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THE DOMESTIC EPIDEMIC IS WORSE THAN WE THOUGHT: A WAKE-UP CALL FOR HIV PREVENTION

Tuesday, September 16, 2008

House of Representatives,

Committee on Oversight and Government Reform,

Washington, D.C.

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Committee Hearings

of the

U.S. HOUSE OF REPRESENTATIVES

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4 THOUGHT: A WAKE-UP CALL FOR HIV PREVENTION

5 Tuesday, September 16, 2008

6 House of Representatives,

7 Committee on Oversight and

8 Government Reform,

9 Washington, D.C.

10 The committee met, pursuant to call, at 10:08 a.m., in

11 Room 2154, Rayburn House Office Building, Hon. Henry A.

12 Waxman [chairman of the committee] presiding.

13 Present: Representatives Waxman, Kucinich, Tierney,

14 Watson, McCollum, Sarbanes, Speier, Davis of Virginia, Shays

15 and Turner.

16 Also Present: Representative Waters.

17 Staff Present: Caren Auchman, Press Assistant; Jen

18 Berenholz, Deputy Clerk; Zhongrui "JR" Deng, Chief

19 Information Officer; Miriam Edelman, Special Assistant;

20 Earley Green, Chief Clerk; Ella Hoffman, Press Assistant;

21 Karen Lightfoot, Communications Director and Senior Policy
22 Advisor; Karen Nelson, Health Policy Director; Leneal Scott,
23 Information Systems Manager; Naomi Seiler, Counsel; Mitch
24 Smiley, Special Assistant; Tim Westmoreland, Counsel:
25 Lawrence Halloran, Minority Staff Director; Jennifer
26 Safavian, Minority Chief Counsel for Oversight and
27 Investigations; Ellen Brown, Minority Legislative Director
28 and Senior Policy Counsel; Jill Schmalz, Minority Counsel;
29 Molly Boyl, Minority Professional Staff Member; Adam Fromm,
30 Minority Professional Staff Member; and Brian McNicoll,
31 Minority Communications Director.

32 Chairman WAXMAN. The committee will come to order.
33 We are here today to discuss some alarming developments
34 in the fight against HIV and AIDS in the United States.
35 The Centers for Disease Control and Prevention recently
36 announced that the HIV epidemic in the United States is
37 growing at a rate far greater than was previously thought.
38 The new figures are a stark reminder that the HIV epidemic is
39 far from over, and that we must take new and urgent steps to
40 strengthen our national HIV prevention efforts.
41 The first cases of what later came to be identified as
42 AIDS were reported in Los Angeles in 1981. Over the next 2
43 years, the case reports accumulated, and we learned that a
44 distinct syndrome was being diagnosed in different
45 populations all across the country. By the mid-1980s, there
46 were an estimated 130,000 new infections every year in the
47 United States.
48 As infections increased, so did our investment in HIV
49 prevention efforts. Even before the virus called HIV was
50 identified as the cause of AIDS, CDC experts had figured out
51 the transmission routes and issued early recommendations for
52 the prevention of infection. The Federal Government started
53 investing significant amounts of funding in prevention and
54 education efforts nationwide.
55 These investments paid off, and the infection rate
56 dropped dramatically, but this is a job that is never done.

57 This was recently demonstrated in dramatic fashion when CDC
58 reported that the real infection rate is much higher than we
59 thought. Over the past 10 years, CDC's official estimate for
60 annual new infections have been about 40,000, but last month
61 CDC announced that, in fact, there were over 56,000 new HIV
62 infections in 2006. The higher figure was due to improved
63 counting methods, not to an actual jump in infections, but it
64 tells us that the epidemic in the United States is and has
65 been growing faster than we had thought.

66 The message these new findings send is clear: We are
67 not doing enough to limit the spread of this deadly disease.

68 What is more, we are still seeing severe disparities in
69 HIV's impact on different populations. Men who have sex with
70 men constitute 57 percent of new infections. Blacks, who
71 make up about 12 percent of the total population, account for
72 45 percent of new HIV infections. Hispanics are also
73 disproportionately affected.

74 Part of the problem is that the Federal Government has
75 not been doing enough for HIV prevention in the United
76 States. In adjusted dollars, the CDC's HIV prevention budget
77 has dropped more than 20 percent since 2002. This year the
78 administration actually asked for a $1 million decrease in
79 HIV funds. This didn't make sense to me, so I asked the
80 Centers for Disease Control to prepare a budget that reflects
81 not what the White House wanted, but rather the agency's

82 professional scientific judgment of what it would take to
83 fully implement effective HIV prevention in the United
84 States.
85 As we will hear today, the administration asked for less
86 than half of what CDC's scientific professionals estimate is
87 necessary for effective HIV prevention. Instead of listening
88 to its own experts, the administration requested that
89 Congress fund HIV prevention programs at far lower levels.
90 What is even more senseless is that by underfunding
91 prevention, the Nation will incur greater treatment costs
92 down the road. It is indisputable that evidence-based HIV
93 prevention saves money in addition to saving lives by
94 avoiding the high cost of medical care and lost productivity.
95 But on this issue the administration apparently prefers to
96 be penny wise and pound foolish.
97 We are here today to learn from some of our Nation's top
98 HIV prevention experts what a truly robust national HIV
99 prevention program would look like. We will hear from
100 leaders at CDC and NIH about how they are attempting to roll
101 out effective programs and research potential new ones. We
102 will discuss barriers to evidence-based HIV prevention, like
103 the Federal needle exchange ban and this administration's
104 stubborn and irrational focus on abstinence-only programs.
105 And because HIV infections don't occur in a vacuum, we will
106 hear recommendations from all of our witnesses on how the

107 Federal HIV prevention response should address the societal
108 factors that contribute to risk, including poverty,
109 homelessness, racial and gender inequality, homophobia, and
110 stigma related to HIV status.

111 I look forward to a constructive discussion of these
112 questions today, but one point should be clear from the
113 outset: The status quo simply isn't acceptable. We
114 undermine public health, and betray some of America's most
115 vulnerable citizens, and allow the further spread of a deadly
116 and still incurable disease by failing to invest in proven
117 prevention methods. We aren't doing everything we can and
118 should, and I hope this hearing will be the first step in
119 returning the necessary spotlight, resources, and political
120 will to HIV prevention efforts in the United States.

121 [Prepared statement of Chairman Waxman follows:]

122 ******** INSERT 1-1 ********

123 Chairman WAXMAN. Before recognizing our very
124 distinguished panel of witnesses, I want to recognize the
125 gentleman from Ohio Mr. Turner for an opening statement.
126 Mr. TURNER. Thank you, Mr. Chairman. Thank you for
127 holding this hearing to examine new data on the incidence of
128 HIV infection on the United States. We appreciate your
129 longstanding dedication to public health issues and your
130 abiding commitment to meet the many challenges posed by the
131 AIDS epidemic.
132 Using a more sensitive surveillance tool, the Centers
133 for Disease Control found 56,300 new HIV infections in 2006.
134 That is a 40 percent higher incidence than previous
135 estimates. The upward adjustment does not reflect an
136 acceleration of the epidemic, but a more precise capability
137 to establish between recent and longer-term infections. So
138 it still appears the epidemic has, in fact, plateaued in
139 terms of new infections per year over the last decade, but at
140 a markedly higher rate than we thought.
141 With this new knowledge about the path and the scope of
142 the epidemic, public health officials can better target
143 efforts to prevent the spread of the virus that causes AIDS.
144 How to bring those prevention tools to at-risk groups has
145 always been a challenge at every level. This more accurate
146 data should inject a renewed sense of urgency into the
147 Federal, State, local, and private-sector partnerships

148 working to stop the spread of HIV. But behind the figures
149 lurks one deadly fact: No prevention strategy works on a
150 person who doesn't know he or she is infected.
151 At any given time, it is estimated fully 25 percent of
152 Americans carrying HIV have not been diagnosed. They are far
153 more likely to engage in high-risk behaviors that expose
154 still others to the silent infection. Breaking that silence,
155 research has proven, the power of information is a barrier
156 against the virus.
157 Once diagnosed and properly counseled, HIV-infected
158 individuals are significantly less likely to engage in
159 behaviors that put others at risk. That leaves public health
160 officials to confront the hard questions: Who should be
161 offered testing? How often? And who pays for any broader
162 HIV screening that might detect latent or unknown infections?
163 HIV/AIDS is not curable, but it is treatable. With the
164 tools at our disposal, we need not consign thousands of our
165 fellow citizens each year to the devastation of preventable
166 HIV infection.
167 Since its outbreak, the United States has played a
168 leading role in research and treatment of HIV and AIDS. One
169 of the witnesses today, Anthony Fauci, is a recognized leader
170 in unlocking the lethal mechanisms by which the virus attacks
171 the immune system.
172 This is an important hearing about the implications of

173 this new CDC data for public health officials and public
174 policymakers. Mr. Chairman, I appreciate your attention to
175 this issue.
176 Chairman WAXMAN. Thank you very much, Mr. Turner.
177 [The information follows:]

178 ******** COMMITTEE INSERT ********

179 Chairman WAXMAN. For our first panel, we are pleased to
180 have Dr. Julie Gerberding, who has been the Director of the
181 Centers for Disease Control and Prevention since 2002. In
182 this role she has led the CDC in its mission of health
183 promotion and disease prevention in the U.S. and abroad.
184 Dr. Gerberding has contributed to more numerous
185 peer-reviewed publications and textbook chapters, and to
186 guidelines and policies on a range of health issues,
187 including HIV prevention. She has served on Federal and
188 non-Federal advisory councils, including the CDC's HIV
189 Advisory Committee, and teaches infectious disease medicine
190 at both Emory University and the University of California at
191 San Francisco.
192 We want to welcome you back to the committee, Dr.
193 Gerberding, and we are pleased that you are here, coming
194 right from Texas where you have been trying to deal with the
195 tragic consequences of the hurricane.
196 Dr. Gerberding is accompanied by Dr. Kevin Fenton, who,
197 since 2005, has served as the Director of CDC's National
198 Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention.
199 He leads the U.S. Government's HIV surveillance and
200 prevention efforts, interacting with State and local
201 agencies, community organizations and researchers nationwide.
202 Dr. Fenton has worked in HIV research, epidemiology and
203 prevention since 1995, including as Director of HIV and

204 Sexually Transmitted Infections Department at the United
205 Kingdom's Health Protection Agency.
206 Dr. Anthony S. Fauci has served as the Director of the
207 National Institute of Allergy and Infectious Diseases at the
208 National Institutes of Health since 1984. He oversees a
209 broad range of research on the prevention, diagnosis, and
210 treatment of infectious diseases, including HIV/AIDS. He
211 continues to conduct his own research on immune, mediated and
212 infectious disease, and has contributed to over 1,000
213 scientific publications.
214 Dr. Fauci served as one of the key advisors to the White
215 House and the Department of Health and Human Services on AIDS
216 issues, and is a member of The National Academy of Sciences,
217 the American Academy of Arts and Sciences Institute of
218 Medicine; and Dr. Fauci has testified on numerous occasions
219 before this committee and other committees that I even
220 chaired in the Congress since the early 1980s.
221 And we are happy to have you here as well.
222 Dr. Fauci is accompanied by Dr. Thomas Insel, the
223 Director of the National Institute for Mental Health at NIH.
224 In that role Dr. Insel oversees the agency's research on
225 behavioral prevention methods for HIV.
226 We are pleased that all of you are here today. It is
227 the practice of this committee that all witnesses who testify
228 before us do so under oath. So if you would please rise and

229 raise your right hand.

230 [witnesses sworn.]

231 Chairman WAXMAN. Your prepared statements will be in
232 the record in full. We would like to ask each of you to make
233 your oral presentation in around 5 minutes. We will have a
234 clock that will allow you to see when the 5 minutes is up.
235 It will be green for 4 minutes, yellow for 1 minute, red when
236 the 5 minutes has passed. And we won't be strict on it, but
237 we would like that to be a guide, so that when you see the
238 red light, since we have many witnesses yet to come, we would
239 like to ask you to try to reach your conclusion so that we
240 can ask questions and hear from the other witnesses as well.

241 Dr. Gerberding, we are pleased to have you.

242 STATEMENTS OF JULIE GERBERDING, DIRECTOR, CENTERS FOR DISEASE
243 CONTROL AND PREVENTION, ACCOMPANIED BY KEVIN FENTON,
244 DIRECTOR, NATIONAL CENTER FOR HIV/AIDS, VIRAL HEPATITIS, STD
245 AND TB PREVENTION, CENTERS FOR DISEASE CONTROL AND
246 PREVENTION; AND ANTHONY S. FAUCI, DIRECTOR, NATIONAL
247 INSTITUTE OF ALLERGY AND INFECTIOUS DISEASE, NATIONAL
248 INSTITUTES OF HEALTH, ACCOMPANIED BY THOMAS INSEL, DIRECTOR,
249 NATIONAL INSTITUTE FOR MENTAL HEALTH, NATIONAL INSTITUTES OF
250 HEALTH

251 STATEMENT OF JULIE GERBERDING

252 Dr. GERBERDING. Thank you very much.
253 I would like to start with my first slide, which is a
254 reflection on Ike striking in Galveston. I did visit the
255 hurricane territory yesterday, and for the record I would
256 like to acknowledge the tremendous effort of State health
257 commissioner Dr. Lehi and the whole pantheon of experts in
258 public health across the State that are performing miracles.
259 I think we all recognize that hurricanes represent
260 urgent public health threats, and when people recognize an
261 urgent threat, they hold nothing back in responding to it.
262 Unfortunately, on the next slide we have another urgency, and

263 that is the urgent reality of HIV/AIDS in America. Last
264 month I spent 2 weeks at San Francisco General Hospital
265 taking care of patients, and on my service I had two
266 undiagnosed AIDS patients die; I had several individuals come
267 in with the opportunistic infections that we started seeing
268 in 1981 when I was an intern. And in that community, we
269 learned that there is an epicenter of HIV transmission among
270 men who have sex with men, and particularly among African
271 Americans.

272 Similarly, I visited Oakland earlier this year, and
273 found to my astonishment--and found an even grimmer situation
274 in terms of HIV transmission in that community.

275 On my next graphic I tried to represent the progress
276 that we have made despite these current situations. And we
277 are currently proposing federally a $24.1 billion HIV budget
278 for all AIDS-related activities at the Federal level. Of
279 that, 4 percent is reflected in CDC's prevention budget. And
280 I think over time we have had some good news. We are
281 definitely seeing people live longer with HIV, and many are
282 thriving despite the complications of the drug treatment and
283 everything else that having a chronic illness represents.

284 In addition, we have made tremendous progress in
285 perinatal AIDS, in reducing the incidence among injection
286 drug users and among heterosexuals at high risk.

287 We have also seen the rate of transmission decline over

288 time. That means for every 100 HIV-infected individuals, the
289 number of new people that they infect has continued to drop
290 precipitously since the early phases of the epidemic.
291 And, finally, I think studies do show that prevention
292 interventions can work. We have evidence of efficacy in at
293 least 49 behavioral interventions, and several others are on
294 the docket for coming forward.
295 Let me just quickly show you the pictures of what these
296 statistics look like. The red line here is the number of
297 people in America living with HIV, and the blue line are the
298 number of new cases that were reported that precipitated this
299 hearing. And you can see that although the number of people
300 with HIV in our country continues to increase, the number of
301 new infections is holding steady over the past several years
302 and declining as the large picture in the United States;
303 meaning that our interventions are successful, or we would
304 see that blue line go up commensurate with the red line.
305 On the next graphic, you can see the picture of
306 perinatal transmission, again, evidence that prevention can
307 work.
308 On the next graphic, the picture of what is happening
309 recently among people at high-risk heterosexual contact. And
310 I could repeat that for injection drug users and others.
311 But on the next graphic we have the sobering statistic
312 that is my frame for the urgent reality that we are facing,

313 and this is the incidence rates going up among men who have
314 sex with men in the United States.
315 On the next graphic I show some statistics that were
316 released last week which really reflect a detailed
317 understanding of the epidemiology of this risk, showing that
318 while overall the majority of men who have sex with men and
319 get HIV infection are white, there is disproportionate
320 representation of African Americans, and particularly young
321 African Americans and Hispanics. They are represented here
322 way out of proportion to their prevalence in society.
323 And on the next graphic we have the rates of HIV
324 infection which use as the denominator the number of people
325 in our society in those categories. So you can see that
326 African Americans have an infection rates that is about seven
327 times that of whites, and Hispanics have a rate that is about
328 three times that of whites across America.
329 So this is very serious information, and it tells us
330 where we need to target our prevention interventions.
331 So let me conclude by telling you what I think are the
332 priorities for those prevention interventions. We have
333 submitted a long professional judgment. We have tried to put
334 everything in there we could think of. We understand the
335 reality of the budget, but we wanted you to know what the
336 universe of possibility might be. So on the first slide, I
337 am trying to summarize some of those interventions that

338 relate to finding the leading edge of the epidemic.

