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CAPACITY TO CARE IN A WORLD LIVING WITH AIDS

HEARING

BEFORE THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS UNITED STATES SENATE

ONE HUNDRED SEVENTH CONGRESS

SECOND SESSION

EXAMINING ISSUES RELATED TO HEALTH CARE FOR PATIENTS WITH THE AIDS VIRUS AND WHAT CAN BE DONE TO ADDRESS THE GLOBAL HIV/AIDS PANDEMIC

APRIL 11, 2002

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CAPACITY TO CARE IN A WORLD LIVING WITH AIDS

THURSDAY, APRIL 11, 2002

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The committee met, pursuant to notice, at 10:38 a.m., in room SD-106, Dirksen Senate Office Building, Hon. Edward M. Kennedy (chairman of the committee) presiding.

Present: Senators Kennedy, Dodd, Wellstone, Murray, Clinton, Frist, Warner, and Sessions.

OPENING STATEMENT OF SENATOR KENNEDY

The CHAIRMAN. The hearing will come to order.

We welcome our guests this morning who bring to this issue the challenges that we are facing in international AIDS a wealth of experience and an extraordinary sense of compassion and a series of recommendations about how we as a country can be even more effective in giving this the kind of world priority that it deserves.

I am going to recognize Senator Clinton, whose schedule is complicated, and who has been a real leader in our committee on this issue as she is on many other issues, and then I will say a word about some of my colleagues.

Senator Frist has been a great leader. He has traveled to Africa a number of times and has been very much involved in this issue as well as in other health issues. We are obviously very, very grateful for his presence and involvement.

Senator Warner has been a very active supporter of all of these efforts and very much wanted to have the opportunity to listen to our witnesses as well.

In just a moment, I will also talk about the leadership that has been provided by other colleagues on other committees which has been so valuable and helpful, but I want to extend just a word of very special appreciation to the leadership that Senator Clinton has provided. We are enormously grateful for her words at this time.

OPENING STATEMENT OF SENATOR CLINTON

Senator CLINTON. Thank you very much, Mr. Chairman.

I think we can tell by the number of people who are here that this issue has enormous impact here in our country and around the world, and I am very grateful to all the witnesses who are here and particularly pleased that my friend and someone who has really led

with his own charitable giving, the effort to deal with HIV/AIDS, Elton John, could be with us today. I asked Chairman Kennedy if we could just put a piano in here, and he could sing his testimony, but we did not get that worked out in time—maybe the next time.

We are also grateful to Sandra Thurman, who is president of the International AIDS Trust, for working in this area for so many years, and Dr. Allan Rosenfield from Columbia University in New York. And indeed, we are also grateful to Dr. Mugyenyi and also our last witness, Deborah Dortzbach.

All of these people represent the most forward-looking, effective advocacy and practice when it comes to HIV/AIDS. I am delighted that this hearing is being held by this committee, because we know that we have to have a united effort in our country. I want to thank Senator Frist for working with me on a bill that we introduced last year which really follows up on the work that he has done for so many years in Africa. This bill would send more trained doctors and nurses and health professionals to countries where we could help to provide additional resources, both money and human, in the great struggle against HIV/AIDS. So I appreciate not only Senator Frist's leadership but his example.

Having a trained, stable work force is one of the keys, but clearly, that is not enough. I would hope that the United States' efforts would be significant. In the United States, roughly 70 percent of the $10.8 billion of Federal resources spent on HIV/AIDS over the years has gone to care and treatment. Globally, the percentage of dollars spent on care and treatment is only 10 percent. We have to have a much broader range of reaction that takes into account all the various challenges that we confront.

I appreciate Secretary-General Kofi Annan's call for a $10 billion investment worldwide. I think, as a Senator who represents a State where we have struggled with HIV/AIDS for years and as someone who in the previous administration was privileged to go not only to Africa, but to Asia several times, that the United States' fair share of this effort should be 25 percent at minimum. I do not think that we have stepped up and given the resources that this emergency really demands from the United States.

We also have to better utilize the extraordinary expertise available in our Federal Government and assets in institutions like HHS which, through its various agencies—HRSA, CDC, NIH—over which this committee has jurisdiction, has tremendous expertise that needs to be utilized. HHS has been a key partner in the so-called Life Initiative since it was launched, virtually tripling the United States' investment in international HIV/AIDS efforts.

So today, we will look at the problem in light of what we could do, what we could do more, what we could do better, especially given HHS' strengths and capacities, and the leadership that the United States should show in addressing this global crisis.

I want to thank the witnesses and many others whom I see in the audience who, through their hard work, their philanthropic efforts, and their political advocacy, have really forced this issue to the forefront of our agenda, and I thank you, Mr. Chairman, for giving us this opportunity to really focus national and international attention. We have a number of ambassadors from different coun-

tries here, many from African countries, and I am very pleased that they are here as partners in this effort.

The CHAIRMAN. Thank you very much, Senator Clinton.

Before recognizing others, I want to thank Senator Gregg, our ranking member, who is not here.

Our leader, Senator Daschle, has given this a very high priority for this session of Congress. Senators Durbin, Corzine, Feinstein, Kerry, and Biden are members of the Foreign Relations Committee who have very, very important obligations and responsibilities in terms of serving that committee and also in this area. We are working very closely with them, as we should. And we are grateful as well to the support that Senator Helms has given to particularly the issues on infants and their various challenges.

I will take just a very brief moment to thank our witnesses for being here.

This is a pandemic that is affecting Africa, but not only affecting Africa—it is expanding into India, Southeast Asia, China, and the Soviet Union. It is something which this committee first held hearings on over 10 years ago, and at that time, the challenge that we faced as a country and as a society was really riddled with ideology, not science, not health considerations, but ideology. And it took a long time for the United States to begin to come to grips with this issue and deal with it in terms of understanding it, willingness to reach out to the millions of people whose lives are so devastated and affected by the scourge of this disease. We have made enormous progress, and it is a real tribute to so many who have worked so hard for so long in helping and assisting Congress and providing leadership in local communities and States as well.

The challenge is out there in terms of the world, and the real challenge is will the United States really rise to this challenge when we have been able in the last 10 years, with the progress that has been made, the research that has been achieved, the understanding about prevention, the new modalities in terms of understanding the challenge that is out in regard to mothers and infants, the reality of understanding the devastation that this scourge causes countries in Africa—we cannot exist on this planet without understanding how our fellow citizens are hurting, and when the United States is prepared to lead, what a difference it can make. We have already seen it; there are encouraging signs.

This is really a wakeup call, and we have individuals on our panel this morning who will help us better understand it, and I am most grateful to all of them, as they have been leaders on this issue day in and day out over such a long period of time. They bring a wealth of understanding, a strong commitment, and they have been incredibly effective, so we can benefit greatly from them, and we look forward to hearing from them in just a moment.

[The prepared statement of Senator Kennedy follows:]

PREPARED STATEMENT OF SENATOR KENNEDY

Today's hearing is about the greatest global public health threat of our times—the spread of HIV/AIDS.

AIDS is the fourth leading cause of death in the world. This terrible disease destroys lives, denies hope to individuals and families, and threatens the well-being of entire countries.

We in America know of the pain and loss that this disease cruelly inflicts. Millions of our fellow citizens—men, women, and children—are infected with HIV/AIDS. And far too many have lost their lives.

While we still seek a cure to AIDS, we have learned to help those infected by the virus to lead long and productive lives through the miracle of prescription drugs.

But this disease knows no boundaries. It travels across borders to infect innocent people in every continent across the globe.

We have an obligation to continue the fight against this disease at home. But we should also share what we have learned to help those in other countries in this life-and-death battle. And we must do all we can to provide new resources to help those who cannot afford today's therapies.

This committee and its members have a deep commitment to sharing the lessons learned in helping our people at home to help others meet great human needs abroad. As we sought to enforce child labor laws at home, we also worked to protect children abroad. As we developed new ways of promoting children's health and public health, we have shared these life-saving discoveries with other countries in need.

And once again, we are called upon to open the doors between nations to do all we can to halt the spread of AIDS, and to treat those infected by it.

Twelve years ago this month, the members of this committee demonstrated their commitment to the care and treatment of Americans living with AIDS by passing the Ryan White Care Act. Since that time, community-based care has become more available, drug treatments have improved that nearly double the life expectancy of HIV positive individuals, and public campaigns have increased awareness of the disease. Yet, advances such as these remain largely the privilege of wealthy nations.

AIDS inflicts a special toll on developing countries. Globally, 40 million people have HIV/AIDS, and the overwhelming majority live in poor countries. Sub-Saharan Africa is the most affected region, where nearly all of the world's AIDS orphans live. AIDS robs poor countries of the workers they need to develop their economies. They lose teachers needed to combat illiteracy and train their workers for modern challenges. In Africa, they have lost seven million farmers needed to meet the food needs of entire nations. AIDS plunges poor nations into even deeper, more desperate poverty.

The presence of HIV/AIDS poses a particularly serious concern for women and girls. Most new infections are among young adults and women. Females who are not infected feel the impact, too. Girls must often leave school to assume responsibilities for sick family members, robbing them of educational opportunities and denying local economies of valuable workers.

Governments can make the difference in battling this epidemic. Where governments in poor countries have been provided resources to fight the spread of AIDS, infection rates have dropped 80 percent. But these countries cannot turn the corner on AIDS on their own. Their governments must be provided the guidance and resources to carry out anti-AIDS campaigns. They need financial help

to afford expensive anti-retroviral drugs. And drug companies must do their part to make these drugs more affordable to the poor.

In addition, more public education is needed. A UNICEF survey found that most young people still have not heard of AIDS or do not understand how the disease is transmitted. By speaking out, our Government can help to lift the stigma and taboo surrounding the disease and save lives.

These challenges are not insurmountable. The epidemic is in its early stages. In most regions of the world, the prevalence rate is still less than 1 percent of the population. But we cannot delay. It only took 10 years for the HIV/AIDS population to double in the Russian Federation. And in South Africa, the rate increased from 1-in-100 people to 1-in-4 in one decade.

Our committee is developing legislation to support and strengthen global treatment and training initiatives.

Our legislation would provide new legal authority and funding to NIH, CDC, HRSA and the Department of Labor to join the global battle against AIDS.

It would promote community-based care models and better access to microbicide research and retroviral therapies.

Our legislation would fund research and treatment models to prevent the transmission of the disease from mothers to their infants.

And it would help countries to develop better training models that support service delivery at the grassroots level.

Today we will hear from witnesses who have devoted themselves to fighting this epidemic by ensuring that prevention, care, and treatment is not just accessible to some people in some countries, but all people in all countries.

We are honored to have you with us today.

The CHAIRMAN. We have been joined by Senator Sessions and thank him very much for joining us.

I will now turn to Senator Frist, who has been so involved and has provided important leadership in this area, if he would say a word.

OPENING STATEMENT OF SENATOR FRIST

Senator FRIST. Thank you, Mr. Chairman.

I too want to thank each of our witnesses. It is wonderful to be able to sit where we are and look out at the witnesses with whom many of us have had the opportunity to interact individually, but also to see the people who have come to this hearing today, members from the public sector, from the academies, from the corporate sector, from the private sector, from the NGOs, from the evangelical community, from the entertainment industry. It really points out to me the fact that in 2002, we have an opportunity which, as the chairman said, we will see if we are up to facing directly and appropriately, but we have an opportunity to address the challenge that has increased over the last 10 years and increased over the last 15 years, but a challenge which is much bigger than any of us as individuals, as Members of the United States Senate, as members of the U.S. Government—much bigger than the United States of America. It really is a global challenge, and the opportunity is there before us.

This particular committee has not formally addressed this particular issue, and I am delighted and thank the chairman and the ranking member, Senator Gregg, for bringing this hearing before us, because we have not formally addressed it in such a comprehensive way in over a decade.

Over that same decade, the number of new infections of HIV, if we look just in Sub-Saharan Africa, has increased from an increase of around 1 million a year to around 3.5 million new infections a year.

We have opportunities that I think are unique for the time today because of the range of people involved. As Chairman Kennedy pointed out, the perspective was much different 10 years ago and even 5 years ago, and as I have followed this issue closely over the last 5 years, I think it is much different than even a year or 2 years ago. Now it is our challenge to capture that intersection of bringing a diverse group of people from the breadth of the political spectrum together to address an issue that is much greater than any of us.

I want to thank my colleague Senator Jesse Helms who, over the last 2 weeks, rightly said that we have within our power the ability to substantially reduce the mother-to-child transmission of HIV/AIDS, something that our panel will address this morning. Senator Helms has pledged to do just that, and I intend to join him in those efforts.

President Bush, Secretary of State Colin Powell, and Secretary Thompson of HHS are also committed to aggressively fighting the global AIDS epidemic.

With the commitment of our Nation's leaders and, as we will talk about this morning, the critical importance of having world leaders from other nations, both affected as well as donor nations, I believe we can stand up to this challenge.

With that, Mr. Chairman, I will stop. I think that issues and the importance of science will come forward. In the meantime, we have a lot to do as we wait for that vaccine. We do not even know if we are going to have that vaccine, and we have a lot to do.

Let me just say thank you, Mr. Chairman, for calling the hearing, and I look forward to hearing from our witnesses.

[The prepared statement of Senator Frist follows:]

PREPARED STATEMENT OF SENATOR FRIST

Mr. Chairman, thank you for calling this hearing. Senator Clinton, I appreciate your efforts to assure that the HELP Committee once again examines the global impact of HIV and AIDS. It has been over a decade since this committee looked at the topic of global HIV/AIDS, and it is critical that we continue to highlight the impact of this disease on our global community. This is not strictly an American problem—it ignores national borders, threatening the entire world.

When I first came to the Senate 8 years ago, my aim was to serve my home State of Tennessee and this great Nation. Since arriving, my steps have also taken me far from the Senate floor—on seven different medical mission trips to Sudan, Africa, and most recently, in January, to Uganda, Kenya and Tanzania.

The trips were to learn more firsthand about the impact that a simple virus is having on the destruction of a continent. Not a family. Not community. Not a state. Not a country. But an entire continent.

The statistics of this global plague are shocking. Each year, 3 million people die of AIDS. Someone dies from the disease every 10 seconds. About twice that many, 5.5 million—or 2 every 10 seconds—become infected. That's 15,000 a day. And what's even more tragic is that 6,000 of those infected each day are young—between ages 15 and 24. Ninety percent of those infected do not know they have the disease. There is no cure. There is no vaccine. And the number of people infected is growing dramatically.

The disease's toll is incalculable. Thirteen million children have been orphaned by AIDS. Over the next 10 years, the orphan population may well grow to 40 million—equivalent to the number of American children living east of the Mississippi River.

As ranking member of lthe African Affairs subcommittee of the Foreign Relations Committee, I have a commitment to increase public awareness of the HIV pandemic in Africa, and most importantly, to develop a strategy to combat and eradicate the disease. What I saw and learned in Uganda, Kenya and Tanzania was extraordinary—coming face-to-face with the human tragedy of HIV/AIDS, and lives cut far too short.

Africa has lost an entire generation. In Nairobi, Kenya, I visited the Kibera slum. With a population of over 750,000, 1 out of 5 of those who live in Kibera are HIV/AIDS positive. As I walked the crowded pathways sandwiched between hundreds of thousands of aluminum shanties, I was amazed that there were only children or elderly individuals. The disease had wiped out the parents—the most productive segment of the population—teachers, military personnel, hospital workers, law enforcement officers.

In Arusha, Tanzania, I met Margaret who developed her first symptoms in 1990. When her husband died, despite her illness, she found the strength to fight his family to keep the family property. Thanks to her brothers, she has a house for her 6 children. I also met Nema in Arusha. She sells bananas to survive and provide for her year-and-a-half old son, Daniel. When Daniel cried from hunger, Nema kissed his hand because she had nothing else to give him but her love.

I had the privilege of visiting with Tabu, a 28 year old prostitute, who was leaving Arusha to return to her village to die. She stayed an extra day to meet with us, and I will never forget her cheerful demeanor and mischievous smile as we met in her small stick-framed mud hut, no more than 12 by 12. Her two sisters are also infected, another sister has already died. Tabu will leave behind an 11-year-old daughter, Adija.

