

# HIV/AIDS, TB, AND MALARIA: COMBATING A GLOBAL PANDEMIC

---

---

## HEARING BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

MARCH 20, 2003

**Serial No. 108-10**

Printed for the use of the Committee on Energy and Commerce



Available via the World Wide Web: <http://www.access.gpo.gov/congress/house>

U.S. GOVERNMENT PRINTING OFFICE

86-056PS

WASHINGTON : 2003

---

For sale by the Superintendent of Documents, U.S. Government Printing Office  
Internet: [bookstore.gpo.gov](http://bookstore.gpo.gov) Phone: toll free (866) 512-1800; DC area (202) 512-1800  
Fax: (202) 512-2250 Mail: Stop SSOP, Washington, DC 20402-0001



## COMMITTEE ON ENERGY AND COMMERCE

W.J. "BILLY" TAUZIN, Louisiana, *Chairman*

MICHAEL BILIRAKIS, Florida	JOHN D. DINGELL, Michigan
JOE BARTON, Texas	<i>Ranking Member</i>
FRED UPTON, Michigan	HENRY A. WAXMAN, California
CLIFF STEARNS, Florida	EDWARD J. MARKEY, Massachusetts
PAUL E. GILLMOR, Ohio	RALPH M. HALL, Texas
JAMES C. GREENWOOD, Pennsylvania	RICK BOUCHER, Virginia
CHRISTOPHER COX, California	EDOLPHUS TOWNS, New York
NATHAN DEAL, Georgia	FRANK PALLONE, Jr., New Jersey
RICHARD BURR, North Carolina	SHERROD BROWN, Ohio
<i>Vice Chairman</i>	BART GORDON, Tennessee
ED WHITFIELD, Kentucky	PETER DEUTSCH, Florida
CHARLIE NORWOOD, Georgia	BOBBY L. RUSH, Illinois
BARBARA CUBIN, Wyoming	ANNA G. ESHOO, California
JOHN SHIMKUS, Illinois	BART STUPAK, Michigan
HEATHER WILSON, New Mexico	ELIOT L. ENGEL, New York
JOHN B. SHADEGG, Arizona	ALBERT R. WYNN, Maryland
CHARLES W. "CHIP" PICKERING, Mississippi	GENE GREEN, Texas
VITO FOSSELLA, New York	KAREN McCARTHY, Missouri
ROY BLUNT, Missouri	TED STRICKLAND, Ohio
STEVE BUYER, Indiana	DIANA DeGETTE, Colorado
GEORGE RADANOVICH, California	LOIS CAPPs, California
CHARLES F. BASS, New Hampshire	MICHAEL F. DOYLE, Pennsylvania
JOSEPH R. PITTS, Pennsylvania	CHRISTOPHER JOHN, Louisiana
MARY BONO, California	JIM DAVIS, Florida
GREG WALDEN, Oregon	THOMAS H. ALLEN, Maine
LEE TERRY, Nebraska	JANICE D. SCHAKOWSKY, Illinois
ERNIE FLETCHER, Kentucky	HILDA L. SOLIS, California
MIKE FERGUSON, New Jersey	
MIKE ROGERS, Michigan	
DARRELL E. ISSA, California	
C.L. "BUTCH" OTTER, Idaho	

DAVID V. MARVENTANO, *Staff Director*

JAMES D. BARNETTE, *General Counsel*

REID P.F. STUNTZ, *Minority Staff Director and Chief Counsel*

---

## SUBCOMMITTEE ON HEALTH

MICHAEL BILIRAKIS, Florida, *Chairman*

JOE BARTON, Texas	SHERROD BROWN, Ohio
FRED UPTON, Michigan	<i>Ranking Member</i>
JAMES C. GREENWOOD, Pennsylvania	HENRY A. WAXMAN, California
NATHAN DEAL, Georgia	RALPH M. HALL, Texas
RICHARD BURR, North Carolina	EDOLPHUS TOWNS, New York
ED WHITFIELD, Kentucky	FRANK PALLONE, Jr., New Jersey
CHARLIE NORWOOD, Georgia	ANNA G. ESHOO, California
<i>Vice Chairman</i>	BART STUPAK, Michigan
BARBARA CUBIN, Wyoming	ELIOT L. ENGEL, New York
HEATHER WILSON, New Mexico	GENE GREEN, Texas
JOHN B. SHADEGG, Arizona	TED STRICKLAND, Ohio
CHARLES W. "CHIP" PICKERING, Mississippi	LOIS CAPPs, California
STEVE BUYER, Indiana	BART GORDON, Tennessee
JOSEPH R. PITTS, Pennsylvania	DIANA DeGETTE, Colorado
ERNIE FLETCHER, Kentucky	CHRISTOPHER JOHN, Louisiana
MIKE FERGUSON, New Jersey	JOHN D. DINGELL, Michigan,
MIKE ROGERS, Michigan	(Ex Officio)
W.J. "BILLY" TAUZIN, Louisiana	
(Ex Officio)	

## CONTENTS

---

	Page
Testimony of:	
Allen, Hon. Claude, Deputy Secretary, Department of Health and Human Services .....	8
Barry, Donna J., Partners in Health .....	35
Green, Edward C., Senior Research Scientist, Harvard Center for Population and Development Studies .....	45
Monico, Sophia Mukasa, Director, AIDS Program, Global Health Council .	39
Smith, Shepherd, President and Founder, Institute for Youth Development .....	32
Material submitted for the record by:	
Barry, Donna J., Partners in Health, letter dated April 3, 2003, enclosing material for the record .....	60
Green, Edward C., Senior Research Scientist, Harvard Center for Population and Development Studies, response for the record .....	61
Monico, Sophia Mukasa, Director, AIDS Program, Global Health Council, letter dated April 23, 2003, enclosing material for the record .....	56
Alan Gutmacher Institute, letter dated March 20, 2003, enclosing statement .....	55
Human Rights Watch, letter dated March 27, 2003, enclosing material for the record .....	62
Smith, Shepherd, President and Founder, Institute for Youth Development, letter dated April 14, 2003, enclosing material for the record .....	59

## HIV/AIDS, TB, AND MALARIA: COMBATING A GLOBAL PANDEMIC

THURSDAY, MARCH 20, 2003

HOUSE OF REPRESENTATIVES,  
COMMITTEE ON ENERGY AND COMMERCE,  
SUBCOMMITTEE ON HEALTH,  
*Washington, DC.*

The subcommittee met, pursuant to notice, at 10 a.m., in room 2322, Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Upton, Greenwood, Wilson, Pitts, Ferguson, Brown, Waxman, Towns, Green, Capps, and DeGette.

Also present: Representative Solis.

Staff present: Patrick Ronan, majority counsel; Steve Tilton, health policy coordinator; Eugenia Edwards, legislative clerk; John Ford, minority counsel; and Jessica McNiece, minority staff assistant.

Mr. BILIRAKIS. I call this hearing to order. I'd like to start off by taking a moment to thank all of our witnesses for appearing before the subcommittee today. We certainly value your expertise and we're grateful for your cooperation and attendance.

Today's hearing will focus on the horrendous impact that HIV/AIDS, tuberculosis and malaria are having in many parts of the world, particularly in Africa. The numbers are certainly staggering. Of the 42 million people estimated to be HIV infected worldwide, approximately 37 million of them live in Sub-Saharan Africa, China, India, Southeast Asia and Latin America.

Although HIV rates are rising at a disturbing rate in many of those countries, the area of the world most affected by this scourge is Africa where nearly 30 million people are HIV infected. An entire generation of Africans are endangered of being decimated by the horrible, yet preventable disease.

We also face daunting challenges with respect to tuberculosis and malaria where one-third of the global population carries the virus that causes TB. There are over 8 million new cases of TB every year, with over 2 million deaths. Over 80 percent of TB cases are found in 23 developing countries.

The interaction between HIV/AIDS is particularly frightening. HIV infected people are much more likely to develop active TB. While TB, in turn, accelerates the onset of AIDS in individuals infected with HIV.

Finally, malaria exacts a similarly gruesome toll in underdeveloped nations. Malaria is the most common life threatening in-

fection in the world. It kills a child every 30 seconds and causes more than 1 million deaths and 500 million infections annually. A full 90 percent of these deaths occur in Sub-Saharan Africa where most of the victims are under 5 years old.

Fortunately, there is hope. President Bush has affirmed the need for the United States leadership in this critical area. As we're all aware, the President pledged \$10 billion in new funding to combat AIDS, TB and malaria globally. In addition, I am pleased that Secretary Thompson is chairman of the board of the Global Fund to fight AIDS, tuberculosis and malaria. I'm sure that with his leadership, the Fund will continue to provide much needed resources to help developing nations fight these terrible diseases.

I am looking forward to hearing the testimony from our witnesses today. I think it's important that we learn about which interventions have been helpful in controlling these diseases and which ones have not, especially if we're going to commit \$10 million of taxpayers' funds to help control infectious diseases in other countries.

We must ensure that whatever funds we dedicate to this effort are used in the most effective manner and I intend to assume that responsibility as the subcommittee moves forward in its work.

While there are strong humanitarian justifications for our level of involvement, we also have a compelling national interest as well. I believe that the growth and development of many of these nations is contingent on managing and ultimately defeating a seemingly unchecked spread of these deadly diseases.

With that, I yield to my friend from Ohio for an opening statement. And again I would ask members of the subcommittee to keep in mind if they would waive their opening statements, they can have as much as 8 minutes questioning later on.

I yield to the gentleman from Ohio, Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman. I want to welcome Secretary Allen. Thank you for joining us again in our Committee. I want to extend a special welcome to Donna Barry, Director of the Russia program called Partners in Health which is a Boston-based NGO which operates TB and HIV treatment programs in the central plains of Haiti and Lima, Peru and in Tomsk, a city in central Siberia and in Russia.

I traveled with Donna and her colleagues of Partners in Health to visit Moscow's largest jail where hundreds of not yet sentenced prisoners infected with tuberculosis are living in small cells with little ventilation. There's a growing problem of multi-drug resistance of so-called MDR-TB in Russian prisons which comes from incorrect or interrupted treatment and inadequate drug supplies. We then visited about a 5-hour flight east to the city of Tomsk. I visited a Russian prison colony Tomsk where only 6 years ago in a prison colony made up of about 1,100, all inmates all infected with tuberculosis only 6 years ago, 65 or so inmates were dying a year to date. Last year no one in that prison died of tuberculosis.

Yesterday, 1,100 people in India died of tuberculosis. In January, in Sub-Saharan Africa, 225,000 people died from AIDS. In 2002, as the chairman said, more than a million people in the world died from malaria.

I want to talk this morning primarily about tuberculosis and publicly thank Heather Wilson, my friend from Mexico, for the work that she has done in tuberculosis, in combatting one of the world's longest existing and terrible diseases.

The chairman said it infects one third of the world's population, one third of the world's population carry the TB bacteria. It's a leading killer of young men and young women and people with HIV worldwide. HIV/AIDS and TB form a lethal combination, each speeding the other's progress. HIV promotes rapid progression of primary TB infection to active disease. It's the most powerful known risk factor for reactivation of latent TB infection to active disease.

HIV patients often die of TB before they succumb to AIDS.

We have effective treatment for TB and a mechanism to provide low cost tuberculosis drugs. The drugs required for treating standard TB cost as little as \$10 for a 6-month regimen in developing countries. Access to these life saving treatments means kids are not pulled out of school to work or care for a sick parent. It means an HIV positive father in the developing world has a few more years of life to provide for his family.

What AIDS and TB experts know, but policymakers consistently under estimate is that preventing and treating AIDS without preventing and treating TB is a virtual death sentence of the developing world. If AIDS doesn't kill you, TB will.

The President said he's committed to spending \$10 billion new dollars for preventing and treating HIV/AIDS worldwide. Unfortunately, only a fraction of that \$1 billion will go to one of the best, most results oriented, easiest to quantify mechanisms available for treating these three killers, the Global Fund to fight AIDS, TB and malaria and I join in the chairman's comments in optimism that Secretary Thompson will chair the Global Fund in the year ahead.

The Global Fund has hired independent accounting firms to oversee distribution of funds. It has the single best reporting mechanism of any other international aid program. It will require quarterly reporting on outcomes, disperse funds based on results, and if they don't see quantifiable positive results, we'll pull the funding after 2 years and spend it elsewhere.

By the end of 2005, the Fund will show the number of medical trained personnel, patients treated and in case of TB, the number of patients cured. USAID has failed to do that in numerous meetings and requests and reporting from that agency.

The President's initiative is aimed, unfortunately, at only 14 countries; 12 Sub-Saharan African countries and Guyana and Haiti in our hemisphere. With the devastation, while greatest in those countries, the problems in most of the rest of the world are even more important because that's where most of the rest of the world lives. The White House plan excludes India, China, Bangladesh, Brazil, Mexico, Pakistan, Indonesia, the countries where literally half the world's population lives and where most of the problems for TB and malaria reside. It excludes 15 of the 22 high-burden TB countries which account for 80 percent of the world's TB population. Despite the President's intentions investing sufficiently in 85 to 100 countries will turn the tide of AIDS. Investing in only 14 countries will make in the words of the Executive Director of

the Global Fund, will make only “a minor dent.” This committee must consider the role of CDC also in addressing this global pandemic. CDC has extensive knowledge and expertise implementing programs that treat malaria and TB and HIV/AIDS. CDC staff provide technical and scientific support for international agencies like USAID and provide support for national infectious disease programs in developing countries.

CDC is driven helping countries implement a strategy specific to and appropriate for each country as the Global Fund will do, not a one size fits all in Christian Brazil and Muslim Bangladesh. It will reduce the incidence of deadly infections.

CDC recognizes what’s outside our borders can easily travel into the U.S., a business woman returning from Russia or a family of tourists returning from India or Africa. Despite CDC’s expertise in infectious disease, they’re handicapped by Congress’ decision to funnel majority of international aid through USAID. CDC has a relatively small budget for the international AIDS program and their work international TB control is almost entirely funded by—

Mr. BILIRAKIS. Please sum up, if you will.

Mr. BROWN. Fifteen more seconds. We can say, Mr. Chairman, without exaggeration that unless we take unprecedented dramatic action to both prevent further spread and to treat all those who require treatment that AIDS, TB and malaria will take a much greater social, political and economic toll than did the Great Plague.

Mr. BILIRAKIS. The chair thanks the gentleman. Mr. Upton for an opening statement.

Mr. UPTON. Thank you, Mr. Chairman. I’ll be very, very brief. I want to insert my record fully into the record, my statement into the record.

Mr. Chairman, the statistics are indeed staggering and unsafe injection practices such as the widespread reuse of syringes designed for a single use only have been linked to the transmission of many of these diseases. In the last Congress, I introduced legislation that embodied a four-pronged approach to improving injection practices. Now we strengthened the procedures for proper needle and syringe disposal. We promoted the availability and use of needles and syringes that could not be re-used. I look forward to working with you on this legislation again in this Congress and I would hope that we could get this passed again in the House as we did last year.

I yield back the balance of my time.

Mr. BILIRAKIS. The chair thanks the gentleman and of course, without objection, the opening statement of all members of the subcommittee will be made a part of the record.

Ms. Capps for an opening statement.

Ms. CAPPS. Thank you, Mr. Chairman. I appreciate your providing this opportunity to examine the very important issue of global AIDS and its terrible toll. I appreciate our witnesses who are here today.

I was pleased to hear the President make a commitment to ending HIV/AIDS, particularly in Africa. It is commendable, but we have to make sure that the funds he has committed are used prop-



erly. No continent has been more devastated by HIV/AIDS than Africa. Sub-Saharan Africa is home to 29.4 million people living with HIV/AIDS. This has been referenced already last year. There were 3.5 million new infections.

But in some places, progress is being made. For example, Uganda. Several organizations including U.N. AIDS and the World Health Organization have touted Uganda's success because they have been able to decrease HIV/AIDS rates. In the late 1980's, Uganda suffered from an HIV/AIDS rate of nearly 30 percent. By the 1990's, the prevalence was down to 10.5 percent. Now it is close to 5 percent. Uganda's programs have proven effective in combating HIV/AIDS, particularly the ABC program is a comprehensive one that does work. It touts the principles of abstinence, be faithful and condom use all together and has been very effective. What makes this program so successful is its integrated and community-based approach. Reports from USAID and U.N. AIDS indicates that comprehensive and community-based approach to HIV/AIDS prevention works best.

The fundamental goal of these public health interventions is to change behavior and it appears that Uganda's use of integrated behavioral changed programs has had remarkable success. There is also no evidence that abstinence works alone. There is no data that sufficiently reports abstinence only rhetoric as causally decreasing rates of HIV/AIDS in Africa.

To remain global leaders in the area of HIV/AIDS prevention, we must promote comprehensive prevention programs. Science is our best guide in these efforts. We cannot allow ideological beliefs and fears to undermine the health of nations.

But I fear that restrictions based on ideology will be attached to the Global Funds we provide. For the past 2 years, the Bush administration has been trying to do just that, putting us in league with countries like Syria, Libya, Sudan, Iran and even Iraq. By making funding contingent by following an abstinence only criterion, we do such a great disservice to our global partners and undercut efforts to prevent the spread of AIDS.

With our scientific and health expertise, we have an obligation to get this right. And I believe we have an obligation to work with local communities according to the values and systems that they have found to be effective an that they support.

In these times, we should not try to be viewed as partners working with countries. We should try to be viewed as partners working with countries, not as outsiders imposing our will on them. We should defer to the experts who repeatedly tell us that fundamental public health approaches must be all encompassing and based on science.

I look forward to hearing from the witnesses today. I hope we can put aside ideology and truly make progress on this critical issue.

I yield back the balance of my time.

Mr. BILIRAKIS. The chair thanks the gentle lady. The gentle lady from New Mexico, Ms. Wilson.

Ms. WILSON. Thank you, Mr. Chairman. I appreciate your having this hearing today. As my colleague from Ohio mentioned, this is

an issue of particular importance to me and I look forward to working with him, particularly on the problem of tuberculosis.

The city of Albuquerque in the State of New Mexico has a long history and connection to the treatment of tuberculosis. In 1903, the first people starting coming to the high desert of New Mexico with its perpetual sunshine and its high, dry climate to treat tuberculosis. In 1912, when New Mexico became a state, the city of Albuquerque's population was one-third active tuberculosis cases. That's a huge number. Next week, in Las Cruces, New Mexico, we are going to be launching a bi-national effort between the United States and Mexico to combat tuberculosis on both sides of the border. So it is steeped in our history, but I think it also represents part of our future.

The No. 1 leading cause of avoidable death in the world is tuberculosis. In poor countries, it's estimated to cost the world about \$12 billion a year. And a lot of it is the connection between tuberculosis and HIV. It's a lethal combination and 15 percent of AIDS deaths are caused by tuberculosis. It's one of the things that can be successfully treated among HIV positive people.