339 The information we just published is the first time we
340 have ever been able to say in real terms, where is the
341 infection now, and how bad is it going, and who is getting
342 it? So we need to expand our ability to do that so that we
343 have that information at the community level and can target
344 those interventions that do work for those individuals.

345 We also need to integrate services. It is great that we
346 have representatives from mental health, substance abuse, and
347 a broad continuum, because there is a syndemic of these
348 factors that come together in the concept of social justice
349 and in social determinants of health that we have to address
350 if we are going to be successful here. And we need to
351 conduct not just individual interventions, but social
352 marketing campaigns.

353 On the next graphic I am emphasizing the importance of
354 finding the people who are infected. This is Epidemiology
355 101, but it is something that we still haven't been able to
356 do successfully in this disease. Twenty-five percent of
357 infected people still don't know they have the virus. So we
358 need to expand access to rapid testing. And, in particular,
359 our Federal facilities need to move to support the CDC
360 guidelines and allow screening for HIV, using the protocols
361 that we have recommended for the routine screening. We also
362 need to have better tests, and we need to focus those tests

363 on finding people early, hopefully as they are
364 seroconverting, because that is the time when they pose the
365 biggest transmission risk, and we are missing them, and they
366 are highly infectious, and they account for a
367 disproportionate part of the epidemic.
368 Now, my last graphic, I mentioned those aspects that
369 relate to the need for new tools. We don't have all the
370 answers here. I wish we did. We have been working on it,
371 but our research budget hasn't really allowed us to update
372 and modernize our toolkit.
373 One area in particular, given the difficulties we are
374 having with the vaccine, are the preexposure treatment trials
375 to determine whether or not taking HIV drugs before you are
376 exposed could result in an overall health benefit and a
377 reduced risk of infection. CDC is conducting three of those
378 studies and are collaborating on a fourth, and I know NIH is
379 doing one, too, as well. So we are hoping that that could
380 put a new biomedical toolkit or two in our toolbox while we
381 are working on some of these other measures that we think are
382 important.
383 I just want to make one final point here. AIDS is a
384 social disease as much as it is a viral disease, and part of
385 bringing people to accept prevention is to create that
386 expectation in an environment of hope. Many of the people
387 who are getting this infection now are functioning in a

388 society that offers them very little hope for education,
389 economic, or social attainment, and if we don't address the
390 underpinnings of the problem, we are never going to be able
391 to get where we need to be as a Nation.

392 So thank you for allowing me to explode with a lot of
393 information in a very short period of time. But we are very,
394 very passionate about this and very committed to this issue.

395 Chairman WAXMAN. Thank you. It is very helpful
396 information.

397 [Prepared statement of Dr. Gerberding follows:]

398 ******** INSERT 1-2 ********

399 Chairman WAXMAN. Dr. Fenton, you are just hear to
400 answer questions?
401 Dr. FENTON. That is right.
402 Chairman WAXMAN. Well, we will have questions for you.
403 Dr. Fauci.

404 STATEMENT OF ANTHONY S. FAUCI

405 Dr. FAUCI. Thank you, Mr. Chairman and members of the
406 committee. Thank you for giving me the opportunity to
407 testify before you here today on the role of the NIH research
408 endeavor in HIV prevention, the subject of this hearing. I
409 guess the slides don't work, so we will go with the--are they
410 up? Okay. There they are.

411 Okay. On the first slide shown on the board there, I
412 want to just emphasize that since the very early days of HIV
413 that you described in your opening statement, in the summer
414 of 1981, there have been some spectacular advances in AIDS
415 research ranging from the initial discovery of the virus to
416 the delineation of the pathogenesis, natural history, but,
417 importantly, treatment.

418 Now, treatment has been one of the more spectacular
419 successes in the development of now over 25 drugs that have
420 transformed the lives of HIV-infected individuals. The
421 results of this have been quite impressive.

422 On the next slide is a review paper showing the results
423 of the first decade of HIV written up in the Journal of
424 Infectious Diseases that there is a conservative estimate of
425 about 3 million lives--years of life have been saved in the
426 United States alone from 1996 through 2005 on the basis of

427 the accessibility of treatment, particularly the combinations
428 of therapies. This has been repeated and verified in Europe,
429 Australia, and Canada.
430 Now, that is the very good news. But the subject of the
431 hearing is what is still going on? So on the next slide,
432 just to reiterate what Dr. Gerberding had said, we still have
433 a major ongoing problem globally and even here in the United
434 States with over one-half million deaths, 1.1 million people
435 infected with HIV, and, as underscored by Dr. Gerberding, 25
436 percent of them are unaware that they are infected. And we
437 know the majority of infections come from an individual who
438 does not know that he or she is infected, transmitted to
439 another individual.
440 And an example is something that is very close to home.
441 We make rounds three times a week at our clinic, up at the
442 clinical center at the NIH, and just last week a patient was
443 presented to me, a resident of the District of Columbia, 38
444 years old, who presented for the first time with advanced
445 tuberculosis, central nervous system lymphoma, and CB4 count
446 of 3, which is about as low as you can get in a viral load.
447 That person clearly was infected for many years, has now
448 compromised his own ability to be treated because he is so
449 advanced, and who knows how many people that that person
450 exposed, mainly because he did not know that he was infected.
451 Now, on the next slide, what about prevention? The NIH

452 and its multiple institutes, particularly our institute,
453 NIAID, NIMH, NIDA, Child Health, and others, have been
454 heavily involved in prevention research. And when I say
455 prevention research, it's to try and get some of the
456 scientific facts that would help inform some of the
457 activities that are implemented so well by the CDC.
458 On this slide we show that if you include vaccine,
459 behavioral change, and microbicides, about 38 percent of the
460 NIH budget is devoted to prevention activities. And I just
461 want to spend a minute to underscore some of the proven
462 strategies as well as those that are still investigational
463 and for which we have remaining challenges on the next slide.
464 Proven HIV prevention strategies again underscores what
465 Dr. Gerberding mentioned, that prevention does work when it
466 is applied and implemented. For example, preventing sexually
467 transmitted disease, cognitive behavior interventions when
468 applied have been shown to work. Behavioral changes
469 regarding sexual transmission are paramount in its
470 prevention. Condom promotion. In a study, a group of
471 studies that were sponsored by the NIH just a year and a half
472 ago on adult male circumcision in an international basis,
473 predominantly in sub-Saharan Africa, showed anywhere from a
474 55 to 65 percent prevention in males who were circumcised
475 that lasted for 3 to 4 years of follow-up and likely much
476 more.

477 The prevention of blood-borne transmission. Clearly
478 needle exchange programs work. There is no doubt about that.
479 Drug treatment programs, methadone and related programs have
480 been shown in a number of studies by the CDC and by NIDA and
481 NIH to work.

482 And probably the most dramatic success story is the
483 prevention of mother-to-child transmission, by treating the
484 mother during pregnancy and the baby soon after delivery, and
485 most recent studies, weeks to months of breast feeding have
486 been truly a great success story.

487 The next slide.

488 There are also some investigational prevention
489 strategies, some of which are in the process of being proven,
490 others that are still challenging. The first is the
491 prevention and treatment of coinfections, such as
492 tuberculosis, malaria, and other sexually transmitted
493 diseases. Not all STDs, or sexually transmitted diseases,
494 when you treat them result in a decrease in HIV transmission,
495 but some do. And we are now continuing our studies to try
496 and delineate that a little bit more clearly.

497 We have been challenged by topical microbicide studies.
498 The initial studies over the past several years have proven
499 not to be effective. They were the first generation of
500 studies that did not incorporate specific anti-HIV drugs;
501 they were merely chemicals that would block transmission, but

502 not in a specific anti-HIV manner. The products that are
503 currently in the pipeline we are cautiously optimistic about.
504 The last two I want to close on is antiretrovirals as
505 prevention and vaccines. By an antiretroviral as prevention,
506 we mean that if you treat people who are infected, you could
507 theoretically and in reality decrease their ability to
508 transmit to others. You can talk about population studies;
509 if you treat enough people in a population, you will get the
510 mean viral load in the population low enough that you might
511 decrease the incidence; but even more potentially exciting is
512 what we call PrEP, and Dr. Gerberding mentioned that on one
513 of her slides, or preexposure prophylaxis. There is a large
514 study conducted by the CDC, several other studies, some of
515 which are conducted by the NIH, looking at a large number of
516 individuals to see if, in fact, this treatment prior to
517 infection would significantly block transmission.
518 And then there is vaccines, which in the history of
519 viral diseases are generally the Holy Grail of how you stop
520 the transmission of a viral infection. We have not been
521 successful thus far. As shown on this slide, at the last
522 meeting this summer in Mexico City of the International AIDS
523 Society, we discussed some of the remaining challenges and
524 the reality that we will not have an HIV vaccine at least for
525 several years at best. I am cautiously optimistic that we
526 will, but up until the time that we do, we are going to be

527 left with the prevention measures that were discussed by Dr.
528 Gerberding and myself and in your own opening statement, Mr.
529 Chairman.
530 So in the last slide, I want to emphasize that point;
531 that when we talk about prevention, it is not unidimensional,
532 and it is not one-size-fits-all. We refer to it as a
533 comprehensive prevention toolbox, of which a vaccine would be
534 a major contribution. But even if we get a vaccine that is
535 effective, we would still have to rely very heavily on the
536 other prevention measures that have been discussed in our
537 various statements.
538 So I will close here, Mr. Chairman, and be happy to
539 answer any questions.
540 Chairman WAXMAN. Thank you very much, Dr. Fauci.
541 [Prepared statement of Dr. Fauci follows:]

542 ******** INSERT 1-3 ********

543 Chairman WAXMAN. Dr. Insel, do you have a statement?
544 Dr. INSEL. No statement, just to go on to questions.
545 Chairman WAXMAN. Okay. I want to start off the
546 questions for you, Dr. Gerberding. I want to ask about CDC's
547 HIV prevention goals and its budget.
548 In January of 2001, and I understand this was before
549 your tenure as Director, CDC released a document called HIV
550 Prevention Strategic Plan Through 2005. At the time, the
551 working estimate of annual new infections per year in the
552 U.S. was 40,000. The agency called this number relatively
553 stable, but unacceptably high, and stated that a new
554 strategic plan for HIV prevention was essential.
555 In this 2001 document, what was CDC's target for
556 reducing annual new HIV infections?
557 Dr. GERBERDING. I would want to let you know that
558 although I was not the CDC Director during this period of
559 time, I was on an advisory committee before I went to the
560 Center, before I went to CDC, so I participated in the
561 earliest phases of that development. And the expectation
562 optimistically at that time was a 50 percent reduction in the
563 number of new infections, to be able to drive the infection
564 rate down to 20,000. At that time we didn't have a lot of
565 evidence to model or base those figures on, but we believed
566 that if we did everything we knew how to do, we could strive
567 for that. It made sense to create a stretch goal, and

568 obviously we didn't make it.
569 Chairman WAXMAN. Because if we look at 2005, fast
570 forward 5 years later, CDC's estimate of annual new
571 infections at that point was still 40,000 a year, and the
572 figure hasn't budged. Why do you think that nothing changed?
573 Was it--what is your assessment?
574 Dr. GERBERDING. I think it is complicated, but there
575 are two factors that probably play a pretty big role. One is
576 the fact that our earlier estimates were made before we
577 recognized the benefits of drug treatment. And so what
578 happened was we suddenly had a larger and larger and larger
579 number of people in our country with HIV who presented a
580 transmission risk to other people because they were surviving
581 instead of dying from the disease. So it was a positive
582 factor, but it clearly made our earlier estimates fairly
583 irrelevant.
584 The second thing is that I don't think we adequately
585 controlled for the generational effect. So as new young
586 people come into the risk environment, they don't
587 behave--kids are not little adults. They don't behave the
588 way we would expect more mature people who have lived through
589 their friends dying to behave. And so we saw increased
590 infection rates, as we are still seeing today, among the
591 youngest people. So our estimates did not adequately adjust
592 for the generational problem of new cohorts at risk.

593 Chairman WAXMAN. When we look at the CDC budget in
594 2001, there was a steady growth in the prevention part. And
595 by that time, in 2007, CDC's HIV prevention budget actually
596 dropped in adjusted dollars just by 20 percent. So while we
597 didn't see the decrease we had hoped for, we saw, in fact, a
598 steady level, which would be that--a failure of the
599 prevention efforts to succeed.
600 At that point, CDC put a document forward extending its
601 HIV prevention through 2010. And what was the goal in that
602 document, if you can tell us?
603 Dr. GERBERDING. I would have to go back and review that
604 particular estimate.
605 Kevin, maybe you can answer that question.
606 Dr. FENTON. Thank you very much for that question.
607 In the 2007 revision of the HIV prevention strategy,
608 what we were attempting to do is to identify shorter-term
609 goals for HIV prevention as well as looking at goals which
610 were achievable within the resources that we had at CDC. One
611 of the experiences we had from 2001 to 2007, as you
612 mentioned, was the fact that our budget remained relatively
613 flat over that time, so it was crucially important that we
614 looked at what was achievable in the next 3 years. In the
615 meantime--
616 Chairman WAXMAN. And the numbers that you found that
617 you thought was achievable was, rather than 50 percent, down

618 to 10 percent; Is that right?

619 Dr. FENTON. That is correct.

620 Chairman WAXMAN. And was that 10 percent goal modeled
621 on the fact that you saw a decrease in the prevention side of
622 the HIV budget?

623 Dr. FENTON. It was modeled on the realities of the
624 existing prevention budget as well as the availability of
625 better information, better surveillance information, better
626 data on incidence which we knew were forthcoming in the next
627 few years.

628 Chairman WAXMAN. And how much did the administration
629 request for HIV prevention for this next fiscal year, 2009?

630 Dr. GERBERDING. The request in the proposed budget is
631 less than the request from last year by a percent or so. So
632 it is a reduction.

633 Chairman WAXMAN. As I understand, that is $752.6
634 million?

635 Dr. GERBERDING. I believe that is correct.

636 Chairman WAXMAN. Now, according to your professional
637 judgment budget, the funding that CDC needs to conduct
638 appropriately scaled-up domestic HIV prevention programs and
639 research for 2009, I understand, is $1.63 billion; is that
640 right?

641 Dr. GERBERDING. If we were able to walk out the door
642 today and do absolutely everything that we knew how to do to

643 full scale, it would be expensive, and those numbers reflect
644 that kind of best-case scenario. I think we also recognize
645 we couldn't go from where we are to where we would like to be
646 as fast as we probably reflected in our budget estimates, but
647 we wanted to give you the flavor that the scale here is one
648 challenge. The "what to do" is the other challenge.

649 Chairman WAXMAN. Well, and just to look at where we are
650 and where you would like us to be and where do you think the
651 money could wisely be spent, the administration is proposing
652 half of what CDC's experts say is necessary. And, in fact,
653 that is an actual decrease of $1 million from fiscal year
654 2008. So the proportion, it appears to us, for domestic HIV
655 funding for prevention would be around 5 percent.

656 Dr. GERBERDING. I think the figure for the large
657 request for domestic HIV, the $24.1 billion overall that has
658 been requested includes about a 4 percent prevention budget,
659 at least according to the analysis that we have been able to
660 review from Kaiser. So it is a very small piece of the
661 overall budget. And I think the concept of a dime of
662 prevention is worth a dollar of cure is what we need to
663 relook at, especially now that we have these new incidence
664 data. In addition, we know that it is cost-saving to prevent
665 HIV because it is so expensive to treat.

666 Chairman WAXMAN. You are telling us that information.
667 Did you tell the President? Did you tell the Secretary of

668 HHS? Did anyone in the administration ever come and ask you
669 over the last 6 years what you and your expert colleagues
670 believed and what you would need in order to turn the
671 domestic epidemic around?
672 Dr. GERBERDING. We have had a lot of briefings on this
673 subject. And I think one of the challenges that I face at
674 CDC is my own expert judgment, that it isn't going to be
675 enough to just do more of the same. We have got to really
676 step back and say, you know what? If you keep doing the same
677 thing over and over again, it doesn't matter how big you do
678 it, you are not really going to solve the problem.
679 So not only do we need to expand what we know can work,
680 we have got to find new things. And so I really want to
681 emphasize that the research for new tools is also a very,
682 very big part of this. And I am sure that Dr. Fauci would
683 agree with that, that there is more we need to know and not
684 just more that we need to do.
685 Chairman WAXMAN. Well, just to conclude my questioning
686 here, you can't do more of the same with less money, even if
687 some of the same things you were doing were successful.
688 Dr. GERBERDING. Unless you are a magician.
689 Chairman WAXMAN. And if you could get new tools, that
690 would be great. But you may not be able to even do the new
691 tools if your prevention budget is decreasing and the
692 population of people being infected is even more than we

693 expected.

