexual partner; and the use of a condom is dependent on their husband's cooperation and is often stymied by the need to have a child. The risk of infection is often greatest when a woman gets married at a young age. Data from Kenya and Zambia show that HIV infection levels among married girls 15–19 years of age were 10 percent higher than for unmarried sexually active girls of the same age (UNAIDS and WHO 2004). A recent review of research by ICRW shows that in countries that are hard hit by the epidemic, when the age difference between spouses is 10 years or more, the risk of HIV infection for the wife doubles, as compared to an age difference of 4 years or less (Luke and Kurz 2002).

Marriage for such young women does not offer any protection because older husbands are more likely to have been exposed to the virus before marriage and therefore are more likely to enter the marriage with HIV infection; because young brides have much less social and economic power than their husbands and therefore have very little leverage to negotiate protection or fidelity; and because newly married couples in most cultures have to prove their fertility by having children which makes it difficult to use the condom, which is also a contraceptive, as a means of protection from infection.

In designing policies for prevention it is important for us to pay attention to marriage as a vulnerability for women and adolescent girls because the majority of women in the developing world are in marriage or some form of long-term relationship and a very large number of them are married before the age of 18. Recent data show that 51 million currently married women were child brides and it is predicted that 100 million more will be married before the age of 18 over the next decade (Mathur et al. 2003). In countries such as Niger, Bangladesh, Chad, Yemen, Ethiopia and Mozambique, more than 50 percent of girls are married before the age of 18 and in some parts of Nigeria and India girls are getting married at the age of 12 or younger. Research also shows that it is poverty, lack of education and a lack of viable economic alternatives for young women that makes child marriage so prevalent—not culture. In fact, our research in India shows that when laws prohibiting child marriage are combined with community education on the risks of child marriage and community interventions that include the participation of parents and young people, the age of marriage can be increased by one year after only four years of intervention (ICRW 2004). And other research in Nepal shows that even in communities where the average age of marriage for girls is less than 18, the desired age of marriage as expressed by girls and their parents is much higher, which suggests that it is not culture but rather poverty and the lack of viable alternative options for girls that prevent families from acting upon their desires (Mathur et al. 2004).

Recommended Actions: To reduce women's and girls' vulnerability within marriage requires that the President's Plan for AIDS Relief must include:

1. An investment in a female controlled method of prevention, such as the female condom or microbicides (substances that women can use to prevent sexually transmitted infections). The female condom is currently too expensive and as a result not accessible to women everywhere. And microbicides urgently need financial support to accelerate their clinical testing to establish their effectiveness.
2. Interventions to increase the age of marriage and as a result reduce the incidence of child marriage in developing countries, respond to the unmet needs of young married girls by investing in access to secondary schools, reproductive health services and information, and non-exploitative economic opportunities. In addition, support, community education initiatives on the risks of child marriage that will protect girls and allow them to be healthy, to complete their education, and benefit from economic opportunities.

In addition, because child marriage is a widespread development problem that needs immediate attention, I urge you, Mr. Chairman, to consider holding a hearing on this important issue.

Violence Against Women: The second vulnerability that women face is violence—both physical and sexual—that directly and indirectly increases their risk of infection to HIV and greatly constrains their ability to seek testing or treatment or look after loved ones who are sick or dying. Statistics from the World Health Organiza-

tion show that anywhere between 10 to 69 percent of women report physical abuse by an intimate partner at least once in their lives and between 7 and 48 percent of girls between 10–24 years of age report their first sexual encounter as being coerced (WHO 2004). In rural Peru, for example, 24 percent of young women said their first sexual interaction was forced and 12 percent of girls in Jamaica who had sex before the age of 20 said they had been raped. Just as there is an AIDS epidemic, there is an epidemic of violence against women that we have been ignoring despite the fact that it has enormous health and economic consequences for women and for the societies in which they live.

Forced or coercive sex presents a direct risk of HIV infection for women that cannot be prevented through any of the strategies currently promoted—A, B, or C. And fear of violence and the threat of abandonment pose significant risks as well because they significantly limit women’s ability to negotiate protection, leave a risky relationship, discuss fidelity, or access testing or treatment services. In a study conducted in Botswana and Zambia, ICRW found that the use of services to prevent the transmission of HIV from infected mothers to their children was low because women were afraid that the use of such services might expose them to stigma and violence at a time when they are most vulnerable—during pregnancy (Nyblade and Field-Nguer 2000). Women’s economic vulnerability and dependency on men makes the threat of violence or abandonment a much more immediate danger than the possible risk of infection and illness five to seven years later.

The link between violence against women and HIV is so strong that a study in Tanzania found that the experience of violence was a strong predictor of HIV status. In this study, conducted among women who sought voluntary counseling and testing services, younger HIV positive women (between 18–29 years) were almost ten times more likely to report partner violence than similarly aged HIV-negative women (Maman et al. 2002).

Recommended Actions: To reduce violence against women, the President’s Plan for AIDS Relief must invest in:

1. The provision of post-exposure prophylaxis—antiretrovirals as prevention of HIV infection—for all victims of rape. This must be made mandatory in all programs funded by the U.S.
2. Communication programs that challenge prevailing beliefs about the acceptability of violence against women. There are several successful communications programs, such as Soul City in South Africa, that can be replicated, which have successfully decreased the tolerance of violence against women.
3. A coordinated health sector response to violence against women. A broad range of health services must address violence against women because women exposed to violence are most likely to seek help at health facilities. For example, voluntary counseling and testing (VCT) clinics should have the ability to identify women who are at risk of violence upon disclosure of their status and provide them with the necessary counseling and mediated disclosure sessions as a potential way to reduce tensions between partners and adverse consequences.

Property and Inheritance Rights: Women’s economic dependency and vulnerability underlies much of their vulnerability in the AIDS epidemic because without economic leverage women cannot insist on protection against infection or fidelity in their marriage or other relationships, nor can they leave a relationship they know to be risky. Access to economic assets such as land and housing, provide an important way to assure women some economic security as well as a means of livelihood and shelter—all of which are important ways to gain economic leverage. Land and property can also serve as collateral for loans in times of crisis.

Yet, there are many countries in which women still do not have the right to own or inherit land and property and even where such laws exist, they are often poorly enforced. As a result women are not guaranteed the most basic economic protection when faced with the death of a spouse or father and as a result can be left destitute and homeless when they most need support and solace. There is now documentation of property grabbing from and eviction of widows who have lost their husbands to AIDS. Such actions are justified through the stigma attached to AIDS. The lack of economic security at such a time greatly increases the probability that women will sell sex for money in order to survive and to feed their children.

Beyond the direct economic benefits, recent research suggests that property ownership can protect against the risk of domestic violence. Research in Kerala, India found that 49 percent of women with no property reported physical violence, whereas 7 percent of women with property did, even when controlling for a wide range

of other factors such as household economic status, education, employment and other variables (Panda 2002).

Recommended Actions: To provide women with economic security, the President's Plan for AIDS Relief must recognize that guaranteeing women and girls' property and inheritance rights as a cornerstone of AIDS prevention and care interventions and must therefore:

1. Support legal literacy programs for women that make them aware of their rights to own property in countries where this right is enshrined in the law;
2. Invest in paralegal services that help families affected by AIDS write wills and create the legal documentation that makes property grabbing less likely.

In conclusion, let me reiterate that the increase in women's HIV infections should serve as a wake-up call to alter the current U.S. approach to AIDS prevention and care—to expand it beyond the ABC approach to an “ABC-plus” approach that includes investments in programs to increase the age of marriage, provide services to allow women as well as their spouses to be safe within marriage, reduce violence against women, and assure women's ownership and control of economic assets such as land and housing. The disempowerment of women is killing women and men, boys and girls in the developing world during their most productive years. Just asserting the need to abstain, be faithful, and use condoms is not enough to protect women and girls from the ravages of the AIDS epidemic—we need more and we need it now. Thank you.

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Chairman HYDE. Thank you, Doctor.
Mr. Ssempe?

STATEMENT OF MR. MARTIN SSEMPA, DIRECTOR, MAKERERE YOUTH MINISTRY IN UGANDA, SPECIAL REPRESENTATIVE TO FIRST LADY OF UGANDA'S TASK FORCE ON AIDS

Mr. SSEMPA. Thank you, Chairman Hyde and all of the distinguished Members of the International Relations Committee. I am Martin Ssempe, a Ugandan Christian pastor and head of an abstinence program for secondary and university students which started in 1988.

More than 10 years ago, as a student at Makerere University, where I currently work, I watched my brother and sister painfully die from AIDS. As a teenager, I, myself, was sexually promiscuous and came to embrace the message of abstinence and faithfulness, having watched the deaths of my brother and my sister. Right now,

I am taking care of their orphans and looking at an older brother who is HIV-positive.

With this in mind, I mince no words when I address my fellow Ugandans every day, and I mince no words with you. The reasons why other Africans and Ugandans are dying is because of sexual promiscuity. That is what is killing us. I was heartened to see the United States' plan to invest more heavily in fighting AIDS in Africa, and do so in a way that not only reflects reality but respects our nation's culture and religion. By this, I mean the ABC approach, specifically, A and B components, and the plan to involve faith-based organizations.

Unfortunately, it is mostly business as usual in Uganda, and AB activists like me are increasingly getting frustrated. Let me say that there are some good people at USAID headquarters that have developed and promoted the ABC policy and are willing to listen, but many people at the faith level are skeptical or biased and seem not to like this policy.

When President Museveni assumed power in 1986, the country was in chaos. We had no funds to purchase condoms, even if we wanted to do so. Foreign advisers, including USAID and CDC, advised us that condoms was the only proven intervention and the only way to prevent AIDS. But President Museveni was a skeptic. He reasoned that even if condoms could prevent AIDS, there was, and is, no way that an adequate supply could be assured in the rural areas.

President Museveni and his wife believed that a better approach, one suited to the realities of Africa, would be to return to traditions of abstinence before marriage and fidelity after marriage. This was later to be called the "ABC approach."

The national response involved the mobilization of all elements of society. We all got together as a village, and it worked, and Uganda has achieved a two-thirds decline in HIV infections, and I understand that this has not occurred elsewhere, including America. President Bush recognized and embraced Uganda's ABC model as the foundation for PEPFAR. USAID actually adopted ABC as its policy for prevention in late 2002, at least, for Africa. So you would think everything would be fine, but it is not so.

USAID and the CDC still favor condoms and are largely skeptical of abstinence-and-fidelity programs. If Congress had not been so wise as to make it law that one-third of the prevention must be for abstinence, I am sure nothing would have changed with the donors in Uganda. But there are ways to get around the law, such as giving abstinence funds to PSI.

PSI is the largest contraceptive social-marketing company in the world. It has also generated controversy around the world for its pro-condom promotion tactics. But PSI shares USAID's philosophy of condoms for everyone, even though many of us in Uganda feel that this approach actually encourages promiscuity, the very behavior that has been killing us.

We have noticed that African countries that have the most condoms also have the highest HIV/AIDS infection. Last year, in conversations with PSI, I told them that I would not promote condoms to youths because I see that as a ticket to death. One of the PSI managers informed me that condom promotion was manda-

tory, and if you are going to work together—our discussions in the PSI boardroom came to an early end. I can name several abstinence groups which have not been funded because of their position against promoting condoms. This, I believe, violates American law.

Mr. Chairman, USAID itself conducted an ABC country study of six countries and has found that condoms alone cannot reduce HIV/AIDS infection. There is a role for condoms, but it is not the primary one.

USAID also financed the development of a national condom policy and strategy. This plan calls for placing a full-time condom officer in every one of our 56 districts. Unfortunately, it gives condoms a privileged status in the fight against HIV/AIDS in Uganda. USAID will say that we Ugandans want this plan, but the truth is it is USAID that wants this plan.

Mr. Chairman, if USAID and PEPFAR really have an ABC policy, why did they not finance a national policy and strategy for abstinence and faithfulness, especially since USAID's own ABC study shows that A and B behaviors are essential?

I have here with me three documents that guide our national AIDS-prevention program. I ask that the Committee allow me to submit the key documents so that the Congress and the American people can see some of the documentary evidence undermining ABC. USAID provided technical assistance and funding for this key document, yet these documents have virtually no abstinence or faithfulness elements. If you look at earlier documents of this sort, they were full of abstinence and being-faithful objectives and impact indicators.

[The information referred to follows:]



Public Policy
International News
Update
***Advocates Strike Agreement on
the Condom, Virginit***

Advocates Strike Agreement on the Condom, Virginit

New Vision, Uganda

09/02/2005

President Museveni and a team of AIDS experts with divergent views have agreed on how to fight sexual transmission of HIV. Below is an abridged version of their paper published in *The Lancet*, an internationally respected medical journal. [Click here to download the entire PDF of the statement.](#)

The HIV/AIDS pandemic is an urgent health and growing humanitarian crisis, especially in the high-prevalent sub-Saharan Africa, where most new infections continue to occur.

On World AIDS Day (Dec 1), two decades after the discovery of the AIDS virus and after millions of deaths, a consensus has to be reached on a sound public-health approach to the prevention of HIV.

Although transmission through injections is a serious and increasing problem, here, we focus on sexual transmission, which continues to account for most infections globally. Sexual behaviour is influenced by many factors not always under an individual's control, including gender norms and social and economic conditions.

However, the public-health community has an obligation to offer accurate information on how to avoid HIV and encourage changes in societal norms. Although prevention should encompass multiple integrated elements including links to expanded treatment-access, behaviours aimed at risk-avoidance and risk reduction must remain the cornerstone.

We call for an end to the polarising debate and urge the international community to unite around an inclusive evidence-based approach to slow the spread of HIV, based on these principles:

First, programmatic approaches must be locally endorsed, relevant to the indigenous social and cultural context and respectful of human rights. Interventions must also be epidemiologically grounded, addressing the main sources of new infections, whether concentrated in high-risk settings such as commercial sex or spread widely through multiple concurrent partnerships.

The ABC (Abstain, Be faithful/reduce partners, use Condoms) approach can play a vital role in reducing the prevalence of HIV, as occurred in Uganda. The elements of this approach are essential to reduce HIV incidence, although the emphasis placed on individual elements needs to vary according to the target population.

Although the overall programmatic mix should include an appropriate balance of A, B and C, it isn't essential that every organisation promotes all of them: each can focus on the part(s) they are most comfortable supporting.

However, people should have accurate and complete information about different prevention options. Thus, when targeting young people, for those, who have not started sexual activity, priority should be to encourage abstinence or delay of sexual onset, hence emphasising risk-avoidance as the best way to prevent HIV, sexually transmitted infections (STIs) and unwanted pregnancy.

After sexual debut, returning to abstinence or mutual faithfulness with an uninfected partner are the most effective ways of avoiding infection. For the young people, who are sexually active, correct and consistent condom use should be supported.

People should be informed that correct and consistent condom-use lowers the risk of HIV and other STIs and pregnancy and they should be cautioned about the consequences of inconsistent use. Prevention programmes should be expanded and parents supported in communicating their expectations about sexual behaviour.

When targeting sexually active adults, priority should be to promote mutual fidelity with an uninfected partner.

The experience of countries, where HIV has declined suggests partner reduction is of central epidemiological importance in achieving large-scale HIV incidence reduction in all epidemics.

People, who have a sexual partner of unknown HIV status should also be encouraged to practise correct and consistent condom use and to seek counselling and testing with their partner.

When targeting people at a high risk of exposure to HIV infection (engaging in commercial sex, multiple partnerships, anal sex with high-risk partners and sex with a person known or likely to be infected with HIV or another sexually transmitted infection), priority should be to promote correct and consistent condom use, alongside approaches such as avoiding high-risk behaviours.

The identification and direct involvement of many-at-risk and marginalised populations is crucial, particularly in more concentrated epidemics, where such populations account for a large proportion of infected people.

It is also critical to expand prevention programmes designed specifically for people living with HIV/AIDS. Community-based approaches involving religious groups, women's and men's associations, care groups, youth groups, health workers, local media and traditional and governmental leadership can foster new sexual behaviour norms as for example occurred with the successful zero-grazing. Prevention programmes should address issues such as stigma, gender inequality, sexual coercion, cross-generational relationships and transactional sex and directly involve people living with HIV/AIDS.

To achieve the prevention, care and treatment objectives specified by the United Nations General Assembly Special Session declarations, the US President's Emergency Plan for AIDS, the Millennium Development Goals and other international initiatives, the global community will need to expand access to services for testing, effective counselling and treatment of HIV, STIs, prevention of mother-to-child transmission and family planning.

Given the importance of averting new HIV infections, emerging evidence on potential interventions such as microbicides or other female-controlled methods, treatment of STIs, male circumcision, and vaccines should be continuously reviewed for inclusion in HIV prevention programmes in a way that fosters overall risk reduction and minimally interferes with the adoption of essential prevention behaviours.

The time has come to abandon divisive polarisation and move forward together in designing and implementing evidence-based prevention programmes to help reduce the millions of new infections occurring each year.

The article was endorsed by the following Ugandans among other international experts:

- President Yoweri Museveni, Uganda
- Daraus Bukenya, African Medical and Research Foundation (AMREF)
- Gideon Byamugisha, World Vision, Uganda
- Heiner Grosskurth, Medical Research Council and Uganda Virus Research Institute
- Jesse Kagimba, Office of the Presidency, Uganda
- Noerine Kaleeba, TASO, Uganda and UNAIDS
- Sam Kalibala, International AIDS Vaccine Initiative; Anatoli Kamali, Medical Research Council Programme, Uganda
- Elizabeth Madraa, Ministry of Health, Uganda
- Sam Okware, Ministry of Health, Uganda
- Sam Ruteikara, CHUSA and Anglican Church of Uganda
- Nelson Sewankambo, Makerere University
- Martin Ssempe, Makerere Community Church of Uganda
- Straight Talk Foundation, Uganda



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Beyond Abstinence

By David Serwadda

Friday, May 16, 2003; Page A29

U.S. legislators have been debating how \$15 billion will be used to fight AIDS around the world. My country, Uganda, has often been cited as an AIDS success story, and rightly so. But the factors behind our success are more complex than they have been portrayed in Washington.

As a physician who has been involved in Uganda's response to AIDS for 20 years, I fear that one small part of what led to Uganda's success -- promoting sexual abstinence -- is being overemphasized in policy debates. While abstinence has played an important role in Uganda, it has not been a magic bullet.

Uganda has reduced HIV prevalence from as high as 30 percent among sexually active adults to 5 percent. This dramatic turnaround is the result of a combination of many HIV prevention approaches. Just as no physician today would offer a patient only one drug to treat HIV infection, we can't offer just one prevention intervention and expect it to succeed.

In Uganda, we have adopted the ABC approach to behavior change -- delayed initiation of sex (abstain), reduction in the number of sexual partners (be faithful) and condom promotion (condomize). All three elements have played an important role in reducing HIV transmission.

But Uganda's strategy goes beyond reducing risky sexual behavior. It includes a broad range of essential interventions, such as HIV counseling and testing, treatment of sexually transmitted diseases and screening of the blood supply.

If policymakers want to learn from Uganda's experience, they will act quickly to step up access to a combination of all these proven HIV-prevention interventions. Today access to these interventions is strikingly low, even in the hardest-hit countries.

The Global HIV Prevention Working Group, an international panel of AIDS experts that I co-chair, recently studied prevention efforts worldwide. The results were sobering: Only 5 percent of women have access to drugs to prevent mother-to-child HIV transmission. Just 12 percent of people have access to voluntary HIV counseling and testing. Of those at high risk, 24 percent have access to AIDS education. Only 42 percent of people in need have access to condoms.

To close these gaps, the Working Group estimates that annual spending must increase by \$4 billion by 2005. The results of this new spending would be dramatic: UNAIDS (the

joint AIDS program run by the United Nations and the World Bank) and the World Health Organization estimate that it could avert 29 million new infections by 2010.

We all agree that it is important to educate people at risk, especially youth, about the benefits of abstaining from sex. But we must not forget that abstinence is not always possible for people at risk, especially women. In much of the developing world, women have very limited social, economic and political power, and they are often highly vulnerable to HIV infection. Many women simply do not have the option to delay initiation of sex or limit their number of sexual partners.

For example, many girls are married by their mid- to late teens and as married women do not have the choice to abstain, even if their partner is HIV-infected. In fact, up to half of all new infections in Uganda occur among steady couples in which one partner is HIV-positive and one is negative. In addition, many women are the victims of sexual violence, while others enter into sex work as the only means to provide for themselves and their families.

The AIDS epidemic will not go away by itself. It will take foresight, leadership and a commitment to using proven prevention interventions to stop new infections. And while we must continue to focus on fighting AIDS in Africa, the world must also learn from Africa's experience and act to contain widespread epidemics in Asia and Eastern Europe while there is still time.

Uganda's lessons are important: While there is no easy answer to the question of how to stop the spread of HIV, we now know that a combination of approaches can work. It's time to stop looking for a magic bullet and use every weapon we've got.

The writer directs the Institute of Public Health at Makerere University in Kampala, Uganda, where he conducts research on the transmission and epidemiology of HIV and AIDS.

Mr. SSEMPA. I do not want to end on a negative note. The new leadership of the Global Health Bureau, as well as Ambassador Tobias, seem to be committed to seeing ABC policy implemented in the way intended. We Ugandans look forward to working with USAID and PEPFAR in solving the problems that I have described.

I would also ask Congress that they would support and fund a draft AB policy which will multiply the AB initiative that has been developed in Uganda across the country and across the world. Thank you, Mr. Chairman.

[The prepared statement of Mr. Ssempe follows:]

PREPARED STATEMENT OF MR. MARTIN SSEMPA, DIRECTOR, MAKERERE YOUTH MINISTRY IN UGANDA, SPECIAL REPRESENTATIVE TO FIRST LADY OF UGANDA'S TASK FORCE ON AIDS

I AM MARTIN SSEMPA, A UGANDA COLLEGE MINISTER.

MORE THAN 10 YEARS AGO, AS A STUDENT AT THE SAME UNIVERSITY WHERE I TEACH, I WATCHED MY BROTHER AND SISTER PAINFULLY DIE FROM AIDS.

AS A TEENAGER I WAS SEXUALLY PROMISCUOUS AND ON THE SAME PATH TO DEATH AS MY BROTHER AND SISTER. THEN I CAME TO UNDERSTAND AND EMBRACE THE MESSAGES OF ABSTINENCE AND FAITHFULNESS.

FOR THESE REASONS I MINCE NO WORDS WHEN I ADDRESS MY FELLOW UGANDANS AND I SHALL MINCE NO WORDS WITH YOU. THE REASON UGANDANS AND OTHER AFRICANS ARE DYING IS BECAUSE OF SEXUAL PROMISCUITY. THAT IS WHAT IS KILLING US. FOR THESE REASONS I WAS HEARTENED TO SEE THE UNITED STATES' PLANS TO INVEST MORE HEAVILY IN FIGHTING AIDS IN AFRICA, AND DO SO IN A WAY THAT NOT ONLY REFLECTS REALITY BUT THAT RESPECTS OUR NATION'S CULTURE AND RELIGION. BY THIS I MEAN THE "ABC" APPROACH, SPECIFICALLY A AND B UNFORTUNATELY, THE USAID AND CDC AGENCIES CONTINUE TO PROMOTE PROMISCUITY AND CONDOMS, AND ARE NOT ALLOWING FAITH-BASED ORGANIZATIONS TO HELP US. IT IS BUSINESS AS USUAL HERE, WE ARE BEGINNING TO LOSE HOPE WE IN AFRICA NEED TO CHANGE OUR BEHAVIOUR AND US REPRESENTATIVES IN UGANDA AND OTHER AFRICAN COUNTRIES NEED TO ACTIVELY IMPLEMENT THE ABC PROGRAM PRESIDENT BUSH AND CONGRESS HAVE APPROVED, WITH THE GREATEST EMPHASIS ON THE A AND B.

WHEN PRESIDENT MUSEVENI AND HIS WIFE ASSUMED POWER FROM IDI AMIN IN THE MID 1980'S THE COUNTRY WAS IN CHAOS. ALL FOREIGN ADVISORS HAD FLED. WE HAD NO FUNDS TO PURCHASE CONDOMS EVEN IF WE WANTED TO SO. THEREFORE, THE MUSEVENIS SPOKE TO THEIR PEOPLE IN THE SAME WAY THEY SPOKE TO THEIR CHILDREN ABOUT HIV/AIDS. "ABSTAIN AND YOU WILL NOT GET IT (MEANING HIV/AIDS)" AND BE FAITHFUL TO ONE UNINFECTED PARTNER AND YOU WILL NOT GET IT." AT THE TIME WE CALLED THE "B" MESSAGE "ZERO GRAZING" MEANING GRAZE IN YOUR OWN YARD AND NOT IN YOUR NEIGHBORS YARD.

PRESIDENT MUSEVENI ACTUALLY TRAVELLED FROM VILLAGETO VILLAGES WITH A BULLHORN DELIVERING THE ABC MESSAGE WITH AN EMPHASIS ON A AND B. HE ADDED THAT IF YOU DID NOT ADHERE TO HIS WARNING YOU WOULD "D" DIE.

THE FIRST LADY OF UGANDA WAS VOCAL ABOUT THE PROGRAM AND ALL PUBLIC AND MANY PRIVATE AGENCIES WERE INVOLVED AND HAD THEIR OWN OBJECTIVES AND WORK PLANS. THE HEALTH MINISTRY, THE LOCAL HEALTH AGENCIES, THE SCHOOLS, THE CHURCHES AND OTHER FAITH BASED ORGANIZATIONS, THE NEWSPAPERS AND THE RADIO—ALL WERE INVOLVED. AND THE PROGRAM WORKED. HIV/AIDS INCIDENCE RATES FELL IN THE LATE 1980S AND THE HIV/AIDS PREVALENCE RATE FELL FROM 21% IN 1992 TO AROUND 6% IN 2002. I KNOW OF NO OTHER COUNTRY WHICH HAS CUT ITS HIV/AIDS PREVALENCE RATE BY TWO-THIRDS.

PRESIDENT BUSH SAW AND EMBRACED THE UGANDA ABC PROGRAM AND MADE IT THE PRESCRIBED HIV/AIDS PREVENTION METHOD FOR THE UNITED STATES. THE ABC PREVENTION METHOD WAS INCLUDED IN THE PEPFAR PLAN WHICH WAS APPROVED BY THE WHITE HOUSE AND CON-

GRESS. SO YOU WOULD THINK EVERYTHING WOULD BE GOOD. RIGHT? WRONG.

TODAY WE FACE A NEW ENEMY IN THE FIGHT AGAINST HIV/AIDS NOT ONLY IN UGANDA BUT IN ALL THE OTHER AFRICAN COUNTRIES. THAT ENEMY IS THE WESTERN BELIEF THAT CONDOMS CAN END THE HIV/AIDS EPIDEMIC.

AS YOU NOW KNOW, THE UGANDA ABC PROGRAM HAS PRODUCED SPECTACULAR RESULTS. CONDOM SOCIAL MARKETING, THE PRIMARY HIV/AIDS PREVENTION METHOD PROMOTED BY THE US AND OTHER WESTERN DONORS FOR THE LAST 18 YEARS HAS NOT WORKED. IN FACT, IN MARCH 2004 UNIVERSITY OF CALIFORNIA PROFESSOR NORMAN HEARST AND SAN FRANCISCO DEPARTMENT OF HEALTH EPIDEMIOLOGIST SANNY CHEN REPORTED IN THE JOURNAL "STUDIES IN FAMILY PLANNING" THAT EXTENSIVE COMPUTERIZED SEARCHES OF SCIENTIFIC CONFERENCE PRESENTATIONS AND PROFESSIONAL JOURNALS UNCOVERED NO EVIDENCE THAT CONDOM SOCIAL MARKETING HAS STEMMED THE DISEASE IN A GENERALIZED EPIDEMIC IN ANY COUNTRY IN THE WORLD.

SO, WHAT IS THE PROBLEM? THE PROBLEM IS THAT MOST OF THE PEOPLE IN USAID AND CDC DO NOT LIKE THE ABC MESSAGE. THEY LIKE THE CONDOM SOCIAL MARKETING MESSAGE. WHY? WHY?