Disease knows no borders, geographic or political. And tuberculosis is arriving in America. Most of the cases in America, 60 percent of the cases, are actually among foreign-born people. So if we want to eradicate tuberculosis in the United States, it must be an international effort. And we have the capacity to eradicate TB. It is within the realm of possibility if we put the effort behind it.

Perhaps most frightening about tuberculosis is the emergence of more and more drug resistant strains of TB. Not only those that are multidrug resistant to five or more drugs, but those that are resistant to even antibiotics become problematic for treatment and much more expensive.

I believe that the eradication of tuberculosis must be an international effort that if we focus on the eradication and treatment of tuberculosis, we will be directly addressing the leading cause of death among those who are HIV positive and that it has tremendous public health benefits here in the United States as well and that's particularly true in border states like my own.

Mr. Chairman, thank you for focusing on this issue. I appreciate your holding this hearing.

Mr. BILIRAKIS. The chair thanks the gentle lady.

Mr. Towns for an opening statement.

Mr. TOWNS. Thank you very much, Mr. Chairman, for holding this hearing today. I want to thank our distinguished witnesses for testifying today on the global HIV/AIDS pandemic.

Today, the International Relations Committee is scheduled to mark up a bill in response to HIV/AIDS. Despite the great efforts of my colleague on that committee, I believe that the nature and enormity of the AIDS problem leaves room for the contribution and expertise of this Committee.

Mr. Chairman, first we must get a firm grasp on the enormity of the problem. AIDS is truly a global killer. The virus respects no national boundaries, no religious affiliation, no race, no gender and no age. In Sub-Saharan Africa, the region of the world most severely affected by HIV and AIDS, there are an estimated 25 million persons infected with the virus. In 7 African countries, 20 percent

of the population is affected. In Botswana, it is estimated that 36 percent of the adult population is infected with HIV.

Other regions of the world have equally alarming statistics. In Asia, the world's most populous continent, 3.5 million people are infected with HIV. Eastern Europe has the most rapid rate of growth in HIV infections. In 20 short months, the number of infected persons in the Russian federation rose from 10,000 to 70,000. That is astonishing. In North America, it is estimated over 900,000 people are infected with HIV. In Latin America, an estimated 1.9 million people are infected. In the Caribbean, it has impacted about 400,000 people.

HIV/AIDS is the leading cause of death in Africa and the fourth leading cause of death worldwide. In the countries most affected in Africa, the life expectancy has declined by 10 years and infant death rates have doubled.

This disease has ravaged families. The loss of one parent can lead to the loss of income, the end of educational opportunities for children and increase child labor. The laws of both parents can be devastated. It has been estimated that by 2010 there will be 40 million children in African who have been orphaned because of the AIDS virus.

Mr. Chairman, that is the equivalent to every child living east of the Mississippi River in this country.

Additionally, the huge number of deaths have caused hardships on social systems, national growth, economic development because those most likely to be affected are adults under 50. This kind of internal disruption may cause political instability and ultimately pose a national security risk.

Mr. Chairman, there is a real life and death need for assistance and we cannot turn away. We cannot content ourselves with notions that somebody, somewhere at some point or some time would do something about it. Compassion and concern are not enough. We must resolve that we will take concrete action here and now. The massive expansion of HIV is not inevitable. This epidemic can be stabilized and reversed. Successful programs include strong, high level political leadership—

Mr. BILIRAKIS. The gentleman's time has long expired. Will you please summarize.

Mr. TOWNS. I will definitely be delighted to, Mr. Chairman, because you allow me to be included in the record, right?

Mr. BILIRAKIS. I will allow you to.

Mr. TOWNS. The national program plan adequate funding and strong involvement. We must work effectively with leaders of the world to achieve these outcomes. We must resolve to act now, not later.

Mr. Chairman, thank you very much for allowing me to go over.

Mr. BILIRAKIS. By all means. Ms. Solis is not a member of the subcommittee, but courtesy certainly to her. You're welcome here and please proceed with your opening statement.

Ms. SOLIS. Thank you. Thank you very much, Mr. Chairman, and also I'd like to thank the Ranking Member, Congressman Brown for allowing me the opportunity to be here to share with you just a few thoughts. I know we have a call right now to go vote, but my concern is obviously the whole issue of addressing AIDS

throughout the entire world, particularly, our lack of diligence and focusing in Latin America and in Central America.

As one of the only Members of Congress who is a Central American or partly through a parent, I find that it's rather distressing that we're not focusing on the effects there of HIV and AIDS, but also malaria and particularly in Central America with respect to Nicaragua. I had a recent visit there last year and found that there is a lot of movement with respect to people leaving the rural areas to the inner cities there, and finding that instead of capping this whole disease of malaria that it's actually on the rise. And would hope that we would extend some thought and perhaps research in that area.

My other concern is that we're neglecting areas like in Mexico where we have 51,000 or more cases of HIV and AIDS; 28,000 that are reported in Central America.

We have something here. We have learned lessons from the past. We should be focusing in on those other areas that need much attention.

I would ask unanimous consent, Mr. Chairman, to submit my further testimony for the record.

Mr. BILIRAKIS. Without objection, that will be the case.

Ms. SOLIS. Thank you.

Mr. BILIRAKIS. All opening statements are vended. Panel One consists of the Honorable Claude Allen, Deputy Secretary of the Department of HHS.

Mr. Secretary, you're more than welcome here. Thank you for taking time to be here at our invitation, of course. I'm going to ask you to start your opening statement, sir, but then I will have to rudely interrupt you.

Mr. BROWN. Mr. Chairman, I ask unanimous consent to put the statement of Mr. Waxman in and something from the Allen-Lugar Institute.

Mr. BILIRAKIS. Without objection, that will be the case.

And when we break, I really don't have any idea of the time. I'm probably going to say we'll break in an hour, but it may be a little longer. I just don't really know what to tell you. I apologize, but unfortunately, that's the way things are.

Mr. Allen, that's the 10-minute bell. Start for maybe 1 minute, that way I know that we've terminated the opening statements.

You can go for 1 minute, if you would, and then if you would maybe defer.

**STATEMENT OF HON. CLAUDE A. ALLEN, DEPUTY SECRETARY,  
DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Mr. ALLEN. Thank you, Mr. Chairman and members of the subcommittee for giving the Department of Health and Human Services this opportunity to talk with you this morning about the global response to HIV, tuberculosis and malaria. This is a subject that is very personal to the President, Secretary Thompson and all of us at the Department. The United States is a blessed Nation and the President has called upon us to provide hope to millions upon millions of people around the world who are suffering from HIV, tuberculosis and malaria.

When the President announced his emergency plan for AIDS relief at the end of January he said it is, "a step toward showing the world the great compassion of a great country." And "a work of mercy."

Indeed, the President's \$15 billion plan will prevent 7 million new HIV infections, treat 2 million HIV infected people with antiretroviral drugs and care for 10 million HIV infected individuals and AIDS orphans.

This initiative will virtually triple our commitment to international HIV/AIDS assistance in 14 countries in Africa and the Caribbean, the two areas of the world that are being devastated by this disease right now.

The President's plan follows on the heels of his new mother-to-child transmission prevention effort or the PMTCP Program which he announced last year.

Mr. BILIRAKIS. Mr. Allen, it might be a good idea before you get into the President's plan that we interrupt you halfway through it if you could just cut at this point and I've discussed this with Mr. Brown and we have probably at least a half hour or so on these votes.

I'm going to say noon to come back. Again, I apologize to you. So many of you have come such a long way.

Mr. ALLEN. That is not a problem, Mr. Chairman. I'd be glad to do so.

Mr. BILIRAKIS. Thank you. So I'm going to recess now until noon.

Mr. ALLEN. Thank you.

[Brief recess.]

Mr. BILIRAKIS. I think we should get started. Mr. Secretary, you started, I think, to go into the President's plan, so to speak.

Mr. ALLEN. Thank you again, Mr. Chairman. The President's plan follows on the heels of his new Mother to Child Transmission Prevention effort or PMTCT which he announced last year. The PMTCT initiative is a strong model of good government and demonstrates how quickly the United States can get much needed resources out the door through our bilateral mechanisms.

HHS, the State Department and the United States Agency for International Development have all worked cooperatively with the White House Office on National AIDS Policy to ensure that the PMTCT program pools all of the resources the U.S. Government has to offer to countries desperate to prevent children from coming into this world HIV positive.

The PMTCT initiative is a part of our overall Global AIDS Program or GAP program. We work directly with 25 countries in Africa, Asia, Latin America and the Caribbean to prevent new infections, provide care and treatment to those already infected and develop the capacity and infrastructure needed to support these programs.

We calculate that these 25 countries account for 90 percent, for more than 90 percent of the world's AIDS burden. For this fiscal year, the budget for Global AIDS Program is \$144 million plus \$40 million for the PMTCT initiative.

I met earlier this week with my counterpart from Cambodia, for example, which is at one of our GAP countries and they're doing extraordinary work with our assistance on the ground. The Presi-

dent's Emergency Plan for AIDS Relief includes both a pledge of support for a dramatic increase in our bilateral assistance and a multi-year commitment to the Global Fund to fight HIV/AIDS, tuberculosis and malaria.

As you know, Secretary Thompson is now the Chairman of the Global Fund. The Secretary and I hope that the President's commitment to HIV/AIDS will encourage other donor countries and the private sector to partner with us by increasing their bilateral assistance to countries where they are present in addition to making contributions to the Global Fund.

We are concerned right now about the fund's ability to finance a third round of proposals. And Secretary Thompson is uncomfortable with the current ratio of donations. The United States should not be responsible for 50 percent of the total pledges as is now the case. The U.S. commitment for fiscal year 2003 alone is 45 percent of what the Global Fund expects to receive. This does not reflect adequately the vision of a true public/private partnership for the Global Fund that the President and the United Nations Secretary General Kofi Annan outlined in the Rose Garden in May of 2001.

Secretary Thompson met with Secretary General Annan last week and asked him to help leverage additional funds among the donor countries, especially in Europe. The Secretary offered to coordinate technical assistance for the fund, to aid the fund's projects and applications as well.

Secretary Thompson is committed to doing all he can to ensure that the fund has adequate resources and function in accordance with the vision of the President and the wishes of Congress, and provides funds to programs and services that will improve and save the lives of those living with this disease.

We must never forget how important the component research is in the fight of HIV/AIDS, tuberculosis and malaria. In fiscal year 2003, the National Institutes of Health will devote \$251 million for AIDS related international research.

We're working here in the United States and around the world to develop laboratory capacity, train scientists and help nations develop prevention and treatment research agendas to deal with these diseases. We're working aggressively also to develop clinical research and trials for HIV/AIDS vaccines. And while we have made tremendous progress in this area, we are still years away from a vaccine. This is why we have to focus our attention on prevention, care and treatment.

As we discuss international programs for prevention, it is important that we, as Americans, do not export our own ideas, but rather allow the countries we aid to develop prevention methods and treatment programs that are sensitive to their own cultures.

I know you will be hearing later this morning about Uganda and their success use of the ABC program of prevention. The A is for abstinence in young people. The B is for being faithful in mutually monogamous relationships. And the C is for condom use in high risk populations with the knowledge that condoms are highly effective in preventing HIV infection and gonorrhea in men, but not as effective with all sexually transmitted diseases.

I have traveled to Uganda and I have seen that ABC is working. Uganda is not the only country in Africa with an increasing rate

of life expectancy. It is indeed the single country in Africa whose life expectancy has increased.

The ABC prevention concept is something that we need to look at very seriously in our own country as well. Unfortunately, I have been to other countries in Africa where the outlook is not very positive. I have been into remote village in Swaziland where a young woman lay dying on the cold ground of her hut in the final stages of AIDS while her children were outside being cared for by their grandmother or her mother. It is predicted that Swaziland will have over 100,000 orphans in the next 5 years and the country now has the highest rate of HIV/AIDS in the world.

I have been to South Africa and to Namibia and seen children who were orphaned by parents who died of AIDS and many of them are living with AIDS. I have been in Ethiopia where I've been able to administer life saving polio vaccines to infants and I've seen desperate medical personnel in all of these countries looking for support and technical assistance in fighting HIV/AIDS, tuberculosis and malaria.

Mr. Chairman and members of the subcommittee, we have a real opportunity to effect change in the world with the President's new initiative. The administration is ready to work with you and to put together a bill that we can all be proud of and Secretary Thompson and I look forward to making sure that this is a reality.

I want to thank you again for allowing me to be here with you this morning and I'm happy to answer any questions that you may have at this time.

[The prepared statement of Hon. Claude A. Allen follows:]

PREPARED STATEMENT OF HON. CLAUDE A. ALLEN, DEPUTY SECRETARY,  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman and Members of the Subcommittee, I am Claude A. Allen, Deputy Secretary of the U. S. Department of Health and Human Services. I am pleased to be here today to provide an overview of the Department of Health and Human Services' activities to combat the global spread of HIV/AIDS, tuberculosis (TB) and Malaria. I bring greetings from Secretary Thompson, and his thanks, as well, for your tireless efforts to address these worldwide pandemics.

At the outset, I would like to acknowledge that we at HHS are in your debt, Mr. Chairman, and in the debt of your colleagues on this Committee, and others in this Chamber, for your support of prevention, care and treatment of these diseases. The leadership of this Committee has been crucial to the U.S. Government's response to this devastating disease, and will continue to be, as Congress and the Administration work together to support the Global Fund for AIDS, TB and Malaria, implement the President's Emergency Plan for AIDS Relief, announced in the State of the Union in January, and implement his international Mother and Child HIV Prevention Initiative, announced last summer. The broad bipartisan support that both these initiatives enjoy—as well as the strong public support—speaks to their vital importance. I look forward to continuing to work with each of you to make them reality.

The United States has a long history of assisting other countries in need. And I am proud to report that the Department of Health and Human Services is continuing that humanitarian tradition in a variety of ways, but most particularly in helping developing countries address the devastation caused by AIDS, TB and malaria.

From Tanzania to Vietnam to Haiti, HHS employees are on the ground, working with Ministries of Health, nongovernmental organizations, faith-based groups, and—equally important—with other U.S. government entities, such as the State Department and the U.S. Agency for International Development (USAID), to develop country-specific solutions to the ravages of AIDS. Together with USAID, we are working with 16 countries and with international organizations such as the World Health Organization to address TB—which infects nearly eight million persons per

year. Worldwide, TB kills two million people each year and is the cause of death for one-third of persons infected with HIV. Further, we work with the World Health Organization (WHO) and other partners to address malaria, which kills an estimated one million children in the developing world each year.

Today, I will provide you with an overview of HHS activities and, I hope, reinforce your long-standing, demonstrated commitment to U.S. support in this essential endeavor.

Three HHS operating divisions are most actively involved in fighting AIDS worldwide. The National Institutes of Health has a strong portfolio of basic research in the areas of HIV and TB, including vital efforts to develop a vaccine to prevent HIV infection and new treatment technologies and strategies. NIH also trains U.S. and foreign scientists as a critical part of its mission. The Centers for Disease Control and Prevention (CDC) has engaged in international applied AIDS research and programmatic efforts since the beginning of the pandemic and supports bilateral and multilateral efforts to address TB and malaria. And the Health Resources and Services Administration (HRSA), through a cooperative agreement with CDC, works to train health care workers internationally to care for people living with HIV and AIDS.

While there is not time today to go over all that we do to address HIV, TB and malaria, permit me to briefly illustrate how, at HHS, the pieces fit together into a strategic plan to combat AIDS around the globe.

#### *Research on AIDS*

Guiding principles for the National Institutes of Health's global research are to:

1. Target research efforts to develop prevention and therapeutic strategies adapted for the unique needs of developing countries;
2. Develop multidisciplinary research programs on AIDS and on malaria and tuberculosis;
3. Build and sustain research capacity in developing countries;
4. Stimulate scientific collaboration and global, multi-sector partnerships; and
5. Work with scientists in countries hardest hit to develop training, communication, and outreach programs.

The United States has been the world's leader in research and practical assistance to battle HIV/AIDS, and NIH's budget confirms that commitment. In fiscal year 2003, NIH will devote over \$2.7 billion on AIDS research, with over \$250 million to be spent on AIDS research and training efforts abroad.

To conduct clinical research on vaccines for HIV/AIDS, the NIH supports the HIV Vaccine Trials Network—or HVTN—a network of 16 domestic and 13 international sites. Directly and through collaborations with investigators, mostly university-based, worldwide, the HVTN also supports laboratory research worldwide to ensure that vaccines are efficacious against a variety of HIV strains found around the world. The HVTN currently is conducting a phase II clinical trial in Haiti, Brazil, and Trinidad/Tobago. HVTN is working with the CDC in several countries, to identify cohorts of populations at risk for HIV infection and build the infrastructure necessary around the world to conduct large-scale efficacy trials of potential vaccine candidates when they become available.

NIH supports a growing portfolio of university-based biomedical and behavioral research for the discovery, development, preclinical testing, and clinical evaluation of interventions to prevent HIV transmission, slow disease progression, and limit disease mortality. NIH-sponsored programs target studies in Africa, Asia, Latin America and the Caribbean on factors related to HIV transmission and the mechanisms associated with HIV disease progression. The HIV Prevention Trials Network—or HPTN—is a worldwide collaborative network designed to conduct research in 16 international and nine domestic sites on promising and innovative biomedical/behavioral strategies for the prevention or reduction of HIV transmission among at-risk adult and infant populations.

A critical element of NIH's research portfolio is efforts to strengthen—or create—the research infrastructure of developing countries as well as the capacity of in-country investigators to conduct clinical trials of therapeutic and preventive therapies. These therapies include treatment for opportunistic infections, such as TB, which kills a large proportion of AIDS patients in the developing world; AIDS vaccines; microbicides, and interventions to prevent mother-to-child transmission.

Capacity-building for international research is a critical issue in all the countries where NIH funds research activities. NIH focuses its efforts in three essential areas:

- **Training Research Scientists**—It is critical to the success of international studies that foreign scientists be full and equal partners in the design and conduct of collaborative studies. To help build capacity in developing countries, NIH, through the Fogarty International Center, funds the AIDS International Train-



ing and Research Program (AITRP). The AITRP provides research training to foreign scientists through grants to U.S. universities. The program has provided training in the U.S. for scientists from developing countries in Africa, Asia, Latin America and the Caribbean, 85 percent of whom return home, and training courses have been conducted in 60 countries. Over 200 senior investigators and health officials in Africa have been trained through the AITRP, and thousands at more junior levels. With 85% of trainees returning home, the AITRP is a model of capacity building. It is no wonder that Dr. Salim Abdool-Karim, Deputy Vice Chancellor for Research and Development at the University of Natal in South Africa, and Principal Investigator of a highly successful Fogarty AITRP grant has described this program as the pre-eminent model of capacity-building for developing countries.

- **Laboratory Capacity**—NIH-supported HIV-related research helps to build laboratory capacity in developing countries, where the research is conducted, through purchase of laboratory equipment and transfer of research technology.
- **Comprehensive International Program of Research on AIDS (CIPRA)**—NIH has launched CIPRA to provide long-term support to developing countries to plan and implement a comprehensive HIV/AIDS prevention and treatment research agenda relevant to their populations, and to enhance the infrastructure necessary to conduct such research. Through this initiative, funding will be provided directly to foreign institutions for HIV research that is relevant to the host country.