694 Dr. GERBERDING. What I am really also--and what I have
695 asked Dr. Fenton to do is to look at whatever the pie is,
696 whatever the investment that we have, and make absolutely
697 sure that whatever we are doing with it, we are getting the
698 absolute maximum out of it that we can. We may need to
699 rebalance. We would like to have more, but we may need to
700 also rebalance what we are doing to make sure that it is
701 making the biggest difference.

702 Chairman WAXMAN. Thank you very much.

703 Mr. Davis.

704 Mr. DAVIS OF VIRGINIA. Of course, Congress appropriates
705 the money, not the administration. So this Congress has the
706 authority to move those numbers up or down appropriately,
707 don't they?

708 Dr. GERBERDING. That is correct.

709 Mr. DAVIS OF VIRGINIA. Okay. And are we spending more
710 internationally on AIDS prevention and treatment than we are
711 nationally now?

712 Dr. GERBERDING. We are spending more internationally
713 for the President's emergency program as well as the global
714 fund.

715 Mr. DAVIS OF VIRGINIA. So basically we have seen more
716 funding for AIDS and HIV prevention and treatment, but it is
717 going internationally instead of--

718 Dr. GERBERDING. May I just qualify that for a
719 statement?
720 Mr. DAVIS OF VIRGINIA. Please.
721 Dr. GERBERDING. Because as I said, our total Federal
722 budget for HIV is 24-some billion dollars a year because of
723 the mass investment that we make in treatment naturally. So
724 we are not spending $24 billion internationally a year.
725 Mr. DAVIS OF VIRGINIA. Now, a full 25 percent of
726 individuals with HIV, I think, are unaware of their
727 infection, and these individuals account for about 50 percent
728 of new infections?
729 Dr. GERBERDING. It is about--it is probably close to 50
730 percent. We know that once people find out what--I think it
731 is actually 58 percent. The undiagnosed people are
732 accounting for about 60 percent of the infections that we are
733 seeing. But we are also learning more recently that probably
734 early infection is a special subset of that group. And so
735 people who are newly infected don't recognize it, aren't
736 getting tested as they develop the systems of the conversion
737 illness, are highly infectious with great--
738 Mr. DAVIS OF VIRGINIA. How long does it take after the
739 contact that you're infected and can pass it on? Is it a
740 matter of hours? Days?
741 Dr. GERBERDING. It is not hours, but it happens faster
742 than we realize now that we have more and more sensitive

743 tests. So although the antibody test may not become positive
744 for many days, the virus is replicating very early on after
745 exposure. And that is why people can transmit even though
746 they don't know they have it.

747 Mr. DAVIS OF VIRGINIA. I recently spent about 10 days
748 in Africa touring some of our facilities that were there on
749 AIDS prevention. One of the problems there is the people
750 that have it now are getting medical care, they are keeping
751 mothers from passing it to their kids, they are able to live
752 seminormal lives. But over there, the men are just not as
753 likely to go in and turn themselves in, and there is still a
754 lot of denial in Africa. Is there anything similar in the
755 United States?

756 Dr. GERBERDING. There are many comparable social
757 issues. One of them is shame; the people are ashamed to have
758 the infection. The other is stigma; they are punished if
759 someone else finds out they have it. And then the third is
760 ignorance. There are still many people in this country and
761 around the world who don't recognize the risk and don't
762 understand that their behavior puts them at risk.

763 Mr. DAVIS OF VIRGINIA. Now, I understand that 38
764 percent of the individuals, roughly, with newly diagnosed HIV
765 are now developing full-blown AIDS within a year of
766 diagnosis. For these individuals, prevention, testing, and
767 treatment strategies don't seem to have worked. What do you

768 see? Is there a granular understanding of this population,
769 what leads to this outcome in people who are being diagnosed
770 and then moving quickly to AIDS?
771 Dr. GERBERDING. Well, the HIV diagnosis is happening
772 perhaps years after the infection has occurred at the time
773 people are beginning to develop symptoms. So it is a failure
774 to diagnose, a failure to reach out and get yourself tested,
775 or a failure for health professionals or people you encounter
776 in--
777 Mr. DAVIS OF VIRGINIA. But that is a diagnosis question
778 and waiting so long?
779 Dr. GERBERDING. So, D, the diagnosis of the prevention
780 paradigm, has got to be a strong emphasize.
781 Mr. DAVIS OF VIRGINIA. Now, as the epidemic has
782 progressed, the perception of HIV/AIDS has changed. The
783 success of effective treatments may have the downside of
784 creating a sense of complacency about HIV/AIDS impact. What
785 are the Federal efforts that are under way in order to
786 address complacency and correct some of these misconceptions?
787 Anything that we can do?
788 Dr. GERBERDING. We need to do so much more than we are
789 doing right now. We need to get AIDS back on the radar
790 screen. We need to highlight the fact that this isn't just
791 something that happens underground; this is something that is
792 still posing a threat to college students and to young men

793 and women across our Nation's fabric. We need to engage
794 community leaders. We need to engage popular opinion
795 leaders. We need to make it clear that it is not a problem
796 "over there," it is a problem at home. And all you have to
797 do is look at the statistics in the metropolitan D.C. Area to
798 see a picture that would suggest we have nothing to be
799 complacent about.
800 Mr. DAVIS OF VIRGINIA. It's remarkable, the medical
801 progress that has been made in this area over the last 10
802 years. I was very surprised. I mean, people who were
803 diagnosed, now it is no longer a death sentence if you take
804 your medication regularly. We are being able to stop it from
805 being passed on to kids and the like. I mean, getting
806 treatment now, if you are HIV-positive, going and getting
807 treatment is literally a lifesaver, Isn't it?
808 Dr. GERBERDING. Treatment is lifesaving. And this is
809 hard to say, but as much as we want people with HIV
810 infections to live and thrive and survive, it is not good to
811 have HIV. These drugs are hard to take. They are wrought
812 with complications and side effects. It is not easy to have
813 HIV and take these drug treatments for a lifetime.
814 Mr. DAVIS OF VIRGINIA. And it is expensive.
815 Dr. GERBERDING. And it is expensive. And it isn't a
816 disease that anyone should want to have, and it is certainly
817 not a disease that we should accept as just part of our

818 advanced society. We still need to prevent this disease.
819 Mr. DAVIS OF VIRGINIA. For the uninsured who are
820 diagnosed HIV-positive, obviously having to take the
821 medication is, what, $1,000 a month. What would it be?
822 Dr. GERBERDING. It depends very much on which regimen
823 you are taking. And there are, fortunately, right now so
824 many good choices that there are a variety of options and a
825 variety of cost factors. But it is not inexpensive. It is
826 one of the most expensive chronic diseases to treat and
827 manage.
828 Mr. DAVIS OF VIRGINIA. Okay.
829 Chairman WAXMAN. Thank you, Mr. Davis.
830 Mr. Tierney.
831 Mr. TIERNEY. Thank you, Mr. Chairman.
832 Thank you all for your testimony here. You have
833 testified about the importance of implementing evidence-based
834 prevention programs, so I want to ask a few questions tying
835 it in on the evidence behind some of our policies that affect
836 the prevention programming.
837 The new CDC incidence numbers show that injection drug
838 use directly accounts for about 12 percent of the new
839 infections. The sexual partners, the children of injection
840 drug users are also indirectly at risk.
841 There is scientific consensus that needle exchange
842 programs reduce the transmission of HIV and other infectious

843 diseases without increasing the rate of drug use. Needle
844 exchange programs also connect people to important health and
845 social services, including drug treatment. These are
846 conclusions that have been reached, as far as I understand
847 it, based on evidence of at least 18 groups of experts and
848 the most prominent professional and public health societies
849 in the world, including the CDC and NIH. Just recently, when
850 the CDC published its August data, the authors noted that
851 infections among injection drug users dropped 80 percent, and
852 they stated that, among other factors, one reason was that
853 drug users, and I quote, have reduced needle sharing by using
854 sterile syringes available through needle exchange programs
855 or pharmacies.

856 So despite this overwhelming mountain of evidence, every
857 year the Labor-HHS Department appropriations bill includes
858 provisions banning the use of Federal funds for the needle
859 exchange programs. So it looks like other programs around
860 the country and communities and States are doing all that
861 they can do, private people, but they are not really being
862 supported by the Federal Government.

863 So, Dr. Fauci, let me start with you, if I could. In
864 your professional scientific judgment, does the public health
865 evidence support the Federal ban on funding needle exchange
866 programs?

867 Dr. FAUCI. No, it doesn't. Actually, I was part of a

868 group that I helped cochair years and years ago to look in a
869 somewhat meta-analysis way of all the data that you referred
870 to asking the two questions, A, does needle exchange help
871 promote illicit drug use; and, B, does it impede or block in
872 many respects the transmission of HIV? And the answer to
873 both of those questions were: It doesn't increase the
874 injection drug use, and it does prevent HIV infection.

875 So the scientific data are really rather firm and
876 totally convincing that injection drug use and the
877 transmission of HIV through injection drug use can be
878 decreased significantly by needle exchange programs.

879 Mr. TIERNEY. Dr. Gerberding and Dr. Fenton, in your
880 professional scientific judgment, do you agree with Dr.
881 Fauci?

882 Dr. GERBERDING. I agree. And I also ran a bridge
883 program to needle exchange in San Francisco, from San
884 Francisco General Hospital, so I had a chance to see
885 first-hand.

886 I want to emphasize the word you used, though,
887 "program," because it isn't just the needle, it is the
888 surrounding education, the reduction in partners and sharing
889 and so forth. So it has to be done in the context of the
890 overall program. And my understanding is that there is
891 actually for CDC a congressional prohibition on using any of
892 our appropriated dollars for needle exchange. So we need to

893 work on this.

894 Mr. TIERNEY. That was the dilemma that I was pointing
895 out.

896 Dr. Fenton, do you also agree?

897 Dr. FENTON. I concur.

898 Mr. TIERNEY. Okay. So let me move on now and ask a
899 question about programs for youth. The new CDC data shows
900 that almost a third of the new infections occur with people
901 under the age of 30. There's been a number of comprehensive
902 sex education programs that appear to show a reduction of HIV
903 or HIV risk behaviors among young people. But aside from a
904 small amount of money in CDC's Department of Adolescent
905 School Health, there doesn't appear to be any Federal funds
906 dedicated to comprehensive sex education. In the meantime,
907 we spend about $1.5 billion on abstinence-only-until-marriage
908 programs.

909 I am aware that no evidence that this kind of narrow
910 program decreases HIV risk. In fact, a longitudinal,
911 independent, congressionally mandated study that came out
912 last year found that the programs had no impact at all on
913 teen behavior compared to the control group. In April, we
914 heard from the American Public Health Association, the
915 American Academy of Pediatrics, and others that these
916 programs are not supported by evidence.

917 So, I want to ask each of you individually, in your

918 professional scientific judgment, do you believe that
919 evidence at this time supports abstinence-only-until-marriage
920 programs as an effective intervention to reduce HIV risk
921 among youth? Dr. Gerberding?
922 Dr. GERBERDING. Let me say that I have spent a great
923 deal of time in preparation for this hearing reviewing those
924 data, and I agree with the conclusions that there is no
925 evidence of benefit from the 10 abstinence-only programs that
926 have been evaluated. And in looking at the comprehensive
927 curricula programs, there is more evidence of benefit, at
928 least in terms of benefit, in knowledge. And hopefully STDs
929 in the long term--although we have never studied an impact on
930 HIV.
931 But I also want to emphasize that there are many in the
932 STD world of science who believe that delaying the entree to
933 sexual behavior is a good and very important part of a
934 comprehensive program. So, abstinence is not a dirty word,
935 but programs that deal with youths' sexual health need to
936 bring to them the entire compendium of tools that we know
937 they may need in their efforts to protect themselves.
938 Mr. TIERNEY. Dr. Fenton.
939 Dr. FENTON. I agree with the statements of Dr.
940 Gerberding. I know of no evidence supporting the
941 effectiveness of abstinence-only-until-marriage programs in
942 preventing STDs or HIV incidence among young people. And I

943 also support and concur with Dr. Gerberding's statement
944 regarding the role of comprehensive sex education programs as
945 an effective tool or as part of an effective program toward
946 better sexual health among our youth.
947 Mr. TIERNEY. Dr. Fauci.
948 Dr. FAUCI. Yes, I agree also. It is pretty clear that
949 if you look at abstinence only in a vacuum, that there is no
950 data to indicate that that decreases transmission of HIV or
951 other sexually transmitted diseases.
952 But, again, to underscore what Dr. Gerberding says, as
953 part of a comprehensive program where you try to delay the
954 sexual debut, but you also inform people of what you need to
955 do if you do not practice abstinence has to go along with
956 that; otherwise, alone in a vacuum, it doesn't work.
957 Mr. TIERNEY. Let me, if I can, conclude by asking, has
958 Health and Human Services ever asked any of you for your
959 opinion on these two subjects?
960 Dr. GERBERDING. We have had many briefings on this
961 subject, and say that as the data have come forward, it has
962 only been recently that we have had evaluation studies pulled
963 together to really ask the question. From a CDC standpoint,
964 our total investment in abstinence every year is about $2.2
965 million, and I actually wish 15 years ago we had made a much
966 bigger investment because we would know the answers to the
967 questions that we are finally now being able to surface. So

968 we erred, perhaps, in retrospect, in not going into this with
969 an open mind and doing those kinds of programmatic,
970 innovative evaluation programs in the first place.
971 Mr. TIERNEY. I would be comforted if the budget
972 reflected the error and changed around and moved some of that
973 money to a more effective place. But it's a little late for
974 that one, I think. Thank you.
975 Chairman WAXMAN. Mr. Shays.
976 Mr. SHAYS. Thank you.
977 A number of years ago, I chaired the committee that
978 oversaw HHS, and we had Donna Shalala come before us because
979 HHS had failed for a year to get the committee together that
980 was to begin to describe how we--and determine how we could
981 protect the blood supply. We had 25,000 hemophiliacs who
982 died. And I never saw it as my purpose to go after the
983 Clinton administration, nor do I think it is my purpose here
984 to go after the Bush administration. But I am really puzzled
985 that this would in any way be a political issue.
986 I would like to know from both our key witnesses have
987 you found in any way that the administration has been
988 unresponsive in trying to deal with this AIDS epidemic?
989 Dr. GERBERDING. I would like to say that my
990 intersection with both Secretaries that I've worked for as
991 individuals, as well as staff from the White House that I
992 have encountered on the issue of domestic and international

993 AIDS, has come to me to ask for science, they have come to me
994 to ask for the data. I don't personally feel that I've come
995 under any pressure to comply with a particular policy.
996 Mr. SHAYS. Have you found them unresponsive?
997 Dr. GERBERDING. No, I haven't. That has not been my
998 experience.
999 Mr. SHAYS. Dr. Fauci, have you found them unresponsive?
1000 Dr. FAUCI. No, I have not. They've listened, several
1001 administrations, the current administration, the Clinton
1002 administration, and the--
1003 Mr. SHAYS. I mean, it seems like it's the one area
1004 where politics has kind of not been part of it, so I would
1005 hate to introduce it now.
1006 What you have basically said to us is the upward
1007 adjustment does not reflect an acceleration of the epidemic,
1008 but a more precise capability to distinguish between recent
1009 and long-term infections. So isn't it clear that we have new
1010 information, and when there is new information, we need to
1011 respond to it? Dr. Fauci?
1012 Dr. FAUCI. Yes. As we get new information, we
1013 certainly do need to respond to it, and that is the reason
1014 for the intensification.
1015 Mr. SHAYS. Isn't this new information that we are
1016 learning? I mean, we are learning that with the epidemic
1017 hasn't gone up, it is just that our statistics were not as

1018 accurate as they could be, correct?

1019 Dr. FAUCI. Yes. As Dr. Gerberding has mentioned, and I

1020 will obviously leave for her to comment on that, the new,

1021 more sophisticated and accurate counting measures indicate

1022 that the incidence or number of new infections per year is

1023 higher than we had thought it was. But it has been stable

1024 since the '90s, so it has not gone up. It is just higher

1025 numbers because of better counting.

1026 Dr. GERBERDING. The new information is based primarily

1027 on new testing activities in the States as well as new tests.

1028 What it tells us is that there is no room for complacency;

1029 55,600--

1030 Mr. SHAYS. Absolutely, there is no room for

1031 complacency. The issue is that we have new information, and

1032 from this new information we can better act on it, correct?