I BELIEVE IT'S BECAUSE THE UGANDA ABC PROGRAM WAS ESTABLISHED BY AFRICANS FOR AFRICANS. THIS ANGERS MANY SO CALLED "PROFESSIONALS" IN THE AIDS COMMUNITY WHO HAVE PROMOTED CONDOM SOCIAL MARKETING.

AIDS PREVENTION IS NOW A BILLION DOLLAR INDUSTRY BASED UPON SUPPLYING HIV PREVENTION PROGRAMS THAT CENTERS ON THE DISTRIBUTION OF CONDOMS.

ABSTINENCE AND BE FAITHFUL DOES NOT GENERALLY FIT IN WITH THE WORLD VIEW OF MANY IN THE AIDS COMMUNITY AND THEIR LIKE MINDED FRIENDS.

SO WHAT HAVE THE USAID AND CDC PERSONNEL DONE IN UGANDA AND OTHER COUNTRIES TO DEFEAT ABC AND PROMOTE CONDOM SOCIAL MARKETING.

1. THEY DISCONTINUED FUNDING A, B, AND ABC PLANS. I HAVE WITH ME AND HAVE PROVIDED TO YOU COPIES OF THE LATEST 3 HIV/AIDS PREVENTION PROGRAM PLANNING DOCUMENTS THAT HAVE BEEN PAID FOR AND/OR SUPPORTED BY USAID. THEY ARE BEREFT OF AB OR EVEN ABC ACTIVITIES.

2. THEY GAVE FUNDING TO PSI, A CONDOM SOCIAL MARKETING FIRM TO BE A PRIMARY ABSTINENCE PROVIDER. WHAT A JOKE THIS WOULD BE IF LIVES WERE NOT AT STAKE. HOW CAN THE LEADING SOCIAL CONDOM MARKETING AGENCY BECOME AN ABSTINENCE ADVOCATE OVERNIGHT?"

3. BY USING PSI IT ALLOWS THEM TO TURN AWAY FAITH BASED GROUPS. I WAS REFERRED BY US OFFICIALS TO PSI. WHEN I TOLD THEM I WOULD NOT PROMOTE CONDOMS BECAUSE MY CONSCIENCE SAYS DISTRIBUTING CONDOMS TO KIDS IS "A TICKET TO DEATH" ONE OF THE PSI MANAGERS INFORMED ME "IF WE ARE GOING TO WORK TOGETHER...WE HAD TO INCLUDE CONDOMS AS A COMPONENT OF OUR PREVENTION." I CAN NAME A HALF DOZEN ABSTINENCE GROUPS WHICH HAVE NOT BEEN FUNDED BECAUSE OF THEIR POSITION AGAINST CONDOMS.

4. US GOVERNMENT PERSONAL ARE NOW ATTEMPTING TO ENCODE THE USAID-FUNDED NATIONAL CONDOM POLICY AND STRATEGY INTO UGANDA LAW WHICH WOULD JUSTIFY MORE SPENDING ON CONDOM DISTRIBUTION AND MAKE IT HARDER FOR ABSTINENCE GROUPS TO COMPETE.

NOW YOU MIGHT ASK "BUT WHY ARE THE USAID AND CDC GROUPS SO INFLUENTIAL IN UGANDA. WHY DOESN'T THE UGANDA GOVERNMENT TAKE ACTION AGAINST THESE AGENCIES IF THEY FEEL SO STRONGLY ABOUT THIS ISSUE?

IN UGANDA AND IN MANY OTHER POOR AFRICAN COUNTRIES MORE THAN HALF THE REVENUES COME FROM OVERSEAS DONORS WITH THE US BEING THE PRIMARY DONOR. IN ADDITION, USAID AND CDC FUND INDIVIDUALS AT INTERNATIONAL RATES WHICH ARE TYPICALLY MANY TIMES WHAT THESE PEOPLE WOULD OTHERWISE EARN. MAKE NO MISTAKE ABOUT IT, YOU AND YOUR IN-COUNTRY REPRESENTATIVES ARE VERY, VERY INFLUENTIAL.

TODAY THE ABSTINENCE MESSAGES ARE GONE. GONE ARE THE 'AIDS KILLS' ADS WARNING TEENAGERS TO ABSTAIN. GONE ARE THE SIGNS

THAT ONCE WARNED TRUCK DRIVERS TO "DRIVE HOME TO THEIR WIVES." THE ABSTINENCE BILLBOARDS HAVE BEEN REPLACED WITH NEW BILLBOARDS ADVERTISING CONDOMS WITH SLOGANS LIKE "SO STRONG, SO SMOOTH." AND THE HIV/AIDS RATE HAS BEGUN TO TICK UPWARDS. IN THE RAKAI DISTRICT WHERE CONDOM PROMOTION OVERSHADOWS THE PROMOTION OF ABSTINENCE AND MARITAL FIDELITY, USAID HAS INCREASED THE LEVEL OF CONDOM USE ONLY TO FIND THAT THE RATE OF NEW INFECTIONS, WHICH HAD BEEN DECLINING, IS NOW BACK ON AN UPWARD TREND. NEW INFECTIONS AMONG MEN HAVE INCREASED BY 50% OVER A DECADE AGO.

CONGRESSMEN AND CONGRESSWOMEN I ASK ONLY ONE SIMPLE THING. PLEASE RESPECT US AS PEOPLE. PLEASE RESPECT THE WISHES OF OUR PRESIDENT AND FIRST LADY. PLEASE RESPECT OUR CULTURE. ASK YOUR AGENCIES IN UGANDA AND ELSEWHERE TO IMPLEMENT THE ABC PROGRAM PRESENTED BY THE WHITE HOUSE AND APPROVED BY CONGRESS. MANY MORE OF US WILL DIE UNLESS YOU DO. MANY OF US WILL BE SAVED IF YOU DO.

Mr. SMITH OF NEW JERSEY [presiding]. Thank you very, very much.

Ms. Watson has to leave for an important engagement, so I would like to yield to her before going to Ms. Burkhalter.

Ms. WATSON. I certainly want to thank the Chair and the two witnesses, in particular. And, Ms. Burkhalter, I am sorry, I will not be here to hear your testimony, but this question goes to Dr. Gupta.

I think you make a real understandable case about the role women play. Could we look at the role men play in the Indian societies since they are dominant? And young women are to be virgins when they marry and so on, so they control.

Would it be helpful, and I just need your comment, to focus on males to try to change their cultural thinking in how they treat women?

And then, Mr. Ssempe, I do know that in south-Saharan Africa, maybe down in South Africa itself, that there was a belief that a male having sex with an infant would then address the spread of AIDS. My real troubling concern is how do you change these cultural patterns: The domination men have over the women; the fact that young women, as young as 13 and 14, are getting married in India and in Africa; and could we put a minimum age limit that a young woman would have to be to be married on the continent?

And then, Dr. Gupta, if you could talk about focusing on male behavior, his societal role, and what we could do.

May I start with Dr. Gupta first?

Ms. GUPTA. Thank you for that very important question.

I think that societal definitions of male and female roles are defined by all of society. While it is important to target educational messages to men and boys about responsibility and respectful behavior toward women, it is equally important to ensure that women get the same messages and that women are empowered to be able to have access to economic resources and education so that they can, in fact, change their own roles.

Part of the problem is the domination continues because women do not have access to economic opportunities. They do not have the same access to jobs, to secure jobs, the same levels of income; they cannot, as I said, own and inherit and control property; there are still huge gender gaps in most countries in the developing world in education, particularly secondary education; and it is those factors

that we can, in fact, change through policy and through sort of prioritizing investments that can make a huge difference in the way in which women's roles are perceived in societies.

So even though cultural norms may define male and female roles in particular ways, policies can make a huge difference in changing those roles and how they are perceived by ensuring an equal distribution of key assets and resources to both men and women.

Ms. WATSON. Are you talking about policies that come from government, governmental policies?

Ms. GUPTA. Yes, from the governments, the national governments, as well as from development-assistance dollars that flow into those governments. A lot of our development-assistance dollars that flow into countries like India do not necessarily have attached to them any conditions about an equal distribution to programs that benefit both women and men.

Ms. WATSON. Thank you. That is something that we can take into consideration.

Mr. Ssempa?

Mr. SSEMPA. Thank you very much. The question regarding why older men would molest little girls in a bid to get a cure for HIV has been known in southern Africa and sub-Saharan Africa, and the cause is bad advice, or sometimes traditional healers giving bad advice to their clients that if they would deflower or defile or sexually abuse a little baby, they would get healed.

The solution to this is both two ways: Training and educating the traditional healers, reaching them. As Ambassador Tobias talked earlier, it is necessary to reach the source of the bad advice that it will be discouraged. Secondly, it is putting in place laws. We have a law in place in Uganda that could be emulated, especially in dealing with the same situation that has been mentioned here of defilement or sexual abuse with the age of consent at 18.

We have made a law in Uganda that sex for any young woman beneath 18 breaks the law, and right now our jails are filled with young men between 15 and 25 who could not control themselves. And it also gives the importance of teaching the message of character education of abstinence. That is why it is also critical to teach the behavior change level. Thank you.

Ms. WATSON. If I may just comment, I hear over and over again that there is a role for the traditional healers to play in our programs, and this is something that we might want to address as a Committee. I appreciate that. I have seen the results of the work they do in various areas of Africa.

Dr. Gupta, is there a national policy on the age, or does it go state by state, that a young person can marry, particularly a woman?

Ms. GUPTA. Are you asking about India specifically?

Ms. WATSON. India specifically.

Ms. GUPTA. India has a legal age of marriage that is 18, but it is not enforced as strictly as it should be. That is the problem.

In most countries, there is a legal age of marriage that is defined as adulthood, that children can only be married when they are adults, but that is not always enforced, and that is part of the problem, is it is not enforced.

So you have laws on the books that are not enforced. We have to strengthen the enforcement mechanisms, but one of the ways to do that is to invest in community-education initiatives to try and explain what the risks of child marriage are, in addition to making sure that children have access to schools and to economic opportunities so that parents do not feel the need to get them married because there is nothing more to do with them once they have passed a particular age.

Ms. WATSON. Thank you so much.

Ms. GUPTA. It is more borne out of poverty, ma'am.

Ms. WATSON. Yes. Thank you so much, and thank you, Mr. Chairman.

Mr. SMITH OF NEW JERSEY. Ms. Burkhalter?

**STATEMENT OF MS. HOLLY J. BURKHALTER, U.S. POLICY
DIRECTOR, PHYSICIANS FOR HUMAN RIGHTS**

Ms. BURKHALTER. It is an honor to be here, sir. Thank you for waiting it out. It has been a long hearing, and I know you have the attention span for a much longer one, but I will not keep you here too much longer.

I did want to say a few words about an issue that Chairman Hyde mentioned as one of the three areas of focus for this hearing, which is the scarcity of the skilled health workforce in Africa.

You know, in thinking about what the President's Global AIDS Initiative has accomplished, it occurs to me that the President's State of the Union address in 2003 and this Committee's initiation of the U.S. leadership legislation that put that vision into operation were based on a fundamentally radical and humane premise. That radical premise was the notion, accepted by few around the world, that poor people with AIDS in Africa should live and not die. And the reason why I say it was a radical premise is that most donors and much of the world had simply written off sick people or people who were not yet symptomatic, but people with AIDS, and particularly in Africa, millions and millions of them. Everyone's focus was on prevention, which, of course, is essential in the fight against the pandemic.

But the concept that an expensive medication could be available to people in countries where national health budgets were pennies per person per year was a truly radical notion. The reason I say "radical" and not "naive" is that it was based on the premise that we will offer treatment—the President and the Congress set an ambitious and extraordinarily brave treatment target—we will offer treatment, and we will build the infrastructure to offer it and to reach the poorest. We will build it as we go. That is exactly what PEPFAR has tried to do, and I salute them for it.

However, the scope of the problem of scarce, skilled health workers in Africa is so vast that even that brave and humane and radical goal, that we will build infrastructure as we go, has to include very substantial building materials and a sort of "PEPFAR II," a second phase, to make that build-as-you-go a reality and to permit the treatment and prevention and care initiatives that are now a part of the international approach to the pandemic in Africa, thanks to the leadership of our country.

Let me give you a sense of the scope of the problem. The Harvard-based, international research effort to try to get a handle on what the skilled, health workforce crisis looked like says that Africa, which has about 600,000 nurses and doctors and pharmacists, needs a million more to even begin to reach the minimal humane targets in infectious disease, maternal health, and child survival. A million more. That means a tripling of the numbers we have now. But at the rate we are going, Africa is losing health workers, not gaining them, and no amount of training and technical-skill transfers can really fundamentally change that dreadful and dire arithmetic.

Let me tell you what it looks like in one particular country because the figure, a million workers needed, does not really resonate; it is simply too big. It is like the figures of genocide in Rwanda or Sudan. The bigger they get, the less meaning they have, and, thus, the less-creative and workable policies we come up with to deal with them. It is just too big.

This is how it looks in Tanzania. The Joint Learning Initiative that I was speaking of notes that Tanzania, which has a relatively high density of workers among African countries—so we are better off in Tanzania for health workers than in many places—faces a shortfall of 35,000 workers to reach the threshold needed. To fill this gap by 2015, to reach the maternal health child survival goals and infectious disease goals that I was referring to, it would take an average annual production of 3,500 physicians, nurses, and midwives.

But current levels of production in the country are less than one-fifth this number, with about 90 physicians and 550 nurses, and that does not even take into account brain drain, outmigration, or the push factors of unsafe workplaces for nurses and doctors, where you do not have occupational safety: Gloves and new syringes, and all of the other things that we take for granted here.

Add the other push factors, which include poor management, not getting paid on time, no respite, no healthcare, no vacation days, no paid vacation days, and you can understand why the new graduates of nursing institutions around the continent leave to get better salaries immediately. It does not help that foreign countries are recruiting heavily to make up for our own scarcities, particularly in the nursing corps.

South Africa sends approximately 3,000 nurses annually to the U.K. alone. So the poorest countries in the world train doctors and nurses for the richest countries in the world. Now, something has to be done about that, and it is going to have to go beyond PEPFAR's very valiant efforts to date.

By the way, I would like to take this opportunity to thank Ambassador Tobias and his staff for their constant willingness to talk to the human rights and the health-activist community. We have never been turned away, to my knowledge, from their door. They are very attentive to the health workforce problem. They know it far better than we do. It is a small staff, and they are working around the clock, but the situation with regard to the health workforce in Africa that they inherited with their bold and brave experiment simply is not going to work for them or for any other health need on the continent.

Accordingly, I have some recommendations for sort of PEPFAR II, if you will, but it is not just limited to treating AIDS and tuberculosis and malaria, though it is desperately needed for those infectious diseases.

Ms. WATSON. Mr. Chair, can I ask the speaker to yield for a minute for a question?

Ms. BURKHALTER. Certainly.

Ms. WATSON. Since we have been talking about the traditional healers, and they seem to be everywhere, in every social group, society, could we use them, work with them, to give them some very menial skills to work, particularly in the rural areas, work with the populace? Would you comment on that, just to increase the numbers?

Ms. BURKHALTER. That was part of my testimony. If you have to leave, I would be glad to jump ahead.

Ms. WATSON. Yes, please.

Ms. BURKHALTER. It is not just traditional healers. The bulk of AIDS care is being delivered by family members or community health workers, and it is an inestimable resource. Many countries depend heavily upon their volunteer health workforce.

It depends on the country, but those that have no potential to begin to graduate the number of nurses and mid-level professionals, in particular; many of these countries do not have nursing schools. The local health workers, community caregivers, and family members and relatives are an essential component. And, yes, indeed, they can take on very important aspects of not just AIDS care but other health initiatives, but not without training and resources and some kind of remuneration.

Without providing home healthcare workers, for example, something back, it can actually exacerbate gender discrepancies and disparities and poverty disparities because women, in particular, who bear the burden of this care, sink further and further down. They are sick themselves, and without something to help them, some supplies and some kind of a stipend, they cannot be expected to take the place of nurses and doctors and all of the other elements of a functioning health system.

Along with that recommendation, which we have included in our testimony, I wanted to talk about some other things, that this new initiative could do. I would like to see a new Presidential Initiative, to make the first one even better than it is and to help it work and achieve and exceed the ambitious treatment care and prevention goals that it has. But also to address the terrible and completely unnecessary rates of mother death in childbirth and baby death before the age of 5, for which the health worker shortage plays a great role in those daily and hourly tragedies, are the things we could look at in a new, global health initiative that would be the third, global foreign-aid initiative on President Bush's watch, but I think this Committee and the President are fully capable of expanding their generous vision to include this essential piece, which, you know, if we had done it really right, we would have put the horse in front of the cart—AIDS drugs.

But if we had not, and you had not had, the extraordinarily helpful vision that we should not wait until we have developed everything we needed to do AIDS interventions properly, we are going

to start it now. If we had waited to just build health infrastructure, we would still be waiting. More importantly, Africans would still be waiting, because we do not have the kind of political force that is needed around the issue of scarce health workers. It is a really tough issue to get at. It is all tangled up in good governance, and solutions to the problem involve better governance and better assistance with better governance, computer databases of health workers and personnel.

There are some things that are not rocket science but that could immeasurably help countries keep track of their workers. These things would help with graft and corruption. Payrolls are notorious places where money disappears—but some of the loss is not because of corruption and venality. It relates to literally not having the skills of governance and the tools of governance. I think PEPFAR can help provide those skills, along with other training.

But, you know, without some way to get at the fundamental problem that contributes to outmigration of health staff from Africa to richer countries, some way or another you are going to have to get to poor salaries, low salaries, and we, as donors, do not do that. We do not pay salaries for health workers, and “we” meaning donors in this country, particularly, do not pay salaries in the public sector.

But the problem is, if you introduce new initiatives, you do not have a larger pool of workers. We do not have recruitment strategies and scale-up for workers that are desperately required to do these new duties and use these new drugs that are now being supplied by the United States and the Global AIDS Fund and others.

So what happens? Well, health workforce issues are so inter-related that you can unwittingly do harm while doing good. For example, there was an American university AIDS research program based in Malawi. The first thing they did when they entered the country was hire 60 nurses off the public health wards, leaving hundreds and thousands of patients with no nurses. So what that means in terms of AIDS prevention is that if a mom is giving birth and bleeding out over here on this side of the ward, and there are 25 other mothers giving birth, who is going to deliver the naviropene to prevent the mother-to-child, and that is if they know about it and have it?

I do not mean to put it so graphically, but truly, not enough nurses means that you cannot load them up with new duties. It is, indeed, upon the nurses and the midwives and the mid-level health professionals that most of those duties fall. There must be more of them. There must be hundreds of thousands more of them. The African countries can neither recruit them from schools nor keep them once they graduate unless there is a system of remuneration and credentialing and support and management and safe workplaces for them to work in so that they will want to stay.

Well, I have gotten to some of my recommendations and not all of them. I am going to stop now because we are out of time, but I just want to say a personal word to you, Chris, and to you, Ms. McCollum. When did you come to Congress, Chairman Smith?

Mr. SMITH OF NEW JERSEY. In 1988.

Ms. BURKHALTER. Well, I got here before you did but just barely. We have worked together for 25 years and during that time, I have

never seen the across-the-political-spectrum collaboration and hope and goodwill and optimism and energy that I have seen around the creation of the U.S. Leadership Bill.

Sure, there are plenty of things to argue about, and we heard about some of it today, as Congressman Lantos said. The Members of the Committee, I think, recognizing that all of these initiatives are needed—and everybody who is serious about prevention knows that—and as a mother of two young daughters, I sure hope the schools they are going to are talking about boy responsibility and about abstinence and faithfulness. And I certainly hope that people at risk, whatever their situations are, are getting exactly the strategies and the choices that they need to keep themselves safe and to keep themselves alive and well.

So we could dissipate the energy and the optimism and the funds, and we could lose that big tent and that consensus that was so extraordinarily carefully crafted by you and by the Chairman and by Mr. Lantos and your colleagues—the issues that I think are not unimportant or insignificant at all—but compared to the billions of dollars that are now going, I think it is chicken feed. I really do, and I think we need billions more, and if we could just hang on to the vision that animated the President and you, we will get the billions, and we will have 100-percent support like you did the last time around. We are here to help you do it. Thank you.

[The prepared statement of Ms. Burkhalter follows:]

PREPARED STATEMENT OF MS. HOLLY J. BURKHALTER, U.S. POLICY DIRECTOR,
PHYSICIANS FOR HUMAN RIGHTS

Chairman Hyde, Representative Lantos, and Members of the Committee: Thank you for inviting me to testify at today's hearing on the HIV/AIDS and the U.S. Response. I am honored to be here. My name is Holly Burkhalter and I represent Physicians for Human Rights, a US nongovernmental organization that employs the skills and the voice of the medical and scientific profession in the service of international health and human rights. I am grateful for the assistance of my colleague, Eric Friedman of Physicians for Human Rights, in the preparation of this testimony.

Just a few years ago the concept of providing antiretroviral drugs, which at the time cost more per capita per day than poor governments spent on health per capita in a year, was largely a fantasy. But the drop in the price of antiretroviral drugs and development of generic medicines of the past five years, the extraordinary commitment of resources by President Bush and the United States Congress, and the creation of a major new international financing mechanism to confront the pandemic, the Global Fund to Fight AIDS, Tuberculosis, and Malaria, have transformed HIV/AIDS for some in sub-Saharan Africa, Asia, and the Caribbean into a manageable disease.

If access to treatment had been withheld from poor countries until they secured the health infrastructure they needed to provide basic primary health care to all, as well as manage an immense HIV/AIDS case load with medicines largely unknown to them, those countries would be waiting for antiretrovirals to this day. Fortunately, the vision of treatment activists and now major donors as well has been to "build it as we go." Accordingly, the President's Emergency Plan for AIDS Relief (PEPFAR) has provided technical assistance, supplies, training, drugs, laboratory equipment, and other resources to countless hospitals and clinics in the fifteen focus countries to create capacity to scale up prevention and care, and graft antiretroviral therapy onto existing health services.

That approach has helped enlarge the number of people receiving anti-retroviral treatment in sub-Saharan Africa from 50,000 in the end of 2002 to 310,000 in December 2004.¹ But it has become increasingly clear that donors and national govern-

¹Office of the US Global AIDS Coordinator, *Engendering Bold Leadership: The President's Emergency Plan for AIDS Relief: First Annual Report to Congress* (March 2005), at 35. Available at: <http://www.state.gov/documents/organization/43885.pdf>; World Health Organization, "3 by 5"

ments must simultaneously confront, ameliorate, and eventually remedy Africa's disastrous shortage of trained health care workers. As Ambassador Tobias indicated in his first report to Congress in August of 2004, "Without a large increase in trained health workers, the human capacity to deliver ART [anti-retroviral therapy] and other therapies will simply be absent."²

While the dearth of health workers is undermining the huge scale up of HIV/AIDS prevention, care, and treatment that Africa needs so desperately, conversely the emphasis on HIV/AIDS services is drawing resources away from other vital health services that are also in short supply. For example, at the 970-bed the Lilongwe Central Hospital in Malawi, only 169 nurses were practicing in mid-2004, compared to the 520 nurses whom the hospital was authorized to employ. The hospital's former staff of 38 laboratory technicians had fallen to only six. The nurses and laboratory technicians were moving to HIV/AIDS programs sponsored by NGOs and overseas universities, precipitating a staffing crisis at this major national referral hospital.³

The health worker shortage may be newly visible to HIV/AIDS activists like me, but it is far from a new problem. Funding for public health in Africa by national governments has been largely stagnant for decades, and "brain drain" of doctors and nurses who migrate to the West has in some countries approached the number of new health worker graduates. Today, Africa faces one of the greatest threats to health and survival in human history—the HIV/AIDS pandemic—but it is in a poor position to confront it. Adding new duties such as AIDS counseling, testing, and treatment to an overburdened health work force without a commitment to dramatically enlarge their numbers will not only undermine new AIDS treatments initiatives, it has the potential to weaken fragile public health systems and erode other primary health activities.

Physicians for Human Rights and the many activist organizations with whom we collaborate want PEPFAR to succeed. Accordingly, we are calling for a second Presidential initiative for health in Africa to accelerate the recruitment, retention, training, and rational deployment of skilled health workers while simultaneously continuing to scale up prevention, care, and treatment of HIV/AIDS so as to meet and exceed the President's 2–7–10 goals and other health goals. We appeal to President Bush and Congress, who have made PEPFAR a reality, to take the fight against HIV/AIDS and other infectious diseases to the next level. We challenge you to develop and fund a "Global Health Workforce Initiative" to help AIDS-burdened countries recruit, retain, and support large numbers of African health professionals, and link them to a trained and supported network of community health workers and home health care givers.

Africa's health worker shortage requires Congress and the executive branch to accelerate and scale up current health systems initiatives and to envision and administer new ones. The crisis requires strategic planning in collaboration with national governments, international organizations, and other donors. American leadership will be needed to permit a loosening of acroeconomic constraints on governments' ability to spend their own and donors' contributions on health and health worker salaries. New programs should specifically invest in public health systems, and plans must be made to "Africanization" PEPFAR-funded treatment, care and prevention initiatives. Durable solutions to the health worker shortage must include investing in African health professionals and giving them incentives to stay home where they are needed most. It means empowering African medical and nursing schools to recruit, train, and provide continuing education. And it will require that the U.S. and other Western countries that recruit African health workers adopt an ethical approach to the brain drain.

Background: Africa's Health Worker Shortage:

Last spring my colleague Eric Friedman visited Rietvlei District Hospital in the Eastern Cape, which is South Africa's most rural province. The hospital superintendent told him that without more doctors, the hospital would be unable to pro-

Progress Report: December 2004 (2005) at 11. Available at: <http://www.who.int/3by5/publications/en/progressreportfinal.pdf>.

²Office of the Global AIDS Coordinator, *Bringing Hope and Saving Lives: Building Sustainable HIV/AIDS Treatment* (August 2004), at 12. Available at: <http://www.state.gov/documents/organization/36287.pdf>.

³Adam L. Kushner, Steven J. Mannion & Arturo P. Muyo, "Secondary Crisis in African Health Care," letter. *Lancet* (May 1, 2004) 363: 1478. Kenya's health ministry has expressed concern that donor focus on HIV/AIDS has left other health priorities, such as malaria and reproductive health, receiving little attention, reducing Kenya's prospects of achieving the Millennium Development Goals. "HIV/Aids Hogs Cash As Other Sectors Suffer," *East African Standard* (Nairobi, Kenya), March 30, 2005.

vide anti-retroviral therapy on any significant scale, even though the government had designated the hospital as the AIDS treatment center for its district of 180,000 people. Eric learned first-hand that without a significant increase in African health workers, ART capacity simply cannot be managed by some of the poorest clinics and hospitals.⁴

The health worker shortage in Africa that is now in the public eye because of the AIDS pandemic has also been a key factor in other health emergencies, including the continent's tragically high rate of maternal mortality. In sub-Saharan Africa, a woman's lifetime risk of maternal death is 1 in 16, compared to 1 in 2,800 in rich countries.⁵ According to the *World Health Report 2005—Make Every Child and Mother Count*, "Putting in place the health workforce needed for scaling up maternal, newborn and child health services towards universal access is the first and most pressing task."⁶

The United Kingdom's Commission for Africa, noting this disparity in its recent report, recommends that African countries and donors unite to add 1 million health care workers to Africa within a decade, nearly tripling Africa's health workforce.⁷ The Commission estimates that Africa requires an immediate annual increase of \$10 billion, rising to at least \$20 billion, in donor assistance to the health sector, including health worker specific needs such as pre-service training and salary.⁸

The health worker shortage has multiple origins, including massive under-investment in health systems, inadequate attention to human resource policies, the death of health workers and enormous burden of care created by the HIV/AIDS pandemic, and deficits in the health worker education system. These problems, in turn, underlie the large-scale migration of health professionals from Africa to wealthier countries, such as the United States and United Kingdom. In some countries, the majority of physicians are leaving, and the number of nurses emigrating has skyrocketed in the past decade.