At home in Tennessee, or even here in Washington, DC., Uganda and Tanzania feel very far away. But the plague of HIV/AIDS and the chaos, despair and civil disorder it perpetrates only leads to the demise of democracy in a country, in a continent, in the world. Without civil institutions, there is disorder.

Last year in South Africa, one of every 200 teachers died of AIDS. In a recent study in Kenya, 75 percent of deaths on the police force are AlDS-related. HIV-related deaths among hospital

workers in Zambia have increased 13 times in over a decade. The aftermath of these losses is devastating to local economies. Botswana's economy is projected to shrink by 30 percent in 10 years; Kenya's by 15 percent. Family incomes in the Ivory Coast have declined by 50 percent, while health care expenditures have risen by 4,000 percent.

African orphans lack teachers, lack role models and leaders. This leaves them vulnerable to criminal organizations, revolutionary militias, and terrorists. Terrorism and crime could become a way of life for a young generation.

Africa is not alone. India, with over 4 million cases, is on the edge of explosive growth. China is estimated to have as many as 10 million infected persons. The Caribbean suffers from one of the highest rates of infection of any region in the world. Eastern Europe and Russia report the fastest growth of AIDS cases.

That is why I'm devoting much of my time to this issue, and in particular, to the impact of HIV/AIDS in Africa. Just as our great Nation is the leader in the war on terrorism, we must continue to lead the fight against AIDS in order to build a better, safer world.

So, where do we go from here? There are three keys to combating this epidemic—(1) Leadership; (2) Prevention and Treatment; and (3) Funding.

As a first step, it takes strong leadership at all levels, and this must come first from the top. President Museveni in Uganda has not been bashful about speaking very publicly to the citizens of his country about HIV/AIDS. Bakili Muluzi, President of Malawi told me that he opens every speech to his countrymen with an admonition about HIV/AIDS. These leaders are acting to bring the disease into the light, to eliminate the stigma sometimes associated with the disease. Others are acting—governments, the United Nations, the World Bank, world leaders, corporations and philanthropies. From President Bush to Kofi Annan and Secretary Powell, world leaders have recognized the call to action and the need to do more.

It is also leadership from people such as Bono, lead singer of the Irish rock band, U2. With his passion for Africa and his "bully pulpit" as a celebrity, he's a credible and accomplished spokesperson on the issue. He joined us in Uganda and Kenya for a couple of days, and I was impressed with his knowledge, his commitment, and his caring.

It takes leadership at all levels to ensure that our efforts are well coordinated, understanding the importance of the diverse stakeholders in the fight against HIV/AIDS. We must coordinate within and across national govennments. We must leverage our precious resources and avoid duplication of effort. As I saw firsthand in east Africa, the best ideas often come from those fighting this disease on the ground. Community participation is essential, and local leadership is critical, particularly as we work to prevent and treat the disease. Let me cite a couple of examples.

In Tanzania, Sister Denise Lynch runs the Uhai Center for the Roman Catholic Diocese of Arusha, serving village schools and churches. Father Bill Freida, a physician at St. Mary's Hospital in Kenya, tells me they serve over 400 HIV/AIDS patients a day, and their chapel and bakery help anchor the community. Dr. Ebenezer Mwasha, in Tanzania, teaches the spiritual and moral values in ad-

dition to proper health and hygiene. The work that these individuals have accomplished, coupled with their faith and commitment, are a true inspiration. Their efforts will pay dividends for many in the years to come. Their leadership on the ground and in the trenches, each and every day, is fundamental to our ultimate success.

We should also salute the leadership of the Centers for Disease Control and Prevention (CDC) and the United States Agency for International Development (USAID). According to President Museveni, our Government's investment in Uganda of $120 million over the last 10 years has been the key to bringing HIV/AIDS prevalence rates down from 14 percent to 8 percent. The presence of these agencies is making a difference.

Until science produces a vaccine, prevention through behavioral change and awareness is the key. And once again, cultural stigmas must be overcome. Through a combination of comprehensive national plans, donor support and community-based organizations, we can make progress. Uganda, Thailand and Senegal are three examples of solid success.

We must encourage people to be tested. This is an opportunity to save countless lives. The more people know, the more likely they are to act. We should increase investments in rapid HIV testing kits and counseling. Access to these tools reinforces prevention messages and guides treatment options. As I saw in Africa, testing centers become centers of hope, a place where those struggling with HIV/AIDS support each other, learn coping strategies, and receive medical treatment and nutritional support.

I was particularly impressed by the work in the Kibera slum of Nairobi at the Kibera Self-Help Programme, run by the CDC. Officials there told me that a negative test provides a powerful incentive to stay healthy, and gives an opportunity to counsel people on risky behavior, ultimately saving lives. A positive test removes the burden of uncertainty and allows for timely treatment and counseling, an important first step in living longer and healthier lives.

In recent months, pharmaceutical companies have sent a message of hope by slashing prices on anti-retrovirals for poor countries. Other treatment regimens may make an even bigger difference in extending life and holding families together. Just as importantly, treatment provides the hope people need to get tested. And there are other public health advantages to treatment that require further research and evaluation. Treatment with anti-retroviral drugs may lower the amount of virus in the blood, potentially decreasing the risk of transmission, both among adults and mother-to-child transmissions.

In addition, access to treatment and drugs is also needed for opportunistic infections, such as tuberculosis (TB) and malaria. For all the damage caused by HIV/AIDS, TB kills more people in Africa with AIDS than any other opportunistic infection. CDC officials in Kenya told me that TB has increased six-fold in the last 10 years, and it's impossible to separate HIV and TB. I've seen first hand in Sudan the re-emergence of TB in strains more resistant, more virulent, than any we have seen before. Malaria is also more rampant in the immunosuppressed. Additionally, in treating severe anemia

that commonly accompanies illness due to malaria, untested blood transfusions make possible additional HIV/AIDS spread.

Let me add that on the subject of vaccines we must continue to search for the tools to reverse the spread of HIV/AIDS. Research and development must continue, and I'm pleased to report that NIH currently has over two dozen vaccine candidates in the pipeline. Someday, and hopefully very soon, we will have a vaccine to prevent this disease.

Finally, support of health care delivery systems—with a special emphasis on personnel training—is essential to effective treatment programs. This fundamental principle is captured in my legislation—"the Global Leadership in Developing an Expanded Response or GLIDER Act," which I introduced last year along with Senator Clinton. The legislation establishes the Paul Coverdell Health Care Corps—a corps of health care professionals to assist in the development of health care infrastructure by training local individuals. The overall design of the Corps is such that health care professionals throughout their career can have a wide variety of opportunities to suit their training.

In sum, I believe there are eight goals we must pursue in this global fight:

1. We must continue to encourage the political, religious and business leaders of the world to unite against the spread of HIV/AIDS and to help those who are afflicted with the disease.

2. We must continue to embrace the new Global Fund for HIV/AIDS, TB, and Malaria. This is not a UN fund, or an American fund. It is a new way of doing business. As an additional show of American support, I am joining Senator HELMS in introducing an amendment to the Emergency Supplemental Appropriations Bill to provide an additional $500 million to prevent mother-to-child transmission of AIDS. These funds would be given to the Secretary of State, who can spend them on bilateral programs and/or give them to the Global Fund for HIV/AIDS, Tuberculosis, and Malaria. The funds would have to be matched by non-governmental sources.

3. We must leverage America's resources and talent. There must be a "call to cure" for our health care professionals to use their talent and expertise.

4. We must encourage and empower coalitions of governments, multi-lateral institutions, corporations, foundations, scientific institutions and NGO's to fill the gap between the available resources and the unmet needs for prevention, care and treatment.

5. We must continue to put community-based organizations, both religious and secular, at the forefront by getting funds to them quickly so they can most effectively reach those who most need help.

6. We must ensure that: international research efforts on disease affecting poor countries is reinforced in a manner that assures the best scientific work in the world will lead to real benefits for the developing world—at a cost they can afford.

7. We must focus on prevention, and support care and treatment options that combine reasonable cost pharmaceuticals with appropriately structured health care delivery systems.

8. Finally, we must provide comfort to the families and orphans affected—to give them hope and dignity.

I can still hear young Daniel's cries of hunger and know that his young mother will not live to see him grow into adolescence, much less manhood; can see Sister Denise as she patiently and capably answers my many questions about the best ways we can help; still hear the pride in Father Freida's voice as he describes his hospital as a place to provide dignity and comfort to the inflicted and dying; and I think of Tabu who has returned to her home village to face death. These images will remain with me; they strengthen my resolve to win the fight against HIV/AIDS.

History will judge how we as a Nation—how we as a global community—address and respond to this most devastating and destructive public health crisis we have seen since the bubonic plague ravaged Europe over 600 years ago.

The task looms large, but by pulling together, with leadership from all—we will eliminate the scourge of HIV/AIDS from the face of the globe in our lifetime.

The CHAIRMAN. Thank you.

I will ask each of my colleagues if they want to say a brief word.

We welcome Senator Murray.

OPENING STATEMENT OF SENATOR MURRAY

Senator MURRAY. Thank you very much, Mr. Chairman.

Let me really thank all of our witnesses for being here today. It is so clear that your commitment to fighting the global AIDS epidemic and your work in developing a compassionate and humane response really has made a difference, so I truly want to thank all of you.

Mr. Chairman, this is such an overwhelming issue, I think, for all of us. When you look at the number of people living with AIDS, the number of children living with AIDS, the people we have lost because of AIDS, it is staggering. But when you add the number of children who are living without a parent or parents, it becomes just overwhelming.

So I think it is very clear that we need a global response to this growing crisis, and the United States cannot remain passive on this issue.

So I really appreciate your holding the hearing today. I look forward to the testimony of all of our witnesses and to working with all of you to respond to this crisis.

The CHAIRMAN. Thank you.

Senator Warner.

OPENING STATEMENT OF SENATOR WARNER

Senator WARNER. Thank you, Mr. Chairman.

I joined this committee because my father was a medical doctor and devoted much of his life to the care of those suffering and also to medical research.

I wish to commend you, Chairman Kennedy, Senator Clinton, Senator Frist, for spearheading the interest here in the United States Senate. I would take it a step further than my good friend to my left, that it is not a challenge, but it is an obligation for the Congress of the United States to be a full partner in this effort.

I welcome the distinguished panel of witnesses today. You have given much of your private and professional lives to this endeavor.

I want to mention, Sir Elton, that a mutual friend of ours, a longstanding friend of mine, Elizabeth Taylor, has done a lot of work in this area, and I get frequent calls on this issue from her.

But I have another reason that interests me. My work here in the Senate is largely in national security and international security, and quite frankly, this disease has had a direct impact on many nations in Africa to be able to maintain internal political and military stability and political and military stability with their neighboring nations. This disease has spread to the point where they are unable to recruit and maintain the necessary armed forces in these respective nations to secure their borders and otherwise.

So we must address this problem here at home, and we must address it worldwide, and the Senate, I hope, with the Congress as a whole will be a full partner.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Senator Dodd.

OPENING STATEMENT OF SENATOR DODD

Senator DODD. Mr. Chairman, I would ask unanimous consent that my opening remarks be included in the record.

I want to thank Senator Clinton and Senator Frist and others for holding today's hearing. Last evening, in fact, Mr. Chairman, I cochaired along with our colleague Senator DeWine the Elizabeth Glaser Pediatric AIDS Foundation dinner, where Morty Barr of the Communication Workers and our colleague Orrin Hatch were honored last evening.

To try to get this in perspective, the numbers get so overwhelming that it becomes very difficult, I think, for average people to get a sense of the magnitude of the problem. But I was struck, going over some of the numbers yesterday in preparation for some brief remarks last evening, that if everyone here just today, as we go through our normal daily work today with our hearings and meetings and whatever else people do, keep in mind that before the day ends, 2,000 children will contract HIV/AIDS. That happens every single day—2,000 kids every, single day. So as we go through the steps of what we consider a normal day, just remember that at the end of this day, there will be 2,000 more children infected, and that goes on every day.

So this is very, very important. I am particularly pleased to see that we have gotten the politics out of the way on this issue, that we are now talking about what we can do. And I think Senator Warner is absolutely right—this is a desperate health condition, but it also goes beyond that. It is a national security issue, and the fact that the world is beginning to really move on this is encouraging, and I am anxious to hear our witnesses.

[The prepared statement of Senator Dodd follows:]

PREPARED STATEMENT OF SENATOR DODD

Good morning, Mr. Chairman, thank you for convening this important hearing. I know of no greater threat to world health today

than the threat presented by EV and AIDS. A simple review of the global numbers regarding the pervasiveness of AIDS is staggering, Mr. Chairman. It is my hope that today's hearing will lead us to strengthen our resolve to take on this horrendous disease that has already robbed us of 25 million lives since its first identification.

Here in the United States, Mr. Chairman, an estimated 850,000 to 950,000 individuals are living with the human immunodeficiency virus, or HIV, according to the Centers for Disease Control (CDC). An alarming one-quarter of these cases are currently undiagnosed. Each year, more than 40,000 Americans will contract HIV, more than half under the age of 25.

An additional 338,000 Americans are living with AIDS. AIDS is now the fifth leading cause of death in the United States among people aged 25 to 44, and the leading cause of death for African-American men in this same age group. However, in the United States progress is being made. The estimated annual number of deaths due to AIDS in the United States fell approximately 70 percent from 1995 to 1999, from approximately 51,000 deaths in 1995 to 15,000 in 2000.

While this decrease is to be lauded, Mr. Chairman, similar decreases in other parts of the world have unfortunately not yet been realized. In fact, the spread of HIV and AIDS throughout the world has grown dramatically during the same period that the United States has decreased the toll extracted by both HIV and AIDS.

Tragically, the Sub-Saharan region of Africa represents only 10 percent of the world's population, but more than 70 percent of the world's HIV and AIDS-infected. More than 28 million people in this region are infected with HIV. Last year alone more than 2.3 million Africans lost their lives to AIDS. Since the beginning of the AIDS epidemic, Mr. Chairman, an astonishing 19 million Africans have succumbed to this terrible disease. In most of the world, Mr. Chairman, the overall rate of HIV infection is 1.2 percent. Alarmingly, the same infection rate in Sub-Saharan Africa is 8.4 percent. In sixteen African nations, infection rates are above 10 percent and the nation of Botswana has reached an infection rate above one-third of its total population.

I feel I would be remiss if I didn't mention the terrible toll that HIV and AIDS have taken on the children of Sub-Saharan Africa. More than 12 million African children have been orphaned since the beginning of the AIDS epidemic. Today, more than 6.5 million AIDS orphans are living in Africa. These orphaned children face increased risk of malnutrition and greatly reduced access to adequate healthcare and educational opportunities. AIDS has literally robbed millions of African children of their parents, and too often, their futures.

Equally tragic, Mr. Chairman, is the fact that countless numbers of children in the developing world will contract the virus that causes AIDS through contact with their own mothers. This year alone an estimated 500,000 children in the developing world will contract HIV from their mothers despite the fact that there exists already drug therapies that can virtually eliminate mother-to-child transmission of this devastating disease.

This is not to say, however, that the solution to the global AIDS crisis rests solely with the availability of lifesaving pharma-

ceuticals. As I know we will hear from our witnesses this morning, just as importantly as access to medicines in our fight against AIDS is the development of adequate healthcare infrastructures in the developing world. We find time and again that without sufficient healthcare resources—such as adequately trained health professionals and access to suitable hospitals and clinics—we will continue to face an uphill battle that medicines alone will not win.

Mr. Chairman, again, thank you for calling this important forum. I look forward to hearing from our witnesses this morning.

The CHAIRMAN. Senator Sessions.

OPENING STATEMENT OF SENATOR SESSIONS

Senator SESSIONS. Thank you, Mr. Chairman, for calling this hearing.

It is indeed time for us to act. We have done a lot, but much more needs to be done. I am not satisfied that any of us, certainly myself included, number one, have been as active as we should be in studying this disease.

I talked to Dr. Frist several years ago, telling him that something needed to be done. He has traveled the world; he has gone out and talked to people and utilized his great scientific and medical expertise to help us focus on how to confront this problem.

I certainly want to pledge my support to it. I believe that we have got to utilize the best science possible. We know, as Senator Dodd mentioned, that we can do more on children. That is something we know we can do. And there are other things that we know work with properly applied resources and scientific work and determination.