A safe and effective HIV preventive vaccine is essential to controlling the AIDS pandemic. But, while we have made tremendous progress in vaccine development, the deployment of a vaccine is likely years away. Other biomedical interventions, such as microbicides, are likewise not yet proven or ready for widespread use.

In the interim, the world's best—and only—hope for controlling the epidemic is through sound prevention programs. And care and treatment programs are essential to helping the millions already infected to diminish the likelihood of infecting their partners, furthering the aims of prevention and helping to keep productive workers and citizens alive.

I will now discuss some of the prevention, care, and treatment work HHS staff are performing in countries hardest hit by this terrible disease. HHS scientists, public health experts, and specialists in AIDS care and treatment form a critical component of the U.S. Government's inter-agency response to the international HIV/AIDS pandemic.

#### *Prevention, Care and Treatment*

Through the HHS Global AIDS Program, CDC works directly with 25 countries in Africa, Asia, Latin America, and the Caribbean to prevent new infections, provide care and treatment to those already infected and develop the capacity and infrastructure needed to support these programs. We calculate that these 25 countries account for more than 90 percent of the world's AIDS burden, based on prevalence estimates released at the end of last year by the WHO and UNAIDS. Targeting our resources to those countries most in need makes sense, and allows us to achieve the greatest results for our modest investment. For this fiscal year, the budget for the Global AIDS Program is \$144 million, plus \$40 million directed by Congress to the President's international Mother and Child HIV Prevention Initiative, jointly managed by HHS and USAID. In addition, CDC supports approximately \$11 million in applied prevention research to support these programs.

CDC's highly trained physicians, epidemiologists—who have special training in the causes, distribution and control of disease in populations—virologists and other laboratory scientists, and public health advisors—who are experts in the science and practice of protecting and improving the health of a community through a variety of measures, including preventive medicine, health education, disease control, refugee health, and sanitation, for example—are providing technical assistance to host-country governments and others working to prevent and control HIV/AIDS.

CDC staff are often located directly in host-country Ministries of Health or their affiliated National AIDS Control Programs. Working in close proximity with public health and medical colleagues from both government and non-governmental organizations allows CDC experts to enhance their services to host-country programs. They are also co-located with USAID colleagues, promoting complementary programming between the two agencies.

In addition to CDC employees, the HHS Global AIDS Program currently has nearly 400 locally employed staff, who serve in a range of capacities, from research scientists, laboratory technicians, nurses and midwives to computer specialists, statisticians, sociologists and support staff. One of the primary goals of the HHS Global AIDS Program is to develop in-country capacity to address HIV/AIDS. Local staff

are employed to form a national cadre of trained professionals who can share their knowledge with others, developing an ever-growing nucleus of trained personnel.

The Global AIDS Program was first funded in fiscal year 2000. It builds on HHS's long and successful history of global initiatives to promote health, in areas such as immunization. For example, in Thailand, CDC staff worked with the Thai government to develop a national mother-to-child HIV prevention program, the first of its kind in the developing world. As a result of this effort, testing has been implemented in all public hospitals and it is estimated that perinatal transmission has been reduced to less than 10 percent preventing more than 1,000 HIV infections in children each year.

All of this work now forms the foundation for HHS support for and involvement in the President's Emergency Plan, which is focused on 14 of the hardest-hit nations, accounting for 50 percent of all HIV infections. This five-year plan is expected to prevent seven million new infections—60 percent of the projected new infections in the targeted countries. Two million HIV-infected people will be treated with anti-retrovirals and care will be provided to 10 million HIV-infected individuals and AIDS orphans. Implementation will be based on a "network model" being employed in countries such as Uganda: a layered network of central medical centers that support satellite centers and mobile units, with varying levels of medical expertise as treatment moves from urban to rural communities. The model will employ uniform prevention, care, and treatment protocols and prepared medication packs for ease of drug administration. It will build directly on clinics, sites, and programs established through USAID, HHS, non-governmental organizations, faith-based groups, and willing host governments.

Although the President's Emergency Relief Plan will not begin until next fiscal year, the first stage of this unprecedented effort is his Mother and Child HIV Prevention Initiative, which has already begun in the same 14 countries and jointly administered by HHS and USAID. HHS and USAID staff have now prepared develop preliminary country-specific plans of action to target one million women annually, provide them with HIV counseling and voluntary testing, essential prenatal care and support services and—most importantly—with the life-saving drugs that will help their babies be born free of HIV infection. We expect that this initiative will reduce mother-to-child HIV transmission by 40 percent among the women treated. A second goal of the initiative is to improve health care systems to provide care and treatment not only to mothers and babies, but to fathers, other children and the broader community as well. Strengthening health care systems is essential to the success of the President's broader Emergency Relief Plan.

HRSA is lending its strength to this initiative through the training of health care providers and the facilitation of partnerships between U.S. hospitals and clinics and their counterparts in the 14 countries ("twinning").

The President's Emergency Plan also increased our pledge to the Global Fund to Fight AIDS, Tuberculosis and Malaria to \$1.65 billion, 50 percent of the total \$3.36 billion pledged to date. Our fiscal year 2003 commitment alone accounts for 45 percent of all resources available to the Fund this year (\$350 million of a total \$780 million pledged or in the bank), and the U.S. is responsible for 37 percent of the Fund's cash on hand. With the exception of Germany and Ireland, major donor countries have not increased their initial pledges, which in most cases extend over several years. Secretary Thompson, who was elected to serve a one year term as Board Chair during the last Global Fund Board meeting in January, is committed to mobilizing additional resources from both donor nations and the private sector. The U.S. strongly supported creation of the Global Fund and continues to support its efforts through technical assistance to partnerships as they develop proposals for the Fund and helping to implement and monitor Global Fund financed programs.

HRSA is lending its strength in the training of health care providers to this initiative, and, more broadly, to HIV/AIDS programs internationally.

For too long, people in the developing world have seen a diagnosis of HIV infection as a death sentence. And it has been. But with the promise of care and treatment, HIV need no longer mean a slow and agonizing death. Parents no longer need dread leaving their children orphaned and at risk themselves for HIV. For the first time, learning your HIV status can be seen as a stepping stone to needed care. An HIV test is the gateway to services. For those who are infected, they will be able to receive treatment—and essential prevention and support services to keep from transmitting the virus to others. For those who are not infected, they can receive vital prevention services to learn how to remain HIV-free, emphasizing the ABCs of HIV prevention. The "A" is for abstinence in young people, the "B" is for being faithful in a mutually monogamous relationship, and the "C" is for condom use in high risk populations with the knowledge that condoms are highly effective in preventing HIV infection and gonorrhea in men, but not as effective with all sexually

transmitted diseases. I have traveled to Uganda, and I have seen that ABC is working. Uganda is the only country in Africa with an increasing rate of life expectancy. The ABC prevention concept is something that we should seriously examine in our own country.

All this is possible because of the hope of care and treatment. We at HHS, in partnership with USAID and other organizations, are making good on this promise. We are providing the essential training, technical assistance and financial support to governments and scientific institutions around the globe to help them help their people. None of this would be possible without the continued support of members of this Committee and your colleagues in the House and Senate.

Thus far, I have focused on HIV and AIDS in this testimony. Let me now make a few comments regarding HHS's contributions to the global control of tuberculosis and malaria. HHS's approaches to both TB and malaria are similar to that of HIV/AIDS, but are more limited in terms of scope and resources.

Both NIH and CDC work to address TB. TB is a global emergency and a leading infectious killer of young adults worldwide. Approximately one-third of the world's population is infected with the bacteria that causes TB and 80 percent of active TB cases originate in 22 high-burden countries. As I noted earlier, TB accounts for one-third of deaths among persons with AIDS. Basic research on TB, including research on a TB vaccine, is conducted at NIH. CDC supports applied research, including operational research to improve programs and clinical research to evaluate new drugs and diagnostics, and program implementation.

In addition to addressing HIV and TB coinfection through the Global AIDS Program, CDC works closely with USAID, international organizations, and 16 countries around the globe to control TB. International partners include the WHO and the International Union Against TB and Lung Diseases (IUATLD). Collaborative efforts include the Stop TB Partnership, technical support to USAID, and technical assistance to specific countries. Technical assistance is focused on countries which contribute most to U.S. cases, are high burden countries, have high rates of multi-drug resistant TB (MDR-TB), are of strategic importance (e.g. countries participating in the HHS Global AIDS Program), or provide opportunities to improve diagnosis and treatment of TB, MDR-TB, and HIV-associated TB.

Spearheaded by the WHO and its international partners, including HHS, a proven effective national case management strategy has been increasingly applied in developing nations. This strategy is termed DOTS—Directly Observed Therapy, Short-Course—which emphasizes consistent drug supply, microscopic based diagnosis, and direct observation of each dose of life saving medication. The World Bank has ranked DOTS as one of the most cost-effective of all health interventions. CDC works with WHO and other partners to expand the current DOTS strategy so that people with TB have access to effective diagnosis and treatment, and to adapt this strategy to meet the challenges of HIV and multi-drug resistance.

CDC and NIH are also actively involved in research on global malaria prevention and control. NIH is engaged in research both domestically and globally with a focus on malaria vaccine development and optimal use of the information on newly characterized malaria genome and the mosquito vector genome. CDC continues to work on U.S. domestic prevention and monitoring and on global collaborations with Ministries of Health, U.S. universities and schools of public health, and non-governmental and faith-based organizations in the prevention and control of malaria in malaria-endemic settings—mostly in sub-Saharan Africa. In fact, much of the HHS global work on malaria is in the same setting where HIV prevention work is underway.

The HHS effort in malaria is widely collaborative with the Department of State, USAID and the Department of Defense. The U.S. leadership in the Global Fund to Fight AIDS, TB, and Malaria has been especially well-received in the malaria community.

Currently available control strategies for malaria have proven to be highly effective in saving lives. Effective prevention exists, as evidenced by the 20 percent reduction in child mortality with the use of insecticide treated bed nets in Africa. Effective antimalarial treatment exists that cures infection and disease. Use of insecticide treated bed nets and preventive treatment can dramatically alter the impact of malaria in pregnant women and their newborns, improving newborn birth weight and reducing anemia in the mother and the newborn, and saving lives.

Finally, as a reason to care about malaria in the context of HIV and AIDS prevention and control, recent studies have shown that malaria and HIV interact broadly. Malaria causes anemia and the needed blood transfusions can be a source of HIV transmission. HIV-infected pregnant women disproportionately contract the disease and exhibit more severe complications, conferring a greater risk to the developing fetus and the newborn. Most recently, studies suggest that malaria is more severe

in HIV-infected adults and that malaria may stimulate HIV viral replication, with potentially greater increased risk for HIV transmission. The widespread co-existence of malaria and HIV in Africa likely means that each is making the other worse and that addressing both is a good policy.

I thank you again, and welcome any questions you have for me.

Mr. BILIRAKIS. Thank you very much, Mr. Secretary. I'm concerned. I've always been concerned when it comes to matters such as this. Research, for instance, medical research, for instance, coordination, lack of duplication of effort and I understand and I've been told and I guess I'm pretty well convinced that there has to be some duplication of effort when it comes to medical research, although I wonder if it has to be quite as much as now takes place.

So let me ask you then about coordination. For instance, the services provided by the Department of HHS, services provided by the Department of State, namely, I guess, US AID. We have the Centers for Disease Control. They will provide some sort of a role as far as this is concerned. Will they not?

Mr. ALLEN. That's correct.

Mr. BILIRAKIS. They will. So let me ask you then, how do you look at it from the standpoint of coordination? I mean resources, sure, we are the wealthiest Nation in the history of the world, but as we're finding out, particularly this week, resources are limited for whatever reason, one reason or another.

So it's best and as I said in my opening statement and I'm sure you agree that we be as efficient as we possibly can be. Can you respond to that in terms of coordination and making sure that the right hand knows what the left hand is going and there won't be any unneeded duplication, etcetera?

Mr. ALLEN. Yes, Mr. Chairman. It's an excellent question in this regard, and it really focuses on how do we make the most use of U.S. resources in terms of addressing HIV/AIDS, tuberculosis and malaria. And frankly, any other issues that we're trying to address internationally.

One of the exciting things that has happened over the last year is with the President's announcement of the Mother to Child Transmission Prevention Program. Through that program, we developed a model that we believe has worked very effectively and we believe this is also a good model to look at in terms of the President's emergency program for AIDS relief in Africa and the Caribbean.

That model actually consists of having USAID, HHS, the State Department, Office of Management and Budget working together and reviewing the 14 countries in which we will be having the Prevention of Mother to Child Transmission Program initiative effective where they're reviewing the grants collectively, making decisions collectively and have found a model that actually works on the ground and that is what we'll be promoting.

With that program, within 4 months of setting up the President's Mother to Child Transmission Prevention Program, we were able to get out four countries fast tracked under that program, Haiti, Uganda, two other countries—let me see, Botswana and I want to forget the fourth one. In the four countries that we've worked in that we fast tracked, we have been able to get out funds recently where they submitted plans and now we're monitoring those plans.

Under this program, we also have set up four, what would be work streams that are looking not only at the medical piece of the plan, but we're looking at the governance piece of the plan, looking at what accountability measures are put in and we'll be following that through completion of the plan. And that is a model that we think not only is effective in terms of coordinating U.S. Government activities, but it also forces coordination of activities in the recipient country, that they will be coordinating their activities across the board to address and get the maximum benefit of the resources that we will be providing and that they will be also utilizing in their countries.

In those countries what will happen is that we will be setting up a series of clinics that we'll be working through that are multi-stage—first of all, we'll start with a central approach, but we will work central medical centers that will be the hub of activity. These are existing hospitals. From there, we'll work through primary satellites that reach beyond those primary centers to begin to have intake of mothers to be tested, screened and then treated. And then we have secondary satellite sites as well. And then ultimately, we'll have rural and mobile units as well working. That is an effective way to build a program on the ground and then have it expand out into farther reaches in those countries.

We believe the coordination is key and we think that we have hit on something that actually can work and be very effective in marshalling the resources that the Congress has entrusted to us to marshal, not just HHS, but across the government as well.

Mr. BILIRAKIS. Will that type of an effort be enhanced by the additional dollars that the President has already relayed to us?

Mr. ALLEN. We believe that that is exactly a great model to pattern this after and the reason for that, we think that as we look at these 14 countries and the reason why we've chosen to target those 14 countries with the President's emergency program for relief of AIDS, we believe that we've already got a model that's working. We already know that they carry about 50 percent of the HIV cases in the world that we'll be trying to address, and we think that this is a model that can work very effectively.

The other two countries, I'm sorry I mentioned—the four countries that we fast tracked already are Haiti, Kenya, South Africa and Uganda. And then we have the 10 others will come along.

Mr. BILIRAKIS. Mr. Secretary, I've gone over my time, but with the indulgence of the few members who are here, just very quickly, you emphasized that we not in a sense, you didn't put it this way, but shoved down the throats of these countries our way to do this. You emphasize, I think, that they should come up with a system which is compatible, if you will, with their demographics, with their population.

Uganda's ABC program, is that something that they initiated?

Mr. ALLEN. Yes, it is. In fact, what's amazing about the Uganda program is that it relied upon at a time when they were not getting a lot of assistance from donor nations and they developed a program that worked very effectively. They turned back to their culture and they looked at what their culture had and one of the things that they honored in their culture was for young women to

be virgins until they were married, until they were at the age of marriage.

Mr. BILIRAKIS. Right, you explained that in your written statement.

Mr. ALLEN. That's right and additionally what was interesting, the B part of it, the being faithful was a zero grazing policy, something that resonated in their culture. And it is our belief that that program of the A and the B and then condom usage in high risk populations was very effective in driving the disease down.

And I've seen that replicated in other countries where if you look at the cultures of these countries there are certain moral values, certain traditions in which those countries, if they can tap into, have a tremendous potential to address the AIDS crisis in those countries.

I'll give you one specific example that doesn't focus on the disease, but actually focuses on what happens when the people are dying from the disease, the orphans issue. Uganda, once again, has turned back to its culture to look at how it will care for orphans. The First Lady of Uganda, Janet Museveni is very adamant in not talking about having orphans or having orphanages. She believes that it is their culture that they would care for individuals who lost one or both parents within the community and that is something in that culture that she spends a lot of time addressing, of how do we care for our young in the cultural context. I think we need to be very aware of the culture that exists around the world that are different from our own and be willing to work with them to find ways to use cultural messages to promote cultural values that protect health and welfare.

Mr. BILIRAKIS. And I think it used to be a part, a major part of our culture a few years ago, sort of changed hasn't it?

Mr. ALLEN. Indeed.

Mr. BILIRAKIS. I will yield to Mr. Brown.

Mr. BROWN. Thank you, Secretary Allen. Thank you again for joining us.

You talk in your testimony about CDC's Global AIDS Program, how CDC has great expertise in dealing with international TB, largely through US AID funding. The President's plan, the \$10 billion, \$15 billion overall, suggested \$200 million per year and the Global Fund did not, to my knowledge, mention CDC.

Are you expecting a significant number of those dollars to go into—to go either through US AID to CDC or directly to CDC for TB and malaria—TB and HIV?

Mr. ALLEN. If I'm understanding your question, Congressman Brown, is that this refers to the Global Fund dollars?

Mr. BROWN. First to the other dollars.

Mr. ALLEN. Okay, to the dollars, the bilateral dollars, we will be utilizing some of the funds that currently exist that CDC receives for their tuberculosis treatment. Within the President's initiative, the way we have set it up as we're treating, for example, in our Mother to Child Transmission Program which we think will be the model for the President's emergency initiative, we treat mothers who we're bringing in to test for HIV, we find them with tuberculosis, we will treat them through that program. And so there will be dollars that will be utilized within the President's proposal, not

only for HIV infection, but also for tuberculosis and malaria, whatever conditions they may have, we will try to treat those.

Mr. BROWN. From my involvement, especially in TB, but all three of these infectious diseases for the last several years on this committee and on the International Relations Committee, I've just seen a much better—of a much more efficient, effective use of dollars on infectious disease with CDC than I have with US AID and I would like that to be reflected in the record and taken back to the Secretary. But I want to shift for a moment to the Global Fund. You said Secretary Thompson and I'm thrilled, and as I've told him personally after another hearing on another subject a couple of weeks ago that he is the chair of the Global Fund. And you said that he will do all he can to make sure that the Global Fund will well funded. You spoke also in your oral testimony about the leverage that the Global Fund, that our dollars in the Global Fund can cause. You did not say this, but implicit in your statement, I believe, is that you can't do the same kind of leveraging and bilateral money in the US AID or under the State Department the way we can through the Global Fund.