In the absence of comprehensive data, country examples and anecdotes highlight the scope of this "brain drain." As of 2001, only 360 of the 1200 physicians trained in Zimbabwe during the 1990s were still practicing in the country.⁹ In 2002/2003, more than 3,000 nurses trained in South Africa, Zimbabwe, Nigeria, Ghana, Zambia, and Kenya registered in the United Kingdom.¹⁰ In 1999, about as many nurses left Ghana as were trained there.¹¹ It is frequently stated that more Malawian doctors practice in Manchester, England, than in all of Malawi.¹² Brain drain is accelerated as wealthy nations, facing shortages in their own health workforces, actively and aggressively recruit health professionals from some of the countries that can least afford to lose them.

⁴Holly Burkhalter & Eric A. Friedman, *Physicians for Human Rights Testimony on "AIDS Corps": HRH/HIV Opportunities: Equity and Sustainability* (Dec. 2, 2004), at 1–2. Available at: http://www.phrusa.org/campaigns/aids/pdf/testimony_aids-corps.pdf.

⁵World Health Organization, *World Health Report 2005—Make Every Child and Mother Count* (2005), at 11. Available at: <http://www.who.int/whr/2005/en/index.html>.

⁶World Health Organization, *World Health Report 2005—Make Every Child and Mother Count* (2005), at overview 7. Available at: <http://www.who.int/whr/2005/en/index.html>.

⁷Commission for Africa, *Our Common Interest: Report of the Commission for Africa* (March 2005), at 188. Available at: <http://www.commissionforafrica.org/english/report/thereport/13chap6.pdf>. The recommendation is based on the November 2004 report of the Joint Learning Initiative, a collection of more than 100 global health experts who spent two years studying the global health worker shortage. Joint Learning Initiative on Human Resources for Health and Development, *Human Resources for Health: Overcoming the Crisis* (2004), at 33–34. Available at: <http://www.globalhealthtrust.org/Report.html>.

⁸Commission for Africa, *Our Common Interest: Report of the Commission for Africa* (March 2005), at 188. Available at: <http://www.commissionforafrica.org/english/report/thereport/13chap6.pdf>.

⁹Regional Network for Equity in Health in Southern Africa (EQUINET), Health Systems Trust (South Africa) & MEDACT (UK), *Health Personnel in Southern Africa: Confronting maldistribution and brain drain* (2003), at 15. Available at: <http://www.equinafrica.org/bibl/docs/healthpersonnel.pdf>.

¹⁰DFID Health Systems Resource Centre (James Buchan & Delanyo Dovlo), *International Recruitment of Health Workers to the UK: A Report for DFID* (Feb. 2004), at 8. Available at: http://www.healthsystemsresource.org/publications/reports/int_rec/int-rec-main.pdf.

¹¹Regional Network for Equity in Health in Southern Africa (EQUINET), Health Systems Trust (South Africa) & MEDACT (UK), *Health Personnel in Southern Africa: Confronting maldistribution and brain drain* (2003), at 16. Available at: <http://www.equinafrica.org/bibl/docs/healthpersonnel.pdf>.

¹²Clare Nullis-Kapp, "Health worker shortage could derail development goals," *Bulletin of the World Health Organization* (Jan. 2005) 83(1): 5–6. This anecdote provides a sense of the migration of Malawian doctors to Manchester, England, though the accuracy of this anecdote does not appear to have been definitively documented.

This migration, or brain drain, is part of a more complex flow of health workers from poorer to wealthier developing countries, from the public sector to the private sector, including for-profits as well as NGOs and vertical AIDS programs, and from rural to urban areas. This last flow creates disparities within countries that in some cases are so great that they mirror the global disparities. For example, two regions in Ghana have only 34 nurses per 100,000 population, whereas another region has 120 nurses per 100,000 population. The physician disparity is greater still. One region in Ghana has only one physician per 100,000 population, while another region has 30 physicians per 100,000 population.¹³

Health workers are leaving, in large part, because they are unable to meet their own needs or those of their patients. Their wages are inadequate, sometimes not even enough to cover their basic living expenses. They have few opportunities to develop themselves professionally, and fear contracting HIV and other infections on the job, especially because they often lack the gloves and other protective gear. Poor management and planning, leading to including inadequate supervision, enormous workloads, late paychecks, and inadequate training, further harms health worker morale. Health workers are trained to heal, but because they lack sufficient medicines, supplies, and equipment, all too often they can do little more than minister to death.

A key factor in the continent's brain drain of skilled health workers is the fact that hospitals and clinics in much of sub-Saharan Africa lack basic infection control, sanitation, and occupational safety.¹⁴ A survey by Physicians for Human Rights of more than 1,000 health workers in Nigeria suggested that fear of occupational exposure to HIV/AIDS contributes to stigma and discrimination against people with AIDS because health workers are afraid they will contract the virus from them. Even in Free State, South Africa, a recent survey conducted at children and maternity units, including labor and pediatric wards, in 30 hospitals found that 49% of health workers reported shortages of protective gear at some point during the course of the year. In Uganda, the Mulago Hospital—the country's major referral hospital—did not launch a comprehensive program of universal post-exposure prophylaxis until last month, and other Ugandan government hospitals have yet to do so.

Responding to the Shortage: Training Health Professionals Is Not Enough

Ambassador Tobias and his associates are attempting to address the health worker shortage and have made some innovative grants, such as supporting a Zambian scheme to offer incentives for urban doctors to relocate to underserved rural areas. But to the best of our knowledge, the American contribution to the African health work force has largely been limited to the training of health workers. The \$150 million "twinning center" managed by HRSA, for example, is aimed at linking U.S. and African institutions for purpose of training. And the Institute of Medicine's soon-to-be-released report on the overseas placement of US health professionals recommends that a global health service be principally for the purpose of training African counterparts. Numerous contracts and grants have been made to train doctors and nurses in the use of antiretroviral therapy.

But training alone is not the answer to the health work force crisis in Africa; indeed, it may even accelerate health worker flight. If working conditions, salaries, benefits, management and opportunities for health workers in their own countries are not also addressed, additional training simply makes it more likely that the newly skilled nurse or doctor will be recruited or seek out a job in the U.S., Canada, or Europe at a vastly higher salary. As Dr. Elizabeth Madraa, who organizes anti-retroviral therapy training for health workers in Uganda, stated, "We keep training and they go to NGOs (nongovernmental organizations) or abroad where they can get better money, then we have to train [more people] again."¹⁵

To recruit the vast numbers of students to nursing and medical school and prevent new graduates from leaving, national governments, donors, and international institutions must join forces to eliminate the "push factors" that discourage trained workers from staying home—the unsafe working conditions, low pay, poor super-

¹³Ghana Ministry of Health, presented at the Oslo Consultation on Human Resources for Health, Oslo, Norway, February 24–25, 2005. Available at: [http://www.norad.no/default.asp?FILE=items/3070/108/Oslo presentation 2.ppt](http://www.norad.no/default.asp?FILE=items/3070/108/Oslo%20presentation%202.ppt).

¹⁴Physicians for Human Rights, *An Action Plan to Prevent Brain Drain: Building Equitable Health Systems in Africa* (June 2005), at 40–43. Available at: <http://www.phrusa.org/campaigns/aids/pdf/braindrain.pdf>; Physicians for Human Rights, *HIV Transmission in Health Care Settings: A White Paper by Physicians for Human Rights* (March 2003), at 37–38. Available at: http://www.phrusa.org/campaigns/aids/who_031303/workers.html.

¹⁵Charles Wendo, "Uganda leads way in innovative HIV/AIDS treatment," *Bulletin of the World Health Organization* (April 2005) 83(4): 244–245, at 244. Available at: <http://www.who.int/bulletin/volumes/83/4/en/infocus.pdf>.

vision, absence of benefits, staggering work loads, and dearth of supplies, medicines, and equipment that sabotages worker satisfaction and patient health.

Even with substantial investments, the recruitment and retention of hundreds of thousands of nurses, pharmacists, technicians and doctors is at best a multi-year project, and poor people need health services today. We urge the Administration and Congress to make the training of and assistance not only to skilled health professionals but also to community health workers and home care givers an essential component of a Global Health Workforce Initiative.

Malawi's experience of HIV/AIDS initiatives draining workers away from other life-saving health interventions is a sobering check on AIDS treatment activists' conviction that if health services are equipped to deliver antiretroviral drugs they will be able to handle virtually anything. In fact, assistance to Africa to confront HIV/AIDS has not had the desired impact of "lifting all the boats" because health worker scarcity is so great that the current workforce cannot necessarily absorb new duties, patients, and activities. But investing directly in health worker recruitment and retention, training and rational deployment required for HIV could also have that positive impact on public health generally.

Investing in Communities

In the absence of sufficient numbers of skilled health workers, some countries and communities with severe skilled health worker shortages rely heavily upon volunteers, family members, and community health workers in the fight against the pandemic. Other countries and communities may include community health workers as a planned and important component of their health systems. Indeed, part of WHO's strategy for achieving its 3 by 5 initiative of 3 million people in developing countries on AIDS treatment by 2005 has been providing training 100,000 people, about half of whom WHO has expected would be community health workers providing treatment support.¹⁶

Both caregivers and community health workers can contribute to the health of their communities. An August 2004 study of family and volunteer caregivers in Uganda and South Africa contracted by USAID noted that ". . . home care programmes, if properly planned, can relieve the pressure that the care of HIV/AIDS patients has on formal health care facilities . . . there is also evidence to suggest that such programmes have clear health, social and economic benefits for the patients, families and communities."¹⁷ Community health workers have a central part of the success of the AIDS treatment program being implemented by Partners in Health in a remote, rural area of Haiti, where community health workers observe patients taking their medication, respond to concerns of patients and their families, and provide moral support.¹⁸

At the same time that both community health workers and family and volunteer caregivers can provide important health services, both community health workers and caregivers require significant support structures. The study on Uganda and South Africa warned that without substantial investment in the home-based care, the approach could exacerbate gender and poverty inequalities among families and communities.¹⁹ Providing stipends, micro-credit or salaries to women engaged in this work would help them, and offering them training, supplies, and drugs will help the adults and children with AIDS who rely on them. Compensation is also important to maintaining the motivation of community health workers, who are also likely to be poor and require financial or material support.

Along with compensation and training, community care-givers and those in their care would also benefit greatly if the community care-giving structure is linked to supervision and support from, and a referral network of, health professionals and care-giving organizations. Supervision and training are also key elements of the success of community health workers. A career structure, a possibility for increased responsibilities and compensation, always with adequate supervision and support, can also enhance the success of community health workers.

¹⁶ World Health Organization, *Mobilizing Communities to Achieve 3 by 5* (2003). Available at: <http://www.who.int/3by5/publications/briefs/communities/en/>.

¹⁷ Olagoke Akintola (Health Economics and HIV/AIDS Research Division), *A Gendered Analysis of the Burden of Care on Family and Volunteer Caregivers in Uganda and South Africa* (August 2004), at 6. Available at: <http://www.ukzn.ac.za/heard/research/ResearchReports/2004/Gendered%20Analysis%20of%20Burden%20of%20Care%20-%20Uganda%20%20SA.pdf>.

¹⁸ Paul Farmer et al., "Community-Based Approaches to HIV Treatment in Resource-Poor Settings," *Lancet* (Aug. 4, 2001) 358: 404–409, at 405.

¹⁹ Olagoke Akintola (Health Economics and HIV/AIDS Research Division), *A Gendered Analysis of the Burden of Care on Family and Volunteer Caregivers in Uganda and South Africa* (August 2004), at 4. Available at: <http://www.ukzn.ac.za/heard/research/ResearchReports/2004/Gendered%20Analysis%20of%20Burden%20of%20Care%20-%20Uganda%20%20SA.pdf>.

The Challenge

Mitigation and eventual resolution of Africa's health worker shortage is long overdue, and harder today than it ever was given the West's insatiable appetite for foreign nurses and the untold attrition of health workers, particularly nurses, due to illness, care giving at home, and death from HIV/AIDS. HIV prevalence in health workers is typically similar to that in the general population. In Malawi, 3% of health workers were dying annually by 1997, a fatality rate six times higher than it had been before the AIDS pandemic. In Lusaka, Zambia, in 1991–1992, the HIV-prevalence rate among midwives was 39%, and among nurses, 44%.²⁰ Much as Malawi, HIV/AIDS has caused illness and death rates of Zambia's health workers to increase five- to six-fold.²¹ Resolving it requires an unprecedented degree of strategic planning and cooperation between national governments, international agencies, and other donors.

Recommendations: The Next Phase of US Support for Health in Africa

Greatly increased spending by national governments and by foreign donors and international organizations is required to enable countries to meet AIDS prevention, care, and especially treatment targets and to sustain a high level of coverage for these interventions. These systemic improvements to what is typically the weakest part of health systems in Africa—personnel—will greatly enhance countries' capacity to improve health in all areas, from combating other major diseases such as tuberculosis and malaria to improving child survival and driving down unspeakable levels of maternal mortality that plague much of Africa.

We envision an initiative with four main pillars:

First, the United States should provide technical assistance to countries in assessing their current health workforce situations, in determining their health workforce needs to achieve health targets, such as the Millennium Development Goals, and in developing strategies to achieve those goals.

The strategies should be linked to overall health system development strategies so that health worker strengthening occurs in concert with the other aspects of health system strengthening require to achieve Millennium Development. So as to guide both national budgets and donor assistance, the strategies should include costing estimates. The strategies should also include coordination among donors and the national government to ensure that the full cost of implementing these strategies is covered.

While the national government will determine the strategic process, the United States should encourage broad participation, including by health workers themselves and leaders of rural communities. This will help ensure both that the strategy is consistent with and informed by health workers' needs and the needs of communities, especially those in rural areas who presently have the least access to health services. The United States can also promote, or at least ensure that countries seriously consider, other examples of good practice, such as closing the gap between the pay for physicians and other health workers,²² promoting equity in the international distribution of health workers, and incorporating all sectors—public, non-for-profit private, NGO, faith-based, and for-profit private—in planning processes.

Second, the United States should help fund the implementation of these strategies. The activities funded should be determined by national strategies, by the needs as expressed by the people of those countries. Based on strategies that countries have already begun to implement, as well the needs common to the region that will determine the strategies, elements that will likely be in most or all of these strategies include:

- Higher salaries for health workers
- Incentives for health workers to serve in rural areas

²⁰ Alan Whiteside, "Chapter 4: HIV/AIDS, Health, and Education" in International AIDS Economics Network (Steve Forsythe, ed.), *State of the Art: AIDS and Economics* (July 2002), at 25. Available at: <http://www.iaen.org/library/statepidemic/chapter4.pdf>.

²¹ Avert.org, *The Impact of HIV & AIDS on Africa*. Available at: <http://www.avert.org/aidsimpact.htm>. Accessed April 12, 2005.

²² In Ghana, on top of their salaries both doctors and nurses receive extra compensation through the Additional Duty Hours Allowance (ADHA). Doctors, however, have received far greater allowances than nurses. This caused frustration among nurses, who felt that they were not appreciated. Since the introduction of the ADHA several years ago, nurse emigration from Ghana has increased significantly. DFID Health Systems Resource Centre (James Buchan & Delanyo Dovo), *International Recruitment of Health Workers to the UK: A Report for DFID* (Feb. 2004), at 21, 23. Available at: http://www.dfidhealthrc.org/shared/publications/reports/int_rec/int-rec-main.pdf.

- Improved health worker safety, including full implementation of universal safety precautions, post-exposure prophylaxis for health workers potentially exposed to HIV, tuberculosis infection control, and hepatitis B vaccination
- Improved human resource management, including improving human resource policies and enhancing management skills of local health managers
- Increased capacity of health training institutions, such as medical, nursing, and pharmacy schools
- Providing continuous learning opportunities to health workers
- Support for community health workers, including compensation, training, supervision, supplies, and linkages to health professional support and referral systems. Training, supporting and deploying people living with AIDS as counselors, prevention advocates, and care givers should be a priority.
- Re-hiring and rational deployment of retired or unemployed health professionals
- Health system improvements not specifically related to human resources for health, such as assuring adequate and dependable provision of supplies and essential drugs.

Third, while it is necessary for countries to have human resources for health strategies, enough is known about what is needed to begin funding many interventions immediately, and indeed, the urgency of the crisis demands this. There is no need to wait for fully formed strategies for the United States to begin to provide financial and technical support that will actually begin to help retain health workers, train new ones, and increase health services in rural areas. Much of what is needed, such as ensuring health worker safety and improved human resource management, will be part of any comprehensive strategy on strengthening the health workforce. All health workers need the gloves and other gear to keep them safe. All human resource systems will have to provide health workers with sound supervision, career structures, clear job descriptions, and on-time pay. And all countries will need to have the capacity to know who their health workers are and where they are, which will require computerized databases of their health workforce.

Furthermore, even where a complex strategy may be required, as for determining exact training needs or salary structures, pressing needs in such areas as training and salary support may be ripe for immediate funding, even before the strategies are fully established. For example, the nursing school that is part of the Harare Central Hospital in Zimbabwe had only three nurse tutors (professors) in the beginning of 2004, though the school officials say that at least fifteen are required.²³ These posts need to be filled. As of 2003, Kenya had 4,000 nurses, 1,000 clinical officers, 2,000 laboratory staff, and 160 pharmacists or pharmacy technicians who were unemployed not because they were not needed, but because the government could not afford to pay them.²⁴ These workers need to be hired.

Fourth, the United States should support efforts by the World Health Organization and others to collect and disseminate country lessons and experiences in human resource policies and efforts to recruit, retain, and equitably deploy their health workers. Information of both successful and unsuccessful practices should be widely available so countries learn both from the experiences of other countries, adopting successes to their own circumstances and avoiding other countries' mistakes. One way that the United States do this is by supporting a regional observatory on human resources for health at WHO's African region headquarters. This observatory would promote evidence-based human resource policymaking, share experiences with human resources reforms among regional policymakers, and increase human resource policymaking capacity.

Along with learning from experiences elsewhere, countries should also learn from their own experiences, and adjust their strategies based on those experiences. The United States should therefore help countries develop strong monitoring and evaluation capacities.

Fortunately, this Administration and this Congress have shown that they are up to the task. The two major new foreign aid initiatives of the past several years,

²³ IRIN, "Health set to worsen," *IRINnews.org*, Jan. 9, 2004. Available at: http://www.irinnews.org/report.asp?ReportID=38835&SelectRegion=Southern_Africa&SelectCountry=ZIMBABWE.

²⁴ Jong-wook Lee, "Global health improvement and WHO: shaping the future." *Lancet* (2003) 362: 2083-88. Available at: http://www.who.int/whr/2003/media_centre/lee_article/en/index4.html; Jongwook Lee, *Meeting of Interested Parties: Opening Session*, Geneva, Switzerland, Nov. 3, 2003. Available at: http://www.who.int/dg/lee/speeches/2003/MIP_Openingsession/en/.

PEPFAR and the Millennium Challenge Account, both represent new ways of doing business. The adoption of the U.S. Leadership Against HIV/AIDS, TB, and Malaria Act of 2003 represents the vision of Members and Senators from across the political spectrum. It was the high-water mark of legislative and executive branch cooperation, and it made possible an unprecedented contribution to health in some of the poorest countries in the world. We believe that with the leadership of the President and this Committee, you can make a new and desperately needed contribution in the form of direct support of African health workers that will sustain and broaden the programs you launched in 2003. We stand ready to work with you to reach that noble goal.

Thank you.

Mr. SMITH OF NEW JERSEY. Ms. Burkhalter, thank you very much for your testimony and for these many years. When I chaired the International Office of Human Rights Committee, you were a frequent witness and provided us much valuable insight in writing the trafficking laws and all of the other pieces of legislation when you worked with Human Rights Watch. I always appreciated your take, and now with the physicians' group, it is very, very helpful. So thank you.

And the focus you bring on the scarcity of healthcare professionals and providers in Africa is an issue that has gotten too little attention here in Washington, perhaps elsewhere as well, so I know you have talked about it before, but I think that whole focus needs to be enhanced, and also the brain drain which just leads to people being unhelped, unattended to.

We have a scarcity of nurses in this country, but, still, it is a matter of what is the ratio of patients per nurse as opposed to no nurse at all. So I think your point is very, very well taken.

I would like to ask you, if I could, and you began to allude to it at the end, with regard to the importance of behavior change. You know, I have been a very strong believer over these years that just like we admonish countries through human rights law with a linkage to penalties and rewards if human rights are adhered to or not adhered to, I think the most salient case where human rights linkage to rewards and punishments is in the area of trafficking. As you know, I was the prime sponsor of the Trafficking Victims Protection Act, and there were a large number of people, Democrats and Republicans, who were part of the coalition that got it passed, and some people, both sides of the aisle, who did not want to have any penalty as a result of misbehavior, in this case, modern-day slavery with coerced prostitution and slave labor of other kinds.

But it has proven itself. Countries have changed their laws. Forty-four or 45 countries have totally rewritten their laws because a small but, nevertheless, real sort of Damocles is hanging over them with regard to loss of U.S. foreign aid. So it focused the mind.

Behavioral change—that is on the micro level, individuals—is what the abstinence promotion was, and still is, all about, as well as the to-be-faithful mindset. I think it is the soft side of racism to suggest that some parts of the world are unwilling to be taught that, and Uganda, in a situation where Ugandans told the rest of the world that their leadership, moral, political, could admonish their young people to defer. It is not a matter of never having sex; it is a matter of deferral to the more appropriate time and to be faithful to one's partner, you know, whether it be a wife or husband

or a situation where they are just exclusive, just the male and the female.

My point being that we see, I think, a potential dissolution of that or a lessening emphasis on that. Mr. Ssempe's testimony is an indictment, I think, of some of the contractors that are doing business who, when it gets down to real-world implementation, are failing to carry out the clear, nonambiguous intent of Congress and the President to not discriminate against those who feel that the AB should be emphasized and the C perhaps not at all.

That is what the conscious clause was all about, and perhaps you might, Mr. Ssempe, might want to speak to that further because, as you have pointed out, and I have heard this from other individuals as well, there is a concern that the infection may go up again, and perhaps already is, because that message is not being reinforced over and over and over again in young people with regard to the abstinence part.

Our language said condoms can be distributed. That is a large commodity procurement that this country makes every year, but there are those who feel that that is not the means where there is the highest rate of efficacy, so they choose another way. So perhaps, Mr. Ssempe, you might want to speak to that as well.

And then, Dr. Gupta, if I could, and all of you might want to speak to this, and, Holly, you might want to speak to this as well, one of the amendments I offered to Mr. Hyde's bill had to do with hospice—not that any of us think that hospices are going to spring up all over Africa or anywhere else in the developing world—but hospice training, so that those who have HIV/AIDS and are in, particularly, those final, very hard last weeks and days are not treated like lepers and put off in a corner somewhere to die not just a miserable death but an exceedingly lonely death as well.

We have had come to this Committee in the past faith-based groups, including a priest and a nun from South Africa who were doing great model-type work, prototyping work in South Africa where they teach the lessons of hospice and how it can help, and, Ms. Burkhalter, you might want to speak to that issue as well.

I have other questions, but if that could be the beginning.

Ms. BURKHALTER. I did not know about the hospice provision. I just think it is a wonderful thing.

I was talking to my colleague, Eric Friedman, who is the researcher at Physicians for Human Rights upon whom this testimony is based, and I neglected to thank him at the outset—I would not be here without his very good work and good fellowship.

I think it is a wonderful initiative with hospice care because probably most people are dying at home. Eric was telling me, when he visited hospitals in Africa recently, just a couple of months ago, that many sick people do not come because there are not enough nurses to care for them. And he mentioned that there was a nurse that he talked to at a recent conference of nurses that took place in Tanzania, mentioned to him that a nurse was being sued because someone died in a hospital without a nurse at his side. She was just dumbfounded by that. She said, "We cannot possibly be at their side; there are not enough of us."

Can you imagine how they must feel when they come back to visit a patient, when they have 100 patients, and they are dead?

We do not often think about what the health professional herself or himself, what kind of a toll that must take on them. But that is the reality, that people die alone. They die alone often in hospitals because there are not enough people to even hold their hands and be with them as they leave this life.

Your notion that hospice care and education can not only help the dying but help the living, the people with AIDS who are not dead but who might be shunned by their communities. Ambassador Tobias said something about all healthcare being local, and I really like that comment because the issues that the three of us at this table care about very much and, I am certain, are in agreement on, which are care and treatment of the sick and dying, abuses against women and children, stigmatization of people with AIDS; all of those things really have to be addressed at the community level.

In addition to the provision of services for the very poorest who do not have access to nurses and doctors and trained health professionals, which is where, I think, any kind of health worker initiative has to include the community health worker. They can do a lot of the things that, at least, nurses and other caregivers might do, and, at the same time, particularly if their core of workers includes people with AIDS, will just help more than anything else to chip away at that stigma that makes the death of a person with AIDS so lonely.

Mr. SMITH OF NEW JERSEY. If you could just respond on the behavioral-change issue.

Ms. BURKHALTER. I am just very, very interested in the leadership, the role of national government and civil society in making changes and helping contribute to safer behaviors that have played an important role in not just Uganda, but different kinds of behavior changes elsewhere, in the United States itself, as a matter of fact. And I think that finding ways to shore them up and publicize safe behavior, particularly in countries where women and girls are very much at risk because of tolerated behavior—you know, we tolerated domestic violence here until rather recently. But there was sort of a norm change. The health community was a part of that norm change, and I would love to see them empowered to do so in Africa. There are not enough of them, though.

But the cultural norms that could stigmatize somebody who is having sex with a child or a teenaged girl, or the cultural norms that could say, "We do not beat up wives and girlfriends in this community," it seems to me, are very much a part of the A and B message. That is something on which everybody can agree. I think that the standard by which Congress should look at all of the prevention programs we fund is not either/or, of course. The bill encompasses all three, but we should be funding the best of all three.

Mr. SMITH OF NEW JERSEY. Mr. Ssempe?

Mr. SSEMPA. Yes, Mr. Chairman. Thank you for that comment.

We have noticed that in places where there are more condoms being distributed, more than A and B, we see that there is an increase in HIV/AIDS, and you would not expect that because I do not think that the people who distribute condoms really want that.

The recent research that has come out was the Reichart research that was all over the news and seemed to credit condoms for the success of Uganda turning back the tide, but actually the opposite

is true. We find that, in the particular area where the project was, there is such an influx of condoms that there are 185—agents having double condoms in Rakai, more condoms, and in other areas where there are very few condoms, like Moroto and Karamoja, there is less HIV.

Even on an international level, we notice that countries such as South Africa, Botswana, Zimbabwe, and Kenya that have higher levels of condoms correspondingly have higher levels of HIV, something that has got all of us asking the question: What is going on here? Because the people, like PSI, who are working on this same message are not intending to spread HIV/AIDS, but it is worthy of further investigation.

The other point I would like to make, Mr. Chairman, is having been successful in convincing—has been two things, one, essential fatigue, but then also there are elements that just do not like the message of A and B. So this morning, with the demonstration in the room, there are people just opposed to A and B, and as Ambassador Tobias said, partnership between U.N. AIDS and PEPFAR, the development of the three critical ones, the development of one single strategic framework, one single monitoring and evaluation, one single coordinating entity.

I have those documents here, but increasingly in Uganda we are seeing a systematic elimination of A and B, and it concerns me as an activist. I do not want to come back 2 or 3 years from now, and in the country that was credited for studying the ABC, that it is practically gone. So I am concerned, and we are concerned about it. To a great extent, it is an overreaching agenda of some who do not like the balanced ABC message. Thank you, Mr. Chairman.

Ms. BURKHALTER. I just want to comment on two points that you raised. I was not aware either of the amendment on hospice training, which I think is a wonderful idea. As you probably know, it is women who bear almost the entire burden of care in most countries that are affected by this epidemic, and they do so with very little available to them by way of resources or information. I think the first step, therefore, is to just ensure that they get the water, the gloves, the needles, the simple information about what is safe and what is not, so that they can deal with the loved one's care in a way that is safe for them.