1033 Dr. GERBERDING. That is exactly why--

1034 Mr. SHAYS. Now, do either of you appear before the--

1035 Chairman WAXMAN. If you will forgive me. I know it is

1036 your 5 minutes, but it seems to me you haven't let a witness

1037 complete a sentence yet. And I know you only have a limited

1038 time, but I would be glad to yield.

1039 Mr. SHAYS. I am sorry, I just have a number of

1040 questions, but I am delighted to have you continue.

1041 Dr. GERBERDING. I think the important message here is

1042 that we need to be able to have this kind of information at

1043 the community level, because it tells us right where we need
1044 to go. This data tells us nationally we need to go to men
1045 who have sex with men, African Americans and Hispanic people,
1046 and do a lot more than we are doing right now in those
1047 targeted populations. But in communities there will be even
1048 more specific information that can tell us how to use the
1049 resources we have to get the most benefit from it.
1050 So you are absolutely right. This information has
1051 to--it tells me that we need to reframe what we are doing.
1052 And I have asked Dr. Fenton to bring in experts and really
1053 look at our portfolio as it exists in light of this new
1054 information, and say where are we and where should we be.
1055 Mr. SHAYS. And I congratulate the both Chairman and
1056 Ranking Member, because I know they worked together in having
1057 this hearing. This is a huge piece of information. It
1058 really isn't political information, it is new knowledge,
1059 based on new science, and we need to respond to it.
1060 I would like to make sure, do you either, any of the
1061 four of you, make presentations before the Congress on
1062 funding requests?
1063 Dr. FAUCI. Yes. We defend the budget every year at our
1064 appropriations hearing in front of the House and the Senate.
1065 Mr. SHAYS. And you are never required to say something
1066 that is not true before those hearings, correct?
1067 Dr. FAUCI. Correct.

1068 Mr. SHAYS. So in other words, if a committee member
1069 asked you a question about your funding needs, you would be
1070 very candid with them; is that not correct?
1071 Dr. FAUCI. Yes.
1072 Mr. SHAYS. Is that correct?
1073 Dr. GERBERDING. Yes.
1074 Mr. SHAYS. So if someone on the committee said, is this
1075 enough money to do your job, and you said--you didn't think
1076 it was, you would tell them, well, we think we need more; and
1077 if we had more, we would put it to this use. Is that
1078 correct?
1079 Dr. GERBERDING. Well, Mr. Shays, there is the reality
1080 as an agency head, and I know Dr. Fauci feels this as an
1081 institute head, we can always think of good ways to spend
1082 money to do more than we are doing. But we also have to
1083 respond to the realities of the budget proposals that are put
1084 in front of us. But when you ask me for my professional
1085 judgment, I give you my very best answer, unconstrained by
1086 any other realities.
1087 Mr. SHAYS. So any member on that committee who says, do
1088 you need more money in these areas, and how you would use it,
1089 you would let them know?
1090 Dr. GERBERDING. I tell the truth.
1091 Mr. SHAYS. Thank you.
1092 Ms. MCCOLLUM. Mr. Chairman, if I may, as an

1093 appropriator on that committee.

1094 Mr. SHAYS. Sure.

1095 Ms. MCCOLLUM. I think what Dr. Gerberding said was
1096 honest, but I think it honestly needs to be said that she
1097 comes in and she does her job as an utmost professional. She
1098 is very, very honest, as everyone is from CDC, NIH. But they
1099 all defend--they all defend the President's priorities and
1100 the President's choices.

1101 Mr. SHAYS. Right. And then you, as a member of the
1102 committee, feel very inclined to ask very candid questions.
1103 And I know that, based on the testimony, that they would give
1104 you a candid response in return.

1105 Ms. MCCOLLUM. And then if we do anything, it is called
1106 an earmark by the President.

1107 Mr. SHAYS. So I will just conclude by saying, in the
1108 end this was a budget agreed to by a Democratic Congress,
1109 suggested by a Republican President. It is a bipartisan
1110 budget. And in the end, we have to work together to come up
1111 with the best conclusions.

1112 Thank you very much.

1113 Chairman WAXMAN. Without objection, the Chair would
1114 like to recognize himself for an additional minute. Hearing
1115 no objection.

1116 Dr. Fauci and Dr. Gerberding, as I understand it, when
1117 you come before the Congress, you are defending the budget

1118 submitted by the administration; isn't that correct?

1119 Dr. FAUCI. Correct.

1120 Dr. GERBERDING. Correct.

1121 Chairman WAXMAN. Now, unless you are asked what your
1122 professional judgment might be, you are there to represent
1123 the administration.

1124 Dr. Gerberding, when I asked you questions earlier, you
1125 indicated that you thought that you should have had more
1126 money in the prevention efforts going all the way back to the
1127 beginning of your time. And I asked you about whether you
1128 heard from people in the administration, the President,
1129 Secretary, and others, whether they asked you what you really
1130 needed. You said you had lots of meetings held with
1131 superiors who discussed these needs.

1132 I would like to ask you for the record to submit
1133 documents and any other further information about the
1134 meetings you had to tell them what you thought you needed to
1135 prevent the epidemic from increasing in scope.

1136 Dr. GERBERDING. I will do my best to resurrect that.

1137 [The information follows:]

1138 ******** COMMITTEE INSERT ********

1139 Dr. GERBERDING. I must also say that HIV isn't the only
1140 place that we have gone to say we are concerned about.
1141 Mr. SHAYS. Would the gentleman yield for a slight
1142 intervention?
1143 Chairman WAXMAN. Certainly.
1144 Mr. SHAYS. Thank you.
1145 I just want to make sure for the record, was this new
1146 data available--and I don't know what the answer is. But was
1147 this new data that is available today available when the
1148 President and Congress were presenting their--doing their
1149 last budget?

1150 RPTS DEAN

1151 DCMN SECKMAN

1152 [11:04 a.m.]

1153 Dr. GERBERDING. The new data were published in August,
1154 at the beginning of August of this year.

1155 Mr. SHAYS. This year. So it was not available either
1156 to the President or to Congress?

1157 Dr. GERBERDING. That's correct.

1158 Mr. SHAYS. Thank you.

1159 Chairman WAXMAN. In your developing your CDC budget do
1160 you start from scratch from what you believe is needed or do
1161 you receive a preset total from HHS or the Office of
1162 Management and Budget into which you must fit your goals.

1163 Dr. GERBERDING. I think, like every agency, we're given
1164 parameters. They vary from year to year. When I started, we
1165 were given parameters for increases. Recently, we have been
1166 given parameters to have scenarios for a modest increase, a
1167 flat line or a reduction. And we go forward with different
1168 versions of our request based on what parameters are finally
1169 selected by the administration to present the final budget to
1170 Congress. I also present our request to the formal budget
1171 council in the Department, and that is a factor that the
1172 Secretary weighs when he looks at all of the agency budgets
1173 in aggregate, because he had to finally bring the budget
1174 forward.

1175 Chairman WAXMAN. Now, when all is said and done, your
1176 budget now for domestic HIV prevention is around 5 percent,
1177 and that's a drop in the percentage you've had in previous
1178 years, isn't that correct?
1179 Dr. GERBERDING. I'm not sure of the 5 percent figure,
1180 but most of our domestic HIV money is for prevention, but the
1181 amount of money that our government is spending on prevention
1182 is still hovering at about 4 percent of the total.
1183 Chairman WAXMAN. Okay, thanks.
1184 Ms. Speier.
1185 Ms. SPEIER. Thank you, Mr. Chairman.
1186 I had the opportunity recently to spend some time at
1187 Gilead which is a company in my district. And I'm going to
1188 preface my questions based on that fact, because they
1189 provided me with information that I thought was pretty
1190 astonishing. One is that, of the 50,000 new HIV individuals
1191 in America, the vast percentage of them are African American
1192 women. Now that seems to be different from what you provided
1193 today. But their concern to me was that African American
1194 women are the highest increase in those contracting HIV. Is
1195 that not the case?
1196 Dr. FENTON. No, that's incorrect. The majority of new
1197 HIV infections are occurring among men, and the majority of
1198 those are among men who have sex with men.
1199 Ms. SPEIER. So the women, then, the African American

1200 women are an increasing number?

1201 Dr. FENTON. What you may have heard is that the largest
1202 proportion of women who are newly infected with HIV are
1203 African American women. So they account for nearly a
1204 substantial proportion, more than half, or just about half of
1205 the new infections which are occurring in women in the United
1206 States. And then you have smaller proportions of infections
1207 occurring among Hispanics and white women; that may have been
1208 the statistic they were referring to.

1209 Ms. SPEIER. What was most amazing to me was the regime
1210 now for drugs has been reduced, at least with Gilead's work,
1211 to one pill a day, as opposed to 9 or 10 pills in which
1212 patients oftentimes will not take one of the pills because it
1213 is upsetting physically to them. And by being able to just
1214 take one pill, you're getting greater compliance.

1215 What they impressed upon me was the importance of
1216 testing, because as I think one of my colleagues earlier
1217 said, it is not a death sentence anymore. In fact, being
1218 diagnosed with HIV means that you can in fact have a full
1219 life, a full life expectancy. It is just being tested early,
1220 being diagnosed early and getting the drugs and following the
1221 regime that is offered; is that not the case?

1222 Dr. GERBERDING. That is the case. The one pill has
1223 many drugs in it.

1224 Ms. SPEIER. Correct.

1225 Dr. GERBERDING. But they are able to combine them into
1226 a single tablet.
1227 Ms. SPEIER. So listening to them and listening to you
1228 it seems to me that we need to do two things, one is augment
1229 the testing that goes on in this country everywhere. Two, we
1230 require all other countries to come up with National HIV AIDS
1231 plans if they are participating in PEPFAR, but we don't have
1232 a national plan; is that true?
1233 Dr. GERBERDING. We have a national strategy, and we are
1234 committed to updating it in light of the new incidence
1235 information that we are receiving.
1236 We also in, I think in December, Kevin, will be
1237 publishing a new update on interventions that work that we
1238 can incorporate into the national strategy.
1239 Ms. SPEIER. So testing, what do we do to augment
1240 testing in this country?
1241 Dr. GERBERDING. There are some things we are doing
1242 right now. One of the biggest advances is the rapid test,
1243 that allows people to be tested in non-medical environments.
1244 We are really pushing hard to make testing a routine part of
1245 medical care so that when you come in, you get tested. I was
1246 so pleased to see this in action at San Francisco General, it
1247 is night and day compared to even 5 years ago, but that's not
1248 happening everywhere. It is particularly not happening in VA
1249 hospitals and Federal facilities yet because they have

1250 regulations that have to be changed in order for that to
1251 happen. But we need to make testing universally accepted and
1252 acceptable in all kinds of nontraditional environments.

1253 Ms. SPEIER. Would it make sense to make Medicaid
1254 funding contingent on participating in a program where
1255 testing done uniformly?

1256 Dr. GERBERDING. Well, I would like to see us work with
1257 CMS around support for screening, because ultimately
1258 screening will be cost effective for CMS and HERSA and the
1259 other Federally funded health programs, so I think that is an
1260 important lever that we want to pull. And we are working on
1261 how to get those regs changed.

1262 Ms. SPEIER. Finally, in terms of microbicides, that was
1263 heralded some years ago as being an outstanding opportunity
1264 for us to address the issue, particularly in places around
1265 the world, Africa in particular. It appears in your
1266 testimony that I just read that there has been some
1267 disappointing results in the clinical trials. Could you
1268 expand on that please and tell us where you are going with
1269 microbicides?

1270 Dr. GERBERDING. The clinical trial so far with the
1271 available compounds have been disappointing. They have
1272 failed to predict and in some cases may have actually
1273 enhanced transmission because of irritation in the mucosal
1274 tissues in contact with the microbicide, but that doesn't

1275 mean that we won't find compounds that work. And there are
1276 studies ongoing right now in animal models and early clinical
1277 studies looking at both vaginal as well as rectal
1278 microbicides. So this is a very important area for
1279 investment. It is one of those new tools that I'm trying to
1280 make a plea for working collaboratively within NIH, of
1281 course, as well as FDA.

1282 Dr. FAUCI. Most of those studies, Ms. Speier, were done
1283 with microbicides that don't have a specific anti-HIV drug in
1284 it. The second generations are those that are now
1285 incorporating drugs that specifically block the virus, so the
1286 issue that Dr. Gerberding mentioned is one we still haven't
1287 overcome, is the propensity towards vaginal irritation which
1288 can sometimes paradoxically make things worse, but also there
1289 has not been potent anti-HIV drugs in the compounds, which
1290 now the second and third generations ones that we feel a
1291 little bit more optimistic about now are ones that do contain
1292 those compounds.

1293 Ms. SPEIER. And my last question, Mr. Chairman, to both
1294 of you, if you were being asked today how much money.we
1295 should be spending in the United States on HIV and AIDS, how
1296 much would that budget be?

1297 Dr. GERBERDING. We have submitted that for the record,
1298 our professional judgment without constraint. And as Kevin
1299 and I sat down and walked through that budget, I think we

1300 recognize that this isn't just a CDC question, it has to
1301 include the NIH, it has to include SAMSA for mental health
1302 because we can't solve this problem without doing more for
1303 mental health and substance use. And we need to address the
1304 correctional facilities, because a disproportionate part of
1305 the population at risk is in correctional environments. So
1306 we only have a piece, and we probably need to sit down
1307 together as a collaboration and really think through a true
1308 national strategy, and that's what we are proposing to do as
1309 these new data become available.

1310 Ms. SPEIER. Give us a number nonetheless.

1311 Dr. FAUCI. I can give you an NIH number. Our budget,
1312 as you know, has been essentially flat for the last 4 or 5
1313 years. So we have $29-plus billion in research that
1314 we've--that we spend, which is a substantial amount of money.
1315 The difficulty is if you have no increases for several years
1316 in a row, you're really looking at a 3.2 percent decrease per
1317 year in actual real money in the sense of inflationary index.
1318 So you are looking at a minus 12, 13 or plus percent
1319 decrease over a period of 5 years. So when people ask us, in
1320 our professional judgment, which I will give you now, that if
1321 you're looking at what we could use and spend quite well, the
1322 NIH budget is $2.9 billion for AIDS on a budget that's $29
1323 billion for all of NIH, so it is a little more than 10
1324 percent. With a $2.9 billion budget for the NIH for AIDs, we

1325 could spend about $3.35 billion.

1326 Chairman WAXMAN. Thank you, Ms. Speier, your time has
1327 expired.

1328 Ms. McCollum.

1329 Ms. MCCOLLUM. Thank you, Mr. Chair.

1330 People are dying every day in this country because of
1331 AIDS, and the numbers continue to increase despite the fact
1332 that AIDS prevention works. And I know this all too well,
1333 because I recently lost a friend from AIDS. It was a story
1334 that could go with maybe not being tested quick enough. It
1335 is a story this you could talk about fear and discrimination,
1336 but it also includes the Federal Government and the State of
1337 Minnesota not doing what it could do to support people who
1338 are on anti-retro viral treatment and the stress that these
1339 individuals go through when their treatment is threatened or
1340 cut off and then they find themselves scrambling for
1341 treatment.

1342 We're here today because we need to get our energy back
1343 into the need for HIV prevention and education efforts, and I
1344 appreciate sincerely the testimony of the panel. We know
1345 that there are populations now that are more at risk than
1346 other populations. We're here today because the CDC's report
1347 found out this that there were 60, excuse me, 56,000 new HIV
1348 infections last year focused in racial and ethnic minorities;
1349 that's 70 percent of new cases. This is also true of

1350 Minnesota, and I wish Mr. Shays was still here. Maybe he'll
1351 come back.
1352 Minnesota has recorded the highest number of HIV cases
1353 seen in the last 10 years in 2007. With 325 new cases, gay,
1354 bisexual men are the highest group impacted with 77 percent
1355 of all cases. Minnesota also is facing higher increases
1356 among young men and among Latina women. We know that the HIV
1357 rate in African American men and in the immigrant population
1358 is 20 times higher than the statewide average.
1359 Mr. Chair, I would--I'll submit some issues for the
1360 record, but one thing that was brought up in a question was,
1361 well, this is new because we're testing better. Well
1362 Minnesota's been testing since 1985, so it is going up in
1363 Minnesota. I'm--I--I want to ask you, again, do you think
1364 the only reason why you're seeing rates increase in the
1365 populations that I have mentioned and across this country,
1366 the only reason is because testing is more effective, knowing
1367 that States submit records to you on a regular basis?
1368 Dr. GERBERDING. I regret if I implied that we thought
1369 the reason for the number that this was related to testing.
1370 This number is a new number because we have a new diagnostic
1371 test that allows us to tell when somebody was infected, so we
1372 can distinguish very old infections from recent infections,
1373 so that's the test element of the number. But the number
1374 that we are reporting today and the back calculations that we

1375 did using the new methodology of extrapolation over time
1376 allows us to recognize that we've been misunderstanding the
1377 true incidence for a long period of time. In part it is
1378 complicated and I would be happy to sit down an walk through
1379 some of the science of it. But is not that we are doing more
1380 testing, and you're right Minnesota was one of the first to
1381 have HIV reporting and the first to take an aggressive
1382 perspective on that. But, nevertheless, even in Minnesota,
1383 there are undiagnosed people and there is ongoing
1384 transmission.