I thank the chairman for holding this hearing and look forward with interest to hearing the testimony of the witnesses.

The CHAIRMAN. Thank you very much.

Just for the information of committee members, we have been notified that there will be three votes starting at noontime, so we have just over an hour. We will ask our witnesses if they can limit their remarks to about 7 minutes, and that will give each of us a chance to ask one or two questions.

Sandy Thurman, we thank you so much for all that you have done and continue to do. We look forward to your comments.

STATEMENT OF SANDRA L. THURMAN, PRESIDENT, INTERNATIONAL AIDS TRUST, WASHINGTON, DC

Ms. THURMAN. Thank you, Mr. Chairman, and other distinguished members.

I am delighted to once again come before the committee that has played such a pivotal role in America's fight against AIDS. Since the early days of the epidemic, this committee has brought a spirit of commitment and bipartisanship to this vitally important fight.

You have consistently demonstrated that AIDS can transcend politics and party affiliation and that by working together, we can make extraordinary progress. Your leadership in addressing AIDS here at home is unparalleled, and your willingness and commitment to fighting the pandemic around the globe is desperately needed and very, very much appreciated. I want to thank you all for your interest and your support.

In 1982, when I cared for my first AIDS patient as a young hospice volunteer, I never dreamed in a million years that the kind of agonizing death that I witnessed would not have been stopped by the wonders of modern medicine.

A year or so later, I again found myself alone at the bedside of a young African American man at Grady Memorial Hospital in Atlanta who had been abandoned by his family, lost his job and his apartment, and had almost been literally run out of town. He wound up in Atlanta living alone in an AIDS housing program.

I had never seen a young man fail faster than that young man did. I will never forget the look of despair in his eyes as his life slipped away, and I held his bone-thin hand in mine. And while he was grateful for my presence, there was no way on God's green earth that I could replace what he had lost. As he called for his mother and I wiped his brow, I thought at that moment that I would die, too. I always believed that that young man did not really die of AIDS; he died of a broken heart that was a complication of ignorance and fear and discrimination. Surely, I thought at that moment in my life, we could be more compassionate, and surely this thing would come to an end soon.

But I was wrong. The first year that I testified before this committee, I gave more than 50 eulogies for people who died of AIDS—a little more than one a week. The death toll was mounting, and for those of us who were working in AIDS at that time, it became painfully clear that there was no end in sight. Nearly a decade later, I found myself serving in the White House and visiting Africa to witness the epidemic there first-hand—and there was that young man's face again, but it was multiplied by the thousands and indeed, by the millions. It was the first time in my professional career or my volunteer career that I understood what the word "plague" really meant.

By any and every measure, AIDS is a plague of biblical proportion. I do not have to give you all the statistics. You know the statistics—every day, 8,000 people die of AIDS; every day, 14,000 people become infected; and, as Senator Dodd said, each and every day, 2,000 babies are born with HIV.

But while the challenge before us is very, very great, it is not a cause for hopelessness and resignation, but for leadership and action. The good news is that we know what works. In two decades of living with AIDS, important lessons have been learned, and effective interventions have been developed and tested and evaluated over and over again.

Over the past few years, I have had the opportunity to visit a dozen countries in Africa, to go to India, the Caribbean and see first-hand the extraordinary efforts that people on the ground are making with very, very limited resources.

Teenagers are teaching their peers how to protect themselves from HIV using street theater. Nuns on bicycles in rural areas of Africa are delivering medicines to people who need them. Grandmothers are mobilizing to care for orphaned children in their communities. Village by village, nation by nation, we are seeing really impressive results.

Broad-based prevention programs have stopped the epidemic in its tracks in Senegal, dramatically slowed the spread of the infec-

tion in Thailand, and slashed rates of new infections in Uganda by more than half, and we are now seeing the same kinds of results in Cambodia and Zambia.

There is much more that needs to be done, and nowhere is the gap more glaring than in access to medical care and treatment for the millions of poor people living with AIDS, especially those in Africa.

If 8,000 people a day are dying of a disease for which treatments to prolong life and reduce suffering are available, something is terribly, terribly wrong. But the reality is that only 5 percent of people with AIDS in Africa can even get the most basic care—and only a few thousand on the entire continent have access to antiretrovirals or triple-combination therapies. And currently, while the U.S. Government is providing some care and support, we are doing precious little to put pills in the mouths of people who really need them. As a global community, we can no longer sit back and watch this happen.

I take issue with the argument that in the fight against AIDS, we have to choose between prevention and treatment. Survival is not an either/or proposition. Prevention and treatment are both essential and mutually-reinforcing strategies. We certainly learned that in the domestic epidemic in the 1980s.

Unless treatment exists, there is little incentive for people to come and find out their HIV status. Yet it is through voluntary counseling and testing that some of the most effective behavior change actually occurs. Where treatment is offered, counseling and testing centers are literally swamped. I know that Senator Clinton has seen that in Uganda. And as people begin to live with AIDS, their presence in the home, in the workplace, in the church, and in the community begins to reduce the stigma and begins to bring AIDS out into the open where we can deal with it head-on.

Providing care and treatment in Brazil has not only cut their AIDS death rate by 60 percent and saved the Government millions of dollars in hospital costs, but has helped to keep the number of new infections to about half what had originally been projected.

More than a decade ago, in the name of our friend Ryan White, this committee fashioned legislation that has been a lifeline of hope and care for millions of American families living with HIV and AIDS. Today I urge this committee to lead the global community in finding ways to extend that kind of lifeline to families living with AIDS throughout the developing world. As the committee stated in that report: "By dedicating this legislation to Ryan, the committee affirms its commitment to provide care, compassion, and understanding to people with AIDS everywhere. Ryan would have expected no less." That was 12 years ago.

We know the way. What we need now is the will and the wallet to get the job done. It is not a question at this point of whether we can or cannot—it is a question of whether we will or whether we will not.

Mr. Chairman, Secretary Kofi Annan and UN AIDS have called on the global community to collectively provide $10 billion a year for HIV prevention and AIDS care programs in the developing world. If we are going to turn the tide in this epidemic, we have got to ratchet up our response so it begins to match the magnitude

of the challenge. The world cannot keep trying to put out this raging fire with spoonsful of water. It just does not work.

The CHAIRMAN. We will give you another few seconds to wind up.

Ms. THURMAN. Okay.

In fiscal year 2002, the global community is spending approximately $2 billion, with about $800 million from the United States. That is why 250 organizations have asked the United States to commit the $2.5 billion that Senator Clinton talked about to the fight against AIDS.

Mr. Chairman, I urge this committee to by a key player, to authorize at least $400 million at CDC to expand their essential prevention efforts, while directing new and significant attention to care and treatment. As CDC seeks to incorporate care and treatment in their ongoing prevention efforts, I believe the committee should direct HRSA to do the kind of training that they have learned so well in their experience with the Ryan White CARE Act.

The CHAIRMAN. Just to be fair to all of our witnesses, we will ask you to conclude, and we will include your full statement in the record, and it was a very effective one.

Ms. THURMAN. Certainly. Thank you, Mr. Chairman.

[The prepared statement of Ms. Thurman follows:]

PREPARED STATEMENT OF SANDRA THURMAN

Mr. Chairman, Dr. Frist, Senator Clinton and other distinguished members, I am delighted to once again come before a committee that has played such a pivotal role in shaping America's response to AIDS. Since the early days of the epidemic, this committee has brought compassion, commitment and a spirit of bipartisanship to this vitally important fight.

You have consistently demonstrated that AIDS can transcend politics and party affiliation and that by working together we can make great strides. Your leadership in addressing AIDS here at home is unparalleled and your dedication to meeting the AIDS challenge around the world is very much appreciated and desperately needed.

By any and every measure, AIDS is a plague of biblical proportion. To date, 25 million men, women, and children have already died, and each and every day the world loses another 8,000 lives to AIDS. And while 40 million people are now living with HIV, today and every day, 14,000 more will become infected—one every 6 seconds. It is projected that by the decade's end, more than 44 million children will have been orphaned by AIDS—or nearly the same number of children as all those attending public school in the United States.

In just a few short years, AIDS has wiped out decades of development gains in many African nations—where infant mortality is now doubling, child mortality is tripling, and life expectancy is plummeting by 20 years or more.

AIDS is also having a dramatic impact on productivity, trade and investment—striking down workers in their prime, driving up the cost of doing business, and driving down GDP. Many businesses report having to hire at least two workers for every one skilled job, assuming that one will die from AIDS. Already, nurses and teachers are dying faster than they can be replaced.

AIDS is beginning to chip away at security and stability—not just in nations hardest hit, but among neighbors, allies and all of us.

And it is important to remember that the pandemic in Africa is just the tip of the iceberg, with the Caribbean already seriously affected and the fastest growing epidemics now found in India, China, and the Newly Independent States of the former Soviet Union.

But while the challenge before us is great, it is not cause for hopelessness and resignation, but for leadership and action. The good news is, we know what works. In the two decades of living with AIDS, important lessons have been learned and effective interventions have been designed, implemented, and evaluated.

Over the past few years I have had the opportunity to visit a dozen countries in Africa, India, and the Caribbean and to see first hand extraordinary efforts to stem the rising tide of new infections, to provide health care and hope to those who are

sick, and to support children and families left behind—often with very limited resources.

Teenagers are using street theatre to teach their peers how to protect themselves from HIV. Nuns on bicycles are delivering bactrim to people with AIDS in rural communities. Grandmothers are mobilizing to care for orphaned children. And village by village, country by country, in the face of seemingly insurmountable odds, we are seeing impressive results.

Broad based prevention efforts have stopped the epidemic in its tracks in Senegal, dramatically slowed its spread in Thailand, and slashed rates of new infections by more than half in Uganda and now in some populations in Cambodia and Zambia.

But there is much more that needs to be done and nowhere is this gap more glaring than in access to medical care and treatment for the millions of poor people living with AIDS, especially those in Africa. If 8,000 people a day are dying of a disease for which treatments to prolong life and reduce suffering are available, something is deadly wrong. But the reality is that only 5 percent of people with AIDS in Africa can get even the most basic care—and only 5,000 can now afford antiretrovirals. As a global community we can no longer be silent about the extent of this suffering.

I am very troubled by the argument that in the fight against AIDS we must choose between prevention and treatment. Survival is not an either/or proposition. Prevention and treatment are both essential and mutually reinforcing strategies.

Unless treatment exists, there is little incentive for people to learn their HIV status. Yet it is through voluntary counseling and testing that some of the most effective behavior change occurs. Where treatment is offered, counseling and testing centers are swamped, thereby accelerating prevention. And as people begin to live with AIDS their presence in the home, the workplace, the church, and the community reduces stigma and begins to bring AIDS out of the shadows where it can be fought head-on.

Providing care and treatment in Brazil has not only cut their AIDS death rate by 60 percent, saving their government hundreds of millions of dollars in hospitalizations, but has helped to keep their number of new infections to less than half of what was projected.

More than a decade ago, in the name of our friend Ryan White, this Committee fashioned legislation that has been a lifeline of hope and care for millions of American individuals and families living with HIV. Today, I urge this Committee to lead the global community in finding ways to extend that kind of lifeline to families living with AIDS throughout the developing world.

The Ryan White CARE Act fostered the development of community-based systems of health care and support services across this country—including many rural and resource-poor communities. In the early days, these care networks were run by family members, community outreach workers and volunteers, who didn't have triple combination therapies to offer, but could offer compassion, support, treatments for opportunistic infections, and palliative care. And these care systems began to change the course of the epidemic in this country while we moved to make newer and better therapies both available and affordable. Although not directly transferable, this is precisely what needs to happen in highly impacted countries worldwide.

It is true that we will need procurement and distribution systems, more clinics, and more doctors, nurses, and community health workers, more training and capacity, but that can be done. Just think—no matter where in the world you are, you are no more than 2 minutes from a cold Coke. That means, where there's a will, there's a way. In the meantime, district hospitals, private sector clinics, faith-based, employer-based, and community-based programs, and other settings provide safe and effective places to begin delivering care and treatment.

We know the way. What we need now is the will and the wallet to get the job done. The question really isn't can we or can't we—but will we or won't we? I believe that the answer must emphatically be—we will—and soon.

LEADERSHIP AND RESOURCES

Mr. Chairman, what we desperately need is leadership and resources. UN Secretary General Kofi Annan and UNAIDS have called on the global community to collectively provide $10 billion a year for HIV prevention and AIDS treatment in the developing world. If we are going to turn the tide, we need to ratchet up our response so that it begins to match the magnitude of the challenge. The world can't keep trying to put out this raging fire with spoons full of water.

In fiscal year 2002, the global community is spending approximately $2 billion—with slightly more than $800 million coming from the United States Government. As you can see, we are only one-fifth of the way toward our goal. In recent days,

we have been reminded of the power of the United States to mobilize its allies against a common enemy. And no one is in a better position to build the coalition needed to win the war on AIDS.

That's why nearly 250 organizations have called on the United States to move immediately toward its "fair share" of Kofi Annan's "war chest"—or $2.5 billion. To take this one step further—I would actually urge the United States to provide a "leader's share" of the $10 billion—or at least $3 billion—phased-in over the next few years.

This is not a lot of money for something considered a global priority. For example, to prevent even a single casualty from the Y2K virus, the global community invested over $200 billion. Surely with tens of millions, perhaps hundreds of millions of lives at stake—the fight against AIDS deserves such an investment.

LEGISLATION: HOPE, CARE AND A CAN-DO APPROACH

Mr. Chairman, in the context of USG leadership, there is a vitally important role for this committee and for the departments and agencies within your jurisdiction. As in our domestic response to AIDS, I urge this committee to be a key player in shaping our global AIDS action by providing significant contributions to the legislation currently being developed by the Foreign Relations Committee.

I believe that essential components of HELP Committee legislation should include:

Authorizing the CDC to expand essential HIV prevention efforts while focusing new attention on AIDS care and treatment. To that end, I would give serious consideration to a treatment set-aside which would include a Federal match of a private initiative to expand MTCT programs by providing the treatment needed to keep HIV+ parents alive to care for their children.

As CDC incorporates care and treatment into their ongoing prevention efforts, HRSA should be increasingly involved in this process. HRSA is our health care delivery agency and its expertise gained from administering the Ryan White CARE Act is indispensable. HRSA also has a great deal to offer in the area of provider training and infrastructure development—vitally important to making these programs work in the developing world.

In addition, I would strongly urge that the Committee authorize and push workplace-based HIV/AIDS programs through both the CDC and the Labor Department. With 5 to 40 percent of the labor force infected in many countries workplace prevention and treatment programs are essential and have proven effective.

Finally, I urge this committee to work closely with the Foreign Relations Committee on a comprehensive and coordinated global AIDS strategy that allows the range of USG agencies to play to their strengths and collectively maximizes the USG impact.

CONCLUSION

In conclusion, the International AIDS Trust is extremely grateful that this issue is receiving the broad-based bipartisan support it deserves.

There is much hope on the horizon, but that hope will only be realized if we join forces to save lives now. It will take a vibrant global public-private partnership to make this happen. Nevertheless, the pages of history are graced by times of great challenge when the global community mobilized and made a world of difference. As one of our board members, Archbishop Tutu, often says: "If we wage this holy war together—we will win."

Let us seize the day.

With the help of those in this room we are well on our way.

Thank you very much.

The CHAIRMAN. Our next witness is someone who is enormously gifted and talented as a singer and as a songwriter and who, a number of years ago, because of his own deep personal interest and concern and sense of compassion, developed a foundation. That foundation over the period of the past years has given more than $35 million to 55 different nations—an extraordinary act of generosity.

This individual could be in many places around the world today, but he has chosen to be here because of his own very strong commitment, and he brings to this commitment both a wealth of information and caring.

Sir Elton John, we are pleased to have you here and look forward to your testimony.

STATEMENT OF SIR ELTON JOHN, CHAIRMAN, ELTON JOHN AIDS FOUNDATION, BEVERLY HILLS, CA

Sir ELTON JOHN. Senator Kennedy, Mr. Chairman, thank you very much for inviting me. I feel very honored as a British man to be testifying to this committee, and I am very delighted to be here with all of these great colleagues who will be speaking.