And the second point I wanted to make is that in behavior-change communications, I would like to see more investment in that kind of programming for reducing the acceptability of violence against women. That is exactly what I was talking about. That is a normative change that can be brought about. We have done it in this country many times on many different issues. The famous one that comes to mind is with litter in this country, the famous campaign of the American Indian with the tear. It worked.

There are things that can be done. We need mass campaigns at that level while we have community interventions and initiatives led by local organizations that are pointing out the cost. We need the evidence to prove that these are costs to national economies, not just to individual women, and we have the data to show that. It actually reduces your GDP when you have that much violence in a country against women. It reduces productivity. It increases absenteeism.

So there are many reasons, including HIV/AIDS and the spread of it, to invest in doing something about what I think of as another epidemic. If it was a public health issue, we would call it an epidemic.

Mr. SMITH OF NEW JERSEY. I have additional questions, but I may have to submit them for the record. We will go on to Ms. McCollum. We have to vacate this for another hearing that begins at 1:30, regrettably. Ms. McCollum?

Ms. MCCOLLUM. Thank you, Mr. Chair.

There has been a lot of testimony that has been, I believe, well, it should have been started with "in my opinion," and we certainly want to hear people's opinions.

Mr. Ssempe, I have a couple of questions for you. What was the dollar amount you were applying for in your contract that you claim you were turned down for?

Mr. SSEMPE. I do not recall exactly. We were invited by PSI to have discussions.

Ms. MCCOLLUM. You do not recall how much money you were asking for?

Mr. SSEMPE. No. We do not recall how much money we were asking for.

Ms. MCCOLLUM. Okay. I find that kind of unusual, that you would go in and discuss a contract, but you cannot recall how much—

Mr. SSEMPE. We did submit a proposal.

Ms. MCCOLLUM. And how much was the proposal for?

Mr. SSEMPE. I do not recall right now.

Ms. MCCOLLUM. You do not? Okay.

Mr. Chair, I have a couple of things that I would like to submit for the record because I know people have different opinions as to how effective different things are, but when I found this was coming up, and I had an opportunity yesterday to sit at my Web site and learn more about one of the organizations, PSI, that people were giving their opinion on, and wanted to gather some information on what they did with faith-based programs and found out that they had been working with faith-based programs that go back to the late eighties, and different activities in different communities as their faith communities feel comfortable with.

If they just want to do the A and B, or if they want to do the ABC, that faith-based organization is allowed to determine that, but if the faith-based organization is found to be breaking U.S. law in not using scientifically accurate information about condoms, if they choose not to be silent on condoms, then they must be correct in the information that they use when they describe condoms.

Mr. Ssempe, it has been brought to my attention that you do not think condoms, in your opinion, are as effective as the A and B, but have you publicly ever stated that condoms are not effective because they all have holes in them?

Mr. SSEMPE. No, ma'am. I never said that.

Ms. MCCOLLUM. You have never said that.

Mr. SSEMPE. No.

Ms. MCCOLLUM. Mr. Ssempe, I have an article in front of me, because I just want to clear things up for the record, and I am quoting—it is from a *New York Review of Books*, and the author

is Helen Epstein, and she, in an interview, and I do not know if you have had a chance to see her book yet, that you condemn homosexuality, pornography, condoms, Islam, and Catholics, and certain kinds of rock music, women's rights activists—who you say promote lesbian—abortion, and the worship of female goddesses. Is any of that correct, or is it all incorrect?

Mr. SSEMPA. I think that there is a lot of misrepresentation that is put toward people like me who promote abstinence and being faithful. That article came out recently by Helen Epstein, and I have had an opportunity to look at it. It is full of misrepresentation.

I would like to draw one, especially in the part about condoms. In that particular article, Helen Epstein writes that I burned condoms, and I think there was a Congressman who asked a question about that, and it is true. I burned condoms. But what critical piece of element is left out is the fact that those condoms had been banned by the government a few days earlier, that they would pose a significant risk to the population at large. So I was simply fulfilling what the government had ordered, a recall, a destruction of those condoms.

Ms. MCCOLLUM. The government requested you to go to that campus—I believe it was a campus—and the government personally asked you to burn the condoms?

Mr. SSEMPA. It issued a call to recall and destroy all condoms from public. And what happened, I work with college students. It was a season of freshmen. In fact, in that particular article, Helen Epstein says it is a fresh pack of condoms. It was not a fresh pack. It was a deteriorated, recalled pack of condoms that posed a significant, hazardous, life-threatening experience to anyone who would have used it, so that is what happened.

Ms. MCCOLLUM. I am glad you had time to look at the lot number and verify that, and that was not your property that you destroyed. And in your opinion, you thought you were doing something that was good.

You have also said that many of these organizations do not work with the government; they work against the government.

This is, Mr. Chairman, for the record, and I will submit some of my other information for the record because I am going to stick to what I have that is factual, that we have an ad campaign which has the first lady, Janet Museveni in here. It is USAID, and this was done in cooperation with PSI working on it, and it talks about delaying abstinence. You know, it is very, very clear. I think it is an excellent message that that has been put together, and I am sure the first lady is very proud of the work.

In a country where people do not know their status, and people are going to be entering into faithful relationships or entering into marriage, and neither partner knows what their status is, and the prevalence rate is high, would you recommend, Doctor, that that couple seek to protect themselves while they were investigating what their status was and that a condom would be a good thing to use, so that that couple should have had information on condom use available to them?

Ms. GUPTA. Absolutely. There is no question about it. If a couple does not know their individual status, has not had the time or the

opportunity to check it yet, they must protect themselves with the only means that is available currently, which is a condom, until such time as they know what their status is.

The problem that arises for young married couples is when they want to prove their fertility, which is why I was saying that there is a need for microbicides because investments in microbicides that do not have contraceptive properties will actually allow couples to protect themselves from infection and still be able to have a child.

Ms. MCCOLLUM. That is very interesting.

Mr. Chair, I will submit other faith-based organizations that PSI has funded just in the last less than a year.

Mr. SMITH OF NEW JERSEY. Thank you.

Mr. Payne?

Mr. PAYNE. Thank you very much, Mr. Chair. I am sorry that I missed much of the testimony.

It is good to see you again, Ms. Burkhalter. Any time I see your face, I know that there are good things going on. I do not know the other two persons, but I think this is a very important issue, the question that you raised, Ms. Burkhalter, about the draining of professionals.

The same thing is happening, as you know, even more so in the Caribbean Islands, that they are struggling to try to keep their nurses, in particular, there. They train them, they graduate, and as soon as they are in practice for a few years, they are just brought up to the middle Atlantic states or whatever. We have even talked about attempting to see if there could be some allocation to some of those countries for their educational system to expand it a bit so that since we are not going to, it seems like, end the practice, at least there could be some USAID subsidy to the government to increase the number of persons that are going into the field.

I hope that then more would not be brought up, but there is some, I believe, some obligation and responsibility for us who are pulling these nurses in this region, and as you have indicated, it is certainly happening in South Africa.

I also have some concern about the lack of safety with needles, for example. There are ways that needles can be prevented from nurses striking themselves. Retractable, of course, is costly, but even needles that can go back into, which are not automatic, but needles which can go back into the container. Have you had any discussion with any of the world organizations regarding the question of safety of the nurses or the first responders, so to speak?

Ms. BURKHALTER. Well, I am actually very proud to say that Physicians for Human Rights wrote a big, white paper on HIV/AIDS transmission in medical settings. So it is not sexual transmission; it is AIDS transmission from reused needles and from unscreened blood supply. There is argument in the international health community over what level is responsible from this transmission source, but even the smallest numbers, estimates are really huge, and all of them are preventable.

And a related problem, of course, is occupational exposure of the nurses, among the nurses and doctors themselves. I do not really have time to talk about it, but this is a real contributing factor to brain drain. Doctors and nurses are afraid of being infected by

their patients, and it is not just needles. Any open lesion on you or anything open, your eyes. If you are a midwife delivering a baby, and you do not have a gown, a mask, and gloves, and many do not, you are at risk. It is low risk compared to some of the other more efficient transmission modes, but it is a risk, and the perception of risk is enough for people to say, "I cannot work here." The risk contributes to a stigma within the medical community against people with AIDS because they are afraid.

So we actually called for a targeted intervention in helping supply safer workplace activities, and there was an earmark in the original bill over on the Senate side, and they have done an admirable job. On the medical transmission of AIDS, we are the first government to do this, and it is now becoming much more a part of a key prevention method that it was not in the past. But much more needs to be done, and particularly in the area of universal precautions, post-exposure prophylaxis, some of the other things that are not universally available, by any stretch.

Mr. PAYNE. Thank you very much. Time is running out, but I believe that the amount of funds, the \$15 billion sounds great, but, in my opinion, it is just a drop in the bucket that we have put forward. You could not believe that when Secretary Colin Powell was going originally, 5 years ago, our commitment was supposed to be \$200 million for 5 years. It was so disgraceful to even go and say that we are going to do \$200 million as our contribution. We are able to, at least, compel them to, at least, change it to say, well, maybe this is our beginning contribution. The \$15 billion, like I said, in my opinion, is not nearly enough. [Off mike.]

About \$500 billion will be spent each year of 2 years. It is not all spent, but it is in the budget. I do not know how the budget works, how it lays in, but I just know I voted against \$426 billion and voted against these other supplements. The point is that about \$10 billion a week, if you take the trillion dollars spent in 2 years or budgeted in 2 years, \$10 billion a week—that is like, \$1.2 billion a day, maybe just \$1 billion or maybe knock off \$200 million—when you look at numbers like that, and you talk about we are doing such a fantastic job when we are talking about the allocation of what we are doing in a week and a half as relates to the U.S. military effort in the world. This is 5 years, \$15 billion, and we are patting ourselves all over the back. And they are military expenditures. We have to protect ourselves, defend our country, and all of that—I am not un-American, but we are spending about that amount in 2 weeks, not 5 years.

So I think it is the way that you look at things. Where is the money going to come from? I do not know where it is coming from, but a 426 we just approved for the military budget in the supplements; it comes from somewhere. Maybe they just print it. I do not know how that works.

But we have to stop being satisfied with numbers that sound like they are extraordinary. They are extraordinary because we were going to do \$200 million. So I could not agree with you more. There has to be another look at this killer disease that has changed the projections of populations in our years.

And also, I do not want to get into a big debate about the condoms, but I do not know any person—I am a father and have

triplet grandchildren—I do not think there is any adult, any parent, who does not talk abstinence. I have done it. My grandmother and grandparents talked to me about it when I was a kid. I talked about it to my children. Their little 6-year-olds are not talking about it yet, but we all are for abstinence.

But I think we have to be realistic, too, and if the abstinence does not work, then it is absolutely irresponsible to say that condoms should not be used. It is absolutely wrong, and no one knocks abstinence. We would have no problems if everybody abstained until they were married. We would not have unwed children. We would not have malnutrition. It would be fantastic, but in the real world, it is like a world without wars, you know. It is not going to be, and abstinence is not going to be.

As a matter of fact, in “Leave No Child Behind,” in Newark, New Jersey, it is against the Federal law to talk about condoms. You lose your Federal money. That is the law of the land in this country. Absolutely insane. Teachers are just choked up because they only can talk abstinence. Can you imagine that here?

Mr. SMITH OF NEW JERSEY. Would my friend yield?

Mr. PAYNE. Yes.

Mr. SMITH OF NEW JERSEY. We have another hearing.

Mr. PAYNE. That is right. Okay. Sorry I got here late. We usually do not have any limits.

Mr. SMITH OF NEW JERSEY. I would like this to go on for at least another hour, and the gentleman knows that.

Mr. PAYNE. Thank you. I will yield back to you.

Mr. SMITH OF NEW JERSEY. Regrettably, we do have to end. I have some additional questions I would like to submit for the record. Thank you so much for your testimony and for your great work. The hearing is adjourned.

[Whereupon, at 1 o'clock p.m., the Committee was adjourned.]

A P P E N D I X

MATERIAL SUBMITTED FOR THE HEARING RECORD

MATERIAL SUBMITTED FOR THE RECORD BY THE HONORABLE BETTY MCCOLLUM, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESOTA

OUR MISSION

Since 1977, AIDSMark was used social marketing to prevent the spread of HIV/AIDS and other sexually transmitted infections throughout the world. Funded by the United States Agency for International Development (USAID) and managed by Population Services International (PSI), AIDSMark collaborates with USAID missions and other international donors, as well as with host governments, non-governmental organizations and commercial enterprises to:

- ▶ Evaluate current programs to identify a wider range of products and services;
- ▶ Scale up programs for each additional target group and intensity efforts within current target groups;
- ▶ Increase the capacity of programs for management, marketing, communications and research; and
- ▶ Start local programs.



AIDSMark
Changing Behavior, Improving Lives

Social Marketing and the Role of Faith-Based Organizations

Religious leaders' have the power to shape opinions and influence behaviors in their communities. Accordingly, faith-based organizations (FBOs), backed by the authority of traditional religious leaders, churches, mosques or synagogues, can have a far-reaching impact on the HIV/AIDS pandemic by delivering compelling messages about prevention, as well as providing spiritual and social support for those living with and affected by the virus.

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AIDSMark is dedicated to achieving healthy behavior change by adopting private sector marketing techniques. Positioned right alongside the behavior change messages that include assistance being helpful to one's partner and delaying sexual debut are the products and services—such as condoms, STI kits, voluntary counseling and testing and contraceptives—that help normalize and reinforce the better behavior. Advertising, public relations, event promotion, interpersonal communications, celebrity endorsement—all these tools are deployed by AIDSMark in the battle to prevent the spread of HIV/AIDS in countries beset by the disease.

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New Alliances on the Horizon

FBO Partnerships in Action



Our collaborative programs with FBOs are quickly picking up steam around the globe with initiatives such as behavior change, VCT, prevention of mother-to-child transmission, and youth programs.

We are working to establish and facilitate fruitful dialogue among donors, FBOs, community-based organizations and non governmental organizations.

In conjunction with USAID, we are developing a unique training program that builds religious leaders' capacity to develop sustainable, effective, comprehensive approaches to stop the spread of HIV/AIDS, and provide health products and services to their communities.

Participating FBO leaders will:

- Face their own attitudes and stigmas related to the disease, and accept the realities of HIV/AIDS;
- Increase HIV awareness and knowledge, including modes of transmission and prevention strategies;
- Evaluate their own risk factors and engage in risk-reduction behavior, encouraging their adherents to do the same;
- Develop resources and individuals they can draw on to help with HIV/AIDS programs for their communities;
- Recruit and train volunteers, and staff members to minister to the spiritual and emotional needs of PLWHA and their families; and
- Identify spiritual care ministries and develop skills for welcoming, listening, accepting and trust building.

Our work in the field has revealed many FBOs willing to partner with us. Our cooperative efforts are already bearing fruit in HIV-affected countries around the world.

Zimbabwe
Our "New Start" voluntary counseling, and testing (VCT) initiative conducts workshops for Christian leaders to help them understand and fight HIV/AIDS. Youth training balances messages about abstinence, being faithful and condom use, as well as delaying sexual debut, getting early treatment for sexually transmitted diseases and knowing one's HIV status.

Laos
We work closely with the country's largest religious organization at the national and provincial levels, engaging highly respected Buddhist monks in delivering messages of HIV/AIDS prevention.

Myanmar
We have partnered with more than 50 FBOs in Myanmar, arranging educational health talks and trainings to organized church groups and helping individuals train their peers to conduct similar discussions. We help others develop their own programs that teach abstinence, delayed sexual debut and fidelity/partner reduction.

Guatemala
Proyecto Vida is a comprehensive care and prevention program managed by the Mary Knoll sisters of Santo Domingo. With support from PSI, the program operates a residential facility for people living with HIV/AIDS (PLWHA), as well as a behavior change communications project for high-risk groups.

Nigeria
We work with the Federation of Moslem Women to train Islamic clerics in HIV/AIDS stigma reduction, and with a variety of other religious groups to develop key communications products—including a 2002 TV ad featuring highly respected Muslim leader the Sultan of Sokoto.



Faith-Based Alliances

Religious Leaders, Groups Help Influence Behavior

PSI has a history of enlisting religious leaders and groups in its HIV/AIDS prevention efforts, such as Buddhist monks in Cambodia, Laos and Myanmar; Muslim imams in Guinea, Mali and Nigeria; and Christian leaders, such as Archbishop Desmond Tutu, in Kenya, Zambia and South Africa.

Recognizing that religious leaders play a powerful role in shaping the opinions, attitudes and behaviors of the followers of their faiths, PSI collaborates with faith-based organizations (FBOs) that complement PSI's own market-oriented approach.

While FBOs are grappling to align their traditions and teachings with social issues at the root of HIV/AIDS, PSI helps them develop social marketing strategies within the context of their beliefs and shares current best practices for battling the pandemic.

Here are a few examples of how PSI is scaling up its alliances with FBOs:

- PSI launched a partnership with the All Africa Conference of Churches which trains church leaders throughout sub-Saharan Africa on comprehensive prevention strategies in order to mobilize their congregations to curb the spread of HIV. The program trains heads of churches through regional seminars which use individual and collective reflection and assessment of the effectiveness of the churches and their leaders' responses to HIV/AIDS in order to inspire in them to a personal commitment to reverse the epidemic.
- In Malawi, PSI works with FBOs to develop materials and activities for youth that focus on self-esteem and sexuality, and encourage abstinence, secondary abstinence and correct and consistent use of condoms for those who are sexually active and unwilling to return to abstinence. The program helps youth assess their own personal risk, identify the need for voluntary counseling and HIV testing (VCT) and discuss the proper place of sexual activities according to their cultural and faith traditions. PSI also works with FBOs within the context of the broader health issues affecting Malawians, making health products and services available through FBOs.
- PSI works with the Circle of Concerned African Women Theologians and other FBOs to protect vulnerable girls from cross generational sex and promote non-judgmental HIV/AIDS education among youth. The programs challenge congregations and communities to protect the rights of youth by providing them with pertinent knowledge and information on HIV prevention, assisting them to avoid sexual exploitation and to support AIDS orphans.
- In Mali, the Malian League of Imams and Scholars for Islamic Solidarity and PSI have developed standard sermons on HIV/AIDS that are used during Friday prayers. The sermons, or khoutouba, express the gravity of HIV, explain the means of HIV transmission, encourage abstinence and fidelity and promote compassion for people living with HIV/AIDS.

PSI combines its social marketing strategies with the influence of

- PSI FBO Activities
- Back

PSI, African r leaders mobi against AIDS
Watch the video



Mali: PSI works w Malian League of I and scholars for I Solidarity to devel standard sermons address HIV/AIDS

- HIV/AIDS
- Family Plan
- Safe Water Rehydration
- Nutrition/ Micronutrie
- Malaria
- Tuberculosis
- Drug Risk P

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- Social Marketing . Role of Faith-Based Organizations PDF
- In AIDS Battle, P

Harper, Bill

From: David Olson [DOLSON@psi.org]
Sent: Tuesday, April 12, 2005 5:50 PM
To: Harper, Bill; David Olson
Subject: Response to Ssempe's testimony

Importance: High

** High Priority **

Bill,

Here iare some initial thoughts which respond to the testimony of Rev. Martin Ssempe, which I have just faxed you. I have also sent this to Peter Yeo on the staff of the International Relations Committee. I'm checking a few facts with our Uganda office but will not hear back from them until morning. I will pass along any additional information that I receive overnight along tomorrow morning. I will be here until 7:00. Let me know if you have any questions.

David

PSI
 Talk Points

We are concerned that the House International Relations Committee is being used to spread misinformation about PSI, one of the leading non-profits engaged in public health for the past three decades. We wish to note that PSI has not been invited to rebut these groundless charges in committee testimony.

PSI has been a leader in evidence-based public health and an important partner of the U.S. government in the implementation of foreign assistance programs. We have implemented USG international health programs in a variety of sectors, and received high praise for our practical, action-oriented and effective programs. We are committed to supporting USG policy objectives and sound public health strategies.

A few brief points to correct the highly inaccurate testimony of Rev. Ssempe:

1. PSI prevented over 800,000 HIV infections last year alone. This estimate is based on scientific models developed by external experts, and the same models are currently being used by the USG to assess the impact of their investments in AIDS prevention. The model is based on the "Avert" equation as first put forward by Michael Sweat of Johns Hopkins University, and later adopted by John Stover of the Futures Group.
2. PSI is a non-profit organization which implements programs in the areas malaria, safe water, nutrition, family planning and HIV/AIDS prevention. In HIV/AIDS, these programs include abstinence, fidelity, condoms, prevention of mother to child transmission and prevention and treatment of sexually-transmitted infections. We have also launched programs in several countries which deal with the difficult gender norms that put young women at higher risk of HIV acquisition, and we are working closely with the African Union to establish a partnership that will accelerate this work. The African Union provides African solutions to problems on the continent, they are well placed to lead an advocacy initiative against gender violence and inequality, and we are proud to stand along side them as partners.
3. We do not make the promotion of condoms a condition of collaboration with PSI - never have, never will. Our long-standing collaboration with many FBOs who prefer not to distribute or promote condoms is ample evidence of this fact. We work with Ene All Africa Conference of Churches as well as Islamic religious leaders in West Africa. But if they do talk about condoms, U.S. law requires them to provide "medically accurate" information on their effectiveness. U.S. law prohibits FBOs or any other recipient of USG funding to disparage condoms.
4. PSI's response to HIV/AIDS prevention in Uganda and elsewhere is not limited to condoms. PSI uses social marketing to promote a variety of healthy behaviors (such as abstinence and fidelity) not only in HIV/AIDS, but also in malaria, safe water and family planning. PSI learned long ago that commercial marketing approaches can be applied to more

than just products and has done that effectively for over 30 years.

5. It is simply not true that condom social marketing has not worked although we agree that condoms alone do not stem the AIDS epidemic - with the possible exception of Thailand and Cambodia - although it was never expected that they would, but the same could also be said for abstinence and fidelity. If there is one thing we have learned in our years of fighting AIDS, it is that this epidemic requires a multi-pronged response and no single strategy should be expected to curb the epidemic on its own.

6. Rev. Ssempe's organization was turned down for funding by USAID. Rev. Ssempe then applied to PSI for funding and PSI also turned him down. But the decision was based primarily on concerns over the management capability of his organization. But PSI did select three other Ugandan FBOs, which it now supports. So PSI does promote abstinence in Uganda through FBOs, but not Rev. Ssempe's FBO.

7. Rev. Ssempe contradicts himself in Number 1 and 2 of his testimony. First he says that USAID and CDC have "discontinued funding A,B and ABC plans." In Number 2, he states that "they gave funding to PSI, a condom social marketing firm to be a primary abstinence provider." Based on Rev. Ssempe's own testimony then, USAID and CDC are supporting A and B but not in the way Rev. Ssempe would prefer.

8. Rev. Ssempe implies that PSI became "an abstinence advocate overnight." Actually, PSI has promoted A,B and C from the time of its very first HIV/AIDS prevention project in Zaire in 1988. It is true that it focused more on condoms in the early to mid-1990s (but even during this time had some programs with A and B elements) but this was a result of the priorities of donors and local health authorities and not PSI's own agenda. PSI implements programs at the pleasure of the local health authorities and its donors and designs its programs in coordination with the relevant national health authorities.

9. Rev. Ssempe says that "by using PSI, it [USAID] allows them to turn away faith-based groups." As stated above, PSI does work through FBOs in Uganda and, for at least 10 years, not because it was politically correct but because PSI recognized FBOs and religious leaders as effective ways to influence behavior in many countries where they are influential. PSI has worked with Archbishop Desmond Tutu, Buddhist monks in Cambodia and Laos and Islamic leaders in West Africa, such as in Mali where PSI works with imams to incorporate HIV/AIDS messages into Friday sermons.

10. It seems that Rev. Ssempe is not asking for Congress to implement the ABC policy but the "AB" policy since he makes his total disdain of condoms apparent.

Harper, Bill

From: David Olson [DOLSON@psi.org]
Sent: Wednesday, April 13, 2005 9:21 AM
To: Harper, Bill; Yeo, Peter
Subject: PSI/Uganda Response to Martin Ssempe's testimony

Attachments: PSI U Analysis of Budget.xls; FBO JUN-MAR.doc



PSI U Analysis of FBO JUN-MAR.doc
 Budget.xls (... (74 KB)

Here is all the detail you need from PSI/Uganda on their contact with Ssempe. Also attached is a spreadsheet that shows breakdown of their PEPFAR budget since Oct. 1, 2004: 32% has been spent on prevention of mother-to-child transmission, 31% on voluntary counseling and testing, 14% on high risk groups, and 7% each on AB Only, ABC Blitz Teams (I don't know what this is but will try to find out) and targeted condom distribution. Please confirm receipt of this information.

>>> "Sam Nganga" <nganga@psiu.co.ug> 04/13/2005 8:37 AM >>>

Hi David,

I will shortly forward you our recent communication with USAID on Martin Ssempe: that should help provide you with background information. I will also respond to you specific questions by separate email. In the meantime, I'd like to clarify a number of points:

1. Martin Ssempe did approach us with a proposal for a project named the Campus Alliance to Wipeout AIDS (CAWA). His budget was a million dollars. ~~We were concerned when he said that condoms do not work, and have holes in them but we were in broad agreement about A&B. He NEVER said, or inferred, that he had to promote condoms in order to get funding from us.~~

We never formally turned him down and at no point did we ever make it a funding condition for him to speak about condoms. In any event, we did not have \$1 million dollars to give (we only had about \$300k for A & B activities).

2. We work with more than three faith-based organisations. I've attached

a list of some of the activities that we're working with FBO leaders including Canon Gideon Byamugisha, a reknowned HIV-positive church leader who is a member of our board. We do not now, nor have we ever, required these FBOs to promote condoms - we support them in whatever activities are in keeping with their faith.

As an example of our FBO activities, this afternoon - probably while the session is in progress - PSI will be training 20 FBO representatives from six denominations on a parent training program with the Church of Uganda aimed at promoting abstinence, delayed sexual debut and stopping cross-generational sex.

3. Martin Ssempe's comments seem predicated on the assumption that our activities are totally skewed towards condom promotion to the exclusion of all else. This is not true. As you'll see from the attached spreadsheet, we only spend 7% of our HIV funding on condoms distribution.