The Global Fund needs \$6 billion they say over the next 2 years. The President has suggested only \$200 million each year for the next 5 so that's \$1 billion total out of the \$10 billion new dollars. Again, the Global Fund says in the next 2 years it needs \$6 billion. Our Secretary of HHS in our country is the chairman of this committee. Shouldn't we authorize and appropriate significantly more than that?

Mr. ALLEN. I think that we have appropriate sufficient funds currently for the Global Fund and we can look at that. One of the issues that we have to be very careful about is in terms of the balance. Right now, we're funding for the 2003 period, 35 percent of the fund. We have—

Mr. BROWN. Total dollars? Speak dollars and percentages, if you would.

Mr. ALLEN. That's correct. In terms of dollars, our pledge is about \$1.6 billion over the course of the next 5 years is the total pledge that we have going toward the Global Fund as we're proposing.

Of that amount, it is imperative and this is the secretary's desire as chairman of the board is that we need to increase the support that the Global Fund has from other nations.

Let me give you an example of what I'm looking at here. When I look at countries that have contributed to the Global Fund, Spain has a 2-year commitment; Sweden has a 3-year commitment; looks like \$69 million for Sweden. The U.S. by far has made a longer term commitment and a much higher commitment to the Global Fund. We believe it is important that there's an important role the Global Fund plays and we should be supportive of that, but we also believe that we need to be very careful not to have the U.S. fund the work of the Global Fund.

Just as the President envisioned and Secretary General Kofi Annan envisioned when they had the Rose Garden announcement in 2001, this was supposed to be a public/private partnership; public being multi-government and private being bringing industry and NGO's. And currently that is not the way the Global Fund is—

Mr. BROWN. If I could interrupt. We are not known, if you look at statistics, as doing well more than our part in terms of international global poverty and infectious disease.

We rank near the bottom in the percentage of our GDP that goes to any kind of international poverty issues. And for us to sort of back off and say well, we've done more than anybody else. We've done enough. Perhaps on some limited scale we have and I'm very appreciative for what our government has done, what the President is suggesting. But if the Global Fund is going to work and we're always willing to step up militarily as the last night's events and today's events show where we ought to be willing to step up and lead. And that just doesn't mean more than any other country. It means step up and lead and leverage the money the way that we can do.

You talk about 14 countries and I appreciate those are the—you said 50 percent of those 14 countries, 50 percent of the AIDS in the world are in those 14 countries. I'm sure that's true. But TB it's not even close to that. And malaria it's not even close to that. And AIDS in China and Russia, it's not even going to be close to that.

Can I have an extra 2 minutes, Mr. Chairman?

Mr. BILIRAKIS. Without objection.

Mr. BROWN. Thank you.

Mr. BILIRAKIS. You've already used one of those.

Mr. BROWN. I said additional. But it's clear that we need to look larger than those 14. When China and India, when HIV and TB intersect, as Donna Berry's boss says it's the perfect storm and we're going to see numbers rivalling the Great Plague. And if we step up only sort of put our foot in the water, that's really all we've done and it may sound like a lot of dollars, but we're really not doing as much as we should do.

One more point and the model of one size fits all, the Uganda program sounds terrific. I'm really glad we're doing that, that they're doing that and if we can help, but what works in Uganda, what works in a Christian nation may not—a Christian Brazil may not work in a Muslim Bangladesh and what works in Uganda is great, but the CDC, the US AID shouldn't be citing this is the model and pass it around country to country. The Global Fund should make those bilateral decisions, should make those decisions with input from an NGO in Bangladesh or a government—a health ministry in Mexico and fund that way, rather than the U.S. deciding bilaterally this is the best way to do it. Those countries can decide it best.

I frankly have more confidence in the Global Fund working and fitting into that country and doing the local control than I do US AID which has not always done that so very well.

Mr. BILIRAKIS. A very brief response to that.

Mr. ALLEN. Certainly, I would comment on two things. We're not here to advocate one or the other. We believe both are important. The bilateral host is targeted, it's focused and it is able to get out very quickly. We've gotten grants out in 4 months. Global Fund has a role to play in that it can reach much more broadly to address many of the issues that you've raised. We think that both are important, but we need to be very careful on how we balance the re-



sources that go in to ensure that the Global Fund particularly, has multilateral participation.

Mr. BILIRAKIS. There's enough flexibility in the use of this \$10 billion and in the workings of the Global Fund so that if it is determined, after all, the chairman is Secretary Thompson, if it is determined that additional resources above and beyond those that are committed might be very helpful, you know, from maybe a short term standpoint that can take place?

Mr. ALLEN. We would certainly appreciate that flexibility with the \$15 billion.

Mr. BILIRAKIS. Mr. Pitts.

Mr. PITTS. Thank you, Mr. Chairman. Thank you for convening this important hearing and I want to submit my opening statement for the record.

Mr. Secretary, some are arguing that we should use U.S. taxpayer funds and entrust those funds to the Global AIDS Fund rather than a U.S. controlled bilateral program efforts to address AIDS issues globally.

Some people are concerned that the Global AIDS Fund is untested and unproven, unaccountable to the U.S. In fact, the Global AIDS Fund has recently announced that it will give some \$20 million to what the administration has labeled as the axis of evil, \$16 million to Iran and another \$5 million to North Korea. What are your thoughts on the support for the Global AIDS Fund versus bilateral efforts?

Mr. ALLEN. I want to go back to my earlier comment in terms of the difference between bilateral efforts and multilateral efforts, i.e. the Global Fund in this case. They serve two very important purposes, but in some ways very unique purposes that are complementary. We believe in bilateral efforts as in the U.S. Government because it allows us to work with existing partnerships that we have. In the case of HIV/AIDS, tuberculosis and malaria, the bilateral relationships that we have through the Global AIDS program, we already have people on the ground in many of the 14 countries that we're talking about, programs that are up and working and therefore we were able to very quickly target prevention of mother to child transmission with 4 months after we started the program. We've got money going out the door between \$19 and \$29 million to the first four countries and within a couple of weeks we'll get it to the other 10. And so bilateral relationships are very important because we're able to target our activities and focus on those countries that again, in this case, those 14 account for about 50 percent of the AIDS cases worldwide.

On the other hand, the Global Fund is also important. It's important because it is able to do exactly what you're talking about in terms of looking at the humanitarian issues that people are confronting. And while your comments in terms of specific countries and the axis of evil, we do work with countries that we either do not recognize or we do not have formal relations with. Why? Because we believe that when people are suffering we don't punish people because of their governments. Case in point of what we're doing, absolutely right now today. We are not battling the people of Iraq. We're not fighting them. We're seeking to have a leadership change in that country because of the impact that that leadership

has had not only on its own people, but on the world and so I would be very careful not to seek to so narrowly constrict the U.S. participation or resources going to multilateral organizations on a strictly black and white test, whether you're for us or whether you're against us.

What you need to tie it to is very specific strategic goals that serve not only the U.S. interest, but also the world interest in terms of humanitarian assistance.

Mr. PITTS. So what assurance do you have from the Global Fund that they make sure that the international sponsors of terrorism, like in Iran or in North Korea, that the money goes to the people who need it?

Mr. ALLEN. One of the things we have done is specifically and we have some examples of this, is where Secretary Thompson, for example, has met over the last week with Secretary General Annan. He's met with Dr. Piot, the head of U.N. AIDS, other organizations in terms of the Global Fund to talk about these very issues. And what we have done is the Global Fund in many of these countries, for example, in North Korea, they're targeted specifically not to be funds that go to the government, that the government controls, but rather to work closely with nongovernmental organizations, with faith-based organizations and so that we know that that money is not going to serve the governments of those countries, but rather are going specifically to serve the people of those countries in terms of addressing the disease burden that they're carrying.

Mr. PITTS. Another issue. Microbicide research is often mentioned as necessary to help prevent the spread of AIDS. In fact, at least three separate agencies are conducting this type of research, CDC and USAID and NIH. What protocols currently exist between these three agencies to guarantee that there will not be duplication of effort and then if I can ask you part b, we're spending over \$100 million annually to develop these safe sex programs. Can you comment on the role that microbicides may play in global AIDS programs?

Mr. ALLEN. Certainly.

Mr. BILIRAKIS. The gentleman's time has expired, but certainly I will allow you to respond.

Mr. ALLEN. Thank you, Mr. Chairman. As I understand your question, the first question, the Centers for Disease Control and National Institutes of Health are very actively involved in microbicides research. Because those two agencies come under the Department of Health and Human Services, we are working very aggressively within the Department to ensure complementary research, not overlapping research or duplicative research. We're also coordinating our efforts and activities with the Department of Defense and their research efforts. In fact, on my most recent trip to Ethiopia, I had the privilege of visiting with and was briefed by the Department of Defense about their activities in country. And so we are trying to coordinate our activities in terms of HIV/AIDS, tuberculosis, malaria, the health activities that we're working in countries, both here in the United States, but we're actually trying to coordinate those activities in the field so that we're working together.

A good model of that was the most recent vaccine trials that are taking place in Thailand that are being conducted by the military. DOD is overseeing it, but they're doing it with the cooperation and assistance of HHS through the National Institutes of Health. So those are some models that are already existing and we're working to coordinate those activities and working much more closely together than I may have been in the past.

Mr. BILIRAKIS. Thank you, Mr. Secretary. Ms. Capps to inquire.

Ms. CAPPS. Mr. Allen, you say in your testimony that condoms are and I quote, "highly effective in preventing HIV infections and gonorrhea in men, but not as effective with all sexually transmitted diseases."

In the many situations where abstinence is really not a real life option, are you aware of other contraceptive methods that are more effective than condoms in preventing these other sexually transmitted diseases?

Mr. ALLEN. In terms, as I understand your question, if there are more effective methods than condom uses in preventing the transmission of diseases, one of the areas that we're exploring is the area of microbicides. That certainly is an area in some circumstances have been—we have trials that are being conducted, a new compound that is being evaluated, a microbicide to be utilized, to be evaluated to see its effectiveness.

In terms of condom usage and its effectiveness, the National Institutes of Health and Centers for Disease Control in 2001, I believe it was, submitted a report that talked about the effectiveness of condom usage and it said exactly that, that they were highly effective in preventing transmission of HIV and gonorrhea in men and less effective in many other areas. And so we do need to focus on what can work, what is working and of the means for preventing contraception, the condoms are not the most effective for preventing contraception.

Ms. CAPPS. So you're saying that the microbicides are being evaluated, so they're still in the testing phase? They're not readily available and would there be a cost barrier or some kind of access that would be something to challenge as well?

Mr. ALLEN. Well, one of the areas that we're certainly looking at—

Ms. CAPPS. You answered. I do want to get to another point.

Mr. ALLEN. Certainly. One of the areas that we're certainly looking at are the whole range of what would be—that are being researched of microbicides and other activities that can serve in this area as effective tools. I don't have the answer for you on what they all are, but I can provide that for you.

Ms. CAPPS. A yes or no answer. Are these now available for the AIDS community?

Mr. ALLEN. Some yes.

Ms. CAPPS. Some are available now?

Mr. ALLEN. That's correct.

Ms. CAPPS. And being distributed?

Mr. ALLEN. Yes, they are.

Ms. CAPPS. Okay, good. I'm going to move on because there is another topic I'd like you to speak about, but I hope that you could respond to Secretary Powell's comment that will quote with just a

yes or a no. He was quoted as saying that the “whole international community must come together and speak candidly about” and then what he was talking about sex and AIDS. And forget about conservative ideas. He clearly wants to put aside ideology and I’m wondering if you agree?

Mr. ALLEN. First of all, I cannot answer that with a yes or no answer. I think it’s important to put it into the context in which Secretary Powell made that comment.

It is important and we believe that messages are important for specific populations. For young people, we think a consistent message of abstinence until marriage is the healthiest and safest message and so in that regard, we believe messages for target populations are appropriate.

For adult populations, fidelity is an appropriate message.

Ms. CAPPS. Which is part of that ABC that you were talking about with Uganda.

Mr. ALLEN. That’s correct.

Ms. CAPPS. I’d like to move on and I’m very mindful that I’m going to get gavelled down in a minute. The administration’s track record on supporting comprehensive efforts really is not very good. There have been so many efforts to undermine confidence in condoms. At the 2002 U.N. Special Summit on Children, the administration tried to skuttle the global declaration because it encourages comprehensive sex education. 2002, in December, the administration tried to delete a reference to consistent condom use and I quote from another report of another U.N. sponsored conference. “This does not fill me with confidence that a comprehensive approach is really a goal.” I’m wondering how you can distinguish yourself and separate yourself from these past actions, as you’re thinking about the epidemic on our hands?

Mr. ALLEN. I think that it’s important, if I understand what your comments are reflecting on, for example, the Youth Summit. I think the policy and the healthiest policy for young people is abstinence. That is the 100 percent safest, most effective way of preventing not only contraction of HIV/AIDS and other sexually transmitted diseases, but in many cases the most effective way for preventing—

Ms. CAPPS. We have tied abstinence only, sex education, to our welfare reform bill, despite my protestations. Would you go that far with your efforts overseas?

Mr. ALLEN. Again, who am I to question the acts of Congress. That’s the legislation.

Ms. CAPPS. I think you could have an opinion on this.

Mr. ALLEN. I do believe in my capacity as the Deputy Secretary, I do speak in terms of what the Department has proposed and what we believe is that we need to have very appropriate, age appropriate and targeted messages. And for young people, that message is a very clear one, that we’re seeing kids, very young ages, contracting HIV/AIDS, contracting sexually transmitted diseases where they’re not protected by the use of contraception.

We also know that with young people that they’re risk takers and therefore we need to strategize and have appropriate messages that protect them and the message that the administration has promoted, whether that is domestically or internationally that

we're finding is a message that is consistent that protects 100 percent of the time.

Mr. BILIRAKIS. Time.

Ms. CAPPS. I just want to follow up—

Mr. BILIRAKIS. Listen, we have to finish up here some time. We can't continue.

Ms. CAPPS. I just want a yes or no—

Mr. BILIRAKIS. You want a yes or no to your question?

Ms. CAPPS. Yes, to a question. Will AIDS intervention include—as comprehensive, include condom distribution?

Mr. ALLEN. ABC includes condom and distribution.

Ms. CAPPS. And that's part of your—

Mr. ALLEN. That certainly is.

Mr. BILIRAKIS. But that's decided upon by the particular locale, is that right?

Mr. ALLEN. We would be very consistent, again. We believe it is not the place of the United States to impose upon countries the programs that they should have, but we believe that a comprehensive approach means having age appropriate and situation appropriate messages. And ABC is a very consistent message that says condom usage in high risk populations is an appropriate means—

Mr. BILIRAKIS. But you have also indicated that the United States, in spite of the fact that we have a leading role here, would not shove that done—ABC or any other program, down the throats of any—

Mr. ALLEN. I do not believe that is appropriate for us to—

Mr. BILIRAKIS. He said that earlier before you came in.

Mr. BROWN. Would the gentleman yield? I'm confused about one answer.

Mr. BILIRAKIS. Quick answer and a quick response so we can continue here.

Mr. BROWN. Well, why you wouldn't tel la country to do that, would you refuse to fund a country that doesn't, that doesn't follow the model that you're suggesting?

Mr. ALLEN. Again, in terms of—

Ms. CAPPS. For any group.

Mr. BROWN. Would you refuse to fund a program that doesn't go along the lines of ABC?

Mr. ALLEN. I think it's important that programs we would support, it's not a yes or no answer, frankly, because again, each country is going to be very different in how they approach it.

We currently fund programs that do not follow—

Mr. BILIRAKIS. You said countries approach it differently. Would you still fund that country?

Mr. ALLEN. If they had a sound model that can support the prevention of the transmission of the disease, we would work with those countries to try to find—

Mr. BILIRAKIS. It may take more of a discussion than what we have here.

Mr. ALLEN. I'd be glad to engage in that.

Mr. BILIRAKIS. Mr. Ferguson.

Mr. FERGUSON. Thank you, Mr. Chairman. I appreciate your holding this hearing and certainly appreciate the work of the sub-

committee for our continuing fight against the global AIDS situation.

I know the chairman is aware, I want to make sure I call to my colleagues' attention as well, that while we're united in this global fight against AIDS to help needy people throughout the globe, we have to work together to do the same for those who are in need here at home. For too many Americans, these treatments are out of reach without our help.

We have a very important program here at home called the AIDS Drug Assistance Program and I would encourage my colleagues to take a close look at this program because in too many of our home states these programs are consistently underfunded and they can't meet the needs of those who are struggling with HIV and AIDS and who need help in getting access to their medicine.

Secretary Allen, thank you very much for being here today. I appreciate your testimony and under sometimes trying circumstances.

In your testimony, you talk about—I have a long question for you.

Mr. ALLEN. Okay.

Mr. FERGUSON. So bear with me. In your testimony, you talk about building and sustaining a research capacity in developing countries including invaluable infrastructure building. You discussed building onsites and programs which are already established which is a strategy that's extremely important to consider as we think about ways of addressing the AIDS situation.

I'm also intrigued though by approaches that involve private sector entities, both for profit and nonprofit, private sector entities in supporting various countries AIDS programs. There are many private sector entities that have forged valuable partnerships to train medical personnel and build critical infrastructure, not to mention generously donate important resources and medicines. One such program that I want to mention is the African Comprehensive HIV/AIDS Partnerships or the ACHAP program. It's a public/private partnership between Merck and the government of Botswana and the Gates Foundation, which I'm sure you're familiar with.

As you know, this is a program which is working with the government to implement a comprehensive program for HIV prevention, treatment and monitoring that involves strengthening the country's health care infrastructure.

It's not enough just to provide medicines. Obviously, we have to have ways and means of getting these medicines to the people who need them and that's why the infrastructure, as you know, is so important.

There are a lot of other initiatives including the accelerated access initiative and other partnership between five U.N. organizations and the private sector, specifically the research-based pharmaceutical industry to create—to increase access to HIV and AIDS care and treatment in developing nations.

My question, I just wanted to kind of get a little bit of feedback from you and perhaps a little bit more of a detail of your comments and thoughts on some of these partnership programs and also your thoughts on possibly expanding these public and private partnerships in the President's proposal to try and build on some of the progress that we've already made.

Mr. ALLEN. Certainly. The President has articulated and the Secretary has also articulated the importance of the private sector, both the NGO community and the corporate community in battling not only HIV, but tuberculosis, malaria and other diseases.

That is why we're focusing so much on our bilateral programs. The U.S. has a history of working very closely with the private sector, the NGO community and faith-based organizations who in many of these countries are the ones who are providing the prevention, providing the treatment and the care. They're the ones who are doing the counseling and testing. And we believe that that is a model that has worked very well, not only in this country, but through our programs internationally as well.

And for that reason, Secretary Thompson is now the chair of the Global Fund, as wanting to see the Global Fund move more to partnerships with both the private sector, the NGO community and the faith-based community to get them involved in those countries. And so that is a very critical element of what we think is going to be the key to success in combatting HIV, tuberculosis and malaria as both bilaterally and multilaterally through the Global Fund. So that is a linchpin to what we're talking about.