I have worn many hats in my career . . . some of which I have obviously regretted, but the hat of a policymaker is not one of them. I am not going to take up your time to tell you facts and numbers that you already know; instead, I will tell you how I feel.

Twelve years ago last Monday, our friend Ryan White died of AIDS. We were completely devastated, his mother Jeanne most of all. Senator Kennedy, shortly after Ryan died, you called his mom, and you asked her to come to Washington help pass the Ryan White CARE Act.

Ryan White was not the first friend of mine to die from AIDS, and he was not the last, but he taught me the most. People shut him out of school; they shot bullets into his home; they spread lies and slander about him. But Ryan did not hate them. He forgave them. He knew that they were uninformed and that they were afraid. He was troubled, though, when he gained so much sympathy for having AIDS, because he knew it was based on a distinction between people with AIDS who are innocent and people with AIDS who are not. He completely rejected that distinction.

I remember just before Ryan died, sitting at his bedside in the intensive care unit with Jeanne, his mother. Ryan had fallen into a coma. When Jeanne saw the tears streaming down my face, she asked me "What is wrong?" and I said, "With all of our money, we still cannot bring this boy back to life."

But Ryan not only moved me, he moved this committee, because you marshalled this country's first major response to AIDS—the Ryan White CARE Act. Thanks to your efforts, most Americans with HIV/AIDS now have access to care and treatment. This is a very moral and noble thing you have done. Democrats and Republicans came together, and together you gave suffering people hope and relief.

Over the last 10 years, through the Elton AIDS Foundation, I have tried to do as much as I can with the money I have to make a difference. Since 1992, we have spent more than $35 million in 55 countries, trying to eliminate prejudice against people with HIV and AIDS, trying to educate people about how to prevent AIDS, and trying to provide service and support to people living with AIDS and children orphaned by AIDS.

Our first grant in Africa went to The AIDS Support Organization in Uganda, which is now a model of excellence for community-based programs across the continent. Our Foundation has increased access to HIV/STD education and prevention services for 50,000 women in slum areas of Sao Paolo, Brazil—a program so successful that the Brazilian government is putting up the money to double it.

We are funding the Living With AIDS Project in Thailand, where home-based care, counseling and training encourages villages to support—not shun—friends, relatives, and neighbors living with AIDS. The first Elton John AIDS Foundation grant in Russia established a help line in St. Petersburg to provide information and counseling on HIV.

We have also established an AIDS hospice in Soweto—the only project in Soweto providing inpatient care, day care, outpatient care, home care, and education and training. Among people with AIDS, the greatest fear is not of dying, but fear of dying alone. At our hospice, no one dies alone, and we are very proud of that.

But, Mr. Chairman, our hospice in South Africa has eight beds, and the nation has more than 4 million people infected with HIV. We are doing everything we can with what we have, and we have comforted many people and saved many lives, but we have not done nearly enough.

The people out on the front lines fighting this disease need reinforcements, and they need them now. That means more funding for education and prevention, more funding for voluntary testing and counseling, more funding for care of people with AIDS, and more funding for orphans, and it emphatically means more access to treatment.

People with lives to lead and work to do and children to raise must not be left to die just because they are poor. This disease kills mothers and fathers, leaving orphans, and it kills orphans. It will not run its course except to destroy everything in its path.

Mr. Chairman, 95 percent of the new infections come in poor countries. They do not have the resources to defeat it. They desperately need your help. No nation, corporation, foundation, or individual has the money that you have. No one even comes close. This is the Government of the richest nation in history, and I am here asking you for more money to stop the worst epidemic in history.

If the United States says "We have a moral obligation to act," then other major nations will follow. I am not a student of government, but I understand that there are two ends to Pennsylvania Avenue, and this end controls the money.

Senator DODD. Could you tell that to the other end? [Laughter.]

Sir ELTON JOHN. The President cannot sign what you do not pass. If the world is going to make a significant, decisive intervention to change the course of this pandemic, it is going to have to start here, and it might as well start now.

When Ryan White was asked by a reporter if he had a message for medical researchers working on AIDS, he said: "Hurry up." We all need to hurry up. Every day we delay, we lose more lives, and we lose a little more of our own humanity.

Mr. Chairman and members of the committee, we have one thing in common, you and I. We have all been on stage, and we have all heard the roars of the crowd. In my line of work, if you do not really want it to end, you can even keep it going for a few more encores, but soon enough, the lights go up, the crowd files out, and we all go home—and in that silence, we are left to ask ourselves whether what we do makes any difference at all.

When our lives are done, won't we want it to be said that we saw millions of people suffering with disease, millions more at risk, millions more abandoned, a whole continent in danger of dying, and we refused to let it happen?

Mr. Chairman and members of the committee, the United States Government is the biggest possible source of new funding for fighting AIDS. Forty million people are infected with HIV, 8,000 people are dying every day. You have the power to end this epidemic. Please end it. Please end it.

What American has done for its people has made America strong. What America has done for others has made America great. I pray that defeating AIDS will be one more great victory that you will win for the world.

I may be reading from paper, but I really speak from the heart. My dream as a human being is to make sure that care and medicine are available to all human beings so that they can live with dignity and hope. You can make this dream a reality with your commitment to this terrible disease.

Thank you.

[The prepared statement of Sir Elton John follows:]

PREPARED STATEMENT OF SIR ELTON JOHN

Mr. Chairman, and members of the committee, I've worn many hats in my career . . . but the hat of a policymaker is not one of them. I will not take up your time to tell you facts and numbers you already know. Instead, I will tell you how I feel.

Twelve years ago last Monday, our friend Ryan White died of AIDS. We were completely devastated—his mother, Jeanne, most of all. Senator Kennedy, shortly after Ryan died, you called his mom and you asked her to come to Washington to help pass the Ryan White Care Act. Initially, she said no. Ryan was the spokesperson. She couldn't do that. But she did.

The month Ryan died, this committee passed the Ryan White Care Act that dramatically increased funding for care and treatment of people with AIDS. Mr. Chairman, the rest of the world looks at this legislation as a sign of what America can do for its people.

We are here today to explore what America can do for the world.

Ryan White was not the first friend of mine to die from AIDS, and he wasn't the last—but he taught me the most. People shut him out of school; they shot bullets into his home; they spread lies and slander about him. But Ryan didn't hate them. He forgave them. He knew they were uninformed and afraid. He was troubled though, when he gained so much sympathy for having AIDS—because he knew it was based on a distinction between people with AIDS who are innocent and people with AIDS who are not. He completely rejected that distinction.

Over the last 10 years, through the Elton John AIDS Foundation, I have tried to do as much as I can, with the money I have, to make a difference. Since 1992, we have spent more than $30 million, in 55 countries, trying to eliminate prejudice against people with HIV/AIDS, trying to educate people about how to prevent AIDS, and trying to provide service and support to people living with AIDS and children orphaned by AIDS.

Our first grant in Africa went to The AIDS Support Organization in Uganda, which is now a model of excellence for community-based programs across the continent. I am delighted Noerine Kaleeba is here to tell you about it. Our Foundation has increased access to HIV/STD education and prevention services for 50,000 women in slum areas of Sao Paolo, Brazil—a program so successful the Brazilian government is putting up the money to double it. We are funding the Living With AIDS project in Thailand where home-based care, counseling and training encourage villages to support, not shun, friends, relatives and neighbors living with AIDS.

We are reaching women in India with reliable information, affordable condoms and medical care, along with counseling about alternative job opportunities.

We have also established an AIDS hospice in Soweto the only project in South Africa providing inpatient care, day care, outpatient care, home care and education

and training. Among people with AIDS, the greatest fear is not fear of dying, but fear of dying alone. At our hospice, no one dies alone. We are very proud of that.

But, Mr. Chairman, our hospice in South Africa has 8 beds, and the nation has more than 4 million people infected with HIV. We are doing everything we can with what we have, and we have comforted many people and saved many lives. But we have done nearly enough. The people out on the front lines fighting this disease need reinforcements, and they need them now.

That means more funding for education and prevention; more funding for voluntary testing and counseling, more funding for care of people with AIDS, and more funding for orphans. And it emphatically means more access to treatment. People with lives to lead, and work to do, and children to raise must not be left to die just because they're poor.

Senator Helm's op-ed calling for anti-retroviral therapy to help stop HIV-positive mothers from transmitting the virus to their babies is an important first step. But we need to take the second step. We need to treat the mother. If we don't treat her—who will take care of her baby? What if that baby comes to sit here in the Senate 10 years from now and says: "Thank you for giving my mother the medicine that helped saved my life, but why couldn't you give her the medicine that would help save her life? Did you keep me alive just so I could bear the agony of burying my mother?"

The drug companies are the only organizations in the world whose resources can rival those of rich governments in battling this disease. But, in my view, they have broken a public trust. They can't expect to keep pulling in profits, have their research subsidized, and then go missing in the midst of a world-wide health emergency. They can't keep telling us they're in the business of saving lives, if they always put business ahead of saving lives. We need them—and everyone—as partners.

Mr. Chairman, it's late, but it is not too late. If we all step up now with a full commitment to fight AIDS, they can still have a heroic role in ending this epidemic. None have us have done all we could have done or should have done in this fight.

Mr. Chairman, 95 percent of new infections come in poor countries. They do not have the resources to defeat it. They desperately need your help. No nation, corporation, foundation or individual has the money you have. No one even comes close. This is the Government of the richest Nation in history, and I'm here asking you for more money to stop the worst epidemic in history. I am no student of government, but I understand there are two ends to Pennsylvania Avenue, and this end controls the money. The President can't sign what you don't pass.

If the world is going to make a significant, decisive intervention to change the course of this pandemic, it's going to have to start here. And it might as well start now. When Ryan White was asked by a reporter if he had a message for medical researchers working on AIDS, he said: "Hurry up." We all need to hurry up. Every day we delay, we lose more lives, and we lose a little more of our own humanity.

Mr. Chairman and members of the committee, we have one thing in common, you and I. We have all been on stage and heard the cheers of the crowd. In my line of work, if you really don't want it to end, you can even keep it going for a few more encores—but soon enough the lights go up, the crowd files out, and we all go home—and in that silence we're left to ask ourselves whether what we do makes a difference.

When our lives are done, won't we want it to be said that we saw millions of people suffering with disease, millions more at risk, millions more abandoned, a whole continent in danger of dying, and we refused to let it happen. Mr. Chairman and members of the committee, the United States Government is the biggest possible source of new funding for fighting AIDS. Forty million people are infected with HIV. Eight thousand people are dying every day. You have the power to end this epidemic. Please end it.

It's true that one nation cannot defeat AIDS in 200 nations. But 200 nations cannot defeat AIDS without the help of one. This one. If the United States does little, other nations will see in that an excuse to do little. If the United States does a lot, other nations will do a lot, because they will see in your resolve a new hope of victory. When the United States fights, it wins.

Mr. Chairman: what America has done for its people has made America strong. What America has done for others has made America great. I pray that defeating AIDS will be one more great victory.

Thank you very much.

The CHAIRMAN. Thank you very much for a very eloquent and compelling statement. It is certainly a challenge, not only to the

members of our committee here, but to the institution and to the American people.

We are very grateful to you for it.

We will next hear from Dr. Peter Mugyenyi who, since 1992, has been executive director of the Joint Clinical Research Center in Kampala, Uganda and played a major role in the successful Uganda AIDS Control Program. Dr. Mugyenyi is currently chair of the Uganda Health Science Committee.

Uganda has been one of the most successful countries in Africa in reducing HIV and AIDS, and this very special individual has done a very extraordinary job in seeing that that has been achieved.

We welcome you here, Doctor, and we look forward to hearing from you. Thank you very much.

STATEMENT OF PETER MUGYENYI, M.D., DIRECTOR, JOINT CLINICAL RESEARCH CENTER, KAMPALA, UGANDA

Dr. MUGYENYI. Thank you, Senator Kennedy. Thank you for inviting me here. I see some familiar faces. I thank Senator Frist and Senator Clinton.

I testify as a physician who is working in AIDS and who has been involved for over 10 years, and every day of my life I see an AIDS patient as long as I am in my country, Uganda.

I would like to give you some background to what is happening on our continent, because AIDS has devastated the continent of Africa. It has killed the youth in their prime and most productive age, and it has done this at the time when their families most need them.

It has diminished skilled manpower in banks, in industries and institutions, and it has reversed hard-won advances that Africa was making. In fact, as has already been said, it is a significant political and destabilizing force on our continent.

Just to give you a few examples, in Zambia, the country is losing teachers due to AIDS faster than they can train teachers to replace them. Every year, the capacity to train children in that country diminishes. A few years ago, it was estimated that South Africa would lose the economic advantage it had; growth would be down annually by 0.4 percent, GDP by 17 percent, and $20 million of the existing economy would be wiped out, let alone development itself.

The situation has gotten worse since these estimates were made, and the situation is becoming grimmer. As you are aware, Africa is the home of AIDS. Over 70 percent of AIDS patients are found in Africa, and it is the leading cause of morbidity and mortality.

I would like to take this opportunity to give you an example of my country, Uganda, which had the highest prevalence of AIDS in the world, but our government took strong measures through openness, public information, and the AIDS level has been reduced from a high of over 30 percent to the current rate of 6.2 percent.

As good as this might look, it is still unacceptably high and appalling. Yet this is one of the most hopeful scenarios in Africa which needs to be emulated. But the situation elsewhere is much grimmer, and nowhere is it grimmer than in southern Africa itself.

I would like to take you to a small country called Botswana, with a population of over one million, where in some sentinel sites, over

50 percent of women attending antenatal clinics are HIV-positive. Without treatment, 30 percent of these infected women will give birth to infected children.

I would like to talk a little bit more to explain what this means. These infected children will be so sick that they will add to the strain of the medical sector. The mothers themselves—these 50 percent that I talked about—will die without treatment. When they die, they will leave orphans, not to mention the socioeconomic strain on the country and lessened capacity to educate these orphans.

The health facilities in Africa are devastated. AIDS now is the biggest occupier of hospital beds in Africa. But AIDS is a secondary epidemic. These secondary epidemics of tuberculosis have now become a worldwide scourge and are killing most AIDS patients. There are other life-torturing diseases like cryptococcol meningitis, which causes excruciating headaches, tortures patients, and sends them into a coma before it kills them, inevitably, without treatment. That can be repeated for toxoplasmosis, that can be repeated for many other diseases, especially cytomegavirus, which makes them blind, they live for some time, they are totally helpless, and then they die. This is what we live with every day in Africa.

Now, there is overwhelming evidence that prevention works. Uganda has demonstrated that prevention works. However, it is abundantly clear that prevention cannot work without treatment; it just works partway, but not well enough to make an impact on this very devastating epidemic.

The main constraint we have in Africa is the high cost of the drugs. We are tackling, with our colleagues, especially from America, scientific issues that might help to deal with these scientific issues, which we now think are not a constraint to the use of antiretrovirals in Africa.

My center, the Joint Clinical Research Center, has had a highly successful program of AIDS treatment using antiretroviral drugs. We did this without any help from any other country, but we could only do it in a very limited way. Our objective was to demonstrate that it works, and we have abundantly demonstrated that AIDS treatment works and works very well in Africa. Lives are saved in Africa when we use AIDS treatment.

Now, the way forward. Africa needs the United States. Africa needs you to help us to come to grips with this problem.

Currently, drugs are in very, very few places, yet the disease is in Africa. Drugs are where the diseases are not. The drugs should be in Africa. That is where the diseases are, and we need your help to get the drugs there.

AIDS is a catastrophic tragedy, and arguably, surpasses all disasters of the centuries gone by. Yet this is very important—AIDS is actually one of those disasters that can be controlled. There are well-proven methods of controlling it, and there is treatment that is effective and available. We need help to make sure this treatment reaches us, and we look up to you to come to our aid, and when you do, we in Africa will play our role to make sure that this partnership is a winner, not only for Africa, but for the entire developing world, and indeed, the world itself.

Thank you.

[The prepared statement of Dr. Mugyenyi follows:]

PREPARED STATEMENT OF PETER MUGYENYI, M.D.

IMPACT

HIV/AIDS has devastated the continent of Africa, killing the youth at their prime and most productive age, when their families and countries most need them, diminished skilled manpower in key industries and institutions and is reversing the hard worn advances in health, social-economic, and cultural development.