PPS: Martin Ssempe's title is 'Pastor'. In Uganda the term 'pastor' does not necessarily imply that one is ordained. As far as we can tell, he is not an ordained minister and definitely not a 'Reverend'.

regards

Sam Nganga

FAITH BASED ACTIVITIES CARRIED OUT BY PSI/UGANDA
JUNE 2004 – MARCH 2005
 Roughly \$70,447

- Trained religious leaders on stigma and discrimination. Total cost was \$10,000.
 Below is the list of names and contacts of the persons who attended:

RELIGIOUS LEADERS WORKSHOP, JUNE 2004

NAME	TITLE	ORGANISATION	PHONE	E-mail
Rev. Isabirye AB	Rev. Father	Uganda Orthodox	077367218	
Pesajanga Amid	Imaam	IMAU	0772569	
Rev Fr Dimitars Sseruganda	Rev. Father	Uganda Orthodox church	077571669	
Mr. Baboine Wilson	Lay leader	Church of Uganda	-	
Kalycgira Newton	Pastor	Seventh day Adv. Church	077902892	
Karemire James	Pastor	Seventh day Adv. Church	078334068	
Byakika James	Ordinand	Church of Uganda	077378682	
Pastor Banaira Henry	Pastor	SDA Church E.U.F Mbale	077936936	
SHK Musa SSendawula	Imam	IMAU	-	
SH:IK Ahmed Kalibala	Imam	IMAU	077629337	
SH:IK Mubammad Bukenya	Imam	Islamic Medical Association	077502569	sheikbukunya@yahoo.com
Rev. Joshua K Kutegeka	Diocesan Health Coordinator	Church Of Uganda	077471523	joshuakutegeka@yahoo.com
Pr. Bwambale Bonny	Pastor	Seventh day adv. Church	c/o 077373826	
Rev. Nathan Wakling	Priest	Church of Uganda	077566869	
Nakami Sylvia	ASRH Advocate diocese	Church of Uganda	077639894	nakamisylvia@yahoo.com
Kasaja Betty	Pastor	Hoima xtian Fellowship	077878568	nichbetty@hotmail.com
Musoke Barnabas	Youth Advocate	Church of Uganda	077667648	kdeon@afriacoinline.co.uk
Barnabas Opio Ikuya	HIV projects coordinator	Church of Uganda/Prayer palace	078347709	chrisderfoundation@yahoo.com
Dr. Kagimu				imau@uilonline.co.ug

Father Kakuba				saleneighborhood@debezi.net
Rt. Rev Elia Paul Luzida Kizito				mukodisc@online.co.ug
Chris Kyeire				
Kasasira Ruth				
Pastor Kizito	Pastor			sdauu@info.com.co.ug
SH- Rashid Abdul	Imam	IM AU	077813381	
Kiziti Samuel	Pastor	Seventh day Adv Church	077493900	Sammuelkizito2002@yahoo.com
Rev Fr D SSeruganda	Rev Fr	Orthodox Church	077571669	
Suuti Emmanuel	Dev. Officer	Mbale Diocese	071932608	
Rev. Can. David Omella	Archdeacon	Bukedi Diocese	077640528	
Mrs Margare Omella	House wife	Bukedei diocese	077442250	
Rev C Mbukure	Reverand	Church of Uganda	075644011	kdeou@africainline.com
C. Okello Agwaa	Dev. Officer		075546612	
Rev Fr Paul .M. SSeguya	Parish priest/coord.OVS Programme		077937368	
Nkusi Charles	Ass Diocesan Secretary	Lugazi Diocese	87 Lugazi	dheugazi@ucmb.co.ug
Olive Mbabazi	Counsellor	St. Francis HCR	077966590	

- Religious leaders conducted radio talk shows on stigma and discrimination. Facilitation of religious leaders was \$800. Below are the details:

Radio	Week	Date/time	Guest speaker	Language	\$
Capital	Sept 6 – Sept 12	Sept 12 8.30-9.00pm	Rev. Canon Mbukure	English	588
Capital	Sept 13 – Sept 19	Sept 19 8.30-9.00pm	Rev Canon Mbukure & Mr. John Byarugaba (IRCU)	English	588
Top radio	Sept 6 –Sept 12	Sept 10 7 – 8 pm	Pastor Wafula and Christine Barlemwa	Luganda	147
Top radio	Sept 13 – Sept 19	Sept 17 7 – 8 pm	Pastor Wafula and Christine Barlemwa	Luganda	147
Voice of Africa	Sept 6 – Sept 12	Sept 11 7.15 – 8.30pm	Sheik Bukenya & Sheik Ahmed Kalibbala	Luganda	147
Voice of Africa	Sept 13 – Sept 19	Sept 18 7.15 – 8.30pm	Sheik Bukenya & Sheik Ahmed Kalibbala	Luganda	147

Radio one	Sept 6 – Sept 19	Sept 10 7.00-8.00pm	Rev Can Mbukure and Imam Kasoozi	English	588
Radio one	Sept 13 – Sept 19	Sept 17 7.00-8.00pm	Rev Can Mbukure and Imam Kasoozi	English	588
Prime	Sept 27 - Oct 3	Sept 29 11.00am – 12.00pm	Pastor Kizitio & Pastor Kalyegira	Luganda	118
Prime	Oct 4 - Oct 10	October 6 11.00am – 12.00pm	Pastor Kizitio & Pastor Kalyegira	Luganda	118
CBS	Sept 27 – Oct 3	Sept 30 10.00 – 11.00am	Father Isabirye	Luganda	588
CBS	Oct 4 – Oct 10	Oct 7 10.00-11.00 am	Father Isabirye	Luganda	588
Saptentia	Sept 27 - Oct 3	Sept 30 6.00-7.00pm	Father Kakuba	English	147
Saptentia	Oct 4 - Oct 10	Sept 30 6.00- 7.00pm	Father Kakuba	English	147
					\$4,647

- PSI/Uganda worked with Pastor George Okudi, renowned religious singer and Kora award winner, who composed songs on *abstinence and fidelity*, which songs were performed and aired on radio in the districts of Gulu, Lira, Katakwi and Soroti. Cost: \$6,000.
- PSI/Uganda working with the Inter Religious Council of Uganda, the body that brings together all religious denominations in Uganda to develop and pretest materials (brochures and posters) on *abstinence and fidelity*. Currently the research has just been completed by Steadman, the firm that was contracted to conduct the research. Steadman was selected in conjunction with IRCU. PSI/Uganda will also contribute to the production of the final materials. Cost: \$8,000 to Steadman on behalf of FBOs.
- PSI/Uganda works with Kampala Diocese as the lead agency on the Parent Child Communication Program (PCC). Kampala Diocese (Anglican) invited other religious denominations and these include Catholics, Muslims, Seventh Day Adventist, Orthodox, and Born again Christians. Currently a workshop for training of trainers is ongoing and a curriculum is being developed after the trainers will go out to train parents. The area of focus is *abstinence, cross-generational sex and parent-child communication*. Cost: \$26,000.
- A drama on *abstinence and fidelity* is in the process of being developed and this will be distributed through the structures of IRCU.
- Working with UNERELA (Uganda Network of Religious Leaders Living with HIV and AIDS) on the component of *stigma and discrimination*. This is the first organization in Uganda that brings together all religious leaders living and personally affected by HIV and AIDS. It includes all religious denominations in Uganda. They will be conducting a training of trainers workshop next week and

will move to all the five regions of Uganda and show a video on stigma and discrimination. Cost: \$12,000.

- Have distributed materials to the Islamic Medical Association of Uganda (IMAU). These include videos on general information on HIV/AIDS stigma and discrimination, PMTCT, VCT and disclosure. Cost: \$3,000.

Faith-Based Alliances

PSI FBO Activities Inventory

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- Burkina Faso
- Burundi
- China
- Democratic Republic of Congo
- Guatemala
- Guinea/West Africa
- Haiti
- Honduras
- Kenya
- Laos
- Madagascar
- Malawi
- Mali
- Myanmar
- Namibia
- Nigeria
- Thailand
- Uganda
- Zambia
- Zimbabwe

International/Continental/National FBO activities			
Organization	Goal/Intervention	Description of Activities	Status
International			
Faith Fellowship International	HIV/AIDS prevention	PSI and FFI will work together to bring faith-based and scientific-based HIV/AIDS prevention education to FFI member churches.	Under development-
	Training for clergy	The project strategies will include: innovative HIV/AIDS training for pastors and the production of educational materials. Educational materials will include a documentary on stopping cross generational sex, liturgical materials, and a guide on creating effective HIV/AIDS programs in churches. The two partners will also combine their efforts to solicit financial support for this program.	Business plan and memorandum of agreement are under development
	Reduce cross-generational sex		
Continental			
All Africa Conference of Churches (AACC)	HIV/AIDS prevention	The clergy training is designed to motivate and inspire participating church leaders to mobilize their congregations to stop the spread of HIV through comprehensive prevention education strategies and support and care for PLWHA.	First training session June 8-12, 2004. Over 200 heads of denominations attended the summit.
	Training for clergy		
	Care and support	Seminars on how to implement an HIV/AIDS policy in the church and how to develop effective HIV/AIDS	Regional Training commence on

		programs will be held.	Nov. 22, 2004
Proposed Partners and Projects			
Circle of Concerned African Women theologians	Reduce cross-generational sex	Mobilize faith-based communities to fight against cross generational sex. Proposed seminars and bible studies in local congregations and women's groups to be held to address gender inequalities and gender violence.	Waiting for funding
Council of Anglican provinces (CAPA)	Abstinence/delayed sexual debut	Will promote abstinence and fidelity through multiple channels and reach target groups through sermons, church youth clubs, women's groups, bible study, community groups, and schools.	Waiting for funding
Christian Council of Churches of Zambia	Reduce cross generational sex Abstinence/delayed sexual debut	Educational campaign for men and boys and mobilization of Protestant churches in Zambia. PSI is soliciting funding to implement this project.	Waiting for funding
Iitha Labantu/FIDA	Reduce cross-generational sex	Will focus on empowerment of the girl child and strengthening of statutory rape and sexual coercion of minors.	Waiting for funding
World Student Christian Federation (WSCF)	HIV/AIDS prevention Abstinence/delayed sexual debut	Will promote HIV/AIDS prevention education in schools and youth groups with an emphasis on abstinence and delayed sexual debut.	Waiting for funding

Burkina Faso		
Organization	Activity	Description
La Bergerie	HIV/AIDS prevention VCT	La Bergerie is an HIV testing clinic located in Gounghin (Ouagadougou). PSI/BF has provided marketing services, an equipment evaluation, equipment and consumables to increase testing capacity.
FADCO	Condoms/high risk behavior reduction	Through PROMACO, PSI has conducted a training of an association of Muslim religious leaders, FADCO. The activity involved training Imams on HIV/AIDS prevention and transmission. The Imams were requested to follow-up the training with educational sessions at the mosque before and after prayer.

Burundi		
Organization	Activity	Description
Lutheran Evangelist Church	HIV/AIDS prevention Condoms/high risk behavior	PSI has conducted two three-day social marketing events with the church. One was in the Kayanza

	reduction	Province in January 2004 and the other was in the Muyinga Province in March 2004.
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China		
Organization	Activity	Description
DAYTOP	Harm reduction Condoms/high risk behavior reduction	DAYTOP is a voluntary drug detoxification organization and cannot be registered as a faith based organization in China.

Democratic Republic of Congo		
Organization	Activity	Description
Protestant Church in Kinshasa	HIV/AIDS prevention	HIV prevention, Care & Support, Orphans and Vulnerable Children, family planning/reproductive health and child survival activities.
Catholic Youth in Kinshasa Interdenominational "Choirir La Vie" Goma	Condoms/high risk behavior reduction	HIV prevention, Care & Support, Orphans and Vulnerable Children, family planning/reproductive health and child survival activities.

Guatemala		
Organization	Activity	Description
Proyecto Vida	Fidelity/Partner reduction Condoms/high risk behavior reduction	Proyecto Vida runs a home for people living with AIDS as well as a BCC/outreach program for high risk groups (largely CSWs and potential clients). PSI provides training and financial support for their educational activities.

Guinea/West Africa		
Organization	Activity	Description
National Islamic League	Research on the effectiveness of FBOs activities in HIV prevention	HIV/AIDS prevention.

Haiti		
Organization	Activity	Description
Catholic Church ADRA	Promotion of oral rehydration salts	ORS promotion campaign broadcast over Catholic Radio network.
Catholic Relief Services	Promotion of oral rehydration salts	ORS promotion, distribution and training. Purchase of Sel Lavi.
Haitian Health Foundation	Promotion of oral rehydration salts	ORS promotion and distribution in rural areas. HHF uses theater and role playing with mother's groups to teach

		them about the benefits of ORS.
SADA	Promotion of oral rehydration salts	Buy and promote ORS (Sel Lavi). Use theater and role playing with mother's groups to teach them about the benefits of ORS.
	Safe water	Test consumer acceptability of PuR water treatment.
Fermanthe Hospital	Promotion of oral rehydration salts	Training on benefits of ORS.
Lumiere Hopsital	Promotion of oral rehydration salts	Purchase of Sel Lavi.
Caritas	Promotion of oral rehydration salts	Purchase of Sel Lavi.
Salvation Army	Promotion of oral rehydration salts	Purchase of Sel Lavi.
ADRA	Promotion of oral rehydration salts	Purchase of Sel Lavi.
Sun Light Mission	Promotion of oral rehydration salts	Purchase of Sel Lavi.
Oblates Missionaires Mie Immaculée	Promotion of oral rehydration salts	Purchase of Sel Lavi.
St. Paul Clinic	Promotion of oral rehydration salts	Training on benefits of ORS.

Honduras		
Organization	Activity	Description
Catholic Relief Services (CRS) Project Hope	Condoms/high risk behavior reduction	Providing funding for a program that promotes community support and BCC messages for people living with AIDS.

Kenya		
Organization	Activity	Description
39 churches	HIV/AIDS prevention	Advocacy outreach targeting FBOs are usually made through informal HIV/AIDS education activities conducted by PSI advocates. These outreaches are independent activities organized by the advocates themselves. The aim of these outreaches is to speak to men and women of all ages to promote "safe" sexual behaviors that reduce the rate of new infections.
	Stigma reduction/Peer education	
	PSI advocacy program	
Catholic Church	Delayed sex debut and abstinence education	

Laos		
Organization	Activity	Description
The National Front for	Condoms/high risk behavior	The NFC is the governmental body

Construction	reduction Fidelity/Partner reduction Abstinence/delayed sexual debut	responsible for all religious and mass organizations. PSI Laos helps to support the NFC's monthly magazine which is distributed to all faith-based organizations throughout Laos. In return for this financial support, the NFC magazine regularly features news articles to promote HIV/AIDS awareness and prevention, and prints advertisements for Number One condoms.
The Lao Buddhist Association	HIV/AIDS prevention	The Lao Buddhist Association is the largest religious organization in Laos. PSI Laos works closely with the Lao Buddhist Association at both the national and provincial levels. At the national level, Buddhist monks, as model members of Lao society, are regularly invited to work with PSI Laos in promoting HIV/AIDS prevention at traditional festivals and concerts. In keeping with their commitment to helping people, the monks promote abstinence and safe sex as part of the path to virtue.
The Champassak Province Buddhist Association	HIV/AIDS prevention	This provincial religious association in Champassak province worked particularly closely with PSI Laos to develop an IEC/BCC documentary film on HIV/AIDS prevention in 2001. The film features a young Buddhist monk narrating a film that discusses HIV/AIDS transmission, abstinence, fidelity, condom use, and how living a virtuous life will help one to avoid the risk of HIV/AIDS.
Buddhist monks in village wats	HIV/AIDS prevention	PSI Laos' MVU works together with Buddhist monks in village wats and pagodas throughout rural Laos. At the wats, monks provide PSI's MVU team with grounds or a building where they can set up the show. The monks also promote the MVU show throughout the village and endorse the materials which are shown.
Norwegian Church Aid	HIV/AIDS prevention STD prevention	Working together with NCA to promote HIV/AIDS and STD prevention in Savannakhet province, PSI Laos donated condoms and IEC materials to be distributed at the village level. For several years, PSI Laos continued to give NCA free IEC materials, as well as a reduced rate for the purchase of additional Number One condoms. The condom donation was supported by UNFPA, while the IEC materials were purchased with funds from UNDP.
World Vision International	Maternal and child health Optimal birth spacing	Through a grant from the Catalyst Consortium, PSI Laos is partnering with World Vision International in Savannakhet province on a pilot

	Launch of clean delivery kit	project to improve the health and well-being of Lao families. Training on issues ranging from optimal birth spacing to safe delivery to modern methods of contraception is being provided to pharmacists, village health workers and model mothers in the project area. As part of its social marketing activities, PSI will launch a clean delivery kit in late 2004.
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Madagascar		
Organization	Activity	Description
SALFA (Lutheran)	HIV/AIDS prevention	SALFA and SAF-FJKM distribute PSI FP products in their clinics.
SAF-FJKM (Evangelical Christian)	Maternal and Child Health and Family Planning	
	Condoms/high risk behavior reduction	
Catholic Relief Services (CRS)	Malaria prevention	CRS distributes insecticide treated Nets and Sur'Eau water treatment solution.
	Safe Water	
Ligue de la Lecture de la Bible (Evangelical Christian)	Abstinence/delayed sexual debut	Ligue is an AIDS prevention partner.

Malawi		
Organization	Activity	Description
Evangelical Church of Malawi	HIV/AIDS prevention	Seminars aimed at providing youth the skills to delay sexual debut, understand HIV and risky behavior are held. They use videos and discussion groups to facilitate open talk among youth. Hundreds of young people attend these monthly seminars.
Anglican Church of Malawi		
Revival International Church		
Presbyterian		
ANARELA	Supporting clergy living with HIV/AIDS and fighting against stigma	PSI/Malawi's FBO Coordinator serves on the committee that organizes ANARELA's activities in Malawi.
Catholic Church Muslim Association Assemblies of God Presbyterian	Development of IEC materials	Under discussion.
	Abstinence/delayed sexual debut	
World Vision of Malawi	Religious training	PSI/Malawi assists with facilitation of the clergy training for different denominations in Malawi.
National AIDS Commission religious task force	Policy	PSI/Malawi's FBO Coordinator participates in seminars held by the task force.

Mali		
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Organization	Activity	Description
Muslim Association	HIV/AIDS prevention	PSI is working with Muslim leaders to create standard sermons that discuss HIV/AIDS prevention. They also mobilize community and religious leaders to effectively address HIV/AIDS in community and religious forums.

Myanmar

Organization	Activity	Description
PSI/Myanmar has worked with over 50 FBOs. The organizations listed below have their own AIDS prevention programs that teach abstinence/delayed sexual debut and fidelity/partner reduction.		
Myanmar Young Crusaders, Kalay	Fidelity/Partner reduction	Collaboration with FBOs usually takes the form of giving educational health talks and trainings to organized church groups. PSI/Myanmar initiates contact with the groups and gains permission from them to conduct health talk sessions. In some cases, PSI also trains individuals from the group to train their peers to conduct similar talks. PSI provides the groups with leaflets and samplers to distribute to the communities and groups with which they work. PSI also provides family planning services for one faith-based CBO. Joon Mosque in Mandalay opened a free clinic for poor Muslims that provides, among other things, counseling and services for birth spacing. Products used at this clinic are supplied by PSI.
Kalay Methodist Church	Abstinence/delayed sexual debut	
Salvation Army, Kalay	Condoms/high risk behavior reduction	
Myanmar Baptist Church: Taungoo, Kymindine, Insein, Bago, Hinthada		
Myanmar Institute of Theology, Insein		
Myanmar Council of Churches, Yangon		

Namibia

Organization	Activity	Description
Catholic AIDS Action Council of Churches	VCT	Freestanding voluntary counseling and testing under the New Start franchise. (4 centers).
Evangelical Lutheran Church AIDS Program (ELCAP)	VCT	Projects under discussion
Catholic Health Services	VCT	Mission hospital based VCT under New Start brand, 3 centers.
Lutheran Mission Services	VCT	1 center, yet to be completed

Nigeria

Organization	Activity	Description
Church of Nigeria (Anglican)	Fidelity/Partner reduction	PSI sponsored the training of 10

Communion the Evangelical Church of West Africa (ECWA) Christian Aid Ja'amatu Nasir Islam (JNI)	Abstinence/delayed sexual debut Stigma reduction	Islamic Clerics in HIV/AIDS stigma reduction. In 2002, PSI facilitated the production and airing of a television spot by a very religious leader, the Sultan of Sokoto. In addition, PSI has consulted and continues to work with religious groups and leaders to inform development of key communications. Assisting these FBOs to develop an HIV/AIDS strategic plan, training, capacity building for leaders, HIV/AIDS Policy development, and provides HIV technical assistance. Nigeria has signed an MOU with the Muslim Association and The Anglican Church.
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Thailand		
Organization	Activity	Description
Adventist	Harm reduction	PSI has an affiliation with the Adventists that operate dozens of private, 18 month residential rehabilitation programs for Thai drug addicts in Northern Thailand.

Uganda		
Organization	Activity	Description
Muslim Association	HIV/AIDS prevention	In its early months, PSI/Uganda's FBO program has embarked on: radio talk shows to discuss HIV prevention with religious leaders, campus discussion groups to discuss cross generational sex, and technical assistance and funding for ANARELA.
Anglican Church	Care and support	
Seventh Day Adventists	Abstinence/delayed sexual debut	
Catholic Secretariate	Campaign against cross generational sex	
Association of clergy living with HIV/AIDS (ANARELA)	Fidelity/Partner reduction	

Zambia		
Organization	Activity	Description
World Vision	Fidelity/Partner reduction	In September 2000 PSI launched a joint program with World Vision and FHI to target truck drivers and CSWs in six border towns (Corridors of Hope project). This project provides IEC materials and interpersonal education to sensitize the two target groups.

Zimbabwe		
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Organization	Activity	Description
Marondera Lutheran Church & Faith Ministries	HIV/AIDS prevention Fidelity/Partner reduction	New Start VCT is organizing a series of workshops to include many different denominations of church leaders to help them understand the scale, nature and impact of the epidemic and engage them to help fight it.
Marondera Family Praise Church	Condoms/high risk behavior reduction	
Marondera Catholic Church	Abstinence/delayed sexual debut	

Page last updated: 02/28/2005



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April 13, 2005

The Honorable Betty McCollum
 U.S. House of Representatives
 1029 Longworth Building
 Washington, DC 20515

Dear Representative McCollum:

We understand that testimony in today's hearing in the House International Relations Committee will make allegations about PSI that are categorically untrue. We believe PSI to be one of the most effective nonprofit organizations working in international health today, and wish to address these allegations so that the record may be corrected.

Mr. Martin Ssempe, in testimony to be presented today, will allege that PSI refused to work with his faith-based organization (FBO) because he would not agree to promote condoms as part of the scope of work. This is absolutely false. Mr. Ssempe did approach PSI Uganda with a proposal entitled Campus Alliance to Wipeout AIDS. We were in broad agreement on the importance of promoting abstinence and "be faithful" (A and B) even though Mr. Ssempe told us that condoms do not work because they have holes. PSI Uganda never said, or implied, that Mr. Ssempe had to promote condoms in order to get funding from us, and never formally rejected Mr. Ssempe's proposal.

In fact, PSI Uganda works with several FBOs and has supported a wide array of FBO-related activities with PEPFAR funding since June 2004 (a list of these activities is attached). PSI conducts trainings to educate Christian and Islamic leaders and organizations on HIV/AIDS and supports workshops on mobilizing congregations and communities to fight stigma and the spread of HIV/AIDS. PSI has facilitated more than a dozen radio talk shows in which religious leaders addressed stigma and discrimination over this same period.

In addition, PSI Uganda supports the Inter Religious Council of Uganda, the Kampala Anglican Diocese, the Uganda Network of Religious Leaders Living with HIV and AIDS and the Islamic Medical Association of Uganda.

Another example of PSI Uganda's FBO program is taking place this very afternoon — probably while the congressional hearing is in session — when PSI will be training 20 FBO representatives from six denominations on a parent training program

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with the Church of Uganda aimed at promoting abstinence, delayed sexual debut and curbing cross-generational sex.

PSI has not come to FBO work recently, but has a wealth of experience collaborating with a variety of FBOs around the world, including Muslims in West Africa, Christians in Eastern and Southern Africa and Buddhists in Southeast Asia, over the last decade. PSI does not, and has not ever, required our FBO partners to promote condoms. We support FBOs in activities likely to have an impact that are consistent with their faiths.

PSI has on its staff a theologian with a master's degree and PhD. in Theology, Pauline Muchina, born and raised in Kenya, has been instrumental in increasing PSI's outreach to FBOs, especially in Africa.

Mr. Ssempe's comments seem predicated on the incorrect assumption that PSI's activities heavily emphasize condom promotion to the exclusion of A and B. In fact, only 7% of PSI/Uganda's PEPFAR funding went for targeted condom distribution, slightly *less* than what was spent on A and B promotion, over the period from October 2004 to date, and most of our PEPFAR funding during this time went to the prevention of mother-to-child transmission (32%) and voluntary counseling and testing (31%). This shows clearly that our Uganda program is balanced and not at all focused on condoms.

PSI is also working with FBOs across the African continent and has partnered with the All Africa Conference of Churches (AACC) and its influential religious leaders representing 39 countries and 120 million Christians. This partnership began in 2003 and, since that time, PSI has organized four summits and workshops of African religious leaders addressing stigma and the care of people living with HIV/AIDS and developing strategies for promoting abstinence, fidelity and fighting cross-generational sex in both francophone and Anglophone African countries. Earlier this year, Ashley Judd, a member of PSI's Board of Directors, addressed an AACC seminar in Kenya supported by PSI and USAID. She prayed with the religious leaders and called upon them to challenge cultural and religious practices that render young women vulnerable to HIV infection.

In a related issue, we understand that an attempt will be made in today's hearing to suggest that only an FBO is qualified to promote A and B. We call upon anyone taking this position to provide the basis for such a claim. Few, if any FBOs, have as much experience implementing and measuring the impact of behavior change communication campaigns as PSI, which has been doing it for over three decades. While much of PSI's early work focused on *product* social marketing, we have been promoting oral rehydration therapy to treat diarrhea caused by dehydration since 1985 and

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abstinence and fidelity from the time of our first HIV/AIDS prevention project in Zaire in 1988.

It is incorrect to label PSI as a "condom social marketing firm," as will be stated in the hearing today. First, PSI excels in the use of commercial marketing strategies to promote healthy behavior of all kinds. In HIV/AIDS prevention, PSI promotes behavior change involving products (male and female condoms), services (voluntary counseling and testing) and other behaviors not related to products or services (abstinence, mutual fidelity, partner reduction and stigma and discrimination reduction). Second, the word "firm" implies that PSI is somehow a for-profit entity. PSI is, and always has been, a nonprofit organization.

PSI has always been focused on delivering measurable health impact, which is unique in the nonprofit world, and seeks to measure its performance to the extent practicable. PSI does not measure its impact, for example, in terms of how many people it has reached with its communication campaigns or how many messages it has disseminated but by how many HIV infections it has prevented. No other nonprofit we know of characterizes its work in such a tangible way.

In public health, where a multitude of factors determine health outcomes, performance metrics can be problematic. PSI uses a variety of models developed by public health experts to make realistic estimates of its impact. Here are a few examples of PSI's estimated health impact from products and services generated by our programs in 2004:

- PSI pre-packaged malaria therapy and insecticide-treated mosquito bednets averted almost 11 million malaria episodes and 78,000 child malaria deaths;
- PSI safe water treatment prevented 13 million diarrheal episodes and 39,000 child diarrhea deaths;
- PSI voluntary HIV counseling and testing services, sexually-transmitted infection kits and male and female condoms directly averted 809,000 primary cases of HIV infection, and indirectly averted the 1.4 million secondary cases of HIV infection that would have occurred in the following twelve months; and
- PSI voluntary family planning products delivered 10.7 million couple years of protection, averting 6 million unintended pregnancies and preventing 12,000 maternal deaths.

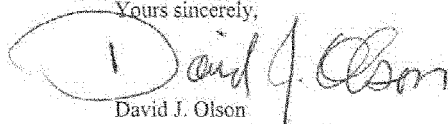
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Such results have caused PSI to be held up recently as a model of what can be accomplished when a nonprofit organization harnesses market forces.

- In his column of Feb. 16, Martin Wolf, associate editor and chief economics commentator at the Financial Times of London, hailed social marketing as "one of the most innovative and effective approaches to delivery," refers to PSI as "the leading organisation in this field," and cites PSI success in preventing malaria in Malawi and Tanzania.
- On March 3, Pulitzer Prize-winning journalist David Wessel of the Wall Street Journal questioned why "a nonprofit that market-loving, results-oriented, compassionate people would love" now finds itself "in the cross hairs of some conservatives." The article characterizes PSI marketing as "clever and bold," says that PSI tries "harder than most other nonprofits, to measure its effectiveness at improving health," points out that "PSI subscribes to the ABC approach to fighting AIDS," and gives examples of PSI's A and B work from Malawi, Zambia and Central America.