1385 Ms. MCCOLLUM. Thank you.

1386 One of the people who took it to the street, took it to
1387 public officials was a wonderful person, our State
1388 epidemiologist, Dr. Michael Osterholm, who made sure that we
1389 kept track of records. And some people called him an
1390 alarmist for going out and talking about it at the time. I
1391 think the alarm needs to go off again, and so I thank you
1392 again for your report.

1393 Mr. Chairman, the Minnesota Department of Health Federal
1394 CDC HIV prevention grant has been reduced by 8 percent in the
1395 past 5 years. Federal CDC STD prevention grants, which is
1396 also a precursor that's been used, has been reduced 4 percent
1397 since 2003. That's despite the number of STD cases has risen
1398 14 percent since 2003.

1399 Mr. Chair, I'm going to submit some information into the

1400 record from the State of Minnesota and the profile of HIV
1401 epidemic. I will be around if there's an opportunity for
1402 more questions. I originally wasn't going to spend my time
1403 so much talking about Minnesota, but I wanted to, for the
1404 public, clear up any misunderstanding that might have been
1405 what these statistics are really indicating to us, and that's
1406 to wake up and to start getting correct information, and to
1407 let today's youth know that treatment is not a cure; it is
1408 not a cure.

1409 Thank you, Mr. Chair.

1410 Chairman WAXMAN. Thank you very much, Ms. McCollum.

1411 We will be, without objection, we will be pleased to
1412 receive the information for the record that you would like to
1413 submit.

1414 [The information follows:]

1415 ******** COMMITTEE INSERT ********

1416 Chairman WAXMAN. Ms. Watson.

1417 Ms. WATSON. Thank you, Mr. Chairman.

1418 I just want to clarify something that was said, and I'll
1419 direct this towards you, Dr. Fenton, as I understood, HIV is
1420 spreading more quickly among African American women than any
1421 other group. Is that correct or not correct?

1422 Dr. FENTON. HIV infection is spreading at the greatest
1423 rate among gay and bisexual men. In fact the data shows that
1424 they are the only group where we have seen consistent and
1425 sustained increases in HIV incidence since the early 1990s.

1426 Ms. WATSON. Then, let me go back, because after the
1427 virus was spread--I mean, identified around 1980, 1981, it
1428 was believed to be among white males having sex with males.
1429 It seemed that there was attention given to that segment of
1430 society, and things improved, and that's where the funding
1431 was going. Maybe 10 years later, there was data showing that
1432 it was moving quicker among African American women, coming
1433 from partners who injected themselves.

1434 As I understand that, there is a disproportionate toll
1435 on African Americans, males, females at this time, and they
1436 account for 12 percent of the population but 45 percent of
1437 the new infections in the year 2006. Is that true?

1438 Dr. FENTON. That's true.

1439 Ms. WATSON. Okay, I might have missed this part of your
1440 testimony, so let me just refer back to it. But can you tell

1441 us more about what CDC is doing in terms of the Heightened
1442 National Response to address HIV and AIDS in the African
1443 American community?

1444 Dr. FENTON. Thank you. I would be delighted to tell
1445 you about that. The Heightened National Response is an
1446 initiative which was started in 2006, and it brings together
1447 CDC or Federal partners and our partners and leaders in the
1448 African American community to focus on the epidemic among
1449 African Americans and to accelerate our prevention efforts.

1450 And the Heightened National Response is built on four
1451 key pillars. The first is to expand HIV testing within the
1452 African American community. The second is to expand the
1453 reach of our prevention services; in other words, to scale up
1454 effective prevention interventions with African Americans so
1455 we know it will have an impact on the epidemic. The third is
1456 to mobilize the African American community. And we have been
1457 really working with a range of amazing African American
1458 leaders to focus and to bring the conversation back to HIV
1459 and the importance of community leadership on HIV/AIDS. And
1460 the fourth pillar is on research, to ensure that we are
1461 investing in research for and by African Americans, so that
1462 we're looking at culturally competent prevention
1463 interventions moving forward.

1464 Ms. WATSON. Now, the main points that you are
1465 describing to us, did you get new funding to be able to

1466 implement?

1467 Dr. FENTON. No, this is a great example of what Dr.
1468 Gerberding said of looking at our existing prevention
1469 portfolio and having to make tough decisions to realign our
1470 existing prevention dollars into what we believe are urgent
1471 threats or urgent realities and to deal with the matters at
1472 hand. And so this is part of the activities that we have to
1473 do in the current environment.

1474 Ms. WATSON. Well, going back and looking at the history
1475 because I chaired the health and human services in the
1476 California Senate for 17 years. I was there when we
1477 identified the virus, and I was there when money flowed in to
1478 address white males having sex with white males. I was
1479 there, too, when we discovered that it was moving among the
1480 African American female community. And I never saw the
1481 funding keep pace with the spread. So I will expect, in
1482 trying to reach your goals to reduce the rate of infection,
1483 that you have not been able to reach those goals of reducing
1484 the rate of infection among that population.

1485 Dr. FENTON. Well, actually, we do know that the
1486 transmission rate of HIV has been declining in the United
1487 States. There are more people living with HIV, but--

1488 Ms. WATSON. But what about African Americans? I really
1489 want to see zero in, because this was a great concern. I
1490 carried the needle exchange program for years. I was called

1491 on the carpet by, particularly, the ministerial community. I
1492 had to go to San Francisco and sit in the hot seat. And it
1493 was very, very difficult to have an understanding that if we
1494 do a needle exchange, at least we take a dirty needle out.
1495 And at that time, as Dr. Gerberding has said, that we're able
1496 then to give information about treatment and at the point of
1497 exchange. And that program only was adopted after Willie
1498 Brown took over, and I was gone at that point.

1499 But I'm still concerned as to what is happening in that
1500 community. And I'm still concerned about resources. And I
1501 would like to know the status of mobilizing the community--I
1502 know we are working through a lost our churches now. Could
1503 you just add to that, please?

1504 Dr. FENTON. Sure. It has been an amazing couple of
1505 years in which we've brought leaders from all walks of life
1506 into the African American community to dialogue with us and
1507 to plan with us. Leaders from the African American faith
1508 communities, from the academic sector, from the business
1509 sector, from grassroots organizations who have come to
1510 Atlanta to talk about their activities and their plans and
1511 look at ways is in which CDC can accelerate efforts towards
1512 prevention. This has been a new way for us to work as an
1513 agency. It is an important way for us to work as an agency
1514 moving forward.

1515 Ms. WATSON. If I might take just another minute, Mr.

1516 Chairman.

1517 Chairman WAXMAN. Without objection, the gentlelady is
1518 yielded another minute.

1519 Ms. WATSON. In the African American community, our
1520 churches are the place where people come together. And that
1521 is a route that I think should be more focused on. And if we
1522 had the necessary budget items, and this is something I have
1523 in mind, to impact those who are appropriators, we really
1524 need to--and I understand also that HIV/AIDS is spreading
1525 among Hispanic Americans now, where it wasn't as heightened
1526 as, 10 years ago, as it appears to be now. So I think that
1527 we need a special program expanded to deal particularly in
1528 the African American community with our churches and other
1529 community programs.

1530 With that, I will say thank you, Mr. Chairman.

1531 And thank you, Dr. Fenton.

1532 Chairman WAXMAN. Thank you, Ms. Watson.

1533 Mr. Sarbanes.

1534 Mr. SARBANES. Thank you, Mr. Chairman.

1535 Thanks to the panel.

1536 I would imagine that just about any condition can be
1537 treated or involves sort of two prongs at least in your
1538 strategy combat it. One is sort of behavioral modification.
1539 The other is treatment. So--but, obviously, there are
1540 certain kinds of conditions, diseases and so forth where that

1541 interplay is more relevant and elastic.

1542 And--so I had a couple of questions. Is there any
1543 evidence, or can you describe how progress on the treatment
1544 front may have contributed to some backsliding on sort of the
1545 behavioral practice or modifying behaviors up front? And if
1546 that has happened, you know, how do you address that? What
1547 are the strategies for--to maintain the intensity and focus
1548 on both strands without having them sort of contribute to
1549 going in the opposite direction with the other? And along
1550 those lines, and this is my only question, so then I ask you
1551 all to just jump in, are there conditions or diseases that
1552 have been good reference points for you to look at where the
1553 analogy is strong enough, in terms of what we are dealing
1554 with HIV and AIDS, of what's happened in terms of how we've
1555 managed those is instructive in terms of the strategies that
1556 we're trying to employ with respect to HIV and AIDS?

1557 Dr. GERBERDING. I'll start. I think that the risk
1558 period for people, all other things being considered, for the
1559 highest chance of transmitting to others is very early after
1560 infection and then again very late in infection when the
1561 viral load is very high. But you can transmit at any time.
1562 So if treatment is successful in suppressing viral load, it
1563 stands to reason that people would be less infectious to
1564 others during that period of time. They also tend to change
1565 their behavior when they know they are infected and protect

1566 other people as a consequence of their disease.

1567 But we are experiencing anecdotal and I think more
1568 systematically a cohort of people who have falsely been
1569 reassured that their lives are going to be unaffected by this
1570 treatment, and so there is some complacency and some
1571 recidivism and increase in risk behavior. And we see that by
1572 indicators such as the incidence of rectal syphilis going up
1573 in some populations where there has been an increase in
1574 unsafe sexual practices, so that is a phenomenon.

1575 There is--it is very difficult to find a good analogy to
1576 HIV in the context that you're asking the question. To some
1577 extent, TB is like that. You have to treat it for a long
1578 time, and people become less infectious when they are in
1579 treatment. They can be falsely reassured by the therapy
1580 early on and be less conscientious about infecting the people
1581 in their households, but AIDS is a pretty unique infectious
1582 disease, a chronic infectious disease for which we have a
1583 chronic infectious disease treatment. And so we're kind of
1584 learning as we go with this one.

1585 Dr. FAUCI. Just to underscore what you said about the
1586 perceptions. The perception of something not being as bad as
1587 we decades ago thought it was, if you look at the environment
1588 that we're in, we used to have hospices and 20 to 40 percent
1589 of the hospital beds in some cities were occupied by people
1590 with HIV infection. It is mostly an outpatient disease right

1591 now.

1592 The public perceptions that put on the face of someone
1593 with HIV, if you look at some of the advertisements for some
1594 of the drugs, you open up medical journals and you page
1595 through the first 10 pages and they have these
1596 extraordinarily healthy looking people rock climbing saying,
1597 I'm doing very well on my Atripla or on my, whatever drug
1598 combination they are on, and it really creates a false
1599 impression that we've been trying to underscore here, and Dr.
1600 Gerberding mentioned it actually formally in her
1601 presentation, is the issue that it is a bad thing to get HIV
1602 infected. Even though with all the very, very effective
1603 drugs we have, it is not a good thing. It's difficult to
1604 take the medications. It is a lifelong disease. If you
1605 stop, we have shown as others have, that the virus bounces
1606 right back, and at this point, we have not been able to cure
1607 it.

1608 Mr. SARBANES. Would you attribute any of the increase
1609 that has been talked about here today to this sort of
1610 misperception, or is it--I'm sure it is hard to draw a
1611 straight line.

1612 Dr. FAUCI. No, I think there is no question in our mind
1613 that when people practice risk behavior, if you question them
1614 and talk about it with them, a significant amount, I can't
1615 give you a number, is due to the feeling that it isn't as bad

1616 as it was back in the early 1980s. Of course, there was an
1617 incredible amount of fear. If you were in New York City or
1618 San Francisco or Los Angeles or some of the other cities, the
1619 fear among the community, particularly among the gay
1620 community, was palpable. There is much less of that now
1621 because of the perception that we can treat it very well.
1622 Chairman WAXMAN. Thank you, Mr. Sarbanes.
1623 Without objection, Representative Maxine Waters, who is
1624 not a member of our committee, will be allowed to sit with us
1625 and enter a statement in the record and to ask questions.
1626 Without objection, that will be the order.
1627 Ms. WATERS. Thank you so much, Mr. Chairman. I am just
1628 so pleased that you are holding this hearing and I would like
1629 to thank you and Ranking Member Tom Davis for this hearing
1630 today.
1631 I'd just like to give a little bit of background and ask
1632 a few questions.
1633 Many people in the black community have long suspected
1634 that the epidemic was worse than our Nation's leaders thought
1635 it was, even before the CDC's new estimates were released.
1636 We knew that African Americans accounted for about half of
1637 all of the new AIDS cases, and we knew that HIV/AIDS was
1638 having a profound impact on African Americans.
1639 In 1998, we sounded the alarm in the halls of Congress
1640 on April 24th, 1998, while I was the Chair of the

1641 Congressional Black Caucus, the CBC held a brain trust which
1642 was sponsored by Congressman Louis Stokes. During that brain
1643 trust, those same members were shocked by the presentation of
1644 Bennie Primm, the executive director of the Addiction,
1645 Research and Treatment Corporation. Dr. Primm's presentation
1646 described the state of HIV/AIDS crisis in minority
1647 communities, particularly the black community.

1648 On May 11, 1998, the CBC held a meeting that brought
1649 together many public health workers, AIDS activists and
1650 representatives from all over the country to tell us about
1651 the impact of the HIV/AIDS in minority communities. That
1652 same day, the CBC called for President Bill Clinton to
1653 declare a public health emergency to combat the crisis in
1654 minority communities.

1655 In the fall of 1998, Lou Stokes, Donna Christensen and I
1656 met with Donna Shalala, the Secretary of Health and Human
1657 Services, to discuss the crisis. We agreed that what we
1658 really needed was not a declaration of a public health
1659 emergency but rather money for programs to address the
1660 crisis.

1661 On October 28th, 1998, the CBC held an event to roll out
1662 the Minority Aids Initiative. The event featured the
1663 participation of President Clinton, Secretary Shalala and
1664 representatives of HIV/AIDS organizations from around the
1665 country.

1666 At the 1998 roll out, we announced that the Minority
1667 Aids Initiative would receive an initial appropriation of
1668 $156 million in fiscal year 1999. The minority AIDS
1669 initiative grew significantly over the next 5 years, but
1670 since then, funding has remained stagnant at about $400
1671 million per year since fiscal year 2003, and at some points,
1672 it dropped below the 400 million.

1673 Having said that, African Americans again have been
1674 seriously and disproportionately affected by HIV/AIDS. There
1675 are more than one half million African Americans living with
1676 HIV/AIDS today. African Americans account of about half of
1677 all the new AIDS cases, although only 12 percent of the
1678 population is black. African American women represent
1679 somewhere between 66 and 75 percent of all the new AIDS cases
1680 among women. And African American teenagers represent 69
1681 percent of all the new AIDS cases among teenagers. I could
1682 go on and on with this.

1683 Are you shocked about this crisis? Are you bothered
1684 about this crisis?

1685 Let me start with Dr. Julie Gerberding. Does this
1686 information shock you?

1687 Dr. GERBERDING. I, as I said before you were here, I
1688 believe this is an urgent situation. Am I shocked by it?
1689 I'm certainly not happy about it.

1690 Ms. WATERS. Do you think it's a crisis?

1691 Dr. GERBERDING. I think it is a crisis.

1692 Ms. WATERS. Mr. Fenton, are you shocked? Do you think

1693 this is a crisis?

1694 Dr. FENTON. I'm saddened, and CBC has portrayed this as

1695 an severe and ongoing crisis among the community.

1696 Ms. WATERS. Do you do think it is a crisis?

1697 Dr. FENTON. I do.

1698 Ms. WATERS. Dr. Anthony Fauci, do you think it is a

1699 crisis?

1700 Dr. FAUCI. Yes, I do, Ms. Waters.

1701 Ms. WATERS. Okay, given we all believe this is a crisis

1702 and these statistics and this information is shocking, what

1703 do you recommend?

1704 Dr. GERBERDING. I would be happy to share the

1705 professional judgment budget that we have presented to this

1706 committee with you, which I think reflects three major focal

1707 areas. One is to know not just who got it then or who is

1708 getting it now, but who is going to do get it if we don't act

1709 and invest in the systems that tell us what to do about that.