In Zambia, the country is losing teachers due to AIDS faster than they can train replacements. Every year, the country's capacity to educate the children for a better future diminishes. A few years ago, economists estimated that AIDS in South Africa will slow down the economic growth by 0.4 percent annually, cut GDP by 17 percent, and wipe out $22 million of the existing economy by the year 2010. The situation has since gotten worse and estimates are being revised upwards. Africa is home to over 70 percent of the world's population of over 36 million people living with AIDS, and is the leading cause of morbidity and mortality.

THE SCOPE OF THE PROBLEM

In early 1990s, Uganda had the highest prevalence of HIV/AIDS in the world, but the government implemented strong preventive measures through a policy of openness, public information, communication and education, and national and international collaboration through patternship of private and public sectors to bring down HIV/AIDS rate from the high level of over 30 percent in some antenatal sentinel sites to the current level of 6.2 percent. However, this rate remains unacceptably and appallingly high. Yet this is one of the most hopeful scenarios in Africa and an example to emulate. For the most of the continent the situation is much grimmer! Currently, the highest rates are in Southern Africa where the epidemic is causing unimaginable suffering, especially to the poorest sector of society. In some sentinel sites in Botswana, a shocking prevalence of over 50 percent of women attending antenatal clinics are HIV positive. Without treatment, over 30 percent of these infected women will give birth to infected children. These infected children will be so sick that they will add to the strain on the already over-stretched health sector. The mothers themselves will die, leaving a generation of orphans without parental guidance, not to mention the social and economic strain on the country and individuals concerned with lessened capacity for education and life achievements. The health facilities are already overwhelmed by the adult infected cases of AIDS who already occupy the vast majority of hospital beds with very serious opportunistic infections. Secondary epidemics of opportunistic infections have emerged and include Tuberculosis that kills most AIDS patients, Crypotoccocol Meningitis that tortures patients with excruciating headaches that progresses to mental confusion, coma and inevitable death if not treated, toxoplasmosis that causes terrible convulsions and eventual death, and Cytomegavirus infection that causes blindness and helplessness, and many other infections that could all be largely prevented, or at least ameliorated, by a program of treatment.

The devastation and AIDS trend all over Sub-Saharan Africa is upward. The epidemic is totally out of control, the continent's economies increasingly unable to cope with the demand and scarce resources are diverted from other developmental programs in vain.

There is overwhelming evidence that strong preventive measures implemented will have a big effect in control of the epidemic. However, it is abundantly clear that without treatment the AIDS epidemic would not be effectively controlled in the developing countries. The main constraint to treatment is the high cost of the AIDS drugs (antiretrovirals) which are beyond the economic means of most developing countries. The lack of adequate infrastructure and trained manpower is also a constraint that need to be addressed, but is not a major handicap to widespread use of Antiretroviral (ARV) drugs in Africa. The Joint Clinical Research Center (JCRC) in Uganda has implemented a highly successful program of AIDS treatment using ARV drugs just as they are used in the United States. The center has gone further to carry out operational research that would inform the way forward for countrywide good practice in ARV drugs use. Of particular importance are low cost, user friendly and sustainable laboratory diagnostic and monitoring tests. JCRC is now working with American scientists to identify simplified and cost effective ARV treatment regimen that may be adopted for wider use in Africa. Pilot projects in Uganda now also being implemented in some parts of Africa have demonstrated that AIDS treatment is feasible, desperately needed, and has the potential to impact on the epidemic control. Each country in Africa given the necessary resources can imple-

ment a successful preventive program, and start AIDS treatment, which can in a stepwise methodology be extendable to the communities. A nationwide referral system of specimens and patients may be one of the practical ways forward as infrastructure develops. An outline of such a program is outlined in the power point slides and can easily be adopted for implementation by all countries.

WAY FORWARD

It needs to be recognized that Africa, and indeed the entire developing world, is in urgent need of help to treat millions of people suffering the now mainly treatable AIDS. Currently, the drugs are not available where they are needed desperately, yet AIDS is the most catastrophic tragedy of humanity today, arguably surpassing all the disasters of the last century put together! Yet there are few disasters that can be so effectively controlled by well proven methods of prevention, care and treatment. Aid for AIDS should not be equated with the "unsolvable" vast problems of the developing world, but rather as part and parcel of the solution to such issues by investing in the human capacity of the people of Africa.

EXPECTED OUTCOME

With appropriate help AIDS can be controlled and moved from a devastating epidemic to a controllable sub-endemic disease. Many lives would be saved and the suffering would be minimized. It would make a saving in economic terms that would be injected into the economies to improve social services and relieve the strain on medical facilities. It would free the infrastructure to deal with the endemic tropical diseases that are also rampant, but only overshadowed by the devastation of AIDS. The governments would be under less pressure from their populations to concentrate on issues of family and development. The interventions are urgent because every year millions are added on.

CONCLUSION

There is great demand for AIDS drugs in developing countries. Huge numbers of desperate people staring death in the face know very well that life saving treatment exists. If they get hold of any drugs, whether fake, generic, bland, under dose or toxic, they will take their chance on it. This is a fertile ground for black-marketeering and for unqualified dealers to step in with disastrous long term implications. Governments and international donors must not let this situation develop further, and need to work together to avert this super-catastrophe, by facilitating an effective program against AIDS.

The CHAIRMAN. Thank you very much, Doctor. You have demonstrated what can be done and give us a great sense of hope, that if we give the support and resources, it can make a very important difference, and you have demonstrated that.

Dr. Allan Rosenfield is currently dean of the Mailman's School of Public Health at Columbia University. He is currently chairman of the New York State Department of Health AIDS Advisory Council and chairman of AMFAR's Public Policy Committee. He has worked abroad, as well as domestically, on family planning and maternal and child health issues. He has pages of international awards, degrees, and achievements.

We are very, very glad to have you here, Doctor. We are thankful for all of your good work in the past and look forward to your testimony.

STATEMENT OF ALLAN ROSENFIELD, M.D.,DEAN, SCHOOL OF PUBLIC HEALTH, COLUMBIA UNIVERSITY; DIRECTOR, MTCT-PLUS INITIATIVE, NEW YORK, NY

Dr. ROSENFIELD. Thank you very much, Mr. Chairman and distinguished members of the committee. Thank you for inviting me to testify and, more importantly, thank you for holding this committee hearing.

I thank my previous panelists, particularly Sir Elton John, for the eloquent presentations that have already been made.

I am an obstetrician/gynecologist by training, so the impact on women and children is particularly touching and moving and important to me as a professional.

I would like to use my time to discuss one of the issues that I think is of key importance and an approach to beginning to introduce more effectively treatment in poor countries.

Mothers and children are suffering the heaviest toll from the AIDS epidemic. More than half the global toll of AIDS involves women and children. In one year, more than 1.5 million women die from AIDS while another 2.5 million become infected. According to UNAIDS estimates for 2001 alone, approximately 2.6 million pregnant women had HIV infection, and more than half-a-million transmitted the virus to their infants.

To put this in perspective, as I think was mentioned earlier, more than 1,500 children become infected each day.

Over the last few years, groundbreaking progress has been made in the prevention of maternal, mother-to-child transmission, called MTCT programs, using a well-established package of low-cost and effective practices including single doses of an antiretroviral drug, nevirapine, for both the mother and the baby.

The Elizabeth Glaser Pediatric AIDS Foundation, UNICEF, Medicins Sans Frontiers, USAID, CDC, and many others are leading this global effort to expand these programs, and there are currently estimated to be more than 200 MTCT prevention sites in more than 20 countries, but we need much, much more.

While MTCT programs to prevent mother-to-child transmission are a tremendous step forward, these programs do not—and I repeat, do not—provide treatment to the mothers themselves. The mothers simply deliver the drug to the babies.

The tragedy is that the babies that we save through the MTCT programs are likely to be motherless by the time they can walk. Affording to studies in Africa, children whose mothers have died are three to four times more likely to die themselves—three to four times more likely to die—if they are orphaned.

I believe we face a social and moral imperative to now add treatment of the mothers and their infected children. Survival of mothers will not only benefit the mothers, but will secure a brighter future for the children and will create optimism that can only further enhance prevention efforts.

When the Elizabeth Glaser Foundation called their sites where the MTCT programs are currently underway, there was uniform and unanimous and enthusiastic support for expanding those programs to provide treatment for the mother, her children, and her partner.

This is a unique moment in the history of the AIDS pandemic. We have an important opportunity to extend care and treatment to mothers and their families given the rapidly increasing possibility of providing treatment in poor areas, reduction in drug prices—and we need to work on that—the recognition that treatment is essential and complementary to effective prevention programs.

The international foundation community has responded to this challenge by responding to a major new initiative called MTCT-

Plus. This program will add care and treatment of HIV-infected mothers and their families to existing MTCT prevention programs. This is a concrete example of how prevention and care can come together. The new initiative under my leadership and based on Columbia University's Mailman School of Public Health is currently supported by a partnership of nine foundations which are listed in the testimony, and is part of the foundation community's response to Kofi Annan's call to action on HIV/AIDS. These include Gates, Hewlett, Johnson, Kaiser, MacArthur, Packard, Rockefeller, Star, and United Nations foundations in a unique and unusual collaboration on the part of these foundations to pool their resources to try to work with the Global Fund in moving this forward.

Our goal is to raise $100 million through the private sector, and we hope that we will be able to include Federal support for this program, perhaps matching that goal before we are finished.

We are building a strong partnership between this program and the Global Fund for AIDS, Tuberculosis and Malaria; and in fact, as some of you know, we will be hosting the next Global Fund board meeting at Columbia University 10 days from today.

What is the aim of the MTCT-Plus initiative? This initiative aims to demonstrate that HIV treatment can be delivered effectively and efficiently in resource-poor countries. It will serve to develop a model that can be replicated by others around the world. We will be working closely with the UN family of agencies, Federal agencies, and nongovernmental organizations on the design and implementation of MTCT-Plus to ensure effective coordination on a regional and global level.

Ladies and gentlemen, committee members, for the pregnant woman with HIV infection today, the future is one of despair. She is offered one hope—the hope for a baby without HIV who will have to survive without her.

In contrast, what we hope that MTCT-Plus will provide for this woman is a chance for her to survive, for her to be able to raise her own children, sustain her family, and contribute to her community.

We urge you to allocate resources to join this private initiative as a public-private partnership, matching the private foundation funding, to expand this effort, and to make HIV care and treatment available to the women and families who desperately need our help.

I think that Sir Elton put it so eloquently: This Government and this country has a unique opportunity to do more. Now is the time to do more. The pandemic is not slowing the way it should. We need help from this committee and from our Congress and from our country.

We believe that with your leadership, resources, and the will to succeed, MTCT-Plus and all the other care initiative that will follow can save the lives of thousands now and create lasting hope for millions in the future.

Again, thank you for allowing me to testify, and thank you for the work that you are doing.

[The prepared statement of Dr. Rosenfield follows:]

PREPARED STATEMENT OF ALLAN ROSENFIELD, M.D.

Mr. Chairman and distinguished members of the committee, thank you for inviting me to testify this morning. The global HIV/AIDS pandemic is clearly the most urgent health threat of our time, and your leadership and determination is very much appreciated.

I am Dr. Allan Rosenfield, Dean of Columbia University's Mailman School of Public Health and DeLamar Professor of Public Health. I am an obstetrician/gynecologist by training and have dedicated my professional career to maternal and child health, both domestically and internationally. I currently chair the New York State Department of Health AIDS Advisory Council and the Public Policy Committee of the American Foundation for AIDS Research. Before joining the faculty at Columbia, I spent 7 years in the developing world—in Nigeria at the University of Lagos Teaching Hospital and in Thailand as Medical Advisor to the Ministry of Public Health.

We have heard moving testimony this morning about the scope of the AIDS tragedy, particularly the devastating impact on children and families. I would like to use my time to discuss one of the solutions—a new multi-foundation program to link prevention with care and treatment for HIV-infected women and their families in the poorest countries.

A PROGRAM TO BUILD ON

Mothers and children are suffering the heaviest toll from the AIDS epidemic. More than 1.5 million women die each year from AIDS, while another 2.5 million become infected. According to UNAIDS estimates for 2001 alone, more than 2.6 million pregnant women carried HIV, and more than half-a-million transmitted the virus to their infants. To put this in perspective, more than 1,500 children become infected each day.

Over the last few years, groundbreaking progress has been made in the prevention of mother-to-child transmission (MTCT) of the virus using a well-established package of low-cost and effective practices, including single doses of the antiretroviral drug Nevirapine for the mother and baby. Nevirapine has been shown to cut transmission of the virus nearly in half and costs only $4 for the mother and child. In many cases, Nevirapine has been provided free of charge by the manufacturer. The Elizabeth Glaser Pediatric AIDS Foundation, UNICEF, Medicins Sans Frontieres, the CDC and others, are leading a global effort to expand MTCT programs, and there are now approximately 180 MTCT sites in more than 20 countries.

While programs to prevent mother-to-child transmission are a tremendous step forward, the tragedy is that the children we save are likely to be motherless by the time they can walk. These orphans face a life of poverty, malnutrition, and a host of social ills. According to studies in Africa, children whose mothers have died are three to four times more likely to die themselves. In the current MTCT programs, the mothers are offered no hope for their own survival, and without the prospect of treatment for themselves, they have less of an incentive to seek testing and participate in prevention programs in the first place. I believe we face a social and moral imperative to treat the mothers.

TOWARDS AN MTCT-PLUS PROGRAM

We have an important opportunity to extend care and treatment to mothers, given the rapidly increasing possibility of antiretroviral treatment in poor areas, drastic reductions in drug prices, and the recognition that treatment is essential to effective prevention. The critical need to go beyond prevention was clearly recognized by the UN Special Session on AIDS last summer in the Declaration of Commitment and by health advocates, international organizations and governments worldwide.

The international foundation community is responding to this challenge by committing to a major new initiative called MTCT-Plus. MTCT-Plus will add care and treatment of HIV-infected mothers and families to existing MTCT prevention programs, in a concrete example of how prevention and care can come together. The new initiative, under my leadership and based at Columbia University's Mailman School of Public Health, is currently supported by a partnership of nine foundations [1] and is part of the foundation community's response to Kofi Annan's Call to Action on HIV/AIDS. We are well on our way towards meeting our private foundation fundraising target of $100 million over 5 years.

[1] Bill and Melinda Gates, William and Flora Hewlett, Robert Wood Johnson, Henry J. Kaiser Family, John D. and Catherine T. MacArthur, David and Lucille Packard, Rockefeller, Starr, and the United Nations foundations.

We are also building a strong partnership between MTCT-Plus and the Global Fund for AIDS, Tuberculosis and Malaria and will host the next Global Fund Board meeting at Columbia later this month. Our aim is to demonstrate to the Global Fund and others in the international health community that treatment can be delivered effectively in resource-poor countries. In addition, we are working closely with UNAIDS and WHO on the design and implementation of MTCT-Plus to ensure effective coordination on a regional and global level. Finally, we see tremendous opportunities for partnerships with bilateral assistance agencies and are already consulting closely with CDC, NIH, and USAID.

The MTCT-Plus initiative will select existing MTCT prevention programs and add the "Plus" component, which includes HIV/AIDS care, treatment and support services for infected women and families. The package of services will include education, counseling, nutritional support, diagnostic testing, prophylaxis and treatment of selected opportunistic infections, like tuberculosis, and anti-retroviral therapy. Patient treatment will be guided by standardized clinical protocols that were developed by an international group of experts. The treatment guidelines will be flexible and will evolve as newer drugs and tests become available and as more is learned about HIV care in resource-poor settings.

The MTCT-Plus care team will be multidisciplinary, and psychosocial support, patient education, and counseling will be available at each visit. Patients will be encouraged to choose from a menu of supportive services, tailored to local circumstances and the needs of affected families. While the focus of the program is on pregnant women and their children, sites will have the opportunity to design a family-centered program, enrolling husbands and other household members. MTCT-Plus will also support community outreach and education, and work to build linkages to local organizations and resources.