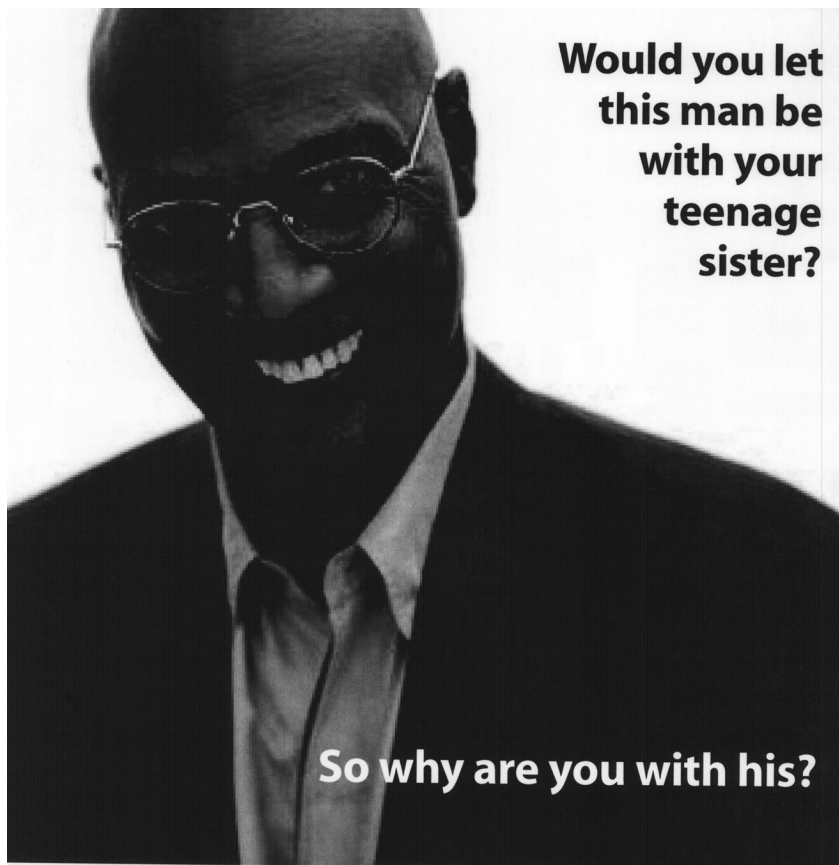
We would like the record to show that PSI's focus will always be on measurable health impact and, in HIV/AIDS prevention, it is clear that the best way to do that is through an appropriate combination of abstinence, fidelity and condoms, working together with the partners (including FBO partners) best qualified to carry out those activities in a targeted way. Few nonprofit organizations have the proven track record of PSI in doing that.

Yours sincerely,



David J. Olson
Director of Public Affairs

DJO:cmf



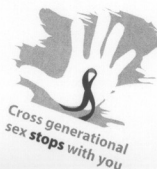
**Would you let
this man be
with your
teenage
sister?**

So why are you with his?

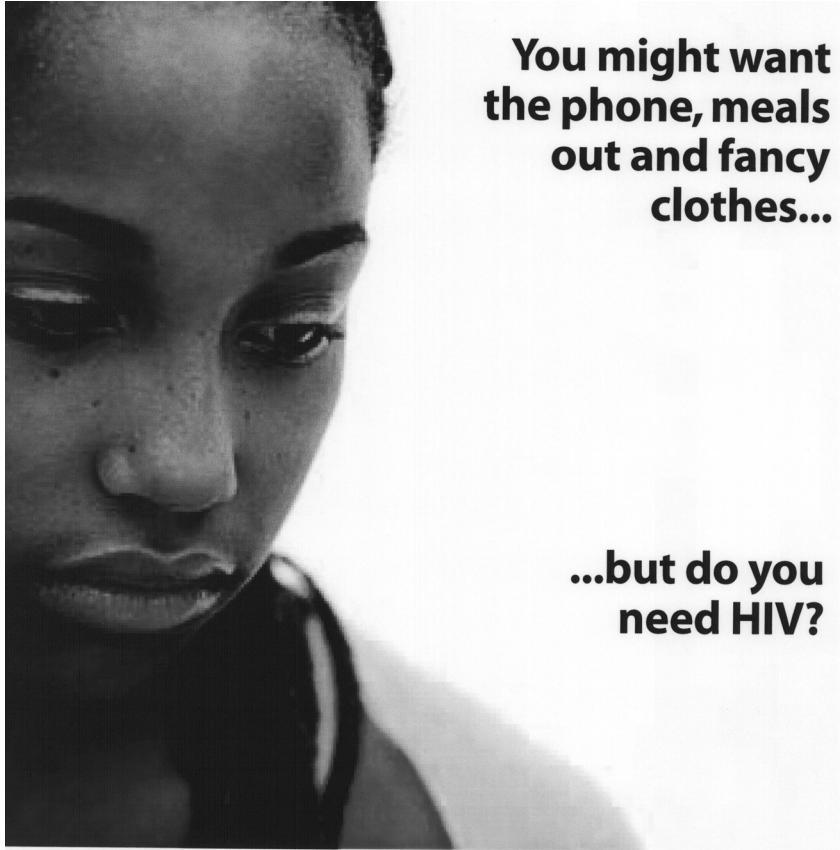
No man would wish harm on his daughter or niece or little sister, but more and more Ugandan men are taking advantage of vulnerable young girls. You probably know some of them and you let them get away with it. You may have even done it yourself. This practice is called cross generational sex, and puts hundreds of young lives at risk of HIV infection and should be stopped.



Office of the First Lady.



Cross generational
sex **stops** with you



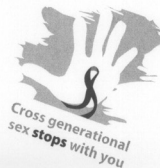
**You might want
the phone, meals
out and fancy
clothes...**

**...but do you
need HIV?**

Girls! The gifts, the nights out and the cash can never be worth your lives and future. Older men are taking advantage of you and putting you at risk of HIV infection, in exchange for material things. This practice is called cross generational sex. Respect yourselves and Say NO to Sugar Daddies.



Office of the First Lady.



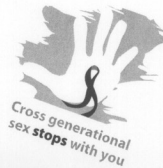
Would you let this man be with your teenage daughter?

So why are you with his?

No man would wish harm on his daughter or niece or little sister, but more and more Ugandan men are taking advantage of vulnerable young girls. You probably know some of them and you let them get away with it. You may have even done it yourself. This practice is called cross generational sex and it puts hundreds of young lives at risk of HIV infection and should be stopped.



Office of the First Lady.





Cross generational sex is a practice that is destroying the lives of young girls in our country. Older men are taking advantage of our daughters, sisters and nieces and infecting them with HIV. It's time for us all to take a stand and put an end to this deadly menace.



Office of the First Lady.





About Population Services International - Uganda

PSI Uganda is a non-profit organization that uses social marketing to provide the means for low-income and other vulnerable people in Uganda to lead healthier lives. We work with the Ministry of Health and other partners in programs for maternal and child health, family planning, safe water, malaria prevention,

and HIV/AIDS prevention. PSI Uganda is the local affiliate of Population Services International (PSI), an international non-profit organization operating in 70 countries around the world. In Uganda, PSI is funded by USAID, CDC and other partners.



PSI Uganda's communication campaigns encourage the use of HIV/AIDS prevention services at the community level.

The major objective of PSI Uganda's social marketing program is to reduce the incidence of HIV/AIDS through activities that include: Voluntary Counselling and Testing (VCT), Prevention of Mother to Child Transmission of HIV (PMTCT),

HIV/AIDS Prevention

Behaviour Change Communications (BCC), condom distribution to high-risk populations, and early treatment of sexually transmitted infections (STIs) among high-risk groups.

VCT and PMTCT

During 2004, PSI partnered with the Ministry of Health and AIDS Information Centres (AIC) to improve access to and demand for VCT services across the country.

PSI also provided PMTCT services through **Profam** - a network of 20 private sector clinics - and worked to sensitise communities and increase demand for PMTCT services at nearly 35 Government of Uganda PMTCT sites.

Behaviour Change Communications

A newly-formed BCC department introduced activities to promote abstinence among young people, and to encourage people who practice high-risk behaviors to use condoms and seek treatment for sexually transmitted infections.

PSI also began working to eliminate cross-generational sex in Uganda - where young girls have sex with older men frequently in exchange for money or gifts. And in partnership with many faith-based organizations, we reached communities with messages on reducing stigma and discrimination against people living with HIV/AIDS.

Improving Reproductive Health




PSI Uganda's family planning program has the goal of improving the reproductive health of women in Uganda by providing better access to high quality hormonal contraceptive products. In addition,

PSI focuses on training health providers in family planning methods, proper management of side effects, and client counselling.

PSI medical representatives trained more than four thousand health care providers in both the public and private sectors, during 2004. As the "gatekeepers" in reproductive health, these providers can teach their clients about the benefits of birth spacing and family planning.

PSI also worked with commercial pharmaceutical distributors to increase sales of **Pipplan** and **Injectoplan** contraceptive products by 76% and 71% respectively. More than 65% of all hormonal contraceptives distributed in Uganda in 2004 were PSI's subsidized, high quality products. *

Malaria Prevention



Working in close collaboration with the Ministry of Health, NGOs, and private sector companies, PSI Uganda's Malaria program aims to reduce the incidence of malaria among pregnant women and children under 5 years of age.

The PSI program focuses on distributing long-lasting insecticide-treated mosquito nets and on promoting the use of these and other treated nets nationwide through media, local dramas and BCC efforts.

Over 80% of these nets targeted vulnerable communities in Northern Uganda where the nets were sold at a highly subsidized price to predominantly rural populations.

In addition to promoting and distributing mosquito nets, PSI also helped the Ministry of Health design and implement a communications program supporting home-based management of fever in children using the Ministry's **Homopak** malaria treatment product. *

PSI Uganda distributed over 180,000 nets nationwide through social marketing in 2004.


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Safe Water Saves Lives



Protect your child from unsafe water!

PUR safe water saves lives. Ask here about PUR.

In November 2004, PSI Uganda launched PUR, an affordable and easy-to-use product that makes water safe to drink without boiling.

The introduction of PUR is part of a safe water education program aimed at reducing sickness and death caused by diarrhoeal diseases among children under 5 years of age. The program also targets other vulnerable groups including people living with HIV/AIDS, internally displaced persons, and people living in urban slums.

PUR is available in retail outlets and pharmacies nationwide.

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Feature

God and the Fight Against AIDS

By Helen Epstein

1.

In 2003, President George W. Bush asked Congress for \$15 billion to fight AIDS in developing countries. During the 1990s, HIV spread rapidly, especially in Africa, where some 250 people were dying from AIDS every hour. The US had been accused of not doing enough to fight the epidemic, and when the bill passed, many conscience-stricken Americans, moved by images in the press of dying women and children, praised the administration. But some were not sure. Much of the money will go to church-affiliated charities or faith-based organizations, including some evangelical Christian groups that have very little experience with AIDS.

While Catholic and Protestant churches have been running AIDS programs since the 1980s, few evangelical Christian groups have done so. Indeed, as the deadly virus spread around the world, many evangelical Christians were silent or worse. Jerry Falwell called AIDS God's judgment on promiscuity, and former Senator Jesse Helms, a longtime congressional ally of the evangelicals, told *The New York Times* in 1995 that AIDS funding should be reduced because homosexuals contract the disease through their "deliberate, disgusting, revolting conduct." When lawmakers moved to amend the Americans with Disabilities Act to protect people with HIV from discrimination, some evangelical Christians lobbied against them. In a 2001 poll, only 7 percent of American evangelicals said they would contribute to a Christian organization that helped AIDS orphans.¹¹

Shortly after the 2000 election, some evangelical Christians began to change their tune. "We cannot turn away," Helms wrote of the global AIDS crisis that had by then killed 20 million people over two decades. "It is true," wrote Ken Isaacs of Samaritan's Purse, an evangelical charity run by Billy Graham's son Franklin, "that when we choose to act outside of God's mandate for sexual purity, we should be prepared to deal with the consequences." "However," he went on, "God calls Christians to tell others of the redeeming love of Christ and the eternal life they can have through him." Also, with so

many people on the verge of death, "AIDS has created an evangelism opportunity for the body of Christ unlike any in history."¹²¹

It is worth noting that during the 2000 campaign, Bush, a born-again Christian, promised to provide more federal funding to faith-based groups working on various social problems. Thus it may be no coincidence that some of the same people who once treated the issue of AIDS with indifference suddenly seemed so concerned about it. Do evangelical Christian groups have a role to play in fighting the AIDS epidemic? Maybe they do, but at the moment they are engaged in an unseemly battle with secular AIDS organizations over US government contracts that could derail what little progress there has been in combating the epidemic.

Most of the \$15 billion in the AIDS plan is to be spent on treatment and care for people with AIDS, but \$1 billion is earmarked for HIV prevention through abstinence-only-until-marriage education. Since 1996, the US government has spent hundreds of millions of dollars on similar programs in American schools. These programs teach children that heterosexual intercourse within marriage is the only safe and acceptable form of sexual behavior. Teachers in those programs are barred from mentioning condoms and birth control—except their failure rates.

Human Rights Watch and other activists point out that every abstinence-only program that has ever been evaluated has failed to reduce rates of teen pregnancy or sexually transmitted diseases, and they fear that the \$1 billion abstinence earmark will have similarly dismal results in other countries. Human Rights Watch has now accused the US government of violating the right of young people to information about sexuality, condoms, and other methods of contraception that could save their lives.¹²³

The US administration used the success of Uganda's HIV prevention program to justify the \$1 billion earmarked for abstinence-only programs. During the 1990s HIV infection rates in Uganda fell, from around 15 percent to around 6 percent, a success that is unique on the continent. In 2000, researchers at USAID began to question why HIV infection rates had fallen only in Uganda and not in other African countries such as Zimbabwe and Malawi, where the epidemic had been raging for almost as long. The difference, they concluded, was that most countries relied too heavily on condom promotion alone, whereas Uganda had a range of programs that encouraged abstinence and faithfulness as well as condoms—a strategy that came to be known as ABC—for Abstain, Be Faithful, or Use Condoms.

In 2002, during the congressional debates over the President's \$15 billion AIDS bill, the virtues of ABC were hotly debated, and unfortunately distorted. Republicans argued in favor of earmarking funds for abstinence-only-until-marriage programs, while Democrats tried to defend funding for condom programs. In the midst of the proceedings, Uganda's First Lady, Janet Museveni, flew to Washington and presented a formal letter to

Republican lawmakers stating that abstinence was key to Uganda's success. Her involvement helped secure the \$1 billion abstinence earmark that appears in the final bill.

Mrs. Museveni's claim that abstinence had triumphed over AIDS in Uganda is incorrect. Between 1988 and 2001, the average age at which young Ugandan women started sexual activity rose by less than a year, even though the national HIV rate fell by some 70 percent.^[4] Most Ugandan girls begin having sex at around age seventeen, a year or so younger than in Zimbabwe, where HIV rates are about five times higher. More than half of all Ugandan women have been pregnant by age nineteen. HIV rates in pregnant teenage Ugandan girls fell rapidly during the first half of the 1990s, but during this time, the rate and ages at which these girls became pregnant—a marker of their sexual activity—barely changed at all.^[5] Moreover, a study carried out in a rural area of Uganda found that young women who abstain from sex until they are twenty are just as likely to become infected with HIV by age twenty-four as young women who first had sex in their teens.

Nevertheless, about four years ago, Uganda's leaders began lecturing the nation about virginity and "moral" conduct. President Yoweri Museveni has claimed that abstinence until marriage is a traditional African value. Before colonial times, if an unmarried girl became pregnant, "the punishment then for the boy and girl was death," he told an audience of AIDS researchers in 2001. "The girl would be tied in dry banana leaves, set on fire, and rolled down a cliff, and the boy speared." But these traditions broke down when the Europeans took over, he said. Society became permissive and eventually HIV began to spread.^[6] Last year, the First Lady led a march for virginity through the streets of Kampala, and the king of the Baganda, Uganda's largest tribe, has pledged that all female virgins will receive a free washing machine on their wedding day. Not to be outdone, leaders of the Karimojong tribe have called for a ban on miniskirts, though Karimojong people traditionally wear no clothes at all.

For decades, corrupt African leaders—from Kenya's Daniel Arap Moi to Malawi's Hastings Banda to Zimbabwe's Robert Mugabe—have been blaming Western decadence for Africa's problems. Even Idi Amin took time out from murdering cabinet ministers and religious leaders to crack down on miniskirts and makeup. Therefore it is worrying that Museveni, whose undemocratic tendencies have been criticized, is drawing increasing attention to the personal morality of others. Nevertheless, the renewed emphasis on abstinence was puzzling. While virginity until marriage may have been valued in the old days, faithfulness in marriage never was. Uganda's traditional chiefs and kings had hundreds and sometimes thousands of wives and concubines; polygamy, of both a formal and informal nature, remains extremely common in Uganda, and the sexual affairs of President Museveni himself are a frequent subject of gossip, as are those of other government officials including those who set the nation's AIDS policy. Among members of parliament, sexual harassment by male colleagues is a fact of life for many female MPs, and prostitution, though officially illegal, flourishes in Kampala's good hotels, including those owned by close political associates of the President and his wife. Porn

magazines abound. Sexual matters such as breast implants and premature ejaculation are fervently discussed in mainstream newspapers and on the radio. According to police reports, among the most frequent culprits in cases of defilement—or sex with a minor—are Christian pastors, along with teachers and policemen, and a local NGO recently urged pastors to use condoms because they were endangering their congregations.

The preaching about abstinence in Uganda thus seemed at odds with the culture. But Africa's masks and secrets are often impenetrable to outsiders. Was this a charade to impress the right-wing bureaucrats in the Office of the US Global AIDS Coordinator who oversee the spending of the \$1 billion earmarked for abstinence-only?

2.

I arrived in Uganda in September 2004 with this question in mind. As I usually do, I stayed at Makerere University in Kampala. It was the beginning of the school year and students were arriving from all over the country. The freshmen dressed in the formal way of 1940s American college men and women, in long skirts and slacks and buttoned-up white shirts with collars. Each year, upperclassmen at Lumumba Hall, a men's dormitory, welcome the freshmen by displaying their dorm mascot on the grass in front of the building. The mascot is a life-sized sculpture of a man made from scrap metal, with a large drain pipe for a phallus. In order to educate their peers about HIV, the students dress the phallus in a new condom every day, and a fresh box of condoms—free for the taking—is placed at its feet. "He symbolizes the culture of our hall of residence," one of the students explained to me. "He has girlfriends, but he always uses a condom." One afternoon shortly after I arrived, a pastor from a nearby church marched up to the statue, removed its condom, set a match to the box of free condoms, and then prayed over the fire: "I burn these condoms in the name of Jesus!" he boomed, and then promised each student a free Bible.

Uganda is in the throes of a born-again Christian revival. With the arrival of the first missionaries in the nineteenth century, nearly all Ugandans became either Catholic or Protestant, but during the past ten years, thousands—perhaps millions—of them have been swept out of their dusty, austere churches into bright new amphitheatres that even on weekdays are filled with music and prayer and swaying worshipers speaking in tongues. Born-again Christianity is catching on throughout sub-Saharan Africa, from the slums of South Africa to the windswept plains of Maasailand, but Uganda's Christian traditions, and its position bordering heavily Muslim Sudan, Kenya, and Tanzania, have made it a magnet for American evangelical missionaries, who have poured huge sums into the country during the past ten years. In the major towns, "crusades"—massive religious gatherings—are held nearly every week, often attended by thousands of people.

At one of these events, I watched a pastor in a silk suit and patent leather shoes warn an enormous crowd against the sins of fornication, homosexuality, pornography, and "nude dancing"—the striptease shows that have recently become popular in the capital. He healed people's livers, backaches, and broken legs, passed around gigantic collection baskets, and jitterbugged vigorously to Christian rock hymns accompanied by a chorus of

Ugandan youths. Around one third of the Ugandan population has been "born again" in the past decade, and new churches are springing up in warehouses, shacks, school auditoriums, and village clearings. At traffic circles in the center of Kampala, men in black suits waving Bibles preach through glimmering exhaust fumes to stalled commuters. Two of Uganda's four TV stations beam in religious programs from around the world, twenty-four hours a day, and quotations from scripture have become part of everyday speech.

Shortly after I arrived, I paid a visit to Martin Ssempe, the pastor who burned the condoms at Makerere. He is an authority on abstinence education in Africa and has given presentations at USAID and led the prayer at Mrs. Museveni's March of Virgins. Ssempe runs a church and sponsors a Billy Graham-style sex- and alcohol-free abstinence rally every Saturday night on Makerere's campus. In his sermons, he condemns homosexuality, pornography, condoms, Islam, Catholics, certain kinds of rock music, and women's rights activists, who he says promote lesbianism, abortion, and the worship of female goddesses.¹⁷ He told me that Satan worshipers hold meetings under Lake Victoria, where they are promised riches in exchange for human blood, which they collect by staging car accidents and kidnappings. In his headquarters, just down the hill from Makerere, there is a special room for exorcisms.

Ssempe is stocky and bald, with a broad avuncular smile. He wears colorful Hawaiian-style shirts and wire glasses. Although born in Uganda, he spent years in the US and his Ugandan accent has a warm American twang. We talked about Satan, homosexuals, pornography, and other sins, and he asked me whether I had any idea where he could obtain \$4 million to buy land for his church. Our meeting was interrupted by numerous phone calls. As I listened and took notes, he shouted in English and Luganda. There had been some sort of crisis. Population Services International—or PSI—a secular organization that had been distributing condoms in Uganda for years, had recently received US government funding to carry out an abstinence program. PSI had used the money to produce a new comic book in which the main characters, a teenage boy and girl, flirt with each other, make out on a couch at her house, and then decide to abstain from sex. In one of the frames, they walk by a condom billboard on the street.

"Look at this!" Ssempe yelled, pointing at the drawing of the condom billboard. "It's horrible. You can't promote condoms and abstinence at the same time!" It would only confuse young people, he said, and send the message that it was really OK to be promiscuous.

"They won't get away with it. I have spoken to the First Lady's office. We need to ensure that George W. Bush's money gets into the right hands," he told me, "Those who are doing abstinence-ONLY, as determined by the legislation."

Last fall, Ssempe and his congregation prayed fervently for a Bush victory in the US presidential election. He reminded me of the African bureaucrats who played the US and

the Soviet Union off each other during the cold war. This time, it was a battle over moral rather than political ideology, but just as in the cold war, a rich country was using foreign aid to fight its battles in developing countries. Now that there is finally a huge amount of money for AIDS programs in Africa, a scramble for it now appears to be underway in Uganda, and faith-based groups like Ssempe's are going to considerable lengths to get rid of the organizations that have been receiving US government contracts for years, especially those that promote condoms.¹⁸² This could have serious consequences, because condoms have helped to control Uganda's epidemic. HIV infection rates fell most rapidly during the early 1990s, mainly because people had fewer casual partners.¹⁸³ However, since 1995, the proportion of men with multiple partners has increased sharply. Condom use increased at the same time, and this must be why HIV infection rates have remained low.

But condom programs in Uganda are now threatened. Under pressure from both the Ugandan and US governments, billboards advertising condoms, for years a common sight throughout the country, were taken down in December 2004. Radio ads with such slogans as "LifeGuard condoms! Ribbed for extra pleasure!" were to be replaced with messages from the cardinal of Uganda and the archbishop about the importance of abstinence and faithfulness within marriage. In November 2004, Engabu, a highly popular Ugandan condom brand, was pulled from the shelves because of alleged problems with its manufacture. At the same time, the government now insists that all condoms entering the country be subjected to additional quality control tests. However, Uganda does not have the equipment to carry out such tests, and this has resulted in a shortage of condoms.

Meanwhile, American evangelical Christian magazines such as *Citizen*, published by Focus on the Family, a Washington, D.C., organization that lobbies against gay rights and abortion, and *World*, edited by Bush adviser Marvin Olasky, have claimed that USAID is pouring money into condom programs in Uganda and ignoring abstinence and monogamy, which, according to the articles, are the only interventions that really work.¹⁸⁴

Condoms have a controversial history in Uganda, and official attitudes toward them tend to shift with the ebb and flow of US government funds. During the 1980s and early 1990s, condoms were not widely available in Uganda, and many people did not believe they really worked. The government did not promote their use and religious leaders denounced them as immoral and "un-African."¹⁸⁵ Health experts at USAID and other international agencies were concerned about this because they were skeptical that Uganda's existing AIDS programs would work. In 1986, the Ugandan Ministry of Health had launched a campaign known as "Zero Grazing"—Ugandan slang meaning "don't have casual sexual relationships," but did not promote condoms.

Then, in the early 1990s, the World Bank, USAID, and other donor agencies set out to make condoms more appealing, not only to citizens, but also to policymakers and religious leaders. By then, population experts had had considerable success encouraging the use of a variety of contraceptives—all initially unpopular—in other developing

countries, with an approach known as "social marketing," which uses advertising and marketing techniques to encourage people to adopt healthful practices. They had found that when condoms and other contraceptives were distributed free of charge in bland medical packaging, people found them unappealing. But when packaged in bright, colorful sleeves, and advertised on billboards and radio spots as sexy and fun, they were much more popular.

Selling condoms in shops, even at very low prices, rather than distributing them free, also added to their cachet. In Uganda, USAID began funding condom social marketing programs in the early 1990s. At the same time, the agency increased funding for the Ministry of Health, the Uganda AIDS Commission, and various church-affiliated organizations run by some of the leaders who most vocally denounced condoms. This new funding had the effect of toning down public criticism of condoms. Meanwhile, the Zero Grazing campaign was gradually phased out.

By the late 1990s, international contractors that specialize in social marketing, such as Population Services International, authors of the comic book that Ssempe complained about, were selling hundreds of millions of condoms each year in Africa. Organizations like PSI don't make money on the condoms they sell, but they do obtain lucrative government contracts to carry out social marketing programs. Uganda's social marketing campaigns were especially dynamic, and, as the Makerere student informed me, condoms had become part of Ugandan culture.

Then, shortly after Mrs. Museveni returned from Washington in 2003, where she had helped Republicans lobby for the \$1 billion appropriated for abstinence programs, Ugandan officials resumed denouncing condoms after a ten-year hiatus. In a speech at an international meeting of AIDS experts in 2004, President Museveni said AIDS was "a moral problem," caused by "undisciplined sex," and that condoms should be reserved for prostitutes. Mrs. Museveni has accused those who promote condoms of racism. "They think Africans cannot control their sexual drives," she said in a speech last year. "We will prove them wrong!" She has warned young people that organizations that promote condoms are only after their money. On a similar note, Information Minister James Butoro, like Mrs. Museveni a born-again Christian, accused condom social marketing organizations of "profiteering."

As it happens, Mrs. Museveni's Uganda Youth Forum (UYF) began receiving US funding to promote abstinence only until marriage to young Ugandans in 2004.^[12]

A large number of new faith-based abstinence organizations like Ssempe's Campus Alliance to Wipe Out AIDS (CAWA) and Mrs. Museveni's UYF have sprung up in Uganda in recent years, including the Glory of Virginitly Movement (GLOVIMA), the Family Life Network (FLN), and American groups such as True Love Waits. Many of these organizations hope to receive US funding from the \$1 billion appropriation for abstinence-only education. US law forbids organizations receiving federal funds from

evangelizing, but every abstinence event I attended involved much praying and discussion of Jesus. As Human Rights Watch points out, it was sometimes hard to tell what the aim of these organizations actually was—preventing AIDS or saving souls.

While I was in Uganda, I met Emily Chambers, a pleasant twenty-six-year-old woman who is in charge of AIDS programs in East Africa for Samaritan's Purse, a US-based charity run by Billy Graham's son Franklin that had just been chosen to receive a multi-million-dollar US government contract to carry out HIV prevention programs. Among other things, the organization plans to train African Christian pastors to carry out abstinence-only education.

I knew that Samaritan's Purse was in favor of abstinence-only, but inevitably some of the pastors they plan to train will be approached by people wanting to know more about condoms. I asked Ms. Chambers whether Samaritan's Purse would recommend that pastors refer such people to other organizations. "We don't know about that yet," she said. But when I asked her about the role of faith in abstinence programs, her eyes opened wide. "It's HUGE," she exclaimed. "Abstinence is near impossible without the helping hand of the Lord."

Later, I met a group of girls who were members of GLOVIMA, the Glory of VirginitY Movement, a Ugandan abstinence club run by an evangelical church. When I asked them how they intended to ensure that their future husbands would be faithful to them, only one hand went up. A little girl in a tartan dress stood up very straight and said, "I will pray for him."

3.