On top of that, we also recognize the need for models and the model that we have hit upon that we believe is working effectively and can continue to work effectively is the network model that I described earlier which is building upon the infrastructure that exists. It starts in the urban area and builds out from there. As you build capacity, you're able to leave behind the infrastructure a trained professional health core there to provide the services that we will not always be there to provide. And so that's a very key element.

Mr. FERGUSON. And that, in fact, is in addition to the lives that are saved, obviously, that infrastructure which is left in place for years beyond is a legacy which we should be so proud of.

Mr. ALLEN. Absolutely. I have traveled throughout Africa over the last 2 years to many countries and the two things that I often hear from those that I visit with are they're so appreciative for the technical assistance that we provide that the U.S. brings through it's multitude of agencies and departments that are working there, but also the fact that we leave behind something that is tangible, equipment. We leave behind trained professionals and we leave behind methodologies, protocols that they can build upon to serve their own people and that's key in terms of what we do.

Mr. FERGUSON. Mr. Chairman, I know my time is up. I don't have another question. I just want to close by saying I for one am tremendously proud of these research-based companies which not only are donating millions and millions of dollars worth of these medicines which they have invested and worked so hard to produce, but are also cooperating in these public/private and non-profit partnerships with countries like Botswana where my uncle served in the Peace Corps, to try and help these populations and to set up these infrastructures which are going to be there far beyond the life of these actual—

Mr. BILIRAKIS. The chair thanks the gentleman.

Mr. FERGUSON. Chairman Bilirakis, I yield back.

Mr. BILIRAKIS. Mr. Ferguson, we're all in good moods the week of St. Patrick's Day.

Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman and Secretary Allen and welcome to our Health Subcommittee.

Mr. ALLEN. Thank you.

Mr. GREEN. I want to shift the focus just a little bit to one of the concerns some of us have is tuberculosis and these days it's an increased prevalence and a multi-drug resistant tuberculosis which is not easily treated by our traditional means.

What kind of research conducted at NIH to develop new treatments for this drug-resistant, multi-drug resistant tuberculosis and at CDC to prevent this dangerous chain of tuberculosis? And again, some of us on the committee, both our Ranking Member, Mr. Brown and I have a District in Houston and if there's a problem in Latin America, we're going to have it in Houston or Miami or the border regions, along the United States and I appreciate the effort.

Mr. ALLEN. Certainly. Mr. Green, one of the things that we're doing through not only the NIH, as you identified, but the Centers for Disease Control, is that we are working with the World Health Organization, the International Union against TB and Lung Disease, as well as USAID to address tuberculosis worldwide.

The United States, we prioritize our activities based upon a number of things. First of all, those countries that contributed most to the U.S. cases, that's a strategic issue that we're addressing. Second, those countries that have high burdens of tuberculosis and then third, those that have high rates of multi-drug resistance, TB and then additionally, we are looking at strategically important countries, those countries in which we have relationships, the GAP countries, the 14 countries that I mentioned in Africa and the Caribbean that we're already working in and those are the countries that we're focusing our activities on.

It includes not only research, but it also includes expansion of what are directly observed treatment programs that short course treatment programs and we even have a U.S.-Mexico border initiative that is focusing on tuberculosis. So across the government, we are very keenly focused on tuberculosis prevention and also in terms of the research that addresses the multi-drug resistant strains that we're finding. And that research is carried on both domestically and internationally that we're working on and I'd be glad to supplement my comments for the record if that would help you to give you some more details on what we're doing.

Mr. GREEN. I'd appreciate it and I think other members of the committee—should we provide the Secretary expanded funding for the CDC in their international tuberculosis effort along the lines of the Global AIDS program at CDC?

Mr. ALLEN. The way that we have—we have about \$2 million, I believe it is, in CDC for Fiscal 2002 that we were using in terms of tuberculosis itself, just as separate and apart from what we were doing internationally. I believe the funding that we have through the program that we've set up, particularly, for example, the Mother to Child Transmission Prevention program that one of the things we will be addressing as we're caring for those mothers with HIV/



AIDS is we're treating them for tuberculosis as well. So the money, when we've asked for the international programs that we're talking about, that would include tuberculosis. It doesn't simply include HIV/AIDS. It goes beyond that to include tuberculosis.

Mr. GREEN. I guess one of my concerns is the President's AIDS announcement is very important and a historical step in addressing AIDS in those 14 countries, but does not address AIDS and tuberculosis in a comprehensive way. The President's 2004 budget actually cuts the bilateral tuberculosis and malaria funding by some \$80 million and greatly under funds the Global Fund on AIDS and tuberculosis and malaria.

Is there a—can you give me a response to that? I know that there's been some success, but I also want to make sure it's a success across the board.

Mr. ALLEN. No, I don't find any cuts in terms of our tuberculosis or malaria funding. For example, in fiscal year 2002, tuberculosis funding was at \$73.6 million and in 2003 it was \$81.7 million and our 2004 request is \$86.1 million, so we're increasing our request for funding for tuberculosis.

In malaria, there's a similar trend; 2002, \$95.7 million; 2003, \$105.3 million and our 2004 request is \$109.1 million, and that's only within HHS, that's the National Institutes of Health. That does not include what USAID has requested in these areas as well and what they've received as well. So I'm not sure where the idea that there's a cut coming from. That doesn't support our budget chop.

Mr. GREEN. Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman. Ms. DeGette to inquire.

Ms. DEGETTE. Thank you, Mr. Chairman. Mr. Secretary, I was very pleased when I heard the President talk about the new emergency plan targeted at the 14 countries for AIDS and I wanted, I've been wondering about some of the details of the plan. Maybe you can help me with some of those.

I know that the President in his budget commits \$10 billion in new money over 5 years to go to these targeted countries and I'm wondering how that money is going to be spent? I saw in your written testimony, for example, that you're planning to treat 2 million HIV-infected with anti-retrovirals and give health care to 10 million additional HIV-infected individuals and orphans.

I'm wondering what the thinking is behind giving retrovirals to only 2 million folks and then I guess just giving palliative care to 10 million additional folks. Why not try to maybe negotiate with the pharmaceutical companies or find some way to provide many more people with the option of having the retrovirals so we could actually keep them alive longer?

Mr. ALLEN. What we're focusing on is what the U.S. is doing in terms of our bilateral relationships and our bilateral programs. This is not to speak about the multilateral programs that will be undertaken in these same countries or even the private sector initiatives that will be undertaken. There's been mention of some of the corporate citizens of the U.S. who are already in Africa with programs that are underway.

The 2 million that we're talking about really focuses on the mothers that we anticipate will be working with us in our pro-

grams that will come into the clinics, be treated and then we will follow them in their communities.

Ms. DEGETTE. And you're going to be giving them the drugs though, right?

Mr. ALLEN. Correct.

Ms. DEGETTE. With the onset of AIDS?

Mr. ALLEN. Correct.

Ms. DEGETTE. How many of the rest of those millions of people who have HIV are going to be able to get the drugs through private multilateral efforts?

Mr. ALLEN. Through the private multilateral efforts, I don't have a number. That is—

Ms. DEGETTE. You can see what I'm—and then will the rest of the \$10 billion be spent on programs like this ABC program and other types of prevention programs? Is that the administration's plan?

Mr. ALLEN. The idea is that we will focus on prevention, treatment and care and research as well, in terms of what we're looking at for the President's program. The program will break out—

Ms. DEGETTE. I mean it just seems—my question, and you know what I'm getting at.

Mr. ALLEN. Actually, I'm not quite sure.

Ms. DEGETTE. Let me try to be specific. We have—I don't know how many million people in these 14 countries are infected with HIV. Do you know that number? Someone is whispering to you. Do you know that number?

Mr. ALLEN. I'm sorry, I missed your—

Ms. DEGETTE. How many millions of people in these 14 countries that the administration is targeting, the 12 Sub-Saharan countries and the other two countries are infected with HIV?

Mr. ALLEN. I can get you those numbers.

Ms. DEGETTE. Thank you.

Mr. ALLEN. Hold on for a second.

Ms. DEGETTE. Sure. Mr. Brown says about 25 million.

Mr. ALLEN. Yes, but you didn't want one specific community totals then?

Ms. DEGETTE. No, right. I just want the total. I'm sorry. So my question is you're putting \$10 billion in new money over 10 years or I'm sorry, over 5 years.

Mr. ALLEN. Correct.

Ms. DEGETTE. In these countries. My question and what you're going to do with U.S. dollars—with Federal dollars, with government dollars is treat 2 million of these 25 million people with anti-retrovirals, right?

Mr. ALLEN. That's correct.

Ms. DEGETTE. So my question to you is are these private philanthropic and other efforts, the multilateral efforts you spoke of how many of the remaining 23 million people are those entities going to treat with the antiretroviral drugs?

Mr. ALLEN. I cannot give you a number as to what the private sector or multilateral organizations will do. What I can point to you to is what the Global Fund is trying to do.

Our efforts are very targeted, very focused on those 14 countries where we find half of the disease, have of those living with the dis-

ease live in those countries. That's what we're focusing and we're going to focus our activities specifically.

Ms. DEGETTE. I think that's swell, but my question is about the drugs.

Mr. ALLEN. Let me see if I can try to answer. If you will be patient with me to try to get to your question. We are working both the U.S. purchasing and providing anti-retroviral treatment, but we also work multilaterally, whether it's through the Global Fund or working with organizations that are already in countries. We work in those countries to find ways of providing antiretroviral treatments.

So there is multilateral activity taking place in which the U.S. is participating—

Ms. DEGETTE. Right, I understand that. I do understand that.

Let me just finish, if I may, Mr. Chairman.

My only question and concern is I think we need to try to work as part of our plan which is multifaceted, I understand.

I think we need to try to work to get these drugs to as many people as we can and any way we can which means—

Mr. BILIRAKIS. Mr. Allen, unless your response is brief, I would suggest that you put it in writing, since that's one of the things we're going to ask of you when we excuse you.

Mr. ALLEN. Certainly and I'd—

Ms. DEGETTE. Mr. Chairman, I think that's an excellent idea.

Mr. ALLEN. I think that's perfectly—

Mr. BILIRAKIS. All right, great. We are finished up with you, sir. Thank you so much. That's a bad way of putting it.

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

Mr. BILIRAKIS. Thanks for your patience.

Mr. ALLEN. It's my privilege.

Mr. BILIRAKIS. And your understanding, Mr. Secretary. As per usual, we will have questions. One has already been posed by Ms. DeGette. Would you like to repose that in writing to him?

Ms. DEGETTE. I think he understands.

Mr. ALLEN. I think I understand your question and I'd be glad to—

Mr. BILIRAKIS. If you understand that, please respond to the committee and of course, there will be other questions submitted to you by the staff and what not and we would expect that you would respond.

Mr. ALLEN. Certainly, Mr. Chairman, and thank you again and it's a privilege to be before you on such an important issue.

Mr. BILIRAKIS. Thank you. Thank you so much. Let's see, the second panel finally we come to it. Mr. Shepherd Smith, President and Founder of the Institute for Youth Development; Ms. Donna J. Barry, Partners in Health, Boston, Massachusetts; Ms. Sophia Mukasa-Monico, Director of the AIDS Program for Global Health Council here in Washington; and Dr. Edward C. Green, Senior Research Scientist, Harvard Center for Population and Development Studies.

Are we all here or are we not here?

Ladies and gentlemen, your written responses have already been submitted to us, so we'll set the clock at 5 minutes and we would

hope that you would complement, if you will, those responses more than anything else.

Mr. Smith, please proceed, sir.

**STATEMENTS OF SHEPHERD SMITH, PRESIDENT AND FOUNDER, INSTITUTE FOR YOUTH DEVELOPMENT; DONNA J. BARRY, PARTNERS IN HEALTH; SOPHIA MUKASA MONICO, DIRECTOR, AIDS PROGRAM, GLOBAL HEALTH COUNCIL; AND EDWARD C. GREEN, SENIOR RESEARCH SCIENTIST, HARVARD CENTER FOR POPULATION AND DEVELOPMENT STUDIES**

Mr. SMITH. Thank you very much, Chairman Bilirakis. I'd like to depart from my written comments right now and just be responsive to some of the opening comments that were made.

First, I'd like to thank you for the many years you have followed this issue, led on this issue and this committee has contributed mightily to America's response and we're appreciative.

I agree with Mr. Towns that this committee should be involved in any legislation that is written or come up in this Congress because you really have the expertise.

Ms. Wilson, Mr. Brown and Mr. Green raised the important issue of tuberculosis. Clearly, we have to have an emphasis on that. One aspect of TB is in respect to how the medications are administered by direct observed therapy. And one part of the conversation about antiretroviral drugs for HIV that I think was being omitted is the need for direct observed therapy in these countries that we have targeted in the President's initiative.

We do not want to put ourselves in a position where we become responsible for helping facilitate the development of drug resistant strains of HIV in parts of the world and so I would caution in an program or legislation that that be a consideration.

I wish Mr. Towns were here because he was very instrumental in putting together the first hearing in 1995 on AIDS in the African-American community and that helped move that issue and funding in that direction which was much needed. With respect to Ms. Capps' comments about the ABC of Uganda, I think that it's important to remember that this isn't ABC in the context that we think of comprehensive sex here in America. It's very targeted. It's abstinence to kids. It's be faithful to those in marriage or in monogamous relationships and it is comments to very targeted communities such as the bars and the prostitutes and so on. So it is ABC, but it's not all lumped together. It's very segmented, having been there and looked at it very carefully and I think you'll hear more from other panelists.

I just would like to hit on the summary points that I had. We really need to address HIV internationally from a medical public health perspective. We need to be more aggressive in diagnosing the disease, meaning it should be a routine practice in clinics that we establish to diagnosis HIV for people who come in. We need to know who we can help and we need to help people know if they're infected.

There's got to be greater coordination in whatever legislation comes forward between the Department of Health and Human Services, USAID and State Department and certainly CDC, as Mr.

Brown was concerned, should and will play an important role, but it needs to be coordinated with respect to what other people are doing.

Again, having been abroad, having seen for myself, we have a great infrastructure on the ground. I would argue that the United States should put the bulk of any resources into a U.S. effort. The Global Fund, I am not convinced yet that it is the best vehicle for this initiative. We are giving close to a majority of the money that goes there, we're making substantial contributions and I wouldn't suggest that we go beyond that.

The important selection of the coordinator who will be in all likelihood at the State Department oversee these activities is going to be a very important decision. The qualifications of that individual are going to dictate a whole lot of how we respond and we would urge the Congress to make sure that that individual one is well qualified and two, has the ability and authority to coordinate this massive effort.

Again, balancing prevention and treatment, we would argue that we need to put a great deal of effort into solid prevention messages because the more people we can have who are uninfected, the less treatment we're going to have to give out over time.

In respect to mother to infant transmission which was mentioned, we're concerned that so much emphasis has been placed on just the mother. In these countries, the father, the husband is critically important to the family unit, often left untreated. When that individual dies, the children are going to be orphaned more quickly, the mother's health is going to decline more quickly and she is left in many instances virtually powerless without her husband, without that male figure. So I think we need to work on saving the whole family when we talk in the context of mother to child transmission.

Mr. BILIRAKIS. Please summarize, Mr. Smith.

Mr. SMITH. Okay, I'm just going to end with the importance in respect to Uganda. It's been mentioned a lot and I know it will be mentioned again, but clearly they are an exception in Africa to this epidemic and they've done it their way and it's highly effective. Other countries have done it our way and they are not effective. And I would say we need to pay more attention to that model.

Thank you.

[The prepared statement of Shepherd Smith follows:]

PREPARED STATEMENT OF SHEPHERD SMITH, PRESIDENT, INSTITUTE FOR YOUTH DEVELOPMENT, BOARD MEMBER, CHILDREN'S AIDS FUND

Thank you, Chairman Tauzin, and all your committee members for holding this hearing on such an incredibly important issue. The first time we presented our views was in 1987 to your health subcommittee, and subsequently gave testimony on several other occasions as president of Americans for a Sound AIDS/HIV Policy in the 1990s regarding the spread of the HIV epidemic in the United States and abroad, and the need to address the epidemic from a medical/public health perspective. This committee is well recognized as the primary House sponsor of AIDS-related legislation throughout the history of the epidemic.

The attention the past chairmen of the full committee and the subcommittee have paid to this issue is remarkable. Congressmen Dingell, Waxman, Bliley, and now Congressman Bilirakis have all made HIV/AIDS a top priority. You're following in that role, too: is very heartening to those of us who care deeply about this issue. In past legislation most HIV/AIDS programs and plans have focused domestically while some of the resources that were allocated went to international efforts. Now,

because of the President's bold initiative, this committee is looking more broadly at the implications of such a plan.

This issue has never been simple, and broadening our focus with more intensity on a global level brings many challenges to bear. The State Department and USAID have historically dealt with many international issues, while the Department of Health and Human Services has often played a significant role of offering technical assistance on health related matters such as the successful campaign to eradicate small pox and the present campaign to eradicate polio. While HIV/AIDS is an issue that now impacts nearly all countries and has economic implications, it is primarily a health issue which needs incredible coordination between these three entities that have played historic roles at the international level.

I was privileged to be part of the US Delegation to the United Nations General Assembly Special Session on HIV/AIDS (UNGASS), and then to travel with Secretary Thompson last year to Africa as part of his delegation. We saw the consequences of this epidemic on that continent, as well as began to shape answers that will benefit all countries. Secretary Thompson's interest and leadership on HIV/AIDS has gone mostly unheralded, but not unnoticed by those of us deeply involved in this issue.

I was very impressed by the infrastructure established both by the State Department and USAID, as well as the support staff provided by HHS in many of the countries visited. Clearly the opportunity to help country by country is well defined by the folks we already have on the ground from the United States. It is my strong belief that we can help significantly given clear leadership and direction from the top of most parts of our government. Substantial and expanded United States resources can probably be better utilized by a United States effort than through the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global AIDS Fund). This is not to say that there should not be a role for the Global AIDS Fund, and indeed this Administration is giving significant resources to it, more than any other country in the world. However, when we're talking about mobilizing such a large effort in such a short period of time, the United States alone is positioned to do this much better than any international entity with all its different perspectives and participants that come into play.

The need for a strong coordinator at the State Department makes a lot of sense to us as well. It is the United States embassies and consulates in foreign countries that people look to for answers and information. Having the coordinator linked with the White House monitoring these activities for State, USAID and the Department of Health and Human Services will allow resources to be marshaled in a way that direct the greatest amount where they are needed most, and reduce the amount of resources that are underutilized or wasted. The coordinator's position needs to be closely linked to the Secretary of State, as well as to the White House National Office on AIDS Policy.

Having traveled to the southern regions of Africa in the early '90s, we were not prepared to see the rates of HIV rising in the countries we visited last year. The HIV epidemics were well defined in the early '90s and we felt that the emphasis on prevention would have led to either a stabilization or a decrease in the HIV epidemic. However, when we visited Mozambique, South Africa, and Botswana we saw that their HIV incidence rates continue to climb. We had to ask ourselves why. On our return we looked at data throughout the entire continent and found that there was one glaring exception to these rising rates, and that was Uganda.