THE FIRST STAGE

The first stage of the program will be to select 10-20 existing MTCT programs to serve as demonstration sites. To be eligible, these sites must be located in resource-poor areas where the HIV prevalence among women is greater than 5 percent; we anticipate that the majority will be in Sub-Saharan Africa. Sites must demonstrate their ability to provide MTCT prevention services, including voluntary testing and counseling, standard obstetric, gynecologic, maternal and pediatric care, and reproductive health and nutritional services. The sites must have the capability to expand their services to provide HIV care to infected women and their children. We are also requiring a demonstration of local community and government support.

Selected sites will be given approximately $200,000 per year for personnel, training, laboratory costs, operational support, and minor infrastructure needs. In addition, we will provide technical assistance, any additional training required, oversight, and drugs including antiretroviral therapy. In some case, we will provide planning grants of up to $15,000 for the development of future applications.

Earlier this year, we initiated a rigorous application process to select our first group of demonstration sites, and we have identified a panel of independent experts to review the applications. Application requirements include detailed descriptions of existing health services, proposed strategies for providing HIV/AIDS care and treatment within one year, and detailed budget proposals. More than 70 MTCT sites have already indicated their intention to apply, and we expect to announce the first sites by June and begin operation by the fall. We plan to select the second group of sites in late 2002.

At current funding levels, however, we only expect to be able to enroll between 25,000 and 50,000 HIV-positive women, children, and family members over the lifetime of the program. A major financial commitment is needed to expand this program to the hundreds of thousands, if not millions, of affected families.

A MODEL FOR THE FUTURE

The MTCT-Plus program provides a path towards bringing HIV care to women and their children. Delivering care and treatment to infected women and their families will prolong their survival—and their children's survival—and improve their well being. It can decrease the stigma associated with HIV and, with the hope offered by treatment, it can strengthen prevention programs. However, the foundation community cannot do this alone. Therefore, we urge the Congress to join us in a public-private partnership to expand this effort and begin making care and treatment available to the women and families who so desperately need our help. We believe that with strong leadership, sufficient resources, and the will to succeed, we can save the lives of thousands now—and create lasting hope for millions in the future. If we work together, we can make a difference.

The CHAIRMAN. Thank you very much, Dr. Rosenfield.

Senator Frist, would you like to introduce Ms. Dortzbach?

Senator FRIST. Yes. Thank you, Mr. Chairman.

I have the pleasure of introducing our final witness today before we go to our discussion period. Ms. Deborah Dortzbach is currently the international director of HIV/AIDS programs with World Relief International in Nairobi, Kenya. Her extensive work in the HIV/AIDS field spans both the United States as well as Africa.

Abroad, Ms. Dortzbach has provided direct medical relief as a nurse in Ethiopia, Eritrea, and Kenya. She has also been program director of health training programs and HIV/AIDS support programs with Mission to the World and MAP International.

Ms. Dortzbach, thank you for being with us this morning.

STATEMENT OF DEBORAH A. DORTZBACH, INTERNATIONAL DIRECTOR, HIV/AIDS PROGRAM, WORLD RELIEF INTERNATIONAL, BALTIMORE, MD

Ms. DORTZBACH. Thank you.

This is not an easy position to be in, last on this panel. But I do look forward to a thunderous encore to this issue that we are addressing today, together. And we will applaud you, our Senators—the world will applaud you—for your energy and enthusiasm and action to what we are presenting to you today.

I have brought someone with me, but you will not see her. Please do listen to what she has to say.

[Remarks of Elizabeth via audiotape:]

> My name is Elizabeth, and I am 11 years old. I live in Kenya with my mother and two brothers. My father died of AIDS 2 years ago. My mom has AIDS. After my father died, relatives came and took all of our family property. Now we struggle to get money for school fees. I do not know what will happen in the future. If my father were alive, I would be the happiest girl in the whole world.

Ms. DORTZBACH. Elizabeth's story is not over. She will still face the death of her mother, the stigma which Sir Elton John referred to of her neighbors and her friends, and she will probably not finish school.

The question we have is what can we do to make an ending that is different for Elizabeth and the millions like her.

Africa has been my home for 22 years. As an American, I was extremely vulnerable one day when a band of rebels entered the hospital where I was working and took me hostage for 26 days.

You know the end of my story—I am here with you today, and I am grateful that I was released and could return to Africa. There, I was hopeful in the 1970s and the 1980s, when we helped children survive to the age of 5. But in the 1990s, we buried them as young people.

I am with World Relief, located right here in Baltimore at our headquarters. We work for about 45 different denominations and all different religious and faith-based groups throughout the world, in 24 countries, and we have been around since 1944.

I would like to suggest a few opportunities that the band of non-governmental organizations, many of whom are here today, can contribute to the challenge before us in this crisis.

We call our HIV/AIDS program Mobilizing for Life, and we work through the family, the basic unit that we are given, to nurture and to care and support and provide for our orphans, extended as well as nuclear.

In Mozambique, there is a group of 50 churches that have shed their different denominational perspectives and are coming together to care, in homes, for 352 orphans.

The faith community is here to stay, beyond our funding cycles and after we leave our rusty four-by-fours. In Kenya, a group called Faraja, which means "comfort" in Swahili, is a simple group of men and women. Their only badge is this little piece of metal, but they are recognized in their community as people who bring comfort. It does not cost anything, but what they give us is priceless.

This did cost something. This small manual, "Hope at Home," is simple enough that even children can understand it and use it, because like it or not, they are the primary caregivers of their dying parents.

I am proud to say that my Government, through USAID, funded this project, and we need more. Financial strengthening is another area of interest for World Relief. We have credit and savings in small loans with more than 73,000 clients worldwide in 10 different countries. Ninety percent of them are women. They do not default on their loans; they have a loan loss rate of less than 2 percent. But what it does give them is a stronger economic base and the financial strength so that they have better options and choices to prevent AIDS from entering their families and affecting their children.

We cannot do this alone—none of us can. That is why we are here today. That is why we plead with you. We need people; we need training; we need networking; we need each other. Only by working together can we make a difference in this crisis.

I am grateful that our organization has partnered with many, including Freedom from Hunger, based in California, and their phenomenal track record in microenterprise development in health education. Together, we have developed a curriculum that is used worldwide in helping community banks understand more about HIV/AIDS.

But it is not just organizations. It is individuals who make the difference. In New York City, I worked with Anna, Jerome, Maribel, Raquel, all of them nurses who wanted to get involved and even come to Kenya and help out in some small way.

There are children in Fredericksburg, VA who are helping to make small bed pads for people in Africa who have problems with bedsores.

I was powerless while being held hostage by terrorists, taken because I was an American. But today, I am strengthened because I am an American. And I know that my country has power, influence, and money to change the course of millions of Elizabeths, their mothers, their dads, their families. We cannot bring back Elizabeth's dad, but we can raise her and love her and help her live until she reaches her 70s.

Join us in the NGO grassroots assault on the terror and tragedy of AIDS.

[The prepared statement of Ms. Dortzbach follows:]

PREPARED STATEMENT OF DEBORAH A. DORTZBACH

Mr. Chairman and members of the committee, thank you very much for the opportunity to appear before this subcommittee. I am Debbie Dortzbach, International Director for HIV/AIDS for World Relief located in Baltimore, Maryland. We are a worldwide organization committed to alleviating suffering in the developing world.

I am here today to represent the non-government agencies and to address how we can contribute to curbing HIV/AIDS and caring for those affected.

I. ELIZABETH'S STORY

You haven't met her, but you know her.

She is one among millions you have talked about in these rooms. It is our time now to listen to her.

> My name is Elizabeth, and I am 11 years old. I live in Kenya with my mother and two brothers. My father died of AIDS 2 years ago. My mother also has AIDS.
>
> When my father died, my uncles came and took all our property. Now it is difficult to get money for school fees.
>
> If my father were alive, I would be the happiest girl in the whole world.

Elizabeth's story is not over. She will face the death of her mother, confusion over what to tell people who scorn AIDS as a curse from generation to generation, the reality of stigma and rejection, the loss of household income, the threat of having to stop school, and the reality of not having an evening meal or the next morning's breakfast.

By 2010 we will have 41.6 million double orphans, those who have lost both mother and father (*Children on the Brink, USAID Report by Susan Hunter and John Williamson, 2000*).

As I think of Elizabeth, I am burdened by the question, "What role can we have in giving Elizabeth's story an ending of hope?"

Africa is also my home, now for more than 22 years. I am an American, and because I am, I was targeted in a 1974 hostage raid on a church hospital in northern Ethiopia, now Eritrea. After 26 days I was released to my husband and 4 months later gave birth to our son.

We returned to Africa, invited to join the vigorous efforts of hundreds of thousands of ambitious and determined Africans in advancing their cultures and countries and participating in their health and development initiatives. I expected years later to leave Africa a changed place: with healthier children, more educated families, men and women honoring each other, and families strengthened with a brighter economic future.

It is more likely that in next 10 years before we retire that many markets and streets will be flooded with orphans, families impoverished for generations, schools barren of teachers, and roads impassable for lack of skilled workers and money to repair them.

In the 1970s and 1980s, we helped children survive to the age of 5. In the 1990s, we buried them as young adults.

As a former hostage, I often wonder why God spared me. Why did I come home? There were two of us taken and Anna was shot, by our captors, in my presence.

Today, I still ask that question, but I know just a bit more of the answer.

We have a job to do.

II. THE CHALLENGES AND CONTRIBUTIONS OF NGOS

Today, I am addressing you as a member of the family of World Relief, a Christian NGO representing more than 49 different denominations in the United States and working in over 24 countries since 1944.

Our challenge is to apply foundations of sound knowledge about what works in AIDS, cultural strengths, spiritual commitments, and decades of public health and behavior change experience.

We know these foundations build success. We need focus to strengthen them. In World Relief we call our HIV/AIDS program, "Mobilizing for Life," and our focus can be summarized around three themes: the family, the faith community, and financial strengthening.

A. The Family

The basic social foundation is the family. To a very large extent, what happens within the family determines the global course of this epidemic. Strengthening communication, education, and cross-generational dialog within the family is one of the goals of a USAID-funded project known as Amkeni, in which we are partners in Kenya.

The project works through churches and other community groups to foster understanding and equip families to reflect on behavior and promote relational and sexual health. *Choose Life: Helping Youth Make Wise Choices* is one tool with many lives. Originally developed through a USAID Rwanda project, (USAID/Rwanda/HARR Award No. 623-A-00-99-00071-00), the manual is adapted and currently in use in training in Kenya.

The family is also the primary institution for care of orphans and other vulnerable family members such as the elderly. Though taxed beyond coping ability in some cases, the majority of extended family members and the community surrounding them are the best homes for children whose parents have died. Every community institution can support the family, keeping children at home where they belong. *Kubatsirana*, a Mozambiquan organization of faith communities in Chimoio representing over 50 churches is an example of communities working together to assist over 352 orphans. Every orphan is known, every village elder oversees their welfare, every church takes on the responsibility of visiting and supervising care regularly, and every school and many businesses in the community assist in meeting basic needs.

B. The Faith Community

In nearly every community in Africa people meet to express their faith. Faith communities are institutions here to stay, beyond our funding cycles and rusted 4x4s. What we build today on the foundation of faith is cost-effective, integrated into life and relationships, and spans generations.

Faraja, meaning comfort in Kiswahili, is a community of people of faith from many backgrounds drawn together out of concern for caring for people with AIDS at home in an urban poor community in Nairobi. Members of *Faraja* dedicate themselves to weekly learning sessions on how to train family members to care for their HIV-positive members. The training occupies no line-item in a budget and does not take place in an expensive hotel, but sitting on wooden benches in a tin-roofed church buried in the sprawling slums. The learners bring their passion and time and commit to working in teams, regularly visiting all sick living near them. What they learn costs nothing to do and can be universally applied and life-changing: the importance of touch and embrace, acceptance and inclusion of persons living with HIV/AIDS (PLHA), the need for PLHAs to stay active in the family and society, the control of TB, preparation for death and the care of orphans left behind. *Faraja* members use a simple home care manual, "Hope at Home." It has photographs and simple, short sentences so even children—who are often the primary caretakers of their parents—can understand and safely assist. Local government clinics and an area hospital provide HIV testing for family members, clinical support and backup for critically ill patients. *Faraja* caregiver trainers are recognized by the red badge they wear, "Wahumu wa Faraja"—people bringing comfort.

In Rwanda, faith communities send their leaders to workshops to apply community advocacy roles, learn principles of counseling in trauma healing, destigmatize AIDS and the misbelief that AIDS is a curse from God, learn the facts about HIV/AIDS, and use training tools to help youth make wise choices about their sexuality. As a result, more than 160 support groups of persons living with AIDS meet weekly in churches for support. Churches are developing their own integrated programs for AIDS interventions in care and prevention, including counseling, training, care, and food distribution.

In Malawi, churches band together in committees to determine how to help the families affected by AIDS living around them. They work community gardens where volunteers cultivate, fertilize, plant, water, weed, and harvest food for orphans.

The church is an advocate for those too weak to speak. In Mozambique, church leaders take village chiefs around their communities to identify orphaned children. More than 352 children in Chimoio are guaranteed the right to free primary education and businessmen and women contribute food and other necessary household items to the orphans.

C. Financial Strengthening

World Relief enables individuals and families affected by HIV/AIDS to live with dignity by addressing the economic burden of HIV/AIDS through micro-enterprise development programs. Economic development opportunities give poor women, who

are among the most vulnerable, better means to make healthy choices about sexuality.

Credit and savings enable families to appropriately address the medical needs of their members with AIDS, continue to nurture children left behind by the death of their parents, and remain engaged with their communities. HIV/AIDS-affected families who participate in micro-enterprise programs continue to earn income, maintain social support, and make wise decisions about treatment options. Micro-enterprise activities also help prevent new infections. Women, who are empowered socially and economically through their micro-enterprises, gain more control of their lives.

World Relief assists in the administration and supervision of microfinance institutions in 10 countries including Rwanda, Mozambique, Burkina Faso, Haiti, and Cambodia, with a loan portfolio of 5.8 USD. These institutions serve 73,000 clients, nearly 90 percent of whom are women, with a loan loss rate of less than 2 percent. Most of these women move on to larger loan cycles and savings schemes.

In partnership with another non-government agency, Freedom from Hunger, we developed an interactive prevention and care curriculum, "Facing HIV/AIDS Together," being used in communities where clients meet regularly as a group to repay their loans (Publication made possible through the G/PHN/HN Grant Award #HNR-A-00-07-00007-00).

In addition to providing basic education on cause and prevention, the curriculum encourages communication within families, mobilizes these groups for community action and helps break down stigma.

Rose Mukamguguje, an HIV-positive Rwandan widow, struggled to feed and educate her children after her husband died. She was forced to pull her six children out of school because she couldn't afford the fees and was concerned about what would happen to them when she died. Before she received a loan to start her own business, Rose was engaged in the back-breaking work of hauling construction materials. In her words: "I used to get temporary jobs fetching water or bricks at a construction site, but this was very difficult for me. The next morning I would be broken. I would be very weak and stay in bed. I got sick more often during this time."

But through this bleak reality glows light—the light of people of faith practicing what they believe in nearly every community in Africa—far from medical outposts, medical professionals, corner pharmacies, means of transportation other than footing, and communication.

III. IMPLEMENTING PREVENTION AND CARE

A. People

In America, we think of hospitals, doctors, and medications when we think of treating AIDS. In reality, we will never have enough accessible hospitals and doctors to meet the demand, and we need to be realistic about the availability of medications over the long haul in most rural communities and urban poor centers where daily earnings are less than the cheapest American hamburger.

But we have people living in community. They are neighbors, teachers, nurses, pastors, and youth. They are the greatest community resource, not yet fully marshaled or supported.

In Malawi, youth groups meet the challenge of helping families with AIDS by hauling jerry cans of water, repairing roofs, tilling gardens. They learn not only how to give community service, but come face to face with the reality of people dying with AIDS—a powerful incentive for delaying sexual activity.

Through working within community structures, equipping, and continued support and encouragement we can meet the most basic needs for not some, but most people living and dying with AIDS and their millions of orphans.