It is a great shame that no American or Ugandan has tried to revive the Zero Grazing campaign, because that program probably contributed greatly to the decline in Uganda's HIV rates. Africans are at higher risk of AIDS than people elsewhere not because they have so many partners, but because they often have more than one long-term partner at a time.^[23] Ugandan tribes, like many in Africa, are traditionally polygamous. Men are entitled to marry as many wives as they can afford to support, and they sleep with them at closely spaced intervals. But polygamous cultures, in which many people conduct several ongoing sexual affairs at once, create fertile ground for the spread of HIV. If all the men slept only with the women they were married to and the women did the same, HIV would not spread. However, extramarital affairs inevitably occur, as they do everywhere. In addition, economic hardship has meant that these days many men have difficulty providing for even one family, but they nevertheless continue to conduct informal relationships with mistresses, who may have additional partners themselves, sometimes out of economic necessity.

Thus the practice of formal and informal polygamy creates a network of simultaneous or "concurrent" sexual relationships that links sexually active people not only to one another but also to the partners of their partners— and to the partners of those partners, and so on—creating a giant web that can extend across huge regions. If one member contracts

HIV, then everyone else in the web may, too.¹¹⁴⁾ Polygamous men generally seek out young women, even as they themselves age. In this way, formal and informal polygamy pumps the virus from one generation to the next.

Long-term "concurrency" is far more common in Africa than in Asia and in the West, where heterosexual people tend to practice "serial monogamy." Martina Morris, a sociologist at the University of Washington, has shown that long-term concurrency is more of a public health danger than serial monogamy because it permits HIV and other sexually transmitted diseases to spread to others quickly, rather than confining them in a single relationship for months or years. Moreover, a recently infected person is much more likely to transmit HIV than a person who has been infected for a while. Thus, when a serially monogamous HIV-positive person eventually finds a new partner, his ability to infect that partner has been reduced. If someone at the hub of a network of concurrent relationships becomes infected, however, he or she is likely to infect his or her other partners very rapidly.

In 1986, Ugandan health officials had not heard of "long-term concurrency" and Professor Morris had not constructed the computer models that traced the transmission of HIV. Nevertheless, the Ugandans knew that HIV was spreading rapidly through networks of sexual relationships, and it was killing people. They also knew it would be unrealistic to insist that all men abandon their extra wives and mistresses, many of whom depend on the men for the opportunity to work on the land and for money and consumer goods for themselves and their children. Zero Grazing was a compromise. It recognized that sexual arrangements in Africa are often different from the Western nuclear ideal and serial monogamy. Zero Grazing was mainly addressed to men, and its real message was:

Try to stick to one partner, but if you have to keep your long-term mistresses and concubines and extra wives, at least avoid short-term casual encounters with bar girls and prostitutes. Also, you mustn't casually seduce and exploit young women, who may be susceptible to your charms and wealth.

During the Zero Grazing campaign, the proportion of Ugandan men and women with casual partners fell by 60 percent. On surveys and in focus groups conducted throughout the country, most people said that they were protecting themselves from HIV by reducing their partners or "sticking to one."¹¹⁵⁾ By the time the Zero Grazing campaign was replaced by condom promotion and other programs in the early 1990s, the decline in the HIV infection rate was well underway. After 1995, when condom social marketing programs took off, the proportion of men with "non-regular" partners rose again. But HIV rates continued to fall, albeit far more slowly. Then, after 2000, HIV rates rose slightly. The reason HIV rates have not soared, even though more men have multiple partners, is almost certainly that the men are using condoms. The reason HIV rates are no longer falling is probably that these men are not using condoms consistently, especially in the longer-term, concurrent relationships where HIV transmission is most likely to occur.

I asked David Apuuli, the affable head of the Uganda AIDS Commission, why the government did not revive the Zero Grazing campaign, which seemed to have been so effective. He giggled, poked me with his elbow, and winked theatrically. "You know what that was all about, don't you?" What Dr. Apuuli meant was this:

What kind of an idiot are you? What do you think the Christians are going to say if we start talking about Zero Grazing? Zero Grazing recognized that polygamy, both formal and informal, was normative and legitimate. That would not fly in the current political and religious climate. Mrs. Museveni would have a fit, and the Bush administration, which pours billions of dollars a year into Uganda, would be very dismayed if the country they hold up as a triumph of abstinence education started promoting Zero Grazing.

But there may be other reasons why Zero Grazing is unlikely to be revived. For one thing, there is no multimillion-dollar bureaucracy to support it. For condoms, there are the large contractors like PSI with headquarters in Washington and thousands of employees in plush offices all over the world. Abstinence-only education is supported by a similarly well-endowed network of faith-based and abstinence-only education organizations, mainly in the US. Zero Grazing was devised by Ugandans in the 1980s, when they were facing a terrible problem, and had to deal with it largely on their own. Now that AIDS is a multibillion-dollar enterprise, donors with vast budgets and highly articulate consultants offer health departments in impoverished developing countries a set menu of HIV prevention programs, which consists mainly of abstinence and condoms. Beleaguered health officials have no time, money, or will to devise programs that might better suit their cultures.

Another reason why abstinence programs are favored over Zero Grazing may have to do with the sexual hypocrisy common to all known societies. The revival of interest in virginity in Africa is not always driven by American money. In southern Africa, many communities have revived the custom of virginity testing—in which older women examine unmarried younger women to ensure their hymens are unbroken. Virginity testing has become so popular among the Zulus that it is sometimes carried out en masse, at football stadiums. Meanwhile, Swaziland's King Mswati III decreed in 2001 that all young, unmarried Swazi women should abstain from sex for five years and wear special tassels in their hair, as a signal to men to leave them alone. Fines were imposed on subjects who broke the rule.

Like other abstinence programs, Swaziland's was not a success. Today, four years after the decree, 40 percent of all Swazi adults are HIV-positive—the highest HIV infection rate in the world. While the King frowns on premarital sex, he tolerates polygamy, and indeed has thirteen wives of his own, at last count. He chooses a new bride each August at the annual Reed Dance Festival, where thousands of topless girls in traditional grass skirts dance and sing his praises. In 2003, when the King chose a seventeen-year-old, he fined himself one cow.

The South African anthropologist Suzanne Leclerc-Madlala attributes the revival of interest in virginity to an increasing sense among elders, especially men, that they are losing control of young people and women. All around they see worsening economic and social conditions and the horror of AIDS, and because they are only human, they blame this state of affairs on the loosening morals of increasingly educated, urbanized women and young people, rather than examining how their own behavior also contributes to these problems.^[16]

4.

After two weeks spent visiting pastors, watching Joyce Meyer sermons on TV, and shopping at stores with names like Trust in God Hardware, I felt I needed a change of scene. One of the women's dorms on Makerere campus has a reputation. "Go there some Saturday night," said a professor I knew. "That's when the men in their big cars come and pick up the girls and take them out. Sometimes you just see men sitting in front of the entrance, waiting. They call it 'benching.'" The dorm in question wasn't far from where I was staying, so one Saturday night I walked over. As I approached, I saw some people sitting along the edge of the parking lot, facing the entrance of the building. At first I thought they were "benchers," but about half of them were women, their eyes glistening with tears. They were watching a Christian movie about a girl who has just told her boyfriend she is suffering from cancer. I watched as they prayed together, and then I spotted a couple walking away from the dorm. As I drew closer to find out what was going on, I realized they were discussing Saint John's Gospel.

Afterward, I wandered over to Pastor Ssempe's abstinence rally at the Makerere campus swimming pool. There must have been three thousand people there and I couldn't get past the huge overflow crowd on the street outside. The show consisted of skits, comedy routines, testimonies from former sinners, prayers, and thundering Christian rock music, sung in local languages by Ugandan stars. The entire audience all swayed together, dancing and singing and waving at the night sky. The music was so powerful the ground itself seemed to tremble.

As the music became increasingly ecstatic, a few members of the audience began to twitch and shake in a peculiar way. Then a woman some distance away from me began to writhe quite violently, and in a fit that might be described as orgasmic, she suddenly flew backward into the crowd and had to be pulled up by her friends.

"She was battling the spirits," one of the students explained to me.

Afterward, as I was walking back to my hotel, the rumble of the music still in my ears, I departed from the crowds of students and followed a dark road lit only by the moon and the occasional approach of slow-moving, yellow-eyed cars. Many of the sidewalks on campus are broken, and here and there the smashed concrete opens into dark, stinking sewage channels below, as if they had been torn open by some spasm of the earth. Flocks of bats hung from the jungley black branches of bottlebrushes and eucalyptus, and giant scavenger birds loomed on the crests of the trees, their long stiff beaks chattering like

tom-toms. Disco music surged from numerous nearby bars, and images of nude dancers and homosexuals and pornographers and beer-addled prostitutes merged with the memory of the hysterical woman at the rally.

Sexuality truly does belong to the world of magic and unreason. It is impossible to plan and control it totally. We were made that way. If sex were an entirely rational process, the species would probably have died out long ago.¹⁷⁹ But the delirious, illogical nature of sex makes setting a realistic HIV prevention policy very difficult. Cheerful, sexy condom ads that fail to address the real dangers of AIDS may promote a fatal carelessness; but an exclusive emphasis on abstinence until marriage may well lead to an even more dangerous hysterical recidivism. The genius of the Zero Grazing campaign was that it recognized both the universal power of sexuality and the specific sexual culture of this part of Africa, and it gave people advice they could realistically follow.

—March 31, 2005

Notes

¹⁷¹ *The Hope Factor: Engaging the Church in the HIV/AIDS Crisis*, edited by T. Yamamori et al. (Authentic Media, 2003) p. 250.

¹⁷² *The Hope Factor*, p. 194.

¹⁷³ See Health and Development Networks, "Condom U-Turn Puts Many Young Ugandans at Risk," May 26, 2004; Human Rights Watch, "The Less They Know, the Better: Abstinence Only HIV/AIDS Programs in Uganda," March 2005; Center for Health and Gender Equity, "Where Is the 'C' in ABC: Implications of US Global AIDS Policy and Funding for HIV Prevention in PEPFAR Focus Countries," March 2005; Thomas J. Coates, "Science vs. Assumption in Public Health Policy: Abstinence Alone Not the Answer," *San Francisco Chronicle*, May 25, 2004; and Esther Kaplan, *With God on Their Side* (New Press, 2004).

¹⁷⁴ Ruth Bessinger, Priscilla Akwara, and Daniel T. Halperin, *Sexual Behavior, HIV, and Fertility Trends: A Comparative Analysis of Six Countries; Phase I of the ABC Study* (Measure Evaluation, 2003), at www.cpc.unc.edu/measure/publications/special/abc.pdf (accessed June 22, 2004).

¹⁷⁵ Even by year. Virtually the same number of fifteen-, sixteen-, seventeen-, eighteen- and nineteen-year-olds became pregnant in 1988 as in 1995, a period when HIV rates in the same group of pregnant girls fell by nearly half. Teenage pregnancy rates did fall significantly between 1995 and 2001, but the use of modern contraceptives, including condoms, nearly tripled during this time, so it is difficult to attribute this to abstinence alone.

Table: Teenage pregnancy in Uganda

Table: Frequency of concurrent and suspected concurrent relationships

^[6] Speech given at "AIDS Care in Africa: The Way Forward," meeting sponsored by the Rockefeller Foundation, Kampala, Uganda, April 19–21, 2001.

^[7] See also Andrew Rice, "Evangelicals vs. Muslims in Africa: Enemy's Enemy," *The New Republic*, August 9, 2004, and Human Rights Watch, "The Less They Know, the Better."

^[8] Similar funding battles between HIV prevention groups focused on abstinence and those focused on condoms are underway in other African countries. See Center for Health and Gender Equity, "Where Is the 'C' in ABC."

^[9] See Rand Stoneburner and Daniel Low-Beer, "Population-Level HIV Declines and Behavioral Risk Avoidance in Uganda," *Science*, April 30, 2004, pp. 714–718. A previous report attributed the decline in infection rates in Uganda mainly to condom use and abstinence. (See Asimwe-Okiror et al., "Change in Sexual Behaviour and Decline in HIV Infection Among Young Pregnant Women in Urban Uganda," *AIDS*, Vol. 11, No. 14, November 15, 1997, pp. 1757–1763.) However, this report miscalculated partner reduction. The authors report that the proportion of people with casual partners—defined as relationships lasting less than a year—fell very little between 1989 and 1995. However, instead of calculating the proportion of *all* sexually active people who have casual partners, the authors reported only those people who were in long-term relationships—lasting more than a year—who also had casual partners. In other words, they omitted from their calculation all those who had partnerships lasting days, weeks, or months only. This population contains many young people who are at very high risk of HIV. When they are included in the calculation, the proportion of those with casual partners fell by around 60 percent, as Stoneburner and Low-Beer have shown.

Recently, various US newspapers suggested that increased condom use and the death of AIDS patients were the main reasons for the decline in HIV infection rates in Uganda. See Lawrence Altman, "Study Challenges Abstinence as Crucial to AIDS Strategy," *The New York Times*, February 24, 2005; and David Brown, "Uganda's AIDS Decline Attributed to Deaths," *The Washington Post*, February 24, 2005.

These news reports were based on a study from the Rakai district of southern Uganda that has been underway for more than a decade. The reports on the study were misleading for several reasons. First, although AIDS certainly increased death rates in Uganda, it has done so throughout eastern and southern Africa. However, HIV rates in Uganda fell by 75 percent in the 1990s, but have since risen or stabilized everywhere else. The HIV epidemic in Zimbabwe, Zambia, and Malawi began only a year or two after Uganda's. If deaths from AIDS were the main reason for Uganda's decline, we should by now have seen huge declines in HIV infection rates similar to Uganda's in these countries. However, HIV rates in these countries today are between three and five times higher than they are in Uganda, and have fallen very little, if at all, during the past fifteen years.

Because HIV infection has no cure, deaths need to occur for HIV prevalence to decline. What happened in Uganda (but not elsewhere) is that sexual behavior changed, so that when people died of AIDS, they were not replaced by an equal number of newly infected people. In other countries, there has been very little prevalence decline, despite a great many deaths. See also Albert H.D. Kilian et al., "Reductions in Risk Behaviour Provide the Most Consistent Explanation for Declining HIV-1 Prevalence in Uganda," *AIDS*, Vol. 13, No. 3 (1999), pp. 391–398.

Although increased condom use probably has contributed to the decline of HIV infection rates in Uganda, it is unlikely to have been the main reason for this success. The survey of sexual behavior in Rakai district referred to in Brown's and Altman's articles was conducted between 1994 and 2003. However, there appears to have been significant behavior change in Rakai and throughout southern Uganda before 1994, which the study described in the news articles did not measure. According to scientific reports on the Rakai project (see references below), HIV rates in Rakai fell rapidly between 1990 and 1996, and much more slowly, if at all, thereafter. In 1990, the HIV prevalence rate in Rakai trading centers was around 35 percent. In 1996, it was around 16 percent. Today, it is around 14 percent. Condom use began to increase rapidly in Rakai only in the mid-1990s. In 1996, when the decline in HIV prevalence was well underway, only 12 percent of people surveyed in Rakai had used a condom in the six months preceding the survey. Thus it is unclear how it is possible to claim that condoms were the main reason for the decline in infection rates that occurred before 1996. Nor was death, or abstinence, for that matter. (See Maria J. Wawer et al., "Dynamics of Spread of HIV-1 Infection in a Rural District of Uganda," *BMJ*, November 23, 1991, pp. 1303–1306; and Maria J. Wawer et al., "Control of Sexually Transmitted Diseases for AIDS Prevention in Uganda: A Randomised Community Trial, Rakai Project Study Group," *The Lancet*, February 13, 1999, pp. 525–535.)

Consistent with the findings of Low-Beer and Stoneburner, focus groups conducted in Rakai itself during the 1980s and early 1990s showed Zero Grazing and "sticking to one" were the most commonly reported responses to the question "What are you doing to protect yourself from HIV?" (See for example Joseph K. Konde-Lule et al., "Focus Group Interviews About AIDS in Rakai District of Uganda," *Social Science and Medicine*, Vol. 37, No. 5, September 1993, pp. 679–684.)

^[10] See Priya Abraham, "Hooked on Failure," *World*, November 6, 2004; and Candi Cushman, "Burying the Truth," *Citizen*, March 2005.

^[11] See Maryinez Lyons, "The Point of View: Perspectives on AIDS in Uganda," in *AIDS in Africa and the Caribbean*, edited by George Bond et al. (Westview, 1997).

^[12] Some of the money for Mrs. Museveni's program is to be channeled through the Children's AIDS Fund or CAF, a US organization. In November 2004, CAF, which is run by a couple who are close friends of President Bush, was promised US government funding, even though the grant proposal it submitted to USAID was deemed "unfit" by a review panel. USAID administrator Andrew Natsios argued that CAF had ties with Janet

Museveni's Uganda Youth Forum, who "is a pioneer in abstinence and be faithful messages," and should therefore be given special consideration. Randall Tobias, the US Global AIDS coordinator, apparently agreed. CAF was formerly known as Americans for a Sound AIDS Policy. In the 1990s, it lobbied to increase federal funding for "Abstinence-only- until-marriage programs," and against extending Americans with Disabilities protection for people with HIV. The disbursement of funds under the President's Emergency Plan for AIDS Relief is disturbingly opaque. According to the Center for Health and Gender Equity, an organization that tracks US government spending on reproductive health, millions of dollars disbursed so far have not been publicly accounted for, in addition to that promised to CAF. See David Brown, "Group Awarded AIDS Grant Despite Negative Appraisal," *The Washington Post*, February 16, 2005, p. A17.

^[13] See Christopher Hudson, "AIDS in Rural Africa: A Paradigm for HIV-1 Prevention," *International Journal of STD & AIDS*, Vol. 7, No. 4 (1996), pp. 236–243; Martina Morris and Mirjam Kretzschmar, "Concurrent Partnerships and the Spread of HIV," *AIDS*, Vol. 11, No. 5 (1997), pp. 681–683; and Daniel T. Halperin and Helen Epstein, "Concurrent Sexual Partnerships Help to Explain Africa's High HIV Prevalence: Implications for Prevention," *The Lancet*, July 3, 2004, pp. 4–6.

Table: HIV prevalence among 15-19 year old pregnant women

^[14] Polygamy is also common in the Middle East, where HIV infection rates are extremely low. However, these cultures are very likely protected by the widespread practice of male circumcision, which probably cuts the risk of HIV transmission by some 70 percent, and by intense surveillance of women's behavior, so that while many men have multiple concurrent partners, few women do. See my "Why Is AIDS Worse in Africa?" *Discover*, February 2004, and John Donnelly, "Circumcised Men Less Likely to Get AIDS," *The Boston Globe*, November 16, 2004.

^[15] Tom Barton, "Epidemics and Behaviours: A Review of Changes in Ugandan Sexual Behavior in the Early 1990s," unpublished report for UNAIDS, Geneva, 1997. Zero Grazing may be a natural reaction to the threat of AIDS. Just as in Uganda, partner reduction, combined with strategic, consistent condom use in casual relationships, has been responsible for HIV declines in Thailand and in the gay community throughout the developed world. See Susan Kippax and K. Race, "Sustaining Safe Practice: Twenty Years On," *Social Science and Medicine*, Vol. 57, No. 1 (July 2003), pp. 1–12; Daniel Low-Beer and Rand L. Stoneburner, "Behaviour and Communication Change in Reducing HIV: Is Uganda Unique?" *African Journal of AIDS Research*, Vol. 2, No. 1 (2003), pp. 9–21; Martina Morris and Laura Dean, "The Effect of Sexual Behavior Change on Long Term HIV Prevalence Among Homosexual Men," *American Journal of Epidemiology*, Vol. 140 (1994), pp. 217–232.

Rates of casual sex have recently been declining in many African countries, including Kenya and Rwanda, and HIV rates are also beginning to fall in these countries. Professor Susan Watkins of the University of Pennsylvania has observed similar behavioral

changes in Malawi, although statistics there are unreliable, so it is hard to say whether this has reduced the spread of HIV. (See Susan Cotts Watkins, "Navigating the AIDS Epidemic in Rural Malawi," *Population and Development Review*, Vol. 30, No. 4, December 2004, pp. 673–705.) It has taken much longer for these changes to get underway outside of Uganda, possibly because there have been no campaigns to encourage partner reduction, and because social and economic factors in other countries may make this kind of behavior change more difficult. (See my "Fidelity Fix," *The New York Times Magazine*, June 13, 2004.)

^[16] Suzanne Leclerc-Madlala, "Protecting Girlhood? Virginity Revivals in the Era of AIDS," *Agenda*, Vol. 56 (2003), pp. 16–25.

^[17] Thanks to Alex Coutinho of the AIDS Support Organization in Uganda for discussions on this point.

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Relationships Between Older Men and Younger Women: Implications for STIs/HIV in Kenya

Kim Longfield, Anne Glick, Margaret Waithaka, and John Berman

The aim of this study is to contribute to the understanding of motivations for cross-generational relationships and how the perception of risk of acquiring sexually transmitted infections (STIs) including HIV affects condom use in Kenya. Eight focus-group discussions were conducted with women and 28 interviews were held with men in four Kenyan towns. Ethnograph 5.0 computer software was used for the analysis of data. Women's primary incentive for engaging in such relationships is financial; men seek sexual gratification. Pressure from peers compels women to find older partners. Although some peers encourage such relationships, other groups, especially wives, same-aged boyfriends, and parents, disapprove of them. Couples are preoccupied by the threat of discovery. STI/HIV risk perception is low, and couples rarely use condoms. Material gain, sexual gratification, emotional factors, and recognition from peers override concern for STI/HIV risk. Women's ability to negotiate condom use is compromised by age and economic disparities. Programmatic strategies include communicating information about such relationships' STI/HIV risk, promoting consistent condom use, decreasing peer pressure to pursue such relationships, and improving women's access to alternative sources of income. (STUDIES IN FAMILY PLANNING 2004; 35[2]: 125-134)

Kenya is one of the nine African countries hit hardest by the HIV/AIDS pandemic, and according to the Joint United Nations Programme on HIV/AIDS (UNAIDS 2002), HIV prevalence among Kenyan 15-49-year-olds has reached 15 percent. Sexual activity is the major mode of HIV transmission in Kenya and accounts for approximately 80 percent of infections (Mulindi et al. 1998). Researchers have found that in addition to high levels of sexual activity, transitory sexual relationships, and insufficient rates of condom use, young Kenyans harbor misinformation about HIV/AIDS transmission, further increasing their risk of infection (Kekovole et al. 1997; Buvé et al. 2001). Data from the last Kenyan Demographic and Health Survey (KDHS) reveal that 56 percent of males and 32 percent of females aged 15-24 re-

ported engaging in sexual activity during the past year (Stat Compiler 2002). Despite high levels of sexual activity, condom use among Kenyan young people remains low. A 2001 study found that only 10 percent of respondents aged 15-19 and 6 percent of those aged 20-24 reported using a condom during their last sex act (Waithaka and Bessinger 2001).

HIV disproportionately affects young women in Kenya. A study in Kisumu revealed that HIV prevalence among sexually active 15-19-year-olds was six times greater among women than among men, and that among 20-24-year-olds prevalence was three times higher among women than among men (Glynn et al. 2001). According to UNAIDS, by the end of 2001, between 12 percent and 19 percent of Kenyan females aged 15-24 were infected with HIV; for males in the same cohort, prevalence was substantially lower, estimated at about 5 percent to 7 percent. Researchers believe that young women's physiological susceptibility and sexual relationships with older partners contribute to their increased risk of infection (MAP Network 2002; UNAIDS 2002). Even though age asymmetries between marital partners in sub-Saharan Africa are the traditional norm, modern patterns of sexual mixing between older men and younger women may account for differences in prevalence rates for sexually

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transmitted infections (STIs) including HIV in the region (Kelly 2001; Laga et al. 2001; Gregson et al. 2002; MacPhail et al. 2002).

In situations where economic conditions are difficult, young women engage in relationships with "sugar daddies," older men who provide money or gifts in exchange for sex (UNICEF et al. 2002). Similar relationships have been documented between young men and older women; however, liaisons with "sugar mommies" do not appear to be as common (Barker and Rich 1992; Calves et al. 1996). The literature provides no established definition of a sugar daddy or standard age difference between partners that constitutes sexual mixing. Several researchers, however, have used an age difference of ten or more years between older men and younger women to investigate the effects of age asymmetry in nonmarital partnerships on the risk of acquiring STIs and HIV (UNAIDS 2000; Laga et al. 2001; Gregson et al. 2002; Luke 2002 and 2003). A comprehensive literature review of quantitative studies conducted in sub-Saharan Africa revealed that 12 percent to 25 percent of young women's partners were ten years older or more (Luke and Kurz, 2002). Likewise, a study conducted in Kenya found that among men older than 30 who reported having nonmarital partners, 25 percent had a partner at least ten years younger than themselves (Luke 2002). Luke and Kurz (2002) and the President's Emergency Plan for AIDS Relief (US Department of State 2004) term these relationships "cross-generational" to indicate a gap in age, in individual and social development, and in other opportunities between two partners.

Several factors within cross-generational relationships present increased risk of acquiring STIs/HIV. Risk perception of infection is generally low, and many men say they prefer young sexual partners because they consider young women to be free from HIV (Chinako et al. 2002; Summers et al. 2002). Young women appear more worried about becoming pregnant or about outsiders discovering their relationships with older men than they are about acquiring STIs/HIV (Silberschmidt and Rasch 2001). Condom use is inconsistent, and men are often unwilling to use condoms with younger partners (Sturdevant et al. 2001). Young women's power to negotiate condom use is compromised by age disparities and economic dependence within such relationships (Mensch and Lloyd 1998; Rao Gupta 2000). Overall, men who engage in relationships with younger women are more likely to be infected with STIs or HIV compared with the women's age-mate cohort, because they have experienced longer periods of sexual activity (Corgen et al. 1998; Kelly 2001; Laga et al. 2001). Cross-generational relationships also increase young men's risk of acquiring an infection when their girlfriends maintain simultaneous relation-

ships with older partners (Calves et al. 1996; Gregson and Garnett 2002).

This study explores the dynamics of cross-generational relationships in Kenya. It describes women's and men's motivations for entering into such relationships, including the various personal, financial, and social rewards associated with such relationships. It also examines couples' perception of risk of acquiring STIs/HIV and evaluates how low levels of risk perception affect sexual decisionmaking, particularly with regard to condom use. Based on the study's findings, the authors recommend programmatic strategies for reducing young women's risk of acquiring STIs/HIV, specifically that which accompanies cross-generational relationships.

Methods

Data were collected in June 2000 as part of a behavior-change communication strategy for young women in Kenya that addresses cross-generational relationships and their association with the risk of acquiring STIs and HIV/AIDS. Staff from Population Services International (PSI) in Kenya together with students from local universities collected the study data. A total of eight focus-group discussions were conducted with sexually active women aged 15-19 who were both in and out of school. Street mobilizers recruited participants and assessed their eligibility with a screening tool. Two focus-group discussions were held in each of four locations: representing both urban and rural locales: Nairobi (urban), Mombasa (urban), Kisumu (rural), and Meru (rural). Female moderators conducted the discussions in the lingua franca, and a note-taker and recruiter were present at each discussion.

In-depth interviews were conducted with 28 men aged 30 and older in the same four regions. Researchers decided to conduct interviews rather than discussion groups with the men in order to maintain their confidentiality and increase the likelihood of capturing men who participate in cross-generational relationships. Male interviewers screened and recruited participants at venues that the discussion-group participants identified as popular among men seeking younger female partners. Interviews were conducted in the lingua franca. Different discussion guides were used for discussions and interviews; however, both guides covered the same study themes. Discussions ranged across motivations for entering into cross-generational relationships, the perceived risks of doing so, relationship dynamics, and circumstances under which older men and younger women meet. All discussions and interviews were audiotaped, translated, and transcribed into English. The authors completed data an-

alysis with the Ethnograph 5.0 software program to highlight common and divergent themes in study transcripts.