Consequently, we put together two groups to visit Uganda, once in August and then again in December 2002, where we tried to carefully examine the US role as well as the role of the Ugandan government in combating HIV/AIDS. It is quite a story, and little wonder why the President in his State of the Union address singled out Uganda as a model country that we should examine carefully and follow. Many of you are aware of the story of Uganda and others here may highlight it as well, but I would like to share a few observations.

It is a relatively poor country, not unlike many of its neighboring African countries. We in the US spend on AIDS alone roughly forty times per capita what Uganda spends on all healthcare issues facing their citizens. They have a declining HIV epidemic; in the United States we either have a stable or rising HIV epidemic. Compared to South Africa, HIV trends are going in opposite directions.

They have promoted a traditional message of celebrating virginity at marriage, encouraging young people to be abstinent until marriage and then asking those who are married to be faithful to their partners, with little emphasis on condom promotion (what has become known as their ABC message). They have had some success in highly targeted condom campaigns, and no documented success in broader condom campaigns. America needs to become known as the biggest promoter of the A and B of ABC, not known as we are now as the biggest provider of C.

Uganda's message contrasts sharply with the messages given out in the southern part of Africa. There the dominant and primary message has been the promotion of condoms. We saw this in the early '90s and were surprised to see an even greater emphasis on our return trip last year. Very few government funded programs focus on abstinence or faithfulness, and certainly most US sponsored programs, whether government or private, focus on the broad social marketing of condoms. There is some emphasis on diagnosis, but even that is often anonymous in nature.

I would like to draw an analogy to what has happened in Africa regarding these two different approaches. It is as if a large group of experts have proclaimed a new method should be promoted regarding the teaching of reading skills. These experts have said this approach will help people read much better.

However, the more the new program is promoted, the worse the scores have gotten. But even though the results are abysmal, it's as if no one wants to stop and say that reading scores have declined and not gotten better. Yet in this one country that has pursued a more traditional approach, the scores have gotten incredibly better. It is very difficult to comprehend why we can't take a few steps back and look at the results of these two different approaches. One is highly effective; one is not. We need to pursue the one that is highly effective and either discontinue or highly modify the one that is not. It's really that simple. And we must allow faith-based groups to promote abstinence and be faithful without coercing them to also promote condoms which, unfortunately, happens all too often.

I'd like to also share with this committee that over the years we have sought to help families affected by HIV here in the United States and abroad. In Africa we not only support families and orphaned children, but we are helping fund a drug trial in Malawi that is looking at mother to child transmission in the context of the whole family. As we pursue trials, it is important to remember that the husband is the primary breadwinner and that without him the health of the mother will decline more rapidly and the children will become orphans more quickly. Consequently, the treatment program under trial through the Children's AIDS Fund is intended to save the whole family and offers a treatment regimen to the husband as well as the wife and children. And it also addresses other health related matters, which we feel is important in structuring all HIV treatment programs abroad.

In closing I would like to share that HIV/AIDS treatment and prevention are critically important for underdeveloped countries. Better prevention messages will ultimately result in less demand for treatment and less suffering from the consequences of HIV infection. We should remember that the biggest predictor of any sexually transmitted disease is the number of lifetime partners; the more partners the more risk, fewer partners less risk, and one uninfected partner in a faithful relationship virtually no risk. The President has it right, Uganda can teach us many important lessons.

Mr. BILIRAKIS. Ms. Barry.

#### STATEMENT OF DONNA J. BARRY

Ms. BARRY. Thank you very much, Chairman Bilirakis and Ranking Member Brown and the other members of the Health Subcommittee for being here today and for holding the hearing. And I'll just repeat a few of the things that I've given out in my written statement, as I think that they really do bear—they're important enough to read and also to hear.

So I just want to say that even on a day like today as a nurse practitioner, as a U.S. citizen, I think I can't really think of anything more important to speak about you with you today. And just to repeat—I won't repeat all the statistics that have been listed already today, but I do want to say that everybody 8,000 people are currently dying of AIDS and 5,000 are dying of tuberculosis. And it's the sad irony is that these are absolutely presentable and treatable diseases.

I do want to applaud the administration and President Bush for announcing the \$15 billion. We have been woefully parsimonious in our support over the past 15 to 20 years and I think that this is a promising start.

The rhetoric now being shared on the world stages is that we need \$14 billion a year to treat all of these diseases sufficiently and I think we need to look at the \$10 billion is being bandied about for what we need for HIV/AIDS and everyone seems to think that this is a very large amount of money and that, in fact, there's no way to come up with it, but just if you would look at my comments to see how reasonable this actually really is. It really only amounts to \$35 per U.S. citizen per year.

I'd like very much to make a strong statement that more of the money from those \$15 billion should be given to the Global Fund. We have some very small, but very successful pilot projects in many of the countries around the world and the Global Fund right now is the only agency with the resources and the capability to scale up these projects. It's a multilateral agency. They coordinate all the different sectors in each country and some questions have been raised about how well this money will be tracked or how well we'll be able to monitor the use of these funds, but Richard Feachem has a public health background, he has a World Bank background and he set up some of the most rigorous monitoring mechanisms for this money that have ever been used in public health. In fact, in Haiti, we have had more monitoring visits to our project down there than we've ever had before since the announcement of our grant was made. And yet, we haven't even gotten the money yet. So I think that we can see that these funds are going to be monitored very, very closely.

I also want to emphasize that we really need to work with all sectors and this is the approach that the Global Fund is taking. In Haiti, we just want to expand from 400 patients to 5,000 patients, but in order to do that we have to work with nongovernmental organizations, we have to work with the public health sector, the government public health sector. Without this, there's no way that we can expand the treatment. There's no way we'll be able to expand the treatment to 2 million patients which the Secretary mentioned.

Bilateral aid has never been sufficient to support large scale projects like this and it will not be sufficient through these initiatives as they've been announced today. That's why the Global Fund is so important and in addition, bilateral aid rarely links tuberculosis and HIV.

I'd like to caution us from using the ABC model too widely as we've heard today. I think that we really don't have the evidence that this is an appropriate model for other countries in the world and I think it also does not address other problems, other ways that HIV is spread such as through IV drug use.

I'd also—the last thing that—one of the last things I'd like to say is we'd like very much to see at least some more tuberculosis money going through the Centers for Disease Control, the CDC. They do excellent work internationally and to my knowledge they do not receive direct funding to work internationally on tuberculosis. In fact, they usually always have to ask for that money from USAID which of course adds an additional layer of bureaucracy and less funding for the actual programs.

Our past interventions through USAID, through other mechanisms have not been very successful in stemming the diseases. This is clear to everyone. Rates are still growing around the world. And



one of the things that Partners in Health and myself advocate is that these are very complex problems. There are not simple solutions. There are no simple solutions. We can't just throw a simple solution at this and expect it to work. As previous public health programs has, such as vaccinations, which are very important, but these requires developing infrastructure in these countries, upon which we can build other programs. So if we set up the infrastructure to treat HIV/AIDS, we'll also be able to treat the tuberculosis. We'll also be able to treat other problems and solve other problems like infant mortality, treating diabetes, hypertension, etcetera.

But my most important message is that we've got to do this rapidly and we've got to do it now. We don't have the time to wait because millions are dying every month.

Thank you.

[The prepared statement of Donna J. Barry follows:]

PREPARED STATEMENT OF DONNA J. BARRY, PARTNERS IN HEALTH

Thank you Chairman Bilirakis, Ranking Member Brown, and the other members of the Energy and Commerce Health Subcommittee for holding today's hearing. And thank you very much for the opportunity to speak at this hearing on HIV/AIDS, TB and Malaria: combating a global pandemic. I am the director for Russia programs at Partners In Health (PIH), a Boston-based NGO, and also work in our tuberculosis and HIV treatment projects in Haiti and Peru. As a nurse practitioner with a degree in public health and as a concerned citizen, I can think of nothing more important to speak with you about today, even as we are on the brink of war. Today there are 300 million infections from malaria each year, 3.7 million persons newly infected with tuberculosis (1/3 of the world's population is already carrying the TB bacteria), and 42 million persons living with HIV, and the numbers continue to grow. In 2002, 3.1 million people died of AIDS; tuberculosis accounted for 2 million deaths and malaria killed more than 1 million people. 8000 people die every day from AIDS...5000 from TB. The sad irony of these statistics is that these are treatable diseases.

During President Bush's State of the Union speech on January 28, he announced a \$15 billion dollar five-year plan to battle HIV/AIDS and this is to be applauded. As a country we have been woefully parsimonious with our support to fight this plague and in the mean time cases and mortality from the disease have continued to increase worldwide. Experts conservatively estimate that we need at least \$14 billion per year in order to contain these diseases worldwide: 10 billion for HIV/AIDS and an additional 4 billion for malaria and TB. While 10 billion dollars seems like a lot of money in this age of deficits, it really is not. It is about 35 dollars per US citizen per year; is less than 25% of the increase in the defense budget in 2002; and is less than 1% of the tax cut we received last year. If indeed the entire \$15 billion will be new spending for HIV/AIDS, this will be a desperately needed, though still inadequate, infusion of funding to fight this dreadful disease. Therefore, it behooves us to spend this much-needed money in the most effective way possible.

The first recommendation that my colleagues at PIH and I would like to share with you today is that more of the funding should be allocated to the Global Fund which has approved projects for funding in over 90 countries and will pay out at least \$1.5 billion in the next 2 years. Small but successful pilot projects are in place that can prevent and treat HIV and TB. However, what is now needed is to take the projects to scale in these countries and the Global Fund is the only agency in the world with the resources and capability to fund and direct such expansion. Moreover, the Global Fund is a Multilateral and coordinated effort that works both through ministries of health and NGOs. The current head of the Global Fund, Richard Feachem is a physician with a public health background and experience at the World Bank and as such has set up some of the most rigorous monitoring mechanisms for this money that have ever been used in public health. Each proposal that has been approved has been developed by a Country Coordinating Mechanism, a consortium of those involved in the prevention and treatment of disease from both the public and private sector. This mechanism is removed from government bureaucracy and politics and is focused only on the use of global fund monies in in-country projects.

In our project in Haiti, we are currently treating 400 patients with Highly Active Anti-Retroviral Therapy (HAART)—one of the largest treatment projects in a developing country. Haiti's application was one of the first to receive Global Fund approval, and in this proposal it is planned to expand this treatment to 5,000 patients. In order to do this, we will need to work with all sectors' not only with community-based NGOs and not only with government entities. It will be important to integrate all of the resources that each sector can contribute. Bi-lateral aid through USAID has never had adequate resources to support large-scale projects of this sort. This, in fact, is why the Global Fund was created and these types of projects are clearly the next phase of fighting these diseases. In addition, few, if any, bi-lateral projects have attempted to link or combine prevention and treatment services for TB and HIV, which is critical in order to control either disease. I'm pleased to hear that language already being discussed in the House and the Senate also includes funding for tuberculosis. The Fund has a specific category of proposals for those countries that wish to apply for joint funding for TB and HIV programs.

Secretary Thompson is currently the Chair of the Fund and as such will have the ability to oversee these projects and ensure their success. I hope that you will consider allocating more funding to the Global Fund as the members of the International Relations Committee recently did. Their plan would authorize the president to contribute up to \$1 billion per year to the Fund and we strongly encourage you follow their lead, if not exceed this amount. However, I would be cautious in using the ABC model too widely as I understand the International Relations Committee is recommending as we do not yet have published data to show that this model is what caused the decline in transmission of HIV in Uganda and it does not address the spread of HIV through IV drug-using populations which is contributing to the sky-rocketing rates of HIV incidence in countries of the former Soviet Union.

If, as many of the news reports and press releases from the government have recently stated, the majority of this \$15 billion dollars will be spent through bi-lateral mechanisms, we would like to encourage that this funding for tuberculosis and HIV/AIDS be shared with both the U.S. Centers for Disease Control and Prevention (CDC) and the U.S. Agency for International Development. The CDC receives no direct funding for their outstanding work on tuberculosis internationally. They are required to request funding from USAID in each country where they work. This adds an additional layer of bureaucracy which subtracts from the amount of funds available for actually treating and preventing HIV and TB.

In addition, the CDC has a proven track record of implementing programs in both tuberculosis and HIV/AIDS in the United States and many other countries around the world. They have extensive networks of health care providers, laboratory experts and researchers who directly implement programs rather than contracting them out to other organizations. They have experience working with both governmental and non-governmental organizations which as I stated above, will be critical to the success of large-scale expansion projects which are so important today. Our projects in Peru, Russia and Haiti are engaged in successful collaboration with projects from CDC and they are the most expert at coordinating work at the level of ministries of health.

I'd like to finish by stating that while US government funding for HIV/AIDS through USAID remained steady, albeit too low, during the nineties, and has increased in the past few years, we have seen little progress in abating the spread of disease, and implementing adequate treatment programs. In addition, USAID funding for tuberculosis has steadily increased from 1998, but cases continue to rise across the world. Some progress has been seen in select countries, but by no means can we say there are positive trends in stemming either of these diseases.

With the additional resource allocation from this Administration, we need to fundamentally rethink the way that we are approaching these complicated health epidemics and rapidly build on the successes which have been achieved. Public health can no longer focus solely on strategies of prevention and "one shot deals" such as vaccination programs. We need to use the grim statistics of the HIV and TB epidemics to rise to the moral challenge before us. That is to truly build and develop the health infrastructure to deal with complex diseases that require treatment, monitoring, and laboratories. This approach, one of tackling the complex health interventions that face us today, will lead not only to the needed impact in the AIDS and TB epidemics, but improvements in other more complex public health challenges from decreasing maternal mortality—which requires blood banking and cesarean section to treatment of patients with diabetes and hypertension. We cannot do this only through bi-lateral aid, the world needs to coordinate its efforts. Successful pilot projects that demonstrate an evidence-based, data-driven sound program on which to build must be expanded. New projects must be started. The AIDS and TB

epidemics will not wait...we must move quickly to begin treating the millions of patients who are waiting before millions more perish before our eyes. Thank you.

Mr. BILIRAKIS. Thank you, Ms. Barry.

Ms. Monico.

#### **STATEMENT OF SOPHIA MUKASA MONICO**

Ms. MONICO. Thank you, Mr. Chairman, ladies and gentlemen, for giving me the opportunity to be with you today to talk about the global HIV/AIDS pandemic. I am a native Ugandan and currently working with the Global Health Council. The Global Health Council is the world's largest membership alliance dedicated to saving lives by improving health around the world.

From 1995 to 2001, Mr Chairman, I was the Executive Director of The AIDS Support Organization, TASO. TASO was founded in 1987 to contribute to the process of restoring hope and improving the quality of life of persons and communities infected and affected by HIV and AIDS. TASO is now recognized around the world as a leader and innovator in the field of AIDS care and support. And this includes prevention and treatment of TB and malaria.

I would like to begin my task by taking advantage of this opportunity and on behalf of the Africans, and my country, Uganda, thank the U.S. Congress for their efforts to increase the U.S. government's spending on global AIDS programs.

In addition, I would like to thank the Americans and President Bush for the Emergency Plan for AIDS Relief in Africa and the Caribbean.

Americans have made a commitment to addressing the global AIDS pandemic because they have seen the programs in place that work. The best example of this is my country, Uganda. Everybody has been talking about Uganda which is now considered to be one of the world's earliest success stories in our attempts to control the HIV and AIDS pandemic. Uganda has been successful due to several important factors, Mr. Chairman, including strong political leadership, a comprehensive prevention program and a resilient community that has formed itself into community-based care organizations to look after people living with HIV and AIDS such as TASO.

In 1986, when President Yoweri Museveni came to office, he realized that HIV and AIDS was ravaging our country. Early on in his presidency, Mr. Museveni spoke out about HIV and AIDS and became an early advocate for reducing the stigma associated with HIV/AIDS. And this strong political leadership was key to Uganda's success. But ladies and gentlemen, a reduction in stigma is not enough to halt HIV transmission. Individuals must take action to change their own behavior and take precautions. Early on in his campaign, President Museveni spoke out candidly and often about the need for individual Ugandans to protect themselves from the virus. Working with nongovernmental and community-based organizations, President Museveni promotes prevention interventions that are creative and culturally appropriate. For some, he promotes a message of delaying sexual debut; for others, he urges them to be faithful to their partners and where all fails, to consistently and appropriately use the condoms. It is this three-part comprehensive prevention message and the message to compassionately care and

support our beloved ones that contributes to the relatively small, but significant success in Uganda.

I cannot stress strongly enough that all these program elements need to be in place for prevention to work. As a Ugandan, I am deeply concerned when I hear people talking about a single element of our successful national program, for example, abstinence, which is always out of context and ascribe all our achievements to that one element. They all must be implemented together in order for prevention to work.

Mr. Chairman, in Uganda, we know that it is important to take into account the ever increasing impact that the epidemic is having on women and girls. A key component is the integration of HIV prevention and care interventions in existing infrastructure such as the traditional family planning services. In rural areas of Uganda, this is a critical way for women to learn about HIV and AIDS in an accommodating and unstigmatized way so that they can take appropriate action to protect themselves and their children from the virus. Integration is an efficient and effective way of getting HIV/AIDS to be in malaria services to those in rural areas, cost effectively and without duplication and in a very coordinated way.

Targetting youth, Mr. Chairman, is also critical to the success of programs in Uganda. Since 1989, schools have integrated HIV education and behavior changing messages into the curriculum. It is called "life skills education" and not abstinence education. Unlike past programs, this sexuality education not only targets girls, but it also targets boys to be part of the solution.

Ladies and gentlemen, Ugandans have given substantial attention to education as we believe that youth friendly approaches, candidly promoting efficient integration of appropriate HIV/AIDS related information, education and communication, as well as a protective environment contributed to our reported increase in delayed sexual debut.

We have also made special efforts to establish programs that provide care and support for pregnant women. Uganda is one of the target countries in the President's MTCT initiative that has been a model in terms of providing care for pregnant women.

Mr. BILIRAKIS. Please summarize, if you could, ma'am.

Ms. MONICO. Yes, in 1 minute.

Mr. BILIRAKIS. Do the best you can. Don't take away from your message.

Ms. MONICO. I'll try to be very fast. One key aspect of MTCT program is the inclusion of voluntary counseling and testing. Hundreds of thousands of women have received prompt care and have avoided infecting their newborns due to this important intervention.

Many of these programs have been established in conjunction with existing family planning and maternal health clinics as women already access services through these outlets. This collaboration is critically important to ensure that those most in need continue to have access to services at the most appropriate locations.

In Uganda, due to the high incidence of HIV, it was critical that the country also develop a strong care and treatment component. By working with strong nongovernmental organizations, faith-based organizations and community-based support groups, flexible,

creative and culturally appropriate interventions were put in place to provide care and support to those living with AIDS. TASO is an example of this.