1710 Second is to get everybody diagnosed who's had it, so they

1711 can benefit from treatment. And the third is to put a

1712 significant effort into new research--

1713 Ms. WATERS. How long have you been at CDC?

1714 Dr. GERBERDING. Six years.

1715 Ms. WATERS. Six years? You heard my background on how

1716 I created the Minority Aids Initiative. I created that
1717 because we needed to focus on building capacity and getting
1718 communities that had little or no resources involved in RFP
1719 processes. We've been working very hard, and I come here,
1720 and I hear you, Mr. Fenton, talk about all this great work
1721 you're doing with minority leaders and minorities
1722 communities. I don't know about it. I've been involved in
1723 this issue for a long time, having created this and watching
1724 the incidence of HIV/AIDS grow in African American
1725 communities across the country.

1726 And I want to know, because I don't get a sense that you
1727 really feel this is a crisis. And when you tell me that,
1728 well, I submitted a budget, take a look at the budget, how
1729 have you sounded the alarm? What have you done to deal with
1730 this growing crisis? Do you see what I just said about
1731 African American teenagers from 13- to 19-years old
1732 representing 69 percent of all the new AIDS cases among
1733 teenagers? Doesn't that bother you?

1734 Dr. GERBERDING. Mrs. Waters, we will be briefing the
1735 Black Caucus this afternoon, but if you would be able to
1736 participate in our enhanced initiative, we would love to have
1737 your voice because we need to get leaders involved in helping
1738 us--

1739 Ms. WATERS. No, no, no, no, no.

1740 Dr. GERBERDING. We need your help.

1741 Ms. WATERS. No.

1742 Excuse me, Mr. Chairman.

1743 I am involved and I have been involved. And the Black
1744 Caucus has been screaming to the top of its voice for help.
1745 We just got one portion of this reauthorized with Ryan White.
1746 The other portions of the funding that we struggle with are
1747 not even official in the budget. What are you going to do
1748 about just getting CDC portion authorized? It is spread out
1749 among several of these agencies, including CDC and NIH and
1750 SAMSA. And I don't see any leadership from--I don't see any
1751 leadership from you.

1752 Now, I know that you think I'm being a little bit harsh,
1753 and I am. I happen to be an African American woman. I don't
1754 want gays and lesbian and African American men and women
1755 fighting about who is worse off. We are all worse off. And
1756 I don't like it when I go out into the communities and I see
1757 all of these little groups struggling and fighting, and the
1758 way you deal with the discretionary money. We need some
1759 leadership.

1760 And I'm so pleased that I am able to be here today, Mr.
1761 Waxman, and I thank you for indulging me in my frustration.

1762 Chairman WAXMAN. Thank you very much.

1763 The gentlelady's time has expired.

1764 Dr. Fenton and Dr. Gerberding, one--once CDC identifies
1765 effective programs, the next step is to disseminate them to

1766 the States.

1767 How does CDC identify effective programs.

1768 Dr. GERBERDING. I would like to ask Dr. Fenton to take
1769 on this in detail, but just to tell you that there is a
1770 two-step process. One is to review the evidence of efficacy
1771 by expert scientists who are in a position to make those
1772 judgments, and we respect that and to get that up in the
1773 compendium, which will be updated again. But in addition,
1774 there is a process of diffusion where we work with an
1775 organization that trains and helps disseminate people. Right
1776 now, there is a bottleneck in the training, so that's one of
1777 the issues we addressed in our professional judgement budget.

1778 Chairman WAXMAN. So you have a research time that
1779 applies a methodological review of studies of existing
1780 programs. They identify the ones that are found to work.
1781 You put it up on the compendium. Isn't that right?

1782 Dr. GERBERDING. Yes. And we expect the grantees who
1783 receive our dollars when they are developing programs to use
1784 those programs that are proven to be effective. But in order
1785 for them to successfully implement them, they often need
1786 training and support, and that's one of the areas that we are
1787 not able to keep up with right now.

1788 Chairman WAXMAN. When the compendium was first released
1789 in 1999, CDC said it would update it annually as effective
1790 new programs were identified, and CDC's experts did identify

1791 a number of additional programs that work, but as I
1792 understand it, you said there is a bottleneck. CDC did not
1793 issue annual updates to the compendium; is that right?
1794 Dr. GERBERDING. I can't go back to 1999, but we have
1795 done two updates since I have been the director of the CDC.
1796 It is a little hard to do it annually because the data from
1797 these programs doesn't come forward that fast, but I think we
1798 are accelerating our ability to do that.
1799 Chairman WAXMAN. When did CDC last issue an update on
1800 the compendium?
1801 Dr. GERBERDING. 2007.
1802 Chairman WAXMAN. Did CDC attempt to get HHS approval to
1803 release an updated compendium prior to that time?
1804 Dr. GERBERDING. I believe we did.
1805 Chairman WAXMAN. And what was the response from HHS?
1806 Dr. GERBERDING. I would have to ask Kevin, who wasn't
1807 the director at the time, to go into the details of this,
1808 because I don't know all the steps involved. We can provide
1809 that paper trail for you. But to suffice to say that it was
1810 not a sped did I process.
1811 Chairman WAXMAN. Okay. Well, I'd like the answer to
1812 that question for the record. I'd also like to know why
1813 didn't HHS approve any updates of the compendium until 2007?
1814 Dr. GERBERDING. I can't answer that.
1815 Chairman WAXMAN. Okay.

1816 Dr. GERBERDING. But I can say, in the recent years,
1817 we've had I think a much more accelerated process, and I'm
1818 satisfied that we are able do it in a timely way now. I hope
1819 we will have the update for 2008 before the end of this
1820 calendar year.

1821 Chairman WAXMAN. Well, it took 8 years to update the
1822 list with crucial information about programs that have been
1823 shown to save lives. And I'm concerned that instead of
1824 encouraging effective HIV prevention, HHS seems to have been
1825 standing in the way. In fact, the committee asked CDC for a
1826 list of dates for which the compendium and other important
1827 HIV prevention documents were submitted to HHS for clearance
1828 and when they were actually released. And my understanding
1829 is that the committee hasn't gotten a response because CDC's
1830 response is still in clearance at HHS.

1831 Does CDC provide training or technical assistance for
1832 implementing the programs it identifies?

1833 Dr. GERBERDING. Yes, we do.

1834 Chairman WAXMAN. And how many organizations are
1835 currently on the waiting list?

1836 Dr. GERBERDING. About 2,000.

1837 Chairman WAXMAN. So 2,000 organizations out there want
1838 to provide identify effective HIV prevention programs, but
1839 they are still on a waiting list. I think that's
1840 unconscionable given the statistics we've been hearing about

1841 today, and I think we need to address it.

1842 Dr. Gerberding, just a clarification of your testimony,
1843 you suggested earlier that one of the reasons that you
1844 lowered your prevention goals is that there are more people
1845 with HIV living because of treatment, but the data for 2000
1846 estimated 945,000 people living with HIV, and for the data
1847 for the most recent year, we find around a million people.
1848 This is about a 5 percent. Does a 5 percent increase in
1849 people living with HIV produce an 80 percent decrease in your
1850 goal and a 20 percent decrease in funding for preventions?

1851 Dr. GERBERDING. I'm not going to be able to do that
1852 math in my head, but I think what you're getting to is, you
1853 know, what is the full picture of the recalibration? And,
1854 again, I was on the advisory committee when we were
1855 struggling to develop that first 50 percent reduction. We
1856 recognized at that time that there was a bell shaped survival
1857 curve for HIV, so the projections were that we would see an
1858 excalation in death rates, and that was factored into the
1859 projection of the transmission. So it was a--I don't want to
1860 say it would be easier to prevent if there were fewer people
1861 living because that isn't our public health goal, but the
1862 calculus was different then. And that's not the only reason,
1863 as I already said, but that is one of the factors--

1864 Chairman WAXMAN. Well, I asked that question--

1865 Dr. GERBERDING. --different as opposed to now.

1866 Chairman WAXMAN. Because I was troubled by the answer
1867 you had given earlier so I just wanted to pursue that point.
1868 And I thank you for responding.
1869 This panel has been very helpful. I think it is unfair
1870 to criticize the four of you for what you are trying to do.
1871 I think you're trying to do the best you can, and you're
1872 trying to do as much as you can without sufficient funds and
1873 without the barriers to your efforts being removed. And the
1874 purpose of having you here is not to criticize you but to try
1875 to be constructive in working with you to be sure that you
1876 have the ability to do the job because we are all very
1877 concerned and frustrated that there are so many people whose
1878 lives are at risk and will be lost unless we in government do
1879 what's needed. And if it is not coming from the U.S.
1880 Government, it is not going to happen at all. I thank each
1881 of you for your testimony today.
1882 I want to now call forward the witnesses for our second
1883 panel, Dr. David Holtgrave. We will wait a minute and have
1884 the second panel come forward.

1885 STATEMENTS OF DAVID HOLTGRAVE, Ph.D., PROFESSOR AND CHAIR,
1886 DEPARTMENT OF HEALTH, BEHAVIOR & SOCIETY, JOHNS HOPKINS
1887 BLOOMBERG SCHOOL OF PUBLIC HEALTH; ADAORA A. ADIMORA, M.D.,
1888 DIVISION OF INFECTIOUS DISEASES, UNIVERSITY OF NORTH CAROLINA
1889 SCHOOL OF MEDICINE; GEORGE AYALA, Psy.D., RESEARCH HEALTH
1890 ANALYST, RTI INTERNATIONAL AND AIDS PROJECT LOS ANGELES;
1891 HEATHER HAUCK, DIRECTOR, AIDS ADMINISTRATION, MARYLAND
1892 DEPARTMENT OF HEALTH AND MENTAL HYGIENE; FRANK OLDHAM, JR.,
1893 PRESIDENT, NATIONAL ASSOCIATION OF PEOPLE WITH AIDS

1894 Chairman WAXMAN. We're pleased that you are here today,
1895 and I want to introduce those of you on the second panel.
1896 Dr. David Holtgrave is founding Chair and professor at
1897 the Department of Health, Behavior and Society at the Johns
1898 Hopkins Bloomberg School of Public Health. Had he served as
1899 director of behavioral and social sciences at the Emory
1900 Center for AIDS Research and as director of the intervention
1901 research and CDC's Division of HIV/AIDS Prevention. Dr.
1902 Holtgrave has focused on the efficacy, effectiveness and
1903 economic evaluation of a variety of HIV prevention
1904 interventions, contributing to over 175 professional
1905 publication.
1906 Dr. Ada Adimora is associate professor of medicine at
1907 the University of North Carolina School of Medicine and

1908 adjunct associate professor of epidemiology at the School of
1909 Public Health. She has been the principal investigator on
1910 multiple CDC and NIH funded research projects and has
1911 published extensively on the epidemiology of HIV in America
1912 with a focus on African Americans. Dr. Adimora a practicing
1913 clinician and a fellow of the American College of Physicians.
1914 Dr. George Ayala, works as a research psychologist and
1915 public health analyst at RTI International's Urban Health
1916 Program in San Francisco, California; is also the executive
1917 officer of the Global Forum on Men Who Have Sex with Men and
1918 HIV. He is the former director of health promotion community
1919 research and capacity building at HIV/AIDS Project LA where
1920 he managed HIV prevention technical assistance research. A
1921 clinical psychologist by training, Dr. Ayala's research
1922 focuses on the mechanisms through which social discrimination
1923 impacts health.
1924 Heather Hauck is the director of Maryland Department of
1925 Health and Mental Hygiene AIDS administration, leading
1926 statewide public health efforts to reduce HIV transmission in
1927 Maryland and to help Marylanders with HIV/AIDS live longer
1928 healthier lives. Ms. Hauck is currently Chair-elect of the
1929 National Alliance of State and Territorial AIDS Directors.
1930 She has served as the section chief of the STD/HIV section
1931 for New Hampshire and as a consultant on HIV program issues
1932 for hospitals, national associations and state public health

1933 agencies.

1934 Frank J. Oldham, Jr., is the executive director for

1935 National Association of People with AIDS. He has spent over

1936 two decades as a leader in HIV policy, administering HIV

1937 programs for the cities of New York and Chicago, and working

1938 in numerous AIDS service organizations. Mr. Oldham has

1939 served and is currently serving on several planning and other

1940 policy bodies, including the New York City Commission on

1941 AIDS; the National Minority AIDS Council; CDC's 5-year

1942 strategic planning committee; and Lambda Lesbian & Gay

1943 Community services.

1944 We are pleased to have you here today. I want to inform

1945 you that, in this committee's practice, all witnesses who

1946 appear before us do so under oath, so we'd like to administer

1947 and oath to you if you would please stand and raise your

1948 right hand.

1949 [Witnesses sworn.]

1950 Chairman WAXMAN. The record will indicate that each of

1951 the witnesses answered in the affirmative.

1952 Your prepared statements will be in the record in full.

1953 We'd like to ask, however, that you limit the oral

1954 presentation to 5 minutes. And we will have a clock that

1955 will tell you, for 4 minutes, it is green; and the last

1956 minute, it will turn orange; and when the time is up, it will

1957 turn red.

1958 Dr. Holtgrave, let's start with you. There is a button
1959 on the base of the mike. Be sure it is pressed so we can
1960 hear you.

1961 STATEMENT OF DAVID R. HOLTGRAVE, Ph.D.

1962 Mr. HOLTGRAVE. Chairman Waxman, Representative Davis
1963 and distinguished members of the committee, thank you for the
1964 opportunity to speak with you.
1965 Today's hearing is truly urgent. CDC's HIV incidence
1966 estimate suggests that there is a new infection every 9 and a
1967 half minutes in the Nation. There is an AIDS-related death
1968 every 33 minutes. The ratio in ethnic health disparities are
1969 staggering. And the lifetime HIV care and treatment costs
1970 for one person can easily top $275,000.
1971 Because of the new incidence estimates, one might ask
1972 two key questions: Are HIV prevention programs effective,
1973 and are they delivered at a sufficient scale in the U.S.? My
1974 answer will be yes to the first question and no to the
1975 second. To assess prevention effectiveness at the National
1976 level, we must examine HIV transmission rates. Obviously,
1977 HIV is spread from a person living with the virus to someone
1978 who is HIV negative. The transmission rate is the number of
1979 new HIV infections in a year divided by the number of people

1980 living with HIV in that year. As seen in this first slide
1981 the HIV transmission rate dropped from over 92 in 1980 to 6.6
1982 in 1991.

1983 On the second slide, we see that the transmission rate
1984 stayed at roughly this level until 1997 when, after the
1985 advent of new therapies, the transmission rate actually went
1986 up temporarily to 7.5. Thereafter it declined once again.

1987 In 2006, the transmission rate appears to be just under
1988 5. This means over 95 percent of persons living with HIV in
1989 the U.S. are not transmitting the virus to someone else in a
1990 given year.

1991 Another key measure of prevention success is the
1992 difference between what we observed in the HIV epidemic and
1993 what would have occurred had prevention programs not been in
1994 place in slide three. From the beginning of the epidemic
1995 through 2006, I estimate very conservatively that roughly
1996 362,000 infections were prevented in the Nation and over 3.3
1997 million quality adjusted life years were saved.

1998 There is a clear relationship between HIV prevention
1999 program funding and incidence, as seen in the fourth slide.
2000 The bottom line is that, in terms of HIV prevention
2001 investment, the Nation gets what it pays for. One must be
2002 concerned, therefore, that when adjusted for inflation, CDC's
2003 HIV prevention budget has fallen over 19 percent since fiscal
2004 year 2002, and in real dollar terms, the investment in the

2005 minority AIDS initiative is also in decline.
2006 Further, CDC's data shows that a small fraction of gay
2007 men in need of HIV prevention services report receiving them.
2008 Clearly our investment in prevention is lacking. We must
2009 therefore scale up the use of evidence-based HIV prevention
2010 tools already at our disposal even we hope for new
2011 intervention, such as a vaccine. As seen in slide five, some
2012 currently available evidence-based HIV prevention
2013 interventions are readily available to us. What's most
2014 important to emphasize is that we possess the technology to
2015 influence HIV-related risk behaviors, and an extensive
2016 scientific literature leaves very little on that point.
2017 So what is the right level of investment? I estimate
2018 that CDC's HIV prevention budget, now at $0.75 billion, needs
2019 to increase to about $1.32 billion per year and remain, on
2020 average, at that level for about 4 years at least so as to
2021 undo the damage done since fiscal year 2002 and to address
2022 HIV prevention needs in the U.S.
2023 What new services could be delivered at this higher
2024 level of investment? On the sixth and final slide, I list
2025 some of these. I believe it would provide sufficient
2026 resources to field the new very large-scale targeted HIV
2027 counseling and testing campaign; a nationwide public
2028 information and anti-stigma campaign; intensive
2029 client-centered, evidence-based prevention services for the

2030 minority persons living with HIV who engage in any risk
2031 behavior that could result in transmission; in brief, the
2032 science-based intervention for 15 million HIV negative
2033 persons at risk of infection.