As with all research, this study faced some limitations that must be taken into account when analyzing data and drawing conclusions from results. Recruiters may not have screened the men adequately for participation, and the locales in which they were recruited may not have been the most appropriate for data collection. As a result, the men who participated may have been ill prepared to discuss cross-generational relationships. Different methodologies were used to obtain information from female and male participants, which may have produced data that are not fully comparable. Transcriptions were sometimes incomplete or varied in quality, and interviewers might have benefited from additional training. Because the discussions were used to obtain data from young women, information about participants' personal experiences is limited. The findings captured by this study reflect social norms rather than individual behaviors. Finally, as for any study reliant upon self-reported data, the potential exists for information bias, especially in underreporting stigmatized or risky behaviors.

Results

Participants' comments reveal that cross-generational relationships are relatively common and that young women actively seek partners who are willing to spend money on them. Relationships are usually short-lived, and the men who pursue younger women do not appear to fit a sugar-daddy stereotype.

Prevalence of Cross-generational Relationships

Discussion-group participants stated that relationships between younger women and older men are common in their localities. Although none admitted to being involved in such relationships, most were quick to point out that they have friends or know other young women who engage in cross-generational sex. The majority of men interviewed reported that they had had a relationship outside of marriage at some point. Most denied ever having relationships with teenagers but admitted that they had been involved with women in their early twenties. Only one participant said that he was having an affair with a teenaged girl at the time of the interview. Some male participants thought that cross-generational relationships are especially common in urban areas.

Urban areas offer a very favorable environment for such affairs to flourish. In rural areas, these affairs are short-lived because the community soon discovers them. (Male consultant, Nairobi, aged 46)

Both male and female participants explained that, consistent with cultural norms, men are expected to initiate encounters with partners. Several female participants described methods young women use to meet older men, however. One strategy is to ask a man for a lift in his car and hope to be seduced. Other women described more direct methods for pursuing partners.

If the man dresses well, then she knows he's got money. . . . So she says to herself, "This one, I'll pursue until we meet." The girl will ensure that she talks to him and starts a relationship. (Female, Nairobi, aged 15-19)

As mentioned above, the male study participants in cross-generational relationships did not fit the traditional sugar-daddy stereotype; they were not all married, wealthy, and aged 35-50, nor did they work at white-collar jobs. Women in the discussion groups listed police officers, *matatu* tents (assistants to minibus drivers), truck drivers, doctors, clerks, bankers, airport workers, and business executives as potential partners. Others noted that ordinary men in their neighborhoods or men whose wives live elsewhere could be partners. The majority of female participants said that older partners come in many varieties, but the most important criterion is that they have some money to spend on their partners.

When asked about traits men seek in young female partners, male participants also recognized the role money plays in cross-generational relationships and described as desirable partners women who were likely to need money to pay for school fees or to supplement their incomes. Many said that men prefer young women in college or in their final year of secondary school. If employed, young women usually work in low-paying jobs as maids, receptionists, secretaries, or telephone operators. Several male participants added that men prefer young women who appear innocent, who are well mannered, and who can keep relationships secret. They also described commonly preferred physical attributes including light skin, a nice figure, firm breasts, large buttocks, and large hips.

Relationship Dynamics

Participants explained how an older man's gift giving is usually accompanied by the expectation that the young recipient will have sex with him. The period of time between initiating contact with partners and engaging in sex may range from a day to three months. Female participants stated that some young women feel obliged to sleep with men who provide them with gifts and money.

For around three months, he doesn't demand anything. . . . He keeps giving you things. Therefore, when he asks you to return the favor, you end up with a guilty conscience and you give him sex in return because you can't return the money. (Female, Nairobi, aged 15-19)

When asked about the duration of cross-generational relationships, participants said that they could last for as little as a month or for as long as a lifetime. Nevertheless, most agreed that these types of relationships generally do not last long. Some participants explained that although cross-generational relationships may contain an emotional component, many are experimental affairs in which the man is pursuing a number of young women.

These things only go on for months [at a time]. You know--it's to satisfy a kind of curiosity. After you've gone with her twice, three times at most, you want to dispose of her fast. You don't keep these girls for long. After all, you're married. (Male administrator, Nairobi, aged 36)

Several discussion and interview participants explained that these relationships often end when the man's wife or the young woman's parents discover them. Women noted other reasons for the termination of cross-generational relationships, including men's failure to honor their financial obligations or their too-frequent demands for sex.

Sometimes he can be dumped if he's too demanding . . . if he always wants sex, like Mondays when you're in class. (Female, Meru, aged 15-19)

Motivations for Engaging in Cross-generational Relationships

Both female and male participants recognized that primary motivations for engaging in cross-generational relationships are different for women and men, but that each partner stands to benefit. For young women, the main incentive is financial gain, whereas for men it is sexual gratification. Both women and men face peer pressure to enter into such relationships, and both seek emotional support from their partners.

Money and Gifts

Female participants explained that most young women pursue older partners who can provide them with money and gifts that are unavailable from partners of their own age. The amount of money a young woman expects could be as little as KShs 20 (US \$.25) or as much as KShs 5,000 (US \$63). Because young men of their own age are

usually still at school and have difficulty obtaining money themselves, many young women have concurrent relationships with older and same-age partners.

With a young man, it depends on his ability. If he can give you money, fine, but most of them usually don't have money. So you're forced to look for someone who has the ability to give you what you want. (Female, Mombasa, aged 15-19)

Most discussion-group participants remarked that young women use money from older partners to obtain essential items for themselves or for their families. They may engage in cross-generational relationships in order to secure funds to cover education-related expenses that parents cannot pay, such as school uniforms, fees, and books. Some said that young women often tell their families that they have taken a "casual" job to make ends meet. Participants said that even if their family members do not believe this explanation, most would not question the young women but would remain silent and continue to benefit from their assistance. Although most participants said that adults disapprove of cross-generational relationships, several believed that parents encourage such relationships by not actively discouraging their daughters from dating older men and by accepting without questions gifts that assist the family in times of need.

Female participants explained that although some young women have legitimate financial needs and seek assistance from older partners, most want to impress their peers and enjoy luxuries such as trendy clothing, hairstyles, jewelry, cosmetics, and toiletries, or outings to expensive restaurants that they cannot otherwise afford or that their parents refuse to or cannot provide. Some participants noted that special food treats such as French fries, cookies, ice cream, or chicken are sometimes enough to entice young women into encounters with older men. A few said that some young women exploit their partners by misrepresenting their financial need because they wish to receive additional funds for luxury items or pocket money.

Some girls are tough. [Their partners] can give them money to pay school fees, but instead they pocket it for their own personal use. (Female, Nairobi, aged 15-19)

Several women in the groups pointed out that older men use their financial security to bribe young women with money and luxury items and lure them into sexual relationships. Male participants echoed this argument and explained that men's economic power allows them to cultivate relationships with young women. They also noted that without money, older men would be unable to attract such partners.

Money and influence make older men capitalize on power to take advantage of younger women. (Male consultant, Nairobi, aged 46)

In interviews, several men argued that older men recognize young women's financial vulnerability and intentionally pursue them because they are less expensive to maintain than partners of their own age and because they make fewer financial demands than older women would. Some noted that young women are satisfied with simple gifts, such as dinner in a restaurant or a new lipstick, whereas older women may expect money for rent or other expensive items.

Sexual Gratification

While all participants agreed that young women pursue older partners for financial and material gain, male participants stated that sexual gratification is men's primary and sometimes only motivation for pursuing cross-generational relationships. They explained that most men believe that sex and happiness are synonymous. They also feel that younger women are able to satisfy a man's needs better than older partners, such as wives, can.

"If you're married and moving around [having sex] with a woman who's 15 or ten years younger than you are, what is your expectation? You won't get married to her. She's just there to satisfy you sexually. (Male consultant, Nairobi, aged 44)

Most male participants noted physical characteristics specific to young women that men find attractive and that they believe are uncommon in older women. Some said that young women are considered hot-blooded and fresh, and that their bodies are young and firm. They also described them as having "firm breasts" and "tender bodies" that are "nice to touch." Some participants explained that men perceive cross-generational relationships as conquests. By engaging in sex with younger partners, older men assure themselves that they are still desirable and can enjoy sex as they did when they were younger.

It's for the thrill and also to conquer. You know, it's nice to conquer and assure yourself that you can still do what you used to do when you were a young man. (Male lawyer, Nairobi, aged 38)

Social Motivations

All female discussion-group participants mentioned peer pressure as a significant motivating factor for engaging in cross-generational relationships. They noted that young women who have older partners brag to their friends about their partners' generosity with money, gifts, and outings. As a result, women can feel excluded from so-

cial circles and pursue older partners in order to "fit in." Several described how young women serve as brokers for cross-generational relationships and help to find older partners for their friends. Men sometimes instigate such arrangements and network with younger women to find partners. Women may ask friends to solicit older partners, knowing the potential benefits of such relationships.

If it's a friend who trusts you and she has a problem similar to yours, maybe a lack of money because her parents are poor, now she'll try and get into a relationship like yours. (Female, Kisumu, aged 15-19)

Several women explained how older men pressure young women to participate in sexual relationships. They noted that although a young woman may not be interested initially, she may be pressured until she concedes. Some participants described instances in which extended family members pressure young relatives by organizing encounters with older men without explaining the arrangement to the young women. Family members, even in-laws, may expect to benefit financially, either through the man's gifts to the young woman or through direct payments he makes to the family without her consent or knowledge.

After making the connection, your sister-in-law will tell you where you'll meet the old man. She'll take you there and go back home. . . . She tells you she'll be back later, but she doesn't come back. Whatever this man tells you to do, you do. If he tells you to go to bed with him, you have no choice because you don't even know your way home. (Female, Nairobi, aged 15-19)

As with young women, men's peers reward them for taking part in cross-generational relationships: Most male participants felt that men's status among their peers is elevated when they are seen with younger, attractive women. Some argued that older men use their money to live vicariously through younger partners. By selecting the right type of partner, they can experience youth, beauty, and intellectual stimulation. They mentioned that some men select women based on their levels of education in order to enhance their own status among peers.

If you're seen with a young girl, your friends say, "This guy, you know, he has such a good babe." It's for identification. It's for status. (Male supervisor, Mombasa, aged 38)

Several men also noted a cultural tolerance for cross-generational relationships. They pointed out that tradition permits older men to use their finances for pursuing younger women if they so choose.

They get into this type of relationship because they want social status and recognition because society approves of that kind of behavior. (Male consultant, Nairobi, aged 46)

Emotional Motivations

Parents' level of involvement in their daughters' lives may be related to the young women's participation in cross-generational relationships. Although some young women who date older partners have strict parents or guardians pressuring them to leave home, others have guardians who are uninvolved in their lives, leaving them to do what they please. Some discussion-group participants stated that young women who are orphans or who live in households that do not provide them with adequate emotional support are more likely than other young women to seek older partners. They explained that daughters of parents who are neglectful may feel that they have no alternative but to find partners who can provide the emotional support they need.

The girls want to be "spoiled" [pampered] by these men. You want him to treat you like a baby—pay constant attention to you. (Female, Mombasa, aged 15–19)

Some female participants believed that young women become involved with older partners to find mentors who can help them work through problems and provide advice about life. They often turn to older men for help in solving problems, making them important, trusted confidants. They explained that many young women prefer older partners because they are perceived to be more mature than young men, that because they have wives, older men know how to take care of women and make them feel important and needed.

Some of the men interviewed for the study suggested that men who married young are likely to pursue cross-generational relationships because they feel cheated out of sexual experiences they should have had when they were younger. In their opinion, engaging in sex with young partners can compensate for lost opportunities. They remarked that men want to go out and have fun the way they did when they were young, but their wives prefer to stay at home. As a result, they may look for younger partners who are willing to go to clubs or to go out dancing.

A few men suggested that some older men are dissatisfied with their marriages because their wives do not dote on them as they did before the responsibilities of family life became paramount. Some explained that men look for partners who will sympathize with their frustrations. One participant joked about how men refer to their younger partners as "ISPs" (independent sex pro-

viders) or "stress managers." A few pointed out that younger women can help men through midlife crises or difficult marriages. Men also appear to enjoy being the older, more experienced partner in a relationship because young women often revere and admire them. Such a dominant position, they said, can provide a man with a much-desired ego boost.

[Men] also need to show their experience in handling women, and that experience can only be shown to some of these younger [women] . . . for men, the ego dominates. (Male lawyer, Nairobi, aged 38)

Risks Associated with Cross-generational Relationships

Despite the advantages young women and older men associate with cross-generational relationships, participants of both sexes admitted that such partnerships carry substantial risks. The majority of participants agreed that the risk of discovery is the most significant risk. Other risks mentioned include pregnancy, emotional abandonment, and financial costs. Of all the risks mentioned, acquiring a sexually transmitted infection or HIV was given the lowest priority.

Discovery of Relationships

The discussion-group participants spoke about women's preoccupation with being discovered in cross-generational relationships. They explained that even though some peer groups encourage such relationships, many people, especially wives, parents, and same-aged boy-friends usually disapprove of them. Young women often lie about their outings and the source of pocket money and gifts. Couples in such relationships generally have sex in discreet locations, such as hotels and guesthouses, or in cars and "green lodges" (bushes). Some reported that young women sometimes skip school to meet their partners, and a few said that young women tell their parents that they are attending funerals when they have, in fact, arranged to meet older partners.

When a wife becomes jealous of her husband's emotional involvement with a young partner or feels threatened by the family's lowered financial resources when her husband gives money to his partner, she may become violent toward the young woman. Several female participants told stories of wives' stalking, threatening, and attacking their husbands' young partners. Such attacks may involve beatings, knifings, poisonings, or scalding with hot water.

Some [wives] can beat you up. You meet somewhere and she tells you, "You're the one who

stole my husband. Today I've got you." So you start fighting on the streets. (Female, Nairobi, aged 15-19)

Young women also fear violence from boyfriends and disapproving parents as well as emotional abandonment if their relationships with older men are discovered. Female participants said that both partners in such relationships may become victims of attack from these individuals. Young women may jeopardize relationships with their family members who disapprove of older partners. When their boyfriends find out about their older partners, the boyfriends usually terminate their relationships with the young women.

Men are most fearful of their wives' discovering their affairs. Wives may leave and take the children, dissolving the family unit. When asked how a man might mitigate risks associated with the discovery of a cross-generational relationship, many male participants recommended that he end the affair and return to his family responsibilities. Others suggested that the man pay more attention to his family while better hiding his extramarital relationships. A couple of participants said that a man can threaten his wife with the possibility of taking a younger partner as a second wife if his wife makes his having an extramarital relationship too difficult.

When the wife discovers [an affair], the man silences her by issuing threats, such as telling the wife that he's taking the [young] lady as a co-wife. (Male accountant, Meru, aged 34)

Pregnancy

The majority of female participants spoke about the risk of pregnancy associated with cross-generational relationships. They noted that when young unmarried women become pregnant in Kenya, they can be expelled from school and kicked out of their parents' homes, and they may jeopardize their marital prospects with same-aged partners. Some female participants believed that, despite young women's hopes for financial support from older partners, many men deny their responsibility for extramarital pregnancies. Many male participants agreed and said that the burden of pregnancy rests primarily on women because men usually have children with their wives and are unwilling to support their children born of other relationships.

Several discussion-group participants thought that men who acknowledge responsibility for such pregnancies commonly pay for abortions. Some male participants agreed, but noted that paying for an abortion is the extent of many men's assistance. The women participants pointed out that when young women are left to resolve pregnancies alone, they may undergo unsafe abortions

or become suicidal rather than face their families and communities.

When a girl becomes pregnant and the man denies responsibility, she's left wondering what to do . . . so she decides it's better to have an abortion. That's why some girls die in the process of getting an abortion. (Female, Nairobi, aged 15-19)

Some female participants described methods young women use to mitigate the risk of pregnancy, including oral contraceptives and Norplant®. Others mentioned that some women avoid sex with older partners during their fertile periods; the number of young women who understand the correct method for determining the days when they are most likely to conceive is unclear, however. Several male participants reported that some men try to avoid the risk of pregnancy by seeking moderately educated women who understand contraceptive methods. These men believe that educated women are less likely than uneducated women to entrap men with unexpected pregnancies.

Abandonment

Female participants described young women's fear of being abandoned by older partners. They explained that women sometimes grow emotionally or financially dependent upon older partners and suffer severe hardship when such relationships end. Several participants were scornful about men's emotional commitment to cross-generational relationships, however, and said that older men "dump" their young partners once their own sexual needs are satisfied.

In some instances, young women adopt a strategy of multipartnering with older partners and same-aged boyfriends. Discussion-group participants explained that such young women maintain relationships with boyfriends in case older partners abandon them.

You think you're the only one who loves this [older] man, but you forget that he can give presents and a good time to someone else. So, even if you have an old boyfriend, you must have a young boyfriend, too. (Female, Meru, aged 13-19)

Financial Constraints

Many men spoke in their interviews of the monetary costs associated with cross-generational relationships. Some explained that young partners may demand more money than their partners initially expected, causing men to finance such extra expenditures by cutting their household budgets. Such measures affect the amount of money available for their children's education, health care, and food, and for household goods.

Relationships are expensive. They take away from the man's family, making the spouse suffer. (Male primary-school teacher, Kisumu, aged 30)

Some male participants also reported that having insufficient funds to support both their young partners and their families can be humiliating, resulting in heavy social pressure for them to demonstrate their ability to provide for multiple partners. Moreover, this sort of financial stress may aggravate a man's relationship with his wife and increase the likelihood of divorce or separation.

STIs and HIV

Most of the study participants believed that couples give little consideration to their risk of acquiring STIs/HIV. Young women and older men perceive their partners in cross-generational relationships to be at low risk for transmitting infection. Young women believe older men to be less risky than their own age-mates because such men are married and do not "move around" (have multiple sexual partners) often. Few young women make the connection between the increased risk of contracting STIs/HIV and their older partners' infidelity. Some female participants also noted that many young women do not understand their older partners' sexual histories and inaccurately assess the risk that accompanies such relationships.

Several male participants stated that despite knowing about STIs and HIV, some men believe that young women pose less risk for infection than do older women. Men sometimes argue that young women are a low-risk group because they are "innocent," sexually inexperienced, or have had few sexual partners.

They believe they're the first person to have sexual activities with these ladies. . . . [They believe] they're very tender [sexually inexperienced], and that they can't transmit diseases. (Male matatu tout, Nairobi, aged 35)

Other factors, including emotions, finances, and sexual desire, can obscure partners' perception of risk of acquiring STIs/HIV. According to female participants, young women's emotional attachment to older partners can interfere with this perception. Also, women may rank other needs above the risk of STIs and HIV infection, for example, their financial need or their desire to be accepted among their peers. For men, an additional obstacle to perceiving personal risk for STIs/HIV is denial. Some male participants said that men are so anxious to have sex with young partners that they deny or do not consider their risk of infection.

Fatalism is another factor impeding couples' perception of risk. Several female participants stated that some

young women deny that they are at risk for infection or they maintain a fatalistic attitude, arguing that there is nothing they can do to prevent infection with STIs/HIV. Likewise, many male participants thought that some men resign themselves to becoming infected, believing that they have already led a full life and it is natural to die when you are older, even if you die from AIDS.

There are men who've made it in life. They've made a shilling, and what they want is to spend [their money] and relieve some stress. . . . So even if they die now, it doesn't matter because they've had the better part of their lives. (Male journalist, Nairobi, aged 40)

Condom Use

Most of the study participants agreed that condom use remains low in cross-generational relationships. They attributed low levels of use to couples' misperception that cross-generational partners are at low risk for STIs and HIV infection. Some participants noted that even if a couple uses condoms at the beginning of their relationship, they often abandoned use after a time, usually after a few sexual encounters.

Several participants of both sexes explained that even if young women recognize the risk of infection while participating in cross-generational relationships, they are often unable to negotiate condom use with their older partners because men are reluctant to wear condoms, dislike them, and believe that they reduce sexual pleasure. Men often employ their dominant position in relationships by refusing to use condoms, sometimes accusing younger partners of not trusting them. A man may threaten to break off the relationship if his partner insists on using a condom. Rather than lose the financial and social rewards they depend on in such relationships, most women acquiesce and forgo use.

The man sometimes doesn't want to use condoms. . . . and if you don't want him to send you away, you go without a condom. (Female, Mombasa, aged 15-19)

Conclusions

The participants in this study reported that young women's primary incentive for becoming sexually involved with older partners is financial and material gain, whereas men commonly seek younger partners for sexual gratification. Similar to the findings reported by Luke (2002), this research shows that Kenyan men who pursue younger women do not fit a sugar-daddy stereotype; rather, they

come from a variety of social and professional backgrounds. It also demonstrates that young women do not perceive themselves as victims of older men but actively seek older partners who can provide them with luxuries and financial support. Although some peer groups encourage cross-generational relationships, couples go to great lengths to ensure that wives, same-aged boyfriends, and disapproving parents do not discover their involvements.

As other studies have done, this research identified as emotional motivations for young women's participation in cross-generational relationships the desire to find a surrogate parent, a mature partner, a supportive mentor, and emotional fulfillment (Meekers and Calvès 1997). It revealed, however, that men, too, have emotional motivations for pursuing younger partners, such as regaining a sense of their youth, escaping household pressures, and relieving stress. Increased status among peers is also a powerful social reward for participating in cross-generational relationships, and men make use of the existing cultural tolerance to justify their pursuit of young women.

Cross-generational couples are preoccupied with generalized risks such as fear of discovery, of pregnancy, of emotional abandonment, and of economic hardship rather than of their personal risk of acquiring STIs and HIV. In general, young women perceive older men to be low-risk partners because they believe older men are not promiscuous and remain faithful to younger partners and wives. Men believe that young partners are at low risk of having STIs/HIV because they lack sexual experience and have had few sexual partners. Even when young women acknowledge the risk older partners pose for transmitting STIs/HIV, they have difficulty negotiating condom use, especially when partners assert their dominant position in such relationships and refuse to use condoms. Older men cite such reasons for resisting condom use as decreased pleasure and a general dislike for the method. When young women maintain multiple relationships with older partners and boyfriends of their same age, young men's risk for infection is increased.

The findings from this study suggest several opportunities for interventions targeting young women and older men in sexual relationships. Additional research on multipartnering and methods for improving couples' risk perception for STIs/HIV could provide information necessary for program design. Immediate programmatic options include disseminating basic messages about the increased risk of STIs/HIV associated with cross-generational relationships. Campaigns should be mounted to encourage condom use and safer sexual practices within cross-generational relationships and to teach young women skills for negotiating condom use with all types of part-

ners. Programs could also use positive role models to encourage young women to seek safer alternatives to cross-generational relationships, to discuss problems among peers, and to increase young women's sense of self-worth (PSU/Kenya 2000). Role models for men could discourage them from pursuing younger partners and enticing them with money and gifts for sexual relationships. Role models could also suggest more appropriate methods for earning social rewards among peers than cultivating relationships with young partners. Potential long-term interventions could include improving young women's access to educational and career opportunities and offering them sources of income independent of men. Programs should also work with communities to determine the best approach for changing social norms and decreasing the acceptability of cross-generational relationships.

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April 20, 2005

Honorable Henry J. Hyde
Chairman
Committee on International Relations
United States House of Representatives
2170 Rayburn House Office Building
Washington, DC 20510

Dear Chairman Hyde:

At last week's hearing, *U.S. Response to the Global AIDS Crisis: A Two-Year Response*, several inaccurate assertions about Family Health International (FHI) were made, possibly based on erroneous or partial information from secondary sources. As Chief Executive Officer and head of FHI, a public health organization based in North Carolina with a proven track record of combating HIV/AIDS in developing countries, I would like to clarify those inaccuracies and respectfully request that this letter and its attachments be included in the hearing record.

Let me first commend the statements both you and Representative Tom Lantos made about gaps in HIV/AIDS services in developing countries. The need for increased capacity on the part of local indigenous and faith-based organizations is evident. As a nonpartisan, nonprofit NGO partnering to combat AIDS under four different Administrations, beginning with President Reagan's in the early-1980s, FHI has been instrumental in bringing literally hundreds of indigenous and faith-based organizations into the fight. As a leader in this effort, we have indeed received significant U.S. government funding; but committee members should know that about 40% of those funds are expended through subcontracts with local indigenous groups, many of them faith-based, as enclosed attachments indicate. The work we do would be impossible without the involvement of our local implementing partners. We strive to maximize their contribution by handling much of the technical and accounting work, while strengthening their capacity for local program implementation. Additionally, approximately 75% of our staff in developing countries is indigenous, assuring that U.S. foreign assistance funding builds in-country expertise for the long haul, while helping to expand local economies through the battle against AIDS.

We agree with you that combating the HIV/AIDS pandemic requires a comprehensive strategy and we have witnessed progress as we have implemented the ABC approach in more than seventy countries in the developing world. We see A and B as the cornerstone of our prevention strategy, with C being recommended in populations where A and B alone are not adequate. At the same time, there is no doubt that sexual violence and gender inequity disrupt and frustrate the



effectiveness of ABC and need to be addressed. Sexual violence brings vows of abstinence to naught and gender inequity means that marriage itself cannot be considered a perfect protection against the virus. We often suggest that a truly comprehensive approach should include ABC...to Z and most definitely agree that increased protection for those most vulnerable to sexual violence should be included.

As Representative Lantos made clear, those infected by HIV/AIDS in the developing world need access to more treatment medicines, which are often beyond their financial means. More generic medications would certainly help. But as both of you noted, the collapsing health care systems in the poorest nations where AIDS is most rampant makes the point moot if we are unable to deliver and administer the medications as they arrive. With offices in nearly 40 countries in the developing world, FHI looks forward to being an increasingly effective part of the solution.

Now if I may correct the inaccuracies raised at the hearing:

Contrary to remarks made by a committee member, I am the Chief Executive Officer and Vice Chair of Family Health International. Dr. Willard Cates is a valued member of FHI's leadership team and a internationally acclaimed public health researcher in the areas of reproductive and family health and HIV/AIDS. He is president of FHI's Institute for Family Health and as such leads FHI's extensive, multidisciplinary research portfolio. But Dr. Cates is not, nor has he been the head of FHI as was asserted by the committee member. Nor is he responsible for providing HIV/AIDS intervention services which are the domain of FHI's Institute for HIV/AIDS under the leadership of Dr. Peter Lamptey, President. Furthermore, the article cited by the committee member, prepared nearly 30 years ago in 1976, was developed by Dr. Cates early in his career, while working for the Federal Government in the Bureau of Epidemiology of the Center for Disease Control (CDC) in what at that time was the Department of Health, Education and Welfare (HEW). The article was a report on research he conducted governed by CDC; he was not in any way representing the views of FHI.

As to the committee member's second point about a definition of abstinence we presumably use in working with young people, I am somewhat at a loss. While we actively promote A, B, and C programs and messages, to my knowledge we have not devised our own definition of abstinence but rather depend on Federal guidance. The only item I could find in our material that might be the source of the misinformation is on a web page on our site, titled Reproductive Health for Young Adults, Section 2 How to Reach Young Adults." It is not aimed specifically at preventing HIV/AIDS and it does not refer to any definition of abstinence but it does provide a list of ways young adults might express sexuality as alternatives to unprotected intercourse. It is similar to and in the same order as items referred to by the committee member. It also includes holding hands and hugging but does not include oral sex, as the member seemed to imply. I would emphasize that it is clearly not aimed at adolescents.

This list for young adults should also be seen in context. Sentences immediately following the list read:



“Unmarried young people need to know that they should not be in a hurry to begin sexual activity – that intercourse is just one of many ways of expressing love, affection and acceptance. They need to decide for themselves when to begin, and not be talked into having sexual intercourse before they are ready. They also need to know alternatives to high-risk sexual behaviors. Abstinence from sexual intercourse is the most effective way to prevent pregnancy and STIs.”

Mr. Chairman, thank you again for your leadership and for considering our request to have this letter and its attachments included in the hearing record. We look forward to a continuing partnership with the President and Congress in putting the spirit of the President’s Emergency Plan into action on behalf of those most vulnerable to HIV/AIDS pandemic.

Sincerely,

Albert J. Siemens, PhD
Chief Executive Officer and Vice Chairman

Attachments