But Mr. Chairman, what we have to realize is that it's relatively low technology and low cost care interventions that have an enormous impact on the lives of those living with HIV/AIDS and in conclusion the next steps in addressing the epidemic in Uganda and around the world is extending antiretroviral treatment in the developing countries. These medications will provide hope to the millions of Africans who do not see a future for themselves or for their communities today. Treatment is not only a humanitarian imperative. Treatment supports prevention efforts by encouraging individuals to learn their HIV status and reduce the stigma to the disease.

Mr. Chairman, AIDS is not inevitable. We have learned a great deal over the last 20 years. It is our common responsibility to address AIDS with a clarity of vision of what we have learned and what works, a comprehensive approach based on the reality of people's lives rather than an external view of how people ought to behave is the right prescription for bringing an end to this tragedy.

Thank you.

[The prepared statement of Sophia Mukasa Monico follows:]

PREPARED STATEMENT OF SOPHIA MUKASA MONICO, GLOBAL HEALTH COUNCIL

Thank you for giving me the opportunity to be with you today to talk about the global HIV/AIDS pandemic. I am a native Ugandan and am currently, the Senior AIDS Program Officer at the Global Health Council. The Global Health Council is the world's largest membership alliances dedicated to saving lives by improving health around the world.

From 1995 to 2001, I was the Executive Director of The AIDS Support Organization (TASO). TASO was founded in 1987, to contribute to the process of restoring hope and improving the quality of life of persons and communities infected and affected by HIV/AIDS. TASO is now recognized around the world as a leader and innovator in the field of AIDS care and support.

I would like to begin my task by taking advantage of this opportunity and on behalf of Africans, and my country Uganda thank the Americans and President Bush's for the "Emergency Plan for AIDS Relief in Africa."

The proposal outlined in the State of the Union message January 28 was substantial and meaningful—President Bush portrayed how the American compassion must extend far beyond your own shores, to include the men, women and children living with HIV/AIDS in the developing world. The President's challenge and the venue through which it was delivered, will go a long way towards increasing American public support for our efforts to fight the human and social devastation caused by AIDS. The onus is now on the Africans and Caribbean to make it work for us, and we look forward to working with the Administration and Congress as this plan is put into action.

WHAT IS AT STAKE?

20 years ago most of the world was ignorant about the evolution of the HIV/AIDS epidemic and how best to respond to it. In 2003 we know AIDS is like a forest fire that is consuming entire countries and must be stopped.

Especially in developing countries, HIV has moved beyond the realm of public health alone and is now a social, economic and security concern.

Since the epidemic began, more than 60 million people have been infected with the virus. It is projected that 200 million people will be infected in 15 years. HIV/AIDS is now the leading cause of death in sub-Saharan Africa and the fourth-largest killer worldwide. To date, AIDS has claimed over 22 million lives.

Today, over 42 million people are living with HIV/AIDS. Ninety five percent of the people with HIV/AIDS live in countries with the least resources and two-thirds of them are in Sub Saharan Africa.

People, families, societies, economies and nations are at risk today—and the risk stems primarily from the likely impact of millions of premature deaths within the next decade among those already infected. Only treatment can alter the trajectory. Moreover those countries with the highest rates of infection are at disproportionately greater risk, which makes treatment there all the more important.

For years, observers have expected the epidemic in Africa to plateau. Yet, each year, the news grows bleaker, as infection rates exceed levels previously thought possible.

In Botswana, the nation with the world's highest infection rate, median HIV prevalence among pregnant women in urban areas increased from 38.5 percent in 1997 to 44.9 percent in 2001. Likewise, in Zimbabwe, Namibia, and Swaziland—where infection rates rival those of Botswana—HIV prevalence continues to increase. In South Africa, in the past ten years, HIV prevalence among pregnant women rose from less than one percent to 25 percent.

After years of relatively slow increases in West Africa, infection rates appear to be rising sharply in Cameroon (from 4.7 percent prevalence in urban populations in 1996 to national prevalence of 11 percent among pregnant women in 2000) and in several districts in Nigeria, the continent's most populous country.

The rate of increase in HIV infections is the highest in Russia and the republics of the former Soviet Union. In Russia, the number of cases rose from just under 11,000 in 1998 to 147,000 by late last year. Prevalence is also increasing in Asia. In India, some 4 million people are infected with the virus, one Indian is getting infected every minute, making India the second largest HIV infected country in the world after South Africa.

HIV also continues its relentless assault on the Caribbean, the world's second most affected region, where HIV prevalence in at least two countries already exceeds 4 percent. The number of people infected grew by nearly 20 percent in North Africa and the Middle East last year, leaving close to half a million people with HIV / AIDS.

#### WHAT IS THE EFFECT?

In its 22 years' course, the HIV/AIDS epidemic has already wiped out more than 50 years of development gains in the hardest-hit countries by cutting short life expectancy, in some cases by more than 20 years.

One of the most immediate humanitarian concerns in the wake of the HIV/AIDS epidemic is children. In 2002 alone, more than 600,000 children below the age of 15 died from AIDS, most of them infected at birth through transmission from their infected mothers. 800, 000 below the age of 15 were newly infected in 2002.

Equally startling is the situation of children orphaned by AIDS. Now counting 14 million, the majority live in sub-Saharan Africa, many in areas struck by food crisis and violent conflict or political disturbances. Making ends meet for these children often means forsaking school and engaging in risky activities for survival, such as transacting sex in exchange of food, shelter and protection. Even in areas where positive signs of reduced incidence of HIV among young people have been registered, such as in Uganda, already existing high prevalence rates make the number of orphans set to increase as death rates in AIDS rise. The number of children who have lost one or both of their parents to AIDS is set to double to almost 25 million over the next decade. Providing them with reliable protection and safe schooling is the best social vaccine to prevent them from also falling prey to AIDS.

More and more, AIDS is attacking young people. Almost half of the 14,000 people newly infected each day are of a young age and altogether some 12 million young people are currently living with HIV/AIDS. The future course of this global epidemic and its links to human security depends on whether the world can protect young people and children everywhere from the devastating effects of the HIV/AIDS epidemic.

Saving future generations calls for more investment in the current prevention, care and treatment interventions as well as research and development into new ones, especially those that can be controlled by women.

Saving people is a humanitarian imperative. Saving development is a political imperative. In 2005, a target year for implementing the Declaration of Commitment on HIV/AIDS, world leaders will have to look into the mirror of accountability and prove that rhetoric has been followed by action.

#### WHAT WORKS?

But it is critical that we look beyond the numbers and begin to examine programs that have worked so that these lessons learned can be applied in other countries. No one country in the developing world has established an HIV/AIDS program that

has shown total success. But those programs that have been successful in provinces or cities have reflected the needs of their community, are implemented by members of the community, and include elements across the continuum of prevention, care and treatment. Some are run by non-governmental organizations and others are run by Ministries of Health—some focus on preventing the spread of the disease while others provide needed palliative care—and others are beginning to provide much needed hope for people living with AIDS by providing treatment.

Prevention, care and treatment serve overlapping but not identical goals. Prevention and care efforts are not additive but rather each strategy increases the impact on the other through synergistic effects. Further, prevention and treatment involve different sectors and constituencies. It is therefore, necessary to invest in all simultaneously to achieve more than would be accomplished by investing in any alone.

#### *Prevention*

Today, prevention efforts reach fewer than 1 in 5 of those at risk. To have an impact on the future course of the epidemic, pockets of success and pilot prevention projects must rapidly become comprehensive programs that reach all those at risk, and obstacles to prevention must be swiftly addressed and overcome.

HIV transmission can be reduced through a wide range of proven behavior change programs that encourage people to:

- delay initiation of sex;
- reduce their number of partners;
- use a condom;
- seek treatment of sexually transmitted diseases; and
- make use of expanded voluntary counseling and testing programs.

Another key prevention strategy is to reduce the transmission of HIV from mother-to-child. The risk of mother-to-child HIV transmission can be reduced by half or more with:

- short courses of antiretroviral drugs,
- voluntary counseling and testing, and
- enhanced reproductive health services.

Effective HIV prevention involves a carefully planned combination of these interventions, reinforced by public policies to combat the social factors that facilitate HIV transmission.

#### *Care*

What makes AIDS uniquely destructive is that it targets adults in the prime of their lives—when they are workers, parents and caregivers. Treating those living with HIV, therefore, saves children from becoming orphans, keeps household and businesses in tact, maintains social cohesion, and enhances the return on social investments in sectors such as education and rural development.

Proven care programs include many different components. They must include the medical treatment of sexually transmitted diseases and opportunistic infections. But, they cannot stop there. They must also include psychosocial support and nutritional support.

#### *Treatment*

In low- and middle-income countries access to anti-retroviral treatment is available to less than five percent of those in need. In Africa, no more than one percent have access to treatment.

Treatment will add years of quality life—which has no price—and saves the health system of even the poorest country several hundred dollars per patient per year in averted palliative and opportunistic infections care. As a single example, an analysis from Namibia, a country with one of the highest HIV rates in the world, found that the provision of HIV care including HAART for all in need, would increase per capita output above the per capita taxes required to fund such a program.

While medical advances have sharply reduced HIV-related death and sickness in industrialized countries, the epidemic continues on as before in developing countries, harming families, burdening the most vulnerable, and robbing entire regions of hope for the future.

The glaring inequality between developed and developing countries in terms of access to anti-retroviral care is unacceptable in an era when treatment regimens exist and are known to reduce suffering and improve the quality of life, to prolong lives and productive life-cycles, and to cut hospitalization costs—all of great benefit to households and communities, to economic and national development, to political stability and human security.

## WHAT IS NEEDED FOR SUCCESS?

UNAIDS and others have studied countries where HIV prevention, care, treatment and support programs have been most successful and identified common characteristics, these include;

- Strong leadership, including visible ownership by national leaders of the fight against the disease;
- Broad awareness of HIV/AIDS among the general population
- Open discussion of sex and a national commitment to sex and sexuality education for youth;
- Active involvement of all sectors, including civil society, religious leaders, and non-governmental organizations;
- Concerted efforts to reduce AIDS stigma, and policy and legal changes to prevent HIV-related discrimination; and
- Availability of external assistance in the financing, development, and implementation of effective prevention programs.

## THE UGANDA EXAMPLE

Uganda is now considered to be one of the world's earliest success stories in our attempts to overcome the HIV/AIDS pandemic. Uganda has seen substantial declines in prevalence, and incidence of HIV/AIDS within the past decade, especially among young people. Uganda was successful due to several important factors, including strong political leadership, a comprehensive prevention program, and community based care programs such as the one that I ran at The AIDS Service Organization. Treatment was not part of the Uganda success story as the cost of anti-retroviral medications makes them unavailable.

In 1986, when our new President Yoweri Museveni came to office, he realized that HIV/AIDS was ravaging our country. Early on in his presidency, President Museveni spoke out about HIV/AIDS and became an early advocate for reducing the stigma associated with HIV/AIDS. This strong political leadership was key to Uganda's success. This reduction of stigma is critical on many levels. When stigma is reduced, individuals are more willing to seek counseling and get tested to learn their HIV status. If stigma is reduced in communities, they become more accepting of those who are positive and are therefore willing to become involved in their care as well. Reducing stigma has benefits for both the community and the individual. When stigma is reduced, an individual is more willing to be tested and therefore is able to take steps to avoid transmission of the virus. This adds to the overall success of a prevention effort

But, a reduction in stigma was not enough to halt HIV transmission—individuals must take action to change their own behavior and take precautions. Early on in his campaign, President Museveni spoke out loudly and often about the need for individual Ugandans to protect themselves from the virus. Working with non-governmental and community-based organizations, President Museveni promoted prevention interventions that were creative and culturally appropriate. For some, he promoted a message of delaying sexual debut; for others, he urged them to be faithful to one partner and to use a condom. It was this three-part message that was effective in Uganda. In my personal experience, I believe that this three-part message is critical. Different populations require different messages and it is critical that people of all ages are educated about how to protect themselves.

I can not stress strongly enough that all these program elements need to be in place for prevention to work. As a Ugandan, I am deeply concerned when I hear people taking a single element of our successful national program—for instance abstinence—out of context and ascribe all our achievements to that one element. They all must be implemented together in order for prevention to work.

In Uganda, we knew that it was important to take into account the ever increasing impact that the epidemic was having on women and girls. The low social and economic status of women, driven by the cycle of poverty, often makes it difficult for women to assert themselves and Uganda took several steps to improve their status, including instituting a requirement that a specific percentage of the Parliament should be female, providing microcredit programs to allow women to gain economic self sufficiency. One other key component was the integration of HIV prevention messages into traditional family planning services. In rural areas of Uganda, this was a critical way for women to learn about HIV/AIDS so that they can take appropriate actions to protect themselves from the virus. Integration is an efficient and effective way of getting HIV/AIDS services to those in rural areas quickly and in settings where men and women are already accessing services.

Targeting youth was also critical to the success of programs in Uganda. Since 1989, schools have integrated HIV education and behavior changing messages into



the curriculum. They are called "life skills education" because without this information and skills about how to protect themselves from HIV, they will not survive in an African country with the HIV incidence rate found in Uganda. Unlike past programs, this sexuality education not only targeted girls but it also included formal information to boys about how they can be part of the solution. Ugandans have given a lot of attention to education as we believe that youth friendly approaches candidly promoting appropriate and efficient integration of the information into education and communication contributed to a reported increase in delayed sexual debut.

Special efforts were also made to establish programs to provide care and support for pregnant women. Uganda is one of the target countries in the President's mother-to-child transmission (MTCT) initiative and has been a model in terms of providing care for pregnant women. One key aspect of MTCT programs is the inclusion of voluntary counseling and testing. Through this counseling, a mother learns her HIV status in order to assure that the appropriate precautions will be taken during birth to limit HIV transmission to her newborn. Hundreds of thousands of women have received care and HIV transmission has been blocked to their newborns due to this important intervention. Many of these programs have been established in conjunction with existing family planning and maternal health clinics as women already access services through these outlets. This collaboration is critically important and will assure that those most in need continue to have access to services at the most appropriate locations.

In Uganda, due to the high incidence of HIV, it was critical that the country also develop a strong care and treatment component. By working with strong nongovernmental organizations, faith based organizations and community based support groups, flexible, creative and culturally appropriate interventions were put in place to provide care and support to those living with AIDS. TASO is an example of an organization that has successfully provided care to those living with AIDS for many years. The key components of our program included:

- Medical care to treat opportunistic infections;
- Preventative therapies in order to avoid the complications from AIDS;
- Supportive counseling and psychosocial support;
- Health education;
- Family planning so that women can make their own decisions about future child-bearing; and
- Nutritional support.

These are relatively low tech and low cost interventions that have an enormous impact on the lives of those living with HIV/AIDS.

In addition, you will note that these interventions represent a multi-sectoral response. AIDS is not just a medical condition for those living in Africa who do not have access to treatment. It must be addressed from a social, economic and medical perspective in order to have an impact on those communities that are most affected.

The next step in addressing the epidemic in Uganda and around the developing world is extending anti-retroviral treatment to the developing world. In his State of the Union address, President Bush outlined his vision and he committed the United States to expanding access to anti-retrovirals. These medicines will provide hope to the millions of Africans who do not see a future for themselves or their communities today. Pilot projects in Africa have begun to see results and people are returning to their previous lives as working and self sufficient members of society. Treatment is not only a humanitarian imperative—treatment supports prevention efforts by encouraging individuals to learn their HIV status and reducing the stigma of the disease.

AIDS is not inevitable. We have learned a great deal over the last twenty years. It is our common responsibility to address AIDS with the clarity of vision of what we have learned and what works. A comprehensive approach, based on the reality of people's lives rather than an external view of how people ought to behave is the right prescription for bringing an end to this tragedy.

Mr. BILIRAKIS. Thank you so very much.  
Dr. Green, please proceed, sir.

#### **STATEMENT OF EDWARD C. GREEN**

Mr. EDWARD GREEN. Thank you, Mr. Chairman and distinguished members of the Health Subcommittee. I'm the Senior Research Scientist at the Harvard School of Public Health. For most of my professional career, I've worked in less developed countries

as a behavioral science research and designer and evaluator of public health programs. I've worked extensively in Africa and other resource poor parts of the world. A great deal of my work is focused on reproductive health and some of this including the social marketing of condoms.

In view of all the sad news we hear about AIDS, especially in Africa, it is my pleasure to share some good news. We've already heard some of it. There are several bright spots in the world when it come to AIDS an the brightest spot of all my be Uganda where infection rates have declined nationally from 21 percent to 6 percent. You heard 30 percent earlier, that would be for urban areas.

The government of Uganda, led by President Museveni, developed a distinction approach to AIDS prevention known as the ABC approach. You've already heard what that is. The abstinence message for the most part took the form of urging youth to delay having sex until they were older and preferably married. Many of us in the AIDS and public health community didn't believe that abstinence or delay and faithfulness were realistic goals. And it seems we were wrong.

Uganda's program began in 1986, the year President Museveni became head of state. Since the rate of new infections began to decline in the late 1980's, it becomes important to know which programs were in place in the latter 1980's and what behaviors changed in order to account for the decline in infection rates. The standard programs we associate with AIDS prevention were not in place in the 1980's.

We now know that there were significant changes in sexual behavior between 1989 and 1995. And these were most pronounced among youth, the very age group primarily targeted by AIDS education and the behaviors that changed the most were the ones emphasized in Uganda's AIDS prevention efforts.

Let me share with you some World Health Organization data we have on some of the key measures of sexual behavior.

The first pertains to premarital sex. The proportion of young males age 15 to 24 reporting premarital sex declined from 60 percent in 1989 to 23 percent in 1995. For females, the decline was from 53 percent to 16 percent.

Now looking at all age groups, 41 percent of males had more than one sex partner in 1989. This declined to only 21 percent by 1995. For females, the decline was from 23 percent to 9 percent.

Now we can compare this with data on condom use. In 1995, about 6 percent of sexually active Ugandans used a condom with some regularity, according to the U.S.-funded Demographic and Health Survey. By 2000, this rose to 11 percent of sexually active Ugandans or 8 percent of all Ugandans. However, these low figures obscure the fact that condom use has become quite high among those who need them most, namely those relatively few who are still having multiple sexual partners. The ABC approach recognizes that some people cannot or will not avoid risky sex, or some are already infected, so they need to reduce their risk with condoms.

What prevention programs existed in the latter 1980's? There was a deliberate attempt to fight stigma and discrimination associated with AIDS and to generate open and candid discussion about the epidemic everywhere, down to the village level. It was AIDS

education in the primary schools. The faith-based organizations were involved from the beginning of the national response and they were particularly adept at promoting the abstinence and faithfulness message.

The AIDS message was not soft-petaled. People were made to fear HIV infection, but not fear people with AIDS. People were also told clearly what to do to avoid infection. The main lessons from Uganda are that, one, sexual behavior can change; two, a comprehensive program promoting abstinence, faithfulness and condom use for nonregular partners can be implemented and this may lead to higher levels of all three outcomes; three, AIDS prevention programs benefit greatly from top-level political commitment and involvement; four, condoms do play a role in risk reduction, but focusing exclusively on condom use is not a panacea for HIV prevention, especially in high prevalence, generalized epidemics such as find in Africa.