2034 What public health impact would this achieve? After 4
2035 years of heightened service delivery, the U.S. could reduce
2036 HIV transportation rates by 50 percent and HIV incidence by
2037 50 percent. Further, we could achieve and maintain a 90
2038 percent level of serostatus awareness of persons living with
2039 HIV. This is a great fiscal investment. The cost per
2040 infection averted via this new heightened response would be
2041 roughly $27,000, and that indicates the prevention programs
2042 could easily save more medical resources than cost to
2043 implement.

2044 But accountability is key. The proposed intensification
2045 of these programs must be accompanied by a quick but careful
2046 review of current HIV prevention resources across the Federal
2047 Government, and we need a national AIDS plan. Further, the
2048 performance of all HIV prevention resources should be
2049 summarized in an annual report card so that mid-course
2050 corrections can be made.

2051 In conclusion, we are at a historic crossroads in the
2052 HIV Epidemic in the U.S. Doing more of the same will achieve
2053 more of the same. And as asserted by a recent report of
2054 Black AIDS Institute, the U.S. is indeed being "left behind."

2055 But we can find the national will to scale up evidence-based
2056 HIV prevention programs sufficiently to change the course of
2057 the epidemic in the U.S. once and for all.

2058 Thank you, again, sincerely for your strong interest in
2059 HIV prevention.

2060 [Prepared statement of Mr. Holtgrave follows:]

2061 ******** INSERT 2-1 ********

2062 Chairman WAXMAN. Thank you very much, Dr. Holtgrave.
2063 Dr. Adimora.

2064 STATEMENT OF ADAORA A ADIMORA, M.D.

2065 Dr. ADIMORA. Thank you for this opportunity to speak
2066 with you.
2067 I have been asked to testify concerning HIV epidemiology
2068 in the U.S. particularly with respect to African Americans
2069 and structural and social forces that affect individual and
2070 community vulnerability HIV.
2071 These are some of the essential concepts. First,
2072 individual level sexual behavior, such as partner number and
2073 condom use, don't completely explain racial disparities in
2074 the U.S. HIV rates. Second, sexual network patterns are
2075 critical in the spread of HIV throughout the population.
2076 A sexual network is a set of people who are linked
2077 directly or indirectly through sexual contact. The
2078 distribution of network characteristics that promote
2079 population HIV spread, like concurrent partnerships and
2080 sexual mixing patterns, appears to differ by race in ways
2081 that increase HIV transmission among African Americans.
2082 Third, social forces and social contacts that is social
2083 macro-economic and other features that are outside the

2084 individual's control contribute to sexual network patterns
2085 that spread HIV. So some potential pathways between HIV and
2086 several social forces are relatively clear. For example,
2087 residential segregation by race supported by structural
2088 mechanisms, like mortgage lending practices, concentrates
2089 poverty in the segregated group.

2090 Segregation may especially influence young people's HIV
2091 risk since residence often dictates school districts which
2092 influence adolescents' social and sexual networks. Also the
2093 sex ratio, the ratio of men to women, is a key determinant of
2094 the structure of the networks. The sex ratio among African
2095 Americans is strikingly low due to high mortality among black
2096 men and is further decreased by high incarceration rates.

2097 The relative scarcity of men contributes to low marriage
2098 and higher divorce rates. There is a strong association
2099 between being unmarried and having concurrent partnerships.
2100 Poverty, another force, works with the low sex ratio to help
2101 destabilize marriage and makes marriage less feasible in many
2102 black communities.

2103 The disproportionate incarceration of black men
2104 dramatically effects sexual networks in black communities.
2105 Incarceration disrupts existing partnerships, making it more
2106 likely that each partner will have concurrent partnerships.
2107 While inmates are in prison, they can join gangs and forge
2108 new long-term links with antisocial networks. These new

2109 links can then connect members of high-risk sub groups to
2110 previously low-risk people and their networks. High
2111 incarceration rates contribute to increased unemployment in
2112 poor minority communities shrinking the number of financially
2113 viable male partners as well as the absolute number of men.
2114 Rod Wallace showed how macro level forces shapes social
2115 contacts and AIDS death rates in a New York City borough. In
2116 the 1970s, New York's fiscal crisis prompted city agencies to
2117 embark on a deliberate policy of planned shrinkage of the
2118 populations in black and Hispanic neighborhoods. The plan
2119 involved withdrawing critical city services, including fire
2120 fighting services, from poor areas that already had high fire
2121 rates. So neighborhoods burned. Many people moved to other
2122 parts of borough, and social networks and community structure
2123 were disrupted. What was presumably not anticipated when
2124 these policies were implemented were the changes in the
2125 geography of drug abuse that resulted from this migration and
2126 the resulting upsurge years later in HIV.
2127 So, finally, the pathways between social forces and HIV
2128 suggest that continuing to focus prevention efforts solely on
2129 individual risk factors and individual determinants won't
2130 significantly impact HIV rates among blacks in the U.S.
2131 Certainly the search for and implementation of effective
2132 biological and behavioral interventions must continue and
2133 must certainly be funded. However, public health research

2134 must also take into account the social forces that are
2135 driving the extraordinary racial disparity in HIV rates in
2136 this country.
2137 I believe several steps, among others, should be taken
2138 immediately. First, the HIV epidemic among African Americans
2139 should be formally declared a national emergency, and
2140 moreover, the U.S. should act as if the epidemic is a true
2141 national emergency by developing and appropriately funding an
2142 effective domestic HIV plan that addresses not only
2143 biological and behavioral interventions but also the
2144 epidemic's social and economic roots. This will require
2145 involving clinicians and public health researchers as well as
2146 experts in sociology, economics, political science, criminal
2147 justice and other disciplines.
2148 Secondly, incarceration affects the health of black
2149 communities. Attention should be given to the markedly
2150 disproportionate incarceration of black men.
2151 Third, comprehensive sex education can be effective in
2152 reducing risky sexual behavior and should be given in
2153 schools.
2154 Thank you very much.
2155 [Prepared statement of Dr. Adimora follows:]

2156 ******** INSERT 2-2 ********

2157 Chairman WAXMAN. Thank you very much, Dr. Adimora.
2158 Dr. Ayala.

2159 STATEMENT OF GEORGE AYALA, Psy.D.

2160 Mr. AYALA. Chairman Waxman and distinguished committee
2161 members, thank you for this opportunity to speak with you
2162 today on the critical topic of HIV prevention in the United
2163 States. It is my privilege to be here with you today.
2164 Presently HIV prevention in the U.S. lacks the resources
2165 and comprehensiveness that will significantly drive down HIV
2166 incidence rates, as has been demonstrated by my esteemed
2167 colleague Dr. Holtgrave. I ask that you consider the
2168 following: Serious HIV-related health disparities often
2169 fueled by stigma and discrimination continue to undermine HIV
2170 prevention efforts in communities of color. Men who have sex
2171 with men continue to make up the majority of new HIV
2172 infections nationally, across race and ethnicity, with black
2173 and Latino men especially hard hit. Only four of the CDC's
2174 49 recommended evidence-based interventions specifically
2175 target gay men, and only one of them is designed address the
2176 needs the gay men of color.
2177 In addition, and just as important to consider, are
2178 these facts: Substance abuse, prevention and treatment are

2179 underfunded and not routinely viewed as integral to overall
2180 HIV prevention efforts. Structural interventions are not
2181 commonly researched or endorsed, even when sound science
2182 support their broadbased adoption, as has been the case with
2183 multi-component syringe access and disposal programs.

2184 Other than new HIV treatments, we have not yet harnessed
2185 the full potential of other promising biomedical
2186 interventions, including pre-exposure prophylaxis and
2187 microbicides. And many science-based prevention
2188 interventions are difficult for community-based providers to
2189 implement because they were tested under research conditions
2190 that are different from real-life settings or tested on
2191 populations other than those currently most vulnerable to HIV
2192 infection.

2193 While HIV testing and treatment are crucial in our fight
2194 against AIDS, a singular focus on testing and treatment is
2195 inadequate and narrows an already sparse continuum of
2196 prevention strategies. We need a comprehensive national HIV
2197 prevention plan in the U.S. At its core, such a plan would,
2198 one, work to eliminate disparities in health access and
2199 stigma associated with HIV, drug use, and homosexuality. The
2200 personal benefits of knowing one's HIV status early are lost
2201 on those who must overcome the significant barriers to
2202 treatment and persistent stigma that keep so many away from
2203 care.

2204 Two, target interventions to those most at risk to HIV
2205 exposure and keep a steady and respectful focus on the
2206 prevention needs of gay and bisexual men, substance users and
2207 women at sexual risk. The alternative is that we accept
2208 silence and denial about sexuality, drug use and economic and
2209 equality, permitting stigma and discrimination to compromise
2210 our provision efforts.
2211 Three, ensure that priority be given to expanding social
2212 science and intervention research aimed at gay and bisexual
2213 men, especially men of color.
2214 Four, make the prevention and treatment of drug and
2215 alcohol addiction central to our HIV prevention efforts. The
2216 risk for HIV infection is heightened by drug and/or alcohol
2217 abuse.
2218 Five, research and adopt community-sensitive structural
2219 interventions to compliment behavior modification programs.
2220 Structural level changes buttress the gains and behavior
2221 change made through individually geared prevention
2222 interventions by addressing the social factors that were
2223 addressed by my colleague Dr. Adimora that underline HIV
2224 vulnerability.
2225 Six, support continued HIV treatment, vaccine and other
2226 biomedical interventions that are safe, ethical, and show
2227 promise of efficacy.
2228 And finally, seven, balance the policy of promoting

2229 pre-packaged evidence-based HIV prevention interventions by
2230 supporting and evaluating more localized bottom-up and
2231 collaborative HIV prevention strategies. It is critical to
2232 respect on-the-ground responses to the HIV/AIDS epidemic by
2233 protecting local control over how HIV prevention strategies
2234 are developed, researched, prioritized and implemented.

2235 In closing, HIV prevention efforts in general have not
2236 received the funding needs--it needs to make them ubiquitous
2237 and continuous, nor have our resources been adequately
2238 targeted to reach those at highest risk for HIV infection.
2239 We need a comprehensive national HIV prevention plan in the
2240 U.S. that clear clearly calls for culturally relevant,
2241 multilevel combination approaches that are well funded,
2242 targeted and sustained over many years.

2243 Thank you.

2244 [Prepared statement of Dr. Ayala follows:]

2245 ******** INSERT 2-3 ********

2246 Chairman WAXMAN. Thank you very much Dr. Ayala.

2247 Ms. Hauck.

2248 STATEMENT OF HEATHER HAUCK

2249 Ms. HAUCK. Good afternoon, Mr. Chairman, Representative
2250 Davis, members of the committee.

2251 Thank you for inviting me to participate on this very
2252 distinguished panel.

2253 State Health Department AIDS directors appreciate that
2254 this committee is focusing on domestic HIV prevention
2255 activities, especially in light of the CDC's release of new
2256 HIV incidence estimates and the alarming rates of infection
2257 among African Americans and gay and bisexual men of all races
2258 and ethnicities.

2259 RPTS JURA

2260 DCMN ROSEN

2261 [12:10 p.m.]

2262 I will focus today on describing State Health Department
2263 HIV prevention portfolios, including the central importance
2264 of HIV/AIDS surveillance. I will also share key
2265 recommendations from State AIDS directors for an HIV
2266 prevention response to end the epidemic in our Nation.

2267 State Health Department HIV directors are responsible
2268 for implementing comprehensive HIV prevention care and
2269 treatment strategies in our States. We have stewards of more
2270 than half of CDC's $692 million budget for domestic HIV
2271 prevention surveillance programs, as well as significant
2272 State resources.

2273 All States implement CDC's required HIV prevention
2274 program components, such as HIV counseling, testing, and
2275 referral, partner services, health education risk reduction,
2276 community planning, program evaluation. Over the past 6
2277 years, however, CDC's funding to State and local health
2278 departments has decreased by $30 million. For many States,
2279 especially medium and low prevalence States, this decline in
2280 Federal funding has resulted in significant reductions in
2281 core components of HIV prevention services. At the same
2282 time, there has also been an increased directive from CDC to
2283 focus resources on HIV testing. When faced with such

2284 directives and funding reductions, States are forced to
2285 eliminate effective interventions that are needed to prevent
2286 HIV transmission in our regions or among our populations.
2287 HIV prevention efforts must be aligned to meet the needs
2288 of those who bear the greatest HIV/AIDS burden in the U.S.
2289 As the recent CDC HIV incidence estimates clearly illustrate,
2290 African Americans, men and women, and gay and bisexual men of
2291 all races and ethnicities are significantly impacted by HIV.
2292 State and local health department HIV programs work to
2293 eliminate health disparities based on race, ethnicity,
2294 gender, sexual identity, and class.
2295 In Maryland, our data show that HIV largely
2296 disproportionately impacts African Americans, regardless of
2297 transmission risk category, and therefore we prioritize the
2298 reduction of health disparities among racial and ethnic
2299 communities as a cross-cutting theme for all of our HIV
2300 initiatives.
2301 A central activity of State HIV prevention programs is
2302 measuring and describing the epidemic through HIV
2303 surveillance activities. These activities are essential to
2304 understanding our local HIV epidemics so that we can then
2305 target HIV prevention activities appropriately. These data
2306 also determine the allocation and distribution of resources
2307 for HIV care and treatment via the Ryan White Program.
2308 The CDC has been unable to adequately sustain funding

2309 for core surveillance or for projects such as the incidence
2310 surveillance projects which led to the new estimates released
2311 in August. For example, Maryland's total budget for HIV/AIDS
2312 surveillance was reduced by 40 percent in the last year, and
2313 the State is no longer funded for incidence surveillance.

2314 The loss of surveillance funds in the States jeopardizes
2315 our ability to know that the populations most impacted by the
2316 HIV epidemic, in Maryland, heterosexuals ages 30 through 49,
2317 disproportionately African American and living in the
2318 Baltimore metro area, Prince Georges and Montgomery Counties.
2319 If we can't describe our epidemics, we can't plan effective
2320 HIV prevention strategies and interventions appropriate for
2321 our local communities. The CDC needs additional funding to
2322 restore and expand incidence surveillance and to shore up
2323 core surveillance across all jurisdictions.

2324 AIDS directors articulated our vision for America's
2325 prevention response in a new blueprint for the Nation, Ending
2326 the Epidemic Through the Power of Prevention, and copies have
2327 been made available to the committee.

2328 Three key elements are required to successfully reduce
2329 the number of new HIV infections. One, adequately fund CDC's
2330 HIV prevention and surveillance program at the level of at
2331 least $1.3 billion annually. Two, significantly invest in
2332 interventions that work to prevent infection, including
2333 research to develop new population specific interventions,

2334 access to sterile injection equipment, enhanced program in
2335 correctional settings, and establish a comprehensive
2336 sexuality education as the standard. Three, meaningfully
2337 invest in programs that support HIV prevention, including STD
2338 treatment, hepatitis vaccinations, substance abuse prevention
2339 and treatment, mental health services, housing, and expanded
2340 research for biomedical intervention.

2341 State and local health departments know that HIV
2342 prevention works, and we know that health department, health
2343 care providers, businesses, faith leaders, community based
2344 organizations, and persons living with HIV and AIDS must all
2345 be equipped with adequate tools and resources to help prevent
2346 new infections.

2347 Thank you again for holding this important hearing and
2348 for your thoughtful consideration of our recommendations to
2349 increase access to HIV prevention interventions provided by
2350 State and local health departments. I look forward to
2351 answering any questions you may have.

2352 Chairman WAXMAN. Thank you very much.

2353 [Prepared statement of Ms. Hauck follows:]

2354 ******** INSERT 3-1 ********

2355 Chairman WAXMAN. Mr. Oldham.

2356 STATEMENT OF FRANK OLDHAM

2357 Mr. OLDHAM. Chairman Waxman and the entire Oversight
2358 Committee, people living with HIV/AIDS thank you for your
2359 demonstrated leadership and an opportunity to speak with you
2360 about the state of HIV prevention in the United States of
2361 America.

2362 As a trusted and representative voice of more than 1
2363 million people living with HIV/AIDS in America, I say with
2364 great confidence that we know our status, and that has
2365 enabled us to save lives.

2366 HIV-related stigma and homophobia, homo-hatred continue
2367 to result in disproportionate HIV incidence among gay and
2368 bisexual men, black and Hispanic men and women, and
2369 individuals challenged by poverty, incarceration, and mental
2370 illness. As a black gay man, a person living with AIDS, and
2371 as a proud American, I ask, is this acceptable in our
2372 America?