World Relief's orphan initiative begins with families, communities, and churches. Rather than a project, it is described as a "movement" known as "Every Church, Every Orphan" seeking to marshal support from every church in every community where there is one to take a census of every orphan in a perimeter around the church and provide regular supervision and support to orphans without families. The support starts before parents die and includes the development of memory books for parents to leave with their children, the planning of the care of orphans with extended family members, and the handing over of family businesses or membership in community banks.

As a global community we must continue striving for available medications for treating AIDS, a universal prevention vaccine, and the interruption of maternal-to-child transmission. In addition to these medical interventions we must continue to struggle with deep root issues engulfing AIDS: early experimentation of sex among youth, adult sexual exploitation of youth, the vulnerability and powerlessness of

many women, stigma, the lack of communication, commitment, respect, and honor in many marriages, economic and social destruction of families.

B. Training

The tenets of training that transform are interactive involvement of the trainees, training that is held in the local environment, utilizing people's own readily available resources, training that builds on beliefs and provides reflection and guidance toward understanding truth when beliefs may contradict fact, and opportunity to act on the lessons learned.

A challenge for NGOs has been to work with some faith-based groups where AIDS is considered a curse or the condom an evil object. When time and effort are taken to meet people on their own terms, using their own community, religious, or family structures, very traditional beliefs can be discussed. Building trust is critical to deciphering error in erroneous traditional beliefs about AIDS. Some religious communities in Kenya began to change some of their views and reduce stigma associated with AIDS through training and role models of key leaders. A lesson learned in a large USAID/AIDSCAP project in 1996 demonstrated that change does occur among church leaders when sources of information can be trusted by church leaders, and they are given opportunity to dialog together.

Training is effective when a variety of training tools are utilized. We have developed mass media radio spots in Rwanda, an interactive video in Malawi and Kenya, low literacy flip charts in Malawi, and curricula for youth and micro-enterprise development. All of these tools have had no "shelf life" and are in demand for reprinting, adaptation and distribution throughout Africa, and some countries in Latin America and Asia.

C. Networking and Collaborating

None of us have the answers or the abilities to fully apply the answers we are discovering. We need each other.

We actively support cross-sectoral collaboration and have attended the monthly meetings of the Private Voluntary Organizations Steering Committee on HIV/AIDS at USAID. We have facilitated getting HIV/AIDS on the agenda of the practitioner networks to which we belong: the Small Enterprise Education and Promotion (SEEP) Network and the CORE network whose focus is maternal and child health. Both of these networks now have working groups to promote the HIV/AIDS agenda and to explore how they can work together more efficiently and effectively.

We also encourage this dialogue at the national level. For example, in Cambodia and the Philippines, World Relief has sponsored forums that bring the economic and health sectors together to discuss cross-sectoral collaboration for HIV/AIDS. In Rwanda, we helped establish the Rwanda Microfinance Forum, a group well aware of the economic issues of HIV/AIDS, addressing economic coping strategies and promoting AIDS education to member organizations. We have worked hard to integrate an appropriate response to HIV/AIDS into our microenterprise development, maternal-child health and youth programs to realize greater impact and more efficient use of our resources.

World Relief helped form a network of local and international NGOs in Malawi that were not only HIV/AIDS specific, but multi-sectoral. The network meets quarterly to inform each other of events, materials developed and lessons learned.

In Kenya, our staff was on the organizing committee of the Kenya AIDS NGO Consortium (KANCO) with present membership over 100 local and international NGOs working in Kenya.

Information is vital to share. For that purpose we attend and present at international forums including the global International AIDS Conferences, the International Conference on AIDS and STDs in Africa, the Microcredit Summits in Asia and Africa, and the Prescription for Hope Conference in Washington, DC.

Collaboration begins at home. Nurses from New York City are keen to not only continue learning about home care initiatives in Africa, but also want to volunteer themselves to help. In this meeting in Manhattan just weeks after September 11 these nurses drank in all they could learn about AIDS in Africa and determined to support the efforts of their nurse colleagues in Kenya. In other areas, children in Virginia are sewing simple bed pads to help control skin problems resulting from diarrhea.

IV. CONCLUSION

In 1974, I was powerless while being held hostage by terrorists, taken because I was an American. Today, I am strengthened because I am an American who, together with you and those you represent, have power, influence and money to change the course of millions of Elizabeths and families with AIDS whose deaths

in the first decade of the 21st century alone will rival the number that died in all the wars of the 20th century. [Remarks prepared for delivery by Vice President Al Gore at the UN Security Council Session on AIDS in Africa, January 10, 2000].

Join the NGO community in their grassroots assault on the terror of AIDS. Embrace the responsibility and challenge before us as Americans.

The CHAIRMAN. Thank you very, very much.

I know that Sir Elton John has to leave in just a few minutes, so I will ask my colleagues if they have particular questions for you, and then we will excuse you if that is all right.

I would just like to ask you one question for a brief response. You have been enormously generous with your time.

You talked about the importance of resources, and that is obviously one of the major factors that have been reviewed by yourself, Sandy Thurman, and others. What other kind of leadership do you think the United States could provide? You have had a chance, obviously, to talk with people in all parts of the world. Resources are a major factor, and they may not be the answer to everything, but it is a clear indication of a nation's priorities, and we cannot minimize that. But what else would you say that you would expect from the United States in terms of leadership?

Sir ELTON JOHN. I think the fact that this committee would even consider granting money and extra money to much-needed projects throughout the African continent—all eyes seem to be on America. This is a great country. You believe it is a great country, and we believe it is a great country. I think that by showing the compassion—the money is one thing, but the humanitarianism and compassion is another. And America always has been a compassionate Nation.

And I think just the publicity that one gets from things like today shows that America cares. All the resources in the world does not take away from the fact that if someone cares, and someone wants things to happen, that is so important as well.

I was very moved by the last speaker, and she was very proud to be an American serving in Africa. That is an advertisement in itself for this country.

I just think that when the reports are made today, just the fact that you are sitting down today, and you care so much as a committee is an incredibly important thing. Compassion these days seems to be in short supply following the events of the last year. There is a lot of anger and hatred in this world, and I think compassion is the strongest form to combat that, and you show that as a committee.

Thank you.

The CHAIRMAN. Thank you.

Senator Clinton.

Senator CLINTON. Thank you so much.

Sir Elton, I want to ask you specifically about what you have done in Brazil, because there is often debate that we cannot—it is what we call a "chicken and egg" problem—we cannot provide the care and treatment because we do not have the infrastructure, but we do not have the infrastructure so we cannot provide the care and the treatment. You were really in on the ground floor with your foundation in Brazil, and as I understand it, you created a program even where the country was not yet ready to face up to

some of the implications of the HIV/AIDS pandemic, and by demonstrating that it worked, you got the government to respond.

Could you describe that?

Sir ELTON JOHN. Well, it is a bit like matching grants, when you fund a grant and get it matched by people. The initiative in Sao Paolo was an extreme success, but it was not done with the government's help. It was done entirely from our organization and with the help of other people. And when the government saw that it was a great success, they helped as well. You set the example. You cannot sit back and wait for things to happen. You have got to go in there. We always investigate everything we do. We send a team out to make sure that our money is being put to the best possible use, and we thought this was an incredible opportunity to do something in Sao Paolo, and it proved to be a huge success. By taking that initiative—you have to take the initiative with this disease; you cannot wait for people to say, "Oh, no." Look at the epidemic that happened in this country in the early 1980s. The government really did not take any initiative at all, and it was up to people to demonstrate their anger and to say, "Listen, we need action."

I think you have to take the initiative sometimes, and then you get people to thinking, "Oh, that works really well. We will help."

We are a very small organization, but we have funded over 53 countries, and we do make sure that in everything we do, the money is really well-spent, and if the success of the venture is apparent, people always take notice. That is all that we can do, really.

Senator CLINTON. Thank you.

The CHAIRMAN. Are there any other questions for Sir Elton?

Senator Warner.

Senator WARNER. Thank you, Mr. Chairman.

Sir Elton, our job, those of us who take an active role in this and have and will continue to do so, is to convince a lot of colleagues. In just a few simple, understandable words—you are approaching a fellow colleague as if you were a Senator—how would you describe the race in terms of the rapid proliferation and expansion of HIV/AIDS, both here domestically in our country, and worldwide, but particularly worldwide; and how fast is the catch-up procedure of medicine and health? Is it not a widening gap between the efforts thus far to attenuate and cure and the race of the disease in terms of its proliferation?

Sir ELTON JOHN. Well, we do have a lot of catching up to do. I would approach someone—if one could precis the doctors' statements and Ms. Dortzbach's speech, which was the most moving testimony you could have—I think you have to approach someone who is skeptical by consistently clubbing them over the head. I mean, we have been talking about this disease for so long, and it has been well-publicized. This epidemic, this pandemic, has had a lot of publicity. But as someone said at the beginning, people still do not seem to get it; they do not seem to get the implications healthwise, economically, and socially, the impact that this is going to have.

You just have to keep on and on and on at these people who are the doubting Thomases of this world. You have already converted Mr. Helms, which is an incredible achievement, and who would have thought? [Laughter.]

So I defy anyone to be uncompassionate in regard to this disease.

Senator WARNER. Again, am I correct in the assumption that the proliferation of this disease is outpacing the efforts to try, scientifically and medically, to care for it?

Sir ELTON JOHN. At the moment, yes. And unless we do something very quickly, it is going to escalate even further; absolutely.

Senator WARNER. Thank you.

The CHAIRMAN. Senator Frist.

Senator FRIST. Thank you, Mr. Chairman.

Sir Elton John, thank you for being here. In my opening remarks, I said that I really do think we have an opportunity, a challenge, and appropriately corrected by my colleague to my right, Senator Warner, an obligation. And you really represent a voice that goes much beyond the voice that we have as political figures. I speak to that because we do have access to money, and the case needs to be made. But your voice goes to what we learn when we are in Uganda and what we learn when we travel around the world, and that is the importance of having leadership, recognized public figures, presidents of countries, stand up and say it is important. It is something that is hard for politicians to do, as my colleague was saying, and your comments about the importance of us as representatives standing up, even if it is unexpected.

Many of us have had the opportunity to meet with President Museveni in Uganda and Muluzi from Malawi and people who have stood up and, at the beginning of every speech they give, no matter what the subject, say "this is the number one priority."

You see more leaders than we see as you travel around the world. What advice do you have for us in talking—because if you do not have the leaders of a country today, including this country but including the recipient countries where the incidence is high, or countries where the rate of growth is high—how best can we get the leadership of those countries involved, and what has your response been in terms of—when you mention your foundation, when you mention HIV/AIDS, to people like in South Africa, the leadership there, who might not quite fully want to approach the issue in the way that you do?

Sir ELTON JOHN. I am just basically an entertainer. I am a quite well-known entertainer, but I am quite aware that when it comes to clout and speaking to politicians, I am an entertainer. I have no delusions about what power I have or how I can convince people.

I think you have to take it to the grassroots level. For example, in Africa, the best way of dealing, I think, with it is getting people like me, or heroes, involved—people who are sports idols, people who are idolized by young people, people whom they will listen to—in Africa, soccer players, for example, African soccer players. If you cannot get to the government, and you cannot change the policy of a government, then start somewhere else. Start at the grassroots level. Get young people's attention by getting the people who are their heroes involved. Then they will listen.

For example, in this country, Magic Johnson is a prime example. He is a great example to young people everywhere in this country, not only African Americans, black Americans. It was an incredible thing to happen; people respected him, and people listened to him.

To make a difference at that level, yes, one can always go to the leader of a country, but it is awfully difficult. It is not easy for me to knock on a door and say, "Oh, by the way, I am popping in for a cup of tea." It is not as easy as that. It is much easier to use one's celebrity and one's success in a local area to get people involved.

This is what I intend to do in Africa when I go there, to take people who are idolized by African kids, whom they will listen to. I always think that young people will always listen. I think that young people are very attentive, very intelligent, and they will listen if they are taught and instructed the right way. And who better to tell them than someone whom they completely look up to?

The same for Russia as well. I intend to go to Russia next year and do the same thing.

So that is the way that I can do it.

Senator FRIST. I think that is very well said, and many of us have had the chance to work with people on this panel and go into the countries directly. I have tremendous faith in young people, and you have more access to them than we do, and we appreciate your work.

Let me just close and say that what I am going to take away in terms of your comments today is what you said about at the end of the night—whether it is entertaining and what you do, or whether it is we as political figures today—when the lights go out, and when you go to bed at night, or 10 years from now when people look back, there is no question that the question is going to be asked, "Did you do everything possible?", and history is going to judge us as a Nation and as a global community as to how well we are both addressing and responding to this most devastating and destructive plague, as Sandy Thurman said, a plague of epidemic proportions.

That is the image that I am going to carry away—when the lights go out, when we go home for recess, leave the United States Senate, do something else, history is going to judge how well we respond.

So thank you for being here.

Sir ELTON JOHN. Could I just say one more thing? I am 55 years of age, and I have made a commitment for the rest of my life to do something for this disease. If we all come together to make that commitment, we will have no conscience, because we will have done that.

If people come together, like this committee, like the people who are testifying, and we roll ourselves like a ball of wool and eventually get to the size of the Indiana Jones thing—if you remember that huge thing that went down—it is an unstoppable thing. Commitment en force, en masse, is an incredible thing.

I have made a commitment for the rest of my life that I will do something for people with AIDS. If we all pull together and do something like that, and we all do it together, we will make the difference—there is no question.

Senator FRIST. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Sessions.

Senator SESSIONS. Thank you for that commitment. It has made a difference.

I talked to a businessman who does a lot of work around the world, and he said that in developing nations, the absolute key is not to give the money too high up the ladder. If you are giving the money to the people doing the work, they will work wonderfully, and things will happen beautifully. If you give it too high up, it does not get to the people who do the work in an effective way.

Many of you have foundations and are leading groups that are smaller, where you can be more effective. We are talking about, if we were to do what Ms. Thurman asked, tripling our contribution to $2.5 billion.

Do you have any suggestions as to how we can make sure that that money actually reaches its greatest potential?

Sir ELTON JOHN. I concur with you totally. What that money has to go toward is training people to build an infrastructure so that people can get the drugs they need in remote parts of countries, and it needs to be run on a government level. But I know what you are saying. I do not know how you do that, because I am just a singer. This is something that the politicians have to make sure that when the money goes to governments, the money is spent in the right way.

I have said before that we are a very small AIDS organization; we can control where everything goes, and we do. We know where every penny goes. But when you get to these vast sums of money that we are talking about here today, you are going to run into those kinds of problems, and I do not personally know myself how you solve them, but I do concur with you that that is a major problem.

Senator SESSIONS. Thank you.

The CHAIRMAN. Thank you, Sir John. We know that you have other appointments, and we are very grateful for all the time you have given. If you need to be excused, we will excuse you, and we will take a few more minutes for questions of the other panelists. We hope you are not going to go beyond our call and that if we need you again, we can—

Sir ELTON JOHN. Please use me as much as you feel you want to use me.

The CHAIRMAN. Good. Thank you very much. If you do have to leave, we will understand.

We have a short time remaining, so maybe we can each ask a question, and we will try to go as long as we can.

If we say that one of the issues is the financial, would you say that the second one is the cultural, and what kind of progress are we making in terms of working through some of these cultural differences?

Let us start with Dr. Mugyenyi, if you would comment, and then perhaps other members of the panel would like to say a word as well on the progress that has been made, the difficulties that we are facing, and any suggestions or ideas that you have to help us deal with these issues.

Dr. MUGYENYI. Thank you, Senator Kennedy.

The most important issue here is not to plan a program outside the developing countries and carry it over there. This normally

faces difficulties. The most important aspect of culture is to work with the people, so that the planning stage involves the indigenous people, that is, the people who are going to get the aid, and the advice on how aid is to be used. It helps address the issue that has been brought up of the higher-ups not taking the money to the grassroots when the planning involves the people. So this is the crucial aspect of this, Senator.

Another important issue in culture is information. It is very important that there is an atmosphere of openness in how AIDS money is used, so that the people themselves become the guardians of good use of the money, and they can only do so once they are informed that such amount of money is available and that such programs have been implemented.

The CHAIRMAN. Can we hear from Dr. Rosenfield?