It may be noted that condom user rates in Uganda are now higher than those found in other countries, as we can see in the figure where Uganda stands out in its relatively low levels of multi-partner sex.

Some in the West have expressed skepticism about the ability of African women to abstain or be faithful since women are often thought to have little power to negotiate sex. Yet, look at the data we have. By 1995, a great majority of Ugandan women, 98.5 percent, were reporting either abstinence or no sex partner outside of their regular partners. Along with the ABC approach, the Ugandan government took various steps to raise the status of women. One measure of the success of these efforts comes from the Demographic and Health survey which asks women if they believe they have the power to refuse unwanted sex, or to insist upon condom use. Uganda ranked first among African nations.

AIDS prevention is largely a behavioral problem that requires a behavioral solution. I believe that AIDS prevention programs in Africa and the developing world generally have become too focused on medical technology and drugs, and not enough on behavior. Evidence from Uganda and some other countries show that when faced with a life-threatening danger, people can and will modify their behavior, once they're given the right information in the right way. Uganda's ABC approach, especially as it was implemented in the early years, that country's epidemic has proven to be an effective model that has worked in Africa and beyond. There are other countries that have implemented ABC approaches and they have also achieved measures of success: Senegal, Zambia, Jamaica and the Dominican Republic.

I see I'm out of time. I would ask that a paper that I co-authored published by USAID called "What Happened in Uganda" be placed in the record.

[The prepared statement of Edward C. Green follows:]

PREPARED STATEMENT OF EDWARD C. GREEN, SENIOR RESEARCH SCIENTIST,  
HARVARD CENTER FOR POPULATION AND DEVELOPMENT STUDIES

Thank you, Chairman Tauzin and distinguished members of the Health sub-committee. I am a senior research scientist at the Harvard School of Public Health. For most of my professional career, I have not been an academic. I have worked in less developed countries as a behavioral science researcher and as designer and

evaluator of public health programs. I have worked extensively in Africa and other resource-poor parts of the world. A good deal of my work has focused on reproductive health, some of this including the social marketing of condoms and oral contraceptives.

In view of all the sad news we hear about AIDS, especially in Africa, it is my pleasure to share some good news. There are several bright spots in the world when it comes to AIDS. The brightest spot of all may be Uganda, where infection rates have declined from 21% to 6% since 1991 [Fig. 1 and Fig. 2].

The Government of Uganda, led by President Museveni, developed a distinctive approach to AIDS prevention known as the ABC approach: Abstain, Be faithful, or use Condoms if A and B are not practiced. The abstinence message for the most part took the form of urging youth to *delay* having sex until they were older, and preferably married. Many of us in the AIDS and public health communities didn't believe that abstinence or delay, and faithfulness, were realistic goals. It now seems we were wrong.

Uganda's program began in 1986, the year President Museveni became head of state. Since the rate of new infections began to decline in the late 1980s, it becomes important to know what programs were in place in the latter 1980s and what behaviors changed, in order to account for the decline of infection rates. The standard programs we associate with AIDS prevention were not in place in the 1980s.

We now know that there were significant changes in sexual behavior between 1989 and 1995. And these were most pronounced among youth, the very age group primarily targeted in AIDS education. And the behaviors that changed the most were the ones emphasized in Uganda's AIDS prevention efforts.

Let me share with you some World Health Organization data we have on some key measures of sexual behavior.

The first pertains to premarital sex. The proportion of young males age 15-24 reporting premarital sex decreased from 60% in 1989 to 23% in 1995. For females, the decline was from 53% to 16%.

Next, looking at all age groups, 41% of males had more than one sex partner in 1989. This declined to only 21% by 1995. For females, the decline was from 23% to 9%. Furthermore, the proportion of males reporting three or more sex partners fell from 15% to 3% between 1989 and 1995.

Now we can compare this with data on condom use. In 1995, about 6% of sexually active Ugandans, used a condom with some regularity, according to the US-funded Demographic and Health Survey. By 2000, this rose to 11% of sexually active Ugandans, or 8% of all Ugandans. However these low figures obscure the fact that condom use has become quite high among those who need them most, namely those relatively few who are still having multiple partners. The ABC approach recognizes that some people cannot or will not avoid risky sex, and so they need reduce their risk with condoms.

What prevention programs existed in the latter 1980s? There was a deliberate attempt to fight stigma and discrimination associated with AIDS, and to generate open and candid discussion about the epidemic everywhere, down to the village level. There was AIDS education in the primary schools. The faith-based organizations were involved from the beginning of the national response and they were particularly adept at promoting abstinence and faithfulness.

The AIDS message was not soft-pedaled. People were made to fear HIV infection, but not to fear people with AIDS. People were also told clearly what to do to avoid infection.

The main lessons from Uganda are that: (1) sexual behavior can change; (2) a comprehensive program of promoting abstinence, faithfulness and condom use for nonregular partners can be implemented and this may lead to higher levels of all three outcomes; (3) AIDS prevention programs benefit greatly from top-level political commitment and involvement; (4) Condoms do play a role in risk reduction, but focusing exclusively on condom use is not a panacea for HIV prevention, especially in high prevalence, generalized epidemics as we find in Africa.

It may be noted that condom user rates in Uganda are not higher than those of other countries, as can be seen in Fig. 3.

#### CONDOM USE WITH LAST NON-REGULAR PARTNER

Where Uganda stands out is in its relatively low levels of multi-partner sex, as seen in Fig. 4.

These figures are from a USAID report of a September 2002 Technical Meeting on "The ABC's of HIV Prevention" (USAID 2002).

Some in the West have expressed skepticism about the ability of African women to abstain or be faithful, since women often have little power to negotiate sex. Yet

look at the data we have. By 1995, the great majority of Ugandan women, 98.5%, were reporting either abstinence or no sex partner outside their regular partners. Along with the ABC approach, the Ugandan government took various steps to raise the status of women. One measure of the success of these efforts comes from the Demographic and Health survey, which asks women if they believe they have the power to refuse unwanted sex, or insist upon condom use. Uganda ranked first among all African nations.

AIDS prevention is largely a behavioral problem that requires a behavioral solution. I believe that AIDS prevention programs in Africa and the developing world generally have become too focused on medical technology and drugs, and not enough on behavior. Evidence from Uganda and some other countries, show that when faced with a life-threatening danger, people can and will modify their behavior, once they are given the right information, in the right way. Uganda's ABC approach, especially as it was implemented in the early years of that country's epidemic, has proven to be an effective model that has worked in Africa and beyond. There are other countries that have implemented ABC approaches, and they have also achieved measures of success: Senegal, Zambia, Jamaica, and the Dominican Republic.

What are the implications for US policy, at least in Africa? It must be acknowledged that program emphasis on condom provision and promotion alone does not seem to have paid off. A 2003 UNAIDS review of condom effectiveness (Hearst and Chen 2003) concluded, "There are no definite examples yet of generalized epidemics that have been turned back by prevention programs based primarily on condom promotion." Correct and consistent condom use surely averts infections, but after many years of effort, most condom use in Africa remains inconsistent. In the words of the UNAIDS review, "There is little convincing evidence that inconsistent condom use provides any protection." In fact, the countries in Africa which have the highest levels of condom availability relative to male population (Zimbabwe, Botswana, South Africa, Kenya) have some of the highest HIV prevalence rates in the world.

Average number of condoms per male 15-49 in African countries for which data are available.  
Source: DKT

Country	Average annual condoms 1989-2000	males 15-59 (in thous.) 1995	Average annual condoms/male 15-59	HIV Prevalence (%)
Benin .....	4,065,408	1,263	3	2.45
Botswana .....	2,436,232	356	7	36
Cameroon .....	10,378,900	3,280	3	8
Ghana .....	9,901,068	4,424	2	3.6
Kenya .....	42,391,034	6,666	6	14
Senegal .....	5,513,517	2,091	3	1
South Africa .....	76,284,892	11,645	7	20
Tanzania .....	27,217,215	7,603	4	16
Uganda .....	16,702,846	4,740	4	6
Zambia .....	12,131,695	2,280	5	20
Zimbabwe .....	29,149,405	2,826	10	25

I am not saying that the two are causally connected, only that we probably need to be thinking of interventions in addition to condom social marketing, since we do not yet see national-level results in Africa. And I say this as someone who has worked in condom social marketing. Meanwhile, evidence is accumulating that reduction in numbers of sexual partners, which can result from abstinence and fidelity interventions, can reduce national HIV prevalence levels.

So this is not to argue against a continuing role for condoms. Rather it is to argue that the US should put some real efforts and resources into promoting balanced ABC programs, especially in generalized epidemics. Condoms in fact seem to have played a significant role in impacting national HIV infection rates in countries like Thailand, where infection are concentrated in high-risk groups. Yet even in Thailand, there was a significant decline in premarital and extramarital sex in the general male population shortly before Thailand's prevalence decline of the mid-1990s.

In sum, AIDS prevention works when done in the right way. I hope a substantial proportion of the new funds for AIDS will be allocated to effective prevention programs.

#### References:

Hearst, N., and S. Chen. (2003). Condoms for AIDS Prevention In The Developing World: a Review Of The Scientific Literature. Geneva: UNAIDS.

USAID (2002). The "ABCs" of HIV prevention: Report of a USAID technical meeting on behavior change approaches to primary prevention of HIV/AIDS. Washington, D.C.: "ABC" Experts Technical Meeting, September 17, 2002.

Mr. BILIRAKIS. Without objection. Thank you very much, Dr. Green. Thanks to all of you.

My emphasis on coordination efforts, I would ask you all to submit to us, this is your opportunity to be king, as we say, in other words, if I had my way type of thing, what you would do. In writing, advise on changes you think should be made and how things should take place, not only in coordination, but in general. We're an ivory tower here and my colleagues, I consider myself an exception. My colleagues are probably the most intelligent, hardest working people I've ever seen. There are exceptions to that too. But we don't—

Mr. BROWN. Mr. Chairman, you have some people in the back of the room from your District and I just want to tell them that you are one of the best Members of Congress.

Mr. BILIRAKIS. Quid pro quo, also up here, so he's got to expect a quid pro quo for the thank you, Mr. Brown.

But anyhow, let us know in writing, tell us what you think should be done. Some things are within the purview of the Congress, some things are within the purview of HHS, CDC, USAID, etcetera, etcetera. We can be influential as far as those areas are concerned. It may not just be legislation.

So I would appreciate that, the committee, I know would appreciate it. Mr. Brown would. As I said before, you are the troops. You are the firing line. You know these things.

Ms. Monico, the ABC program, the ABC concept was one that your country decided upon, is that right?

Ms. MONICO. Yes sir.

Mr. BILIRAKIS. It was not imposed upon you by the United States or any of the organizations?

Ms. MONICO. I think it was a concerted effort. When we started implementing programs in Uganda, we worked very closely with global AIDS participants and WHO, so it was a program that we discussed with WHO, but in implementing it it relied a lot on the Ugandan culture, on the community.

Mr. BILIRAKIS. And I think you all have testified to the success in Uganda. I'm not sure that Ms. Barry agrees how attributable it is to the ABC concept, but I think the rest of you, I don't know about Mr. Smith, I'm not sure he addressed it. I think he does too.

So we have a program which is working in Uganda. And we all agree that that may not work in every locale and we've said that right at the outset.

What role, Dr. Green, if you know, have faith-based groups and organized religion played in the success of the ABC program in Uganda and what role do you believe they should play in the United States global AIDS research.

Mr. EDWARD GREEN. Well, the faith-based organizations were involved in Uganda in AIDS prevention from the very beginning and when the first bilateral USAID program began, I think it was 1991, there were three major faith-based organizations. They were given subgrants through the USAID contractor and were involved in prevention and they—the FBOs, the faith-based organizations were particularly adept at—you might say they have a comparative ad-

vantage in promoting abstinence and faithfulness because this is what—and the three faith-based organizations, groups were Anglican, Catholic and Muslim and we have evaluation research showing that there was—that these organizations reached a lot of people at the grass roots level and there was measurable behavioral change. In fact, I could even cite some statistics of behavioral change that's of greater magnitude than what we have in the charts and it's in my testimony.

Mr. BILIRAKIS. So you would say that the ABC concept should continue to play a role in every instance or virtually every instance?

Mr. EDWARD GREEN. In Uganda or generally?

Mr. BILIRAKIS. Generally.

Mr. EDWARD GREEN. In general, I'd say that the ABC approach as it was implemented in Uganda, we have two basic types of epidemic patterns, concentrated and generalized and in Sub-Saharan Africa and the Caribbean we have generalized epidemics where HIV infection is found in the general population and I think the ABC approach is probably, at least the way it was implemented in Uganda is especially appropriate for Africa and the Caribbean, not that it wouldn't work elsewhere.

Mr. BILIRAKIS. We can spend a lot of time on that particular subject, but in the interest of time here, I'm not going to go any further. I'm going to yield to Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman. Mr. Smith, first thank you for your testimony and for your comments when we were talking in the front row before the testimony about tuberculosis and your support for what Ms. Wilson and I and Mr. Green and others are trying to do.

I don't disagree that abstinence has a place in reducing the rate of HIV/AIDS. I think that's pretty clear. And I certainly don't question what's worked in Uganda. I think you've all spoken and especially Ms. Monico, very articulately and passionately about that.

But I'm not at all convinced that a program that works in one country automatically works in another. I'd like you just to comment on the role, if you would, of abstinence and what's happened in Sierra Leone in terms of rape, in terms of the cases of young girls and Zimbabwe also who desperately want to go to school but can't afford school fees, exchange sex for money in order to go to school and there are cases of young girls and women who are starving and get food for themselves and their families in exchange for sex. I mean if you would respond to using ABC as a model when societies also have to deal with problems like that.

Mr. SMITH. Right. I think actually it's one of the advantages of ABC because it is compartmentalized and they can target where appropriate the use of barrier protection. It's in respect to broad populations when Dr. Green was talking about a generalized epidemic that abstinence and be faithful has their power, abstinence equates to a delay of sexual debut; be faithful equates to a reduction in the numbers of partners. And it's numbers of partners that fuel these STDs.

Regarding more of the exception and that's the case you're talking about where the sex trade or prostitution, the instances where young women, particularly, will sell sex to survive, that's where

you can have people who are very good at reaching these highly defined communities and target condoms, but on a broad scale, it's a different issue than what we're used to here when we talk about comprehensive sex. We think of talking about all these things together and that's really not what we saw when we were in Uganda.

I do know, I want to add one thing. Having gone to Mozambique, South Africa, Botswana where the prevalent message that we have funded and given is condoms, you know, it's not working. So we need to rethink our strategy and I'm not saying we need to impose ABC, but we really need to look at what has worked as well as what hasn't worked.

Mr. BROWN. I don't know that those are always exceptions, some of the things we both talked about, but I accept that. I think you had said in your testimony Uganda has done it their way. Other nations have done it our way. That's part of the point of why here the President's plan will go too much into a one size fits all, it's worked here, let's do it elsewhere. That to me is the attractiveness of the Global Fund. The Global Fund will in a sense contract with Bangladesh, with India, with Brazil, with Mexico, with Eritrea and work their programs through their NGO's or their—or any NGO that's endemic to that country and their health ministries, whatever.

Ms. Barry, I'd like to talk to you for a second about Russia. I'd like to ask you if ABC would work in Russia. Ms. Barry, just for disclosure reasons, is a friend of mine who, with whom I traveled to Siberia and to Moscow with last summer, who speaks fluent Russian, who is a nurse and who has seen this increase in Russia in TB and especially in—beginning in HIV.

Two questions for you. One, would ABC work in Russia and second, what would the Global Fund mean to Russia versus what you've seen with bilateral, particularly USAID activities in Moscow and both in European and Asia and Russia?

Ms. BARRY. As regards to the first question, would ABC work in Russia? The way that the epidemic is spreading in Russia and not just Russia, the entire former Soviet Union, no. Ninety-five percent of the cases of HIV right now that are being spread through IV drug use in Russia, so unfortunately, ABC would not help contain the epidemic in these countries and I just want to reiterate which has already been said today, but Ukraine and Russia right now have the fastest rising HIV rates in the world. And we're at probably 2 million cases in Russia right now. If we don't start containing it, we'll be close to 10 million in a few short years.

Mr. BILIRAKIS. And that is due principally to drug use?

Ms. BARRY. Yes. And we're starting to see the transmission in the heterosexual population as well and in that case, perhaps messages, the ABC message would help in some cases, but I think as I've said in my statement and as Chairman Bilirakis has pointed out, I don't think that we really can pinpoint that the ABC methodology is what has brought the transmission down in Uganda, but that's a different part.

Second part of the question, how the Global Fund would help—

Mr. BROWN. If I could interject one thing. As Ms. Barry talked about the fastest rising HIV/AIDS rates in the world are in Russia and Ukraine, those are also two countries with very, very high



multi-drug resistant TB and that's why Russia and Ukraine and India probably are the next real basket cases in the world that are going to be just devastated by these diseases. I'm sorry.

Ms. BARRY. Thank you for pointing that out and I just wish to say that I was here actually in Washington last week on the Hill and at the State Department and at USAID with three colleagues from Russia trying to talk about that very issue, that we have never seen rates of MDR-TB like we're seeing in Russia today and once HIV and MDR-TB hit there, we really don't know what to expect because we've never seen anything like it before.

As to USAID assistance in Russia, I had a pretty frank conversation with the State Department last week about what I thought of the programs that have been implemented there. I really think, unfortunately that we've frittered away millions and millions of dollars in health care in Russia on some programs that have really shown very little impact there.

To my knowledge, and we are not a USAID recipient so I don't know the inner workings of all the programs, but to my knowledge they've funded very, very little treatment of tuberculosis in Russia and where they have funded it, it has been clearly through other agencies, CDC being one of them. So I think that a Global Fund approach to Russia that would be based on an application that the Russians develop themselves would actually be a much more effective use of our money.

Mr. BROWN. Last follow-up real quick, Mr. Chairman, would that be mostly—would the Global Fund application—Russian applications to Global Fund would they be mostly NGO's or would they be mostly health ministries or obelisk ministries of health or regional kinds of governments?

Ms. BARRY. It depends on which disease you're talking about. I think if we're talking about tuberculosis, it would be much more ministerial, let alone on a local government level. If we're talking about HIV, the NGO's there in Russia have shown really good activity and positive activity in prevention activities, but if we're going to be talking about treatment, I would definitely also be through government entities.

Mr. BROWN. Thank you.

Mr. BILIRAKIS. Ms. DeGette?

Ms. DEGETTE. Thank you, Mr. Chairman. Ms.

Mukasa-Monico, I want to congratulate your country for the work they've done and I just have a couple of questions to ask you about how the ABC program has worked.

The first question is do you think the program would have been successful if you eliminated