2373 HIV prevention can only succeed through access to
2374 evidence-based interventions, accurate information and
2375 education, protected and voluntary HIV testing and screening
2376 services, effective use of care--HIV care and treatment as

2377 prevention, reduced stigma, and increased support for zero
2378 status disclosure, and by addressing structural, systemic,
2379 and economic barriers that continue to perpetuate HIV
2380 vulnerability among the most marginalized groups of
2381 Americans.

2382 This is the basis of support for our communities' call
2383 for a national AIDS strategy that is coordinated, evidence
2384 based, outcome driven, and inclusive of people living with
2385 HIV/AIDS.

2386 We have heard testimony from the Centers for Disease
2387 Control that annual HIV incidents has been as much as 40
2388 percent higher than the past 15 years. Prevention efforts
2389 have been flat-funded in our country for more than two
2390 decades, and the minority AIDS initiative has not been funded
2391 adequately to address the real HIV needs in communities of
2392 color.

2393 As we increase resources for minority AIDS initiatives,
2394 we must be sure to hold organizations that receive MAI funds
2395 accountable. We must scale up HIV prevention in America to
2396 an annual investment of $1.3 billion. This investment will
2397 prove to those at increased risk for HIV that we care about
2398 their lives.

2399 We hope that this will be a priority for the next
2400 administration. In the meantime, we urge an initial
2401 investment of $200 million for fiscal year 2009. The AIDS

2402 communities consent to this request.

2403 Eight years of abstinence only until marriage programs
2404 has had dire human consequences. HIV risk reduction
2405 strategies such as comprehensive sex education and syringe
2406 exchange programs have been proven to reduce HIV infections;
2407 yet, these interventions have not received the requisite
2408 level of Federal funding. It is imperative that we make
2409 decisions based in science and don't sacrifice lives and
2410 waste already constrained resources on programs that have
2411 been proven to be ineffective.

2412 The vast majority of individuals aware of their status
2413 are making decisions about their health and behavior that are
2414 not contributing to the spread of HIV. And I repeat, that
2415 are not contributing to the spread of HIV. Diagnosis, care,
2416 and treatment is effective HIV prevention, and our lives
2417 depend on it. This is all the more reason why we must ramp
2418 up our efforts to make sure people are aware of their HIV
2419 status.

2420 Sixteen years ago, the National Association of People
2421 With AIDS launched National HIV Testing Day, because we
2422 believe that taking an HIV test makes it possible for people
2423 to protect themselves and their loved ones. NAPWA supports
2424 increased in targeted testing at-risk populations, routine
2425 opt out screening for HIV in medical settings, and strongly
2426 believes there is an obligation to link people who test

2427 positive to high quality care, treatment, and support
2428 services. The Kaiser Foundation continues to report that 45
2429 to 55 percent of those with HIV are still not in care. 45 to
2430 55 percent of people who have HIV are not in care.
2431 With the passing of the Early Treatment for HIV Act our
2432 efforts to reform health care, America must ensure access to
2433 comprehensive and coordinated care for all persons living
2434 with HIV/AIDS. Aggressive research and treatment advances
2435 have helped more people live with HIV than ever before. The
2436 benefits of this research extend beyond HIV.
2437 CDC needs more resources to do the requisite research
2438 and work on the ground. HRSA, the National Institutes of
2439 Health, and the substance abuse and health agencies also need
2440 appropriate resources to identify new research opportunities
2441 and collectively further expand the toolkit of prevention
2442 strategies.
2443 Perceptions of stigma directly impact an individuals'
2444 willingness to be open about their HIV status, NAPWA invites
2445 more leadership from all sectors of American society in life
2446 to increase the visibility of people living with HIV and AIDS
2447 and opposes stigmatizing or negative language toward them.
2448 This is especially true in minority communities, in gay
2449 communities, and all communities challenged with social and
2450 economic inequality. The critical issue of AIDS in America
2451 must be a priority for all of us.

2452 NAPWA supports HIV prevention activities that are
2453 culturally and gender specific. NAPWA supports community
2454 mobilization strategies for all communities
2455 disproportionately impacted by this disease, and will launch
2456 the first National Gay Men's HIV Awareness Day on September
2457 27, later this month, in Raleigh, North Carolina. They will
2458 seek to accomplish increased awareness about the needs of gay
2459 men for HIV prevention, care, and treatment, forums to
2460 strategize effective responses to the epidemic in our
2461 community. We ask your support on this historic day, Gay
2462 Men's HIV Awareness Day, September 27. Thank you.
2463 Chairman WAXMAN. Thank you very much, Mr. Oldham.
2464 [Prepared statement of Mr. Oldham follows:]

2465 ******** INSERT 3-2 ********

2466 Chairman WAXMAN. I thank all of you for your testimony.
2467 Dr. Holtgrave, you prepared for us your idea of what a
2468 budget should be for HIV prevention, and it seems like what
2469 you've suggested is pretty much in the same ball park as what
2470 CDC said to us was their best professional judgment. Would
2471 you say that is an accurate statement?

2472 Mr. HOLTGRAVE. I would say so. I would say there are
2473 more points of agreement probably than disagreements. I
2474 think that the central message probably from both is that we
2475 need to substantially scale up our investment in HIV
2476 prevention. And, also, that it is achievable to think about
2477 reducing transmission rates and incidence by 50 percent in
2478 the U.S., and that it will take some years to do so.

2479 I think some of the difference in terms of the $1.3
2480 billion versus, say, the $1.7 billion or so that CDC called
2481 for is that they have some research funding, some activities
2482 on STD, TB, and hepatitis, which are very important, but that
2483 allows for some of the difference. And also, I think we
2484 could even be a little bit more aggressive and achieve the 50
2485 percent reduction a bit sooner than CDC has estimated. But,
2486 again, I think there is much more to agree than disagree
2487 between the two estimates.

2488 Chairman WAXMAN. But both you and CDC suggest that we
2489 could be preventing many more HIV infections than we are
2490 doing now, as well as increasing the proportion of people who

2491 know their HIV status, which of course goes together.
2492 Do you think that the two estimates reflect a general
2493 consensus among HIV experts that better outcomes are within
2494 reach, even based on current knowledge?
2495 Mr. HOLTGRAVE. I believe so. I think there is a
2496 general consensus scientifically that we have an outstanding
2497 array of tools, some of which that Dr. Fauci mentioned
2498 earlier, that are available to us now. And we need to make
2499 sure that we are using those tools. We must develop
2500 vaccines, we must develop microbicides. But we need to use
2501 immediately what we have available at our disposal.
2502 Chairman WAXMAN. Thank you.
2503 Dr. Adimora, I thought your presentation was very
2504 interesting. You presented a perspective that I hadn't heard
2505 before within the African American community. One of the
2506 aspects of the African American community, especially those
2507 who have HIV and AIDS, is that they live--many of them, if
2508 not most of them, live in poverty. How does poverty
2509 contribute to HIV risk for African Americans?
2510 Dr. ADIMORA. There are a variety of pathways between
2511 poverty and HIV and population HIV transmission. In fact, I
2512 would consider this to be--not consider the culprits to be
2513 not only poverty, but also racial discrimination.
2514 Among the pathways that I mentioned were segregation.
2515 And I mentioned some of the ways by which it works in terms

2516 of structuring people's social and sexual networks.
2517 Particularly alarming is the way in which it can structure
2518 the sexual networks of youth. Another issue concerning
2519 poverty is homelessness. Homeless people are particularly at
2520 risk for HIV. I mentioned just a few of the potential
2521 structural interventions that could be implemented, but I
2522 think that attention to homelessness and improved housing is
2523 certainly major consideration, and that relates certainly to
2524 poverty.
2525 Another issue is incarceration, given the
2526 disproportionate incarceration of black men. And I think
2527 that it is important, in thinking about incarceration, there
2528 is sometimes a tendency to start talking about mandatory
2529 testing in prison. Certainly everyone should have available
2530 to them a means for learning their HIV diagnoses and for
2531 appropriate treatment; but in addition, I think that
2532 incarceration is actually a major symbol of racial
2533 discrimination and oppression in this country, and there
2534 needs to be--significant attention needs to be paid to
2535 because of the myriad of consequences that it is
2536 having--well, certainly it is wrong in the first place. But
2537 the other issue is that it is clearly having an impact on the
2538 health of people, particularly black people.
2539 Chairman WAXMAN. You mentioned incarceration in your
2540 original presentation to us. And you said, not only are

2541 people getting HIV when they are incarcerated, but that there
2542 is a social disruption that imprisonment causes. I thought
2543 that was an interesting point. Do you see bias, racial bias
2544 as well as discrimination among gay and bisexual men in the
2545 black community as factors that are important for us to take
2546 note of?

2547 Dr. ADIMORA. Unquestionably. There are pathways
2548 between racial discrimination and HIV infection. This is
2549 beyond a matter of simply social justice because that is a
2550 good thing. The absence of social justice is a major root
2551 cause of many of the racial disparities in health that we are
2552 seeing in the United States, and specifically of HIV
2553 infection.

2554 Chairman WAXMAN. Dr. Ayala, do you have recommendations
2555 on how programs should take into account the specific needs
2556 of gay and bisexual men of color?

2557 Mr. AYALA. As I said in my testimony, very, very few of
2558 the recommended prevention interventions are specifically
2559 designed or geared to men of color, gay men of color.

2560 I think we have to do two things. One, we have to
2561 invest in a greater research portfolio that build with HIV
2562 prevention interventions that are specifically geared to gay,
2563 gay men of color. And the second thing is that we should
2564 take what we have available and tailor them for use in the
2565 communities, both for the target population in question, but

2566 also with consideration to the needs of providers who have to
2567 ultimately implement the interventions.

2568 Chairman WAXMAN. Ms. Hauck, at the State level, you
2569 stated surveillance measuring and monitoring the HIV/AIDS
2570 epidemic is crucial to HIV prevention efforts. The
2571 surveillance data not only helps you understand the epidemic
2572 but appropriately targeting resources. And I understand that
2573 Maryland was among eight States that actually lost funding,
2574 and you mentioned this in your opening statement, to conduct
2575 the kind of new incidence measurements in which the CDC based
2576 its recent estimates.

2577 What has been the impact of this cut on Maryland and
2578 other States?

2579 Ms. HAUCK. Thank you for the question. What happened
2580 at the State level was that our surveillance activities had
2581 been integrated. So we certainly received funding for core
2582 surveillance, which is really the basics of HIV surveillance
2583 and AIDS surveillance. And then we received these--funding
2584 for these projects. And we had integrated all of the
2585 activities, so that we were really gathering information in a
2586 holistic way about our epidemic.

2587 When you start to peel off special projects that have
2588 been integrated into your core surveillance activities, you
2589 are no longer able to fully fund the staff that are gathering
2590 the information, you are not able to do the data collection

2591 that we need to the level that we need the data in order to
2592 accurately describe our epidemic. So we may be missing some
2593 important components, like risk transmission categories, like
2594 race, like ethnicity, as well as potentially missing cases,
2595 because it is a rather intensive process to gather this
2596 information through our surveillance activities.

2597 So I think over time, what you will see is that States
2598 aren't able to sustain even our core surveillance activities,
2599 which again allow us to describe our epidemics, and,
2600 therefore, use that funding to allocate, distribute, and plan
2601 prevention as well as care and treatment services in our
2602 jurisdictions.

2603 Chairman WAXMAN. CDC presented to us their professional
2604 judgment of what the budget should look like; and they would
2605 request more funding to strengthen behavioral and clinical
2606 surveillance activities in the States. Do you think that
2607 they have adequately funded that aspect, in their
2608 professional judgment, budget?

2609 Ms. HAUCK. The National Alliance of State and
2610 Territorial AIDS Directors certainly states that at least an
2611 investment of $35 million in additional funding for
2612 surveillance is needed to both restore the cuts in
2613 surveillance that we've seen over time and to really bring
2614 all the jurisdictions up to standard operating budgets.

2615 Chairman WAXMAN. Dr. Fenton in the first panel

2616 testified about the importance of integrating HIV services
2617 with services for other sexually transmitted diseases. I
2618 want to ask you about that at the State level.
2619 Since 2000, the rate of syphilis in the U.S. has
2620 increased by 76 percent. As you know, this epidemic is
2621 primarily concentrated in the southeastern region of the U.S.
2622 among heterosexual African Americans and men who have sex
2623 with men. What will the States need to do to eliminate
2624 syphilis in these impacted populations? And, should those
2625 efforts be coordinated with HIV prevention efforts?
2626 Ms. HAUCK. Thank you for asking the question, Mr.
2627 Chairman. I'll answer the first part first.
2628 Yes, the CDC's budget for STD prevention has suffered
2629 many of the same declines that the HIV prevention budget has
2630 suffered over the years. Maryland is a southern State as
2631 well, and has certainly seen a significant syphilis epidemic,
2632 especially in Baltimore City and Prince Georges County, among
2633 African Americans, particularly men who have sex with men,
2634 and heterosexuals. And yet our funding has not kept pace
2635 with our need to address the syphilis epidemic in our State
2636 and certainly the majority of States that have had a syphilis
2637 epidemic. So I would say that the increase in resources is
2638 also needed. And we do integrate and do need to continue to
2639 integrate STD prevention and HIV prevention at the State
2640 level and at the local level.

2641 Many of the clients who come to seek services certainly
2642 need to be given similar messages, similar education, similar
2643 screening, and need to receive that in a holistic manner when
2644 they walk in the door of a clinic or an emergency room or a
2645 community-based organization, and we need the resources to
2646 enable the clients to receive those services at the time when
2647 they see them. Thank you.
2648 Chairman WAXMAN. Thank you. We have infection rates
2649 continuing to rise among men who have sex with men, and in
2650 the meantime, discrimination and marginalization of men who
2651 have sex with men remains widespread.
2652 Mr. Oldham, how does discrimination on the basis of
2653 sexual orientation affect gay and bisexual men who are living
2654 with HIV? And have any national campaigns in the U.S. HIV
2655 prevention directly addressed this kind of discrimination?
2656 Mr. OLDHAM. There have been campaigns from
2657 community-based organizations, such as Gay Men's Health
2658 Crisis, the L.A. Gay and Lesbian Center in Los Angeles, and
2659 AIDS-Positive Los Angeles. However, there has not been the
2660 governmental campaigns. Like, for example, we have National
2661 Black AIDS Awareness Day, Chairman Waxman, we have National
2662 Hispanic AIDS Awareness Day and a number--there are 12 of
2663 them.
2664 Even though the new CDC numbers indicate that gay men of
2665 all ethnic backgrounds make up the bulk of the epidemic and

2666 the loss of life in the epidemic, we do not even have a Gay
2667 Men's HIV/AIDS Awareness Day, which is why NAPWA is launching
2668 this on the 27th, to make sure that gay men are aware and are
2669 involved in this epidemic and not complacent about it
2670 themselves, and the rest of society deals with the issues of
2671 homophobia and homo-hatred, as barriers to HIV prevention and
2672 care services for gay men.

2673 Chairman WAXMAN. I want to thank all of you on this
2674 panel for your presentation and your willingness to answer
2675 questions. We may have members submitting to you additional
2676 questions, which you may respond to in writing for the
2677 record, because I know many members had a lot of things that
2678 they wanted to pursue but there are so many competing things
2679 going on that not everybody can be here.

2680 I think the purpose of this hearing has been to sound an
2681 alarm, because we have an increasing HIV epidemic in the
2682 United States. It is different than where we were in the
2683 early days, but it is very much with us. And unless we set a
2684 high priority to do the things we know that will work and to
2685 try to research and develop new ways of approaching the
2686 epidemic, we are going to fall further and further behind.

2687 We know that when budgets are sent to us, they are
2688 budgets that are developed ultimately by the budget people in
2689 the administration. They may get the input from the agencies
2690 and the experts, but they are trying to figure out their

2691 overall priorities. And the overall priority for this
2692 administration has not been to deal with the HIV/AIDS
2693 epidemic in the way that we need to, to stop and prevent the
2694 transmission of this disease.

2695 That is why I was pleased to have CDC and NIH present to
2696 us what their best professional judgment would be. It is
2697 always different when you ask that than what they have to say
2698 to us when they are making presentations before Congress,
2699 because then their presentations have to be consistent with
2700 the views of the administration in which they serve.

2701 Well, I think that presentation to us and your expanded
2702 discussion of the groups that are primarily affected and all
2703 the complications that we need to be aware of is going to
2704 help us face this epidemic and, I hope, to defeat it. Thank
2705 you very much for your presentation.

2706 That concludes the presentations at this hearing, and we
2707 stand adjourned.

2708 [Whereupon, at 12:33 p.m., the committee was adjourned.]

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PRESIDENT, NATIONAL ASSOCIATION OF PEOPLE WITH AIDS

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