Dr. ROSENFIELD. I would just like to reiterate what Peter has said. There is no question that we cannot take a model from the United States and simply impose it. We have to deal with local groups, and local groups have to take the leadership in developing a culturally sensitive or culturally appropriate approach to any health intervention, and particularly one as sensitive and difficult as the AIDS epidemic.

We have seen a wonderful program in South Africa called Love Life, focused on youth, a superb program building on the experience of youth themselves in that particular setting. We need to see programs like that in each country in which funds are allocated.

The CHAIRMAN. Ms. Dortzbach.

Ms. DORTZBACH. Utilizing the principles that Dr. Mugyenyi has described, we have seen a dramatic change in Rwanda with church leaders who at one time were very stigmatizing, reluctant to even mention the word AIDS, and said, "It is not with us." Now, today, as a result of a lot of training, a lot of patience, a lot of advocacy work, there are 180 different support groups for people living with AIDS who are within those same churches.

The CHAIRMAN. Ms. Thurman.

Ms. THURMAN. Simply to add to that that what we saw in the early days of the epidemic here reminds me in large part of what we are seeing in Africa, and that is that the response had to be homegrown, it had to be based in the community and then supported by Federal and State dollars.

I think it addresses what Senator Sessions was saying, that in the Ryan White CARE Act, what made it so successful was the fact that the money came from the Federal Government but went directly into community-based organizations and not through some cumbersome Government process, so that the cultural issues, even at the domestic level, in the communities hardest-hit early on could be dealt with in very sensitive ways.

The CHAIRMAN. I can remember the difference in the cost. In San Francisco, it was about $30,000 to $35,000, and in Boston, about $120,000. So we found out how to really do this and do it right.

Senator Clinton.

Senator CLINTON. Thank you very much.

I want to be sure that I understand the specific recommendations that each of you would make to us, because as we attempt to craft legislation out of this committee, out of the Foreign Relations com-

mittee, and out of other committees that are involved, I hope that we fully appreciate the ideas that you have brought to us.

So to that end, I just want to confirm that in your written testimony, Ms. Thurman, you have specific recommendations regarding the role that the Centers for Disease Control could undertake, including a treatment set-aside which would provide a Federal match of any private funding to expand MTCT programs. I understand that that is one of your recommendations. Is that right?

Ms. THURMAN. It is. We are recommending that at least $500 million be given to CDC to expand their prevention efforts, and then also to expand their care and treatment programs and support and match what the private foundations that Dr. Rosenfield has talked about are doing.

Again, I think this whole idea of public-private partnership at this point in time is very important, and the 30 percent set-aside that we are talking about for treatment would include that $100 million to match what the foundations have done to expand the programs to prevent mother-to-child transmission to treat mothers and other family members.

Senator CLINTON. And that would correspond as well with Sir Elton's recommendation, as well as Dr. Rosenfield's recommendation, about private initiative being given that kind of match.

Ms. THURMAN. Yes.

Senator CLINTON. In addition, you recommend that HRSA, which is one of our Federal agencies that now does a lot of work under the Ryan White CARE Act, be more involved in the developing world; so we would use the expertise that we have already developed here and export that.

Ms. THURMAN. Exactly. We do not need to reinvent the wheel at this point.

Senator CLINTON. Third, you recommend that the committee authorize and try to push a workplace-based HIV/AIDS program through both the CDC and the Department of Labor that would be used in other countries to try to do workplace education along the lines of what has been done in Uganda, Senegal, and other successful programs; is that right?

Ms. THURMAN. Exactly, and that is particularly important where we have anywhere between 5 and 30 percent of the work force infected. Using organized labor and the workplace is our best way to reach those people.

Senator CLINTON. Similarly, both Dr. Mugyenyi and Dr. Rosenfield mentioned the availability and cost of AIDS drugs. This is a difficult challenge, but it is one that we have to address. I think that both with respect to the generally available effective AIDS drugs and the MTCT-Plus program, we are going to have to tackle this in one way or another. It is very troubling to think about the future, because certainly we are focusing today on Africa, but there are many experts who increasingly are telling us that the pandemic is alive and well and spreading in Asia, particularly in India, increasingly in China, and in Russia. So, trying to get ahead of the need for drugs and figure out a way to provide them in a cost-effective manner is critical, I assume.

I very much appreciated Ms. Dortzbach's testimony on the role of microcredit and the role of family financing, which is something

that I believe in very strongly and have worked on for more than—oh, my gosh, a long time—20 years, I guess. And I had not really thought about including microcredit as part of our overall comprehensive AIDS strategy until you mentioned that, Ms. Dortzbach. I think that is something that we really ought to look at, because it goes hand-in-hand with self-sufficiency, with economic activity, which is an important part of dealing with this crisis. So I very much appreciate your description and recommendation on that.

Mr. Chairman, I think we have some very positive suggestions from this panel in addition to their very moving testimony and their own personal commitment. I think we have some ideas that we can get to work on in this committee and can work on with other committees as well.

Thank you.

The CHAIRMAN. Very good. Thank you.

Senator Frist.

Senator FRIST. Thank you, Mr. Chairman.

I would like to come back to two questions, and one, I will direct to Ms. Thurman about the AIDS orphans issue, and then, Dr. Mugyenyi, I want to ask you about the testing component of linking prevention, care, and treatment with testing. When I was with you several months ago, the most remarkable thing that I learned on my last trip to Africa 2 months ago, to Uganda, to see, as Senator Clinton did, the tremendous service in track record, but also culturally-oriented service that you offer there—it was remarkable to me to see the change versus 3 years ago in terms of rapid testing, VCT, voluntary. We have mentioned it in the hearing this morning, but it was remarkable to me that we have been able to condense a test which costs $50 to $60 in American dollars and used to take several weeks—where you lost that "teachable moment." The voluntary part amazed me that it worked so well. The counseling part is the education that we have all mentioned. The testing part, the technology, and the role that technology has played in taking an expensive test that took several weeks, where you lost the "teachable moment," you might not be able to see that individual once again—now, with the test down to $1.20, with certain sensitivity and certain specificity combined in that 1-hour or 45-minute period, you can capture what a physician knows as the teachable moment where somebody who comes seeking information, is receptive, you can give that information and while you are there discuss, whether it is behavior, whether it is treatment options, and again, Sandy Thurman's linkage between prevention, care, and treatment is so critical from a physician's standpoint as we go forward.

Before I have you answer that, let me ask the second question which has to do with the orphans. Father D'Agostino is in the audience today, and many of us have had the opportunity to visit with him on numerous occasions and have seen the tremendous work that he does. When you see the AIDS orphans—and you are almost embarrassed to call them "AIDS orphans," because you see their faces and the delight and the love that he has been able to give them and that they can express—yet, as you said in your testimony, we are going to have 40 million AIDS orphans in the next 40 years.

If you could just address what we can do, and Dr. Mugyenyi, could you comment on the testing, the technology, and the impact it has had.

Dr. MUGYENYI. Thank you, Senator Frist.

That is a very, very important issue, because for a long time, it was thought that Africa would not make headway because it had no technological means of testing for HIV/AIDS and monitoring for antiretroviral drugs.

Testing has indeed made a revolution in Africa. A person comes into our clinic, and just within the same day, in fact, within an hour, we will have had counseling, he will have had discussions with a few other people who are prepared to be available on that day, and then he will get the results on the same day and then see physicians in the same small center that you saw and be able to have a description of how to go forward with treatment.

This can be repeated in many parts of Africa, and we are very proud that we are part of the groups that developed this method.

Another very important question related to testing, Senator Frist, is the expensive monitoring tests. It is embarrassing, Senator, that these tests are now more expensive than the drugs themselves.

Senator FRIST. Could you tell us roughly, in terms of testing for VCT, how much do those little tests cost, approximately?

Dr. MUGYENYI. If you use the conventional method of testing for CD4, you pay about $60.

Senator FRIST. And this is for the monitoring.

Dr. MUGYENYI. Just for the CD4.

Senator FRIST. First of all, for the voluntary counseling and testing, when somebody comes in, HIV-positive or not, about how much does that cost today?

Dr. MUGYENYI. It costs about $200 to do both CD4 and virology testing.

Senator FRIST. For VCT, though, for the voluntary counseling and testing, if somebody walks in the door, and they just want to know if they are HIV-positive, to do the screen for them costs how much?

Dr. MUGYENYI. Oh, in our center now, it is down to $1.

Senator FRIST. One dollar. That is just unbelievable. And you can get the result immediately.

Dr. MUGYENYI. Yes.

Senator FRIST. The second issue you talked about is monitoring, which is the immunologic monitoring over time. How much does that cost now?

Dr. MUGYENYI. That is very expensive, but Senator, in my center, we no longer use those methods. We have, together with American scientists and other scientists, discovered that we can do effective testing using more cost-effective methods. We can now do it for under $30.

Senator FRIST. Thirty dollars. Is that for a year, or per test?

Dr. MUGYENYI. Per test.

Senator FRIST. Per test. And how many tests per year?

Dr. MUGYENYI. We just need two tests per year.

Senator FRIST. Thank you very much.

Ms. THURMAN. And looking at the issue of orphans, I think there are a lot of things that we can do. It is sort of mind-boggling to think that we will have 40 million children orphaned by AIDS. Certainly, Father D'Agostino has done extraordinary work in the orphanage that he runs, but in addition to the orphanage, he has an incredible outreach program, and I think that that is where we have to focus most of our attention, because with 40 million orphans, we are going to have to keep them in communities. In addition to that, we all know from decades of study that children thrive better if left in their own families and in their own communities, and not put in institutions. That needs to be a last resort for us.

So I think there are several things that we can do. We need to give the families support that are caring for orphans. We need to look at microfinance programs like the program that the First Lady of Uganda has started to mobilize, grandmothers who are actually inheriting the care of many orphans when their children die. We need to look at supporting school fees for children, training caregivers. I think we need to prepare the children for the death of their parents. That is something that costs very little, but in terms of their psychology development long-term, it is very, very important when we can to prepare these children for life without their parents; and again, that costs very, very little.

So there are a lot of ways and very cost-effective ways that we can support those children and try to keep them in their communities when we can, but education of these children and school fees is going to be very important, because if they have no means of support, they are going to be very, very vulnerable. So we need to look at that impact as well.

Dr. ROSENFIELD. Senator Frist, could I just add one point? With both the MTCT-Plus initiative and the major, much larger initiative of the Global Fund, we can prevent 40 million orphans over the next 20 years if we take this pandemic seriously now and put in place programs both to put MTCT alone in place to decrease transmission rates, treat the mothers so that the kids are not orphaned, and begin the broad treatment programs.

I would urge the committee to support not only the initiatives that we have talked about, but Kofi Annan's eloquent call to action for his Global Fund; and the United States should be taking, I believe, greater leadership in the support of the Global Fund, because that is the long-term hope that we will not end up with 40 million orphaned children and that we will reverse the absolute death rates that exist now for everybody who is HIV-positive in Africa, Asia and elsewhere.

I do agree, Senator Kennedy, that the figures in India and China are probably significant underestimates of how significantly that epidemic has already reached South and Southeast Asia.

So just think—if India had 5 percent seropositivity, well below some of the rates in Africa, with a billion people, the mathematics there are just mind-boggling. And we are heading there if we do not get ahead of this process, both in prevention and care.

The CHAIRMAN. The vote has started, so we have about 4 or 5 minutes.

Senator Warner.

Senator WARNER. I will be very brief.

Dr. Rosenfield, we are going back and forth, understandably, between the problems abroad and the problems here at home. Ms. Thurman had an opportunity to respond to questions from Senator Kennedy about the domestic situation. Do you wish to add anything about the domestic situation?

Dr. ROSENFIELD. Yes. I think it is obviously at a different level than in Africa, but it is a major issue. It has become predominantly an issue of people of color. I chair the New York State AIDS Advisory Council, and we deal with this all the time. We continue to have deaths. People do break through from treatment.

We need a greater focus and a greater allocation of resources to those who are at highest risk in this epidemic in our country, and that includes the IV drug-using populations, those exposed to those drug-using populations. We see a return among men who have sex with men, particularly younger people who are not believing the stories of older people.

So we do have a heavy challenge still in our own country as well.

Senator WARNER. Thank you.

Dr. Mugyenyi, I mentioned the political and military instability in a number of nations. Can you comment on that? It is the inability to raise and sustain not only internal military forces but internal police and otherwise, which are essential to any government to carry out its policies.

Am I correct that this disease is a direct contributor to a great deal of instability in both of those areas, political and military?

Dr. MUGYENYI. Yes, Senator. This is a very destabilizing factor in our part of the world. The soldiers who are sick are not able to defend their countries; the lack of drugs for a disease that is most important to the people is causing agitation. You have seen the situation in Southern Africa. It is the most important political issue after being the most important health issue.

So you are absolutely right, Senator, that this is not only a health factor but also a highly destabilizing factor in our part of the world.

Senator WARNER. Mr. Chairman, if those witnesses with us today or others following this important hearing have further contributions in that area of political-military instability, I would be happy to review them, and suggest that portions might go into today's record.

The CHAIRMAN. Thank you.

Senator Sessions.

Senator SESSIONS. Thank you, Mr. Chairman.

Dr. Rosenfield, maybe we could summarize a little bit here on some of the things that we have discussed.

How much does it cost—well, let me ask this—what percentage of children with untreated mothers who have AIDS are born with the disease, and what can be done if the mother has the medication, and how much progress in reducing that infection rate can be achieved?

Dr. ROSENFIELD. Without treatment, the transition rate is estimated to be somewhere between 25 and 40 percent. With the simple nevirapine therapy to the mother, a single dose, and the single dose to the baby, we can beat that by at least 50 percent.

Senator SESSIONS. And that is a $4 dose, approximately? How much is it?

Dr. ROSENFIELD. It is something in that range. So we can change that by at least 50 percent.

Senator SESSIONS. And Ms. Thurman, I think you were suggesting that we need to go further than that and deal with the mothers and fathers who are dying of AIDS, and that treatment could prevent these children from becoming orphans.

Ms. THURMAN. It is true. I think that if we treat the mother—and hopefully the fathers, because it creates bad family dynamics if you are treating the mother and not the father—but certainly treating the mother, we again know from years of research that the longer we can keep those infants with their mothers, the more viable they will be in the long term. So that is what we are asking CDC and what Dr. Rosenfield's MTCT-Plus program aims to do, and that is to provide treatment to mothers and other family members so we do not create orphans, so we keep families together. It is about celebrating and supporting the families.

Senator SESSIONS. Let me ask this. What percentage of pregnant women with AIDS are being treated with the drugs? Does anyone konw that?

Dr. ROSENFIELD. With nevirapine today?

Senator SESSIONS. In Africa.

Dr. ROSENFIELD. It is a very small percentage. The program is only 3 to 4 years old. The Glaser Foundation has taken a lead in this, and UNICEF and others are actively involved, but it is still a small program and in need of great additional resources.

I could not give you a percentage, but it is a very small percentage of the total number of women who are currently HIV-positive in Africa.

Senator SESSIONS. So with a $4 treatment, we could dramatically reduce the number of infants born with AIDS, and we are just not reaching those pepole.

Dr. ROSENFIELD. Yes. Certainly, additional funding is needed, but the groups, again, like the Glaser Foundation, UNICEF, Medins Sans Frontiers, CDC, and others, are moving as quickly as they can to work with governments to try to expand these programs.

Senator SESSIONS. Well, that is a challenge.

Thank you.

The CHAIRMAN. Thank you very much.

Again, all of you have been enormously interesting. We will have all of this as an amendment to the Foreign Relations Committee legislation that will be considered. Also, we will all be supportive in terms of these funding mechanisms, and it may come out somewhat differently in terms of different members of the committee, but I think you have a strong sense that we are all going to do as much as we possibly can. That is probably the best way we can thank you very much for a really extraordinary presentation.

We hope that as many of our colleagues as possible will read through the record and review what has been said, because it is enormously persuasive and compelling.

I just want to mention that we do have here with us today Ann Blackmun and her son Christophe. Ann and her son have worked

tirelessly to bring attention to issues of families and children with AIDS. Christophe recently focused on the plight of children with AIDS in Kenya, and did a very outstanding documentary on that. We are very thankful that they could be with us today.

There being no further business, the committee will stand in recess.

[Whereupon, at 12:19 p.m., the committee was adjourned.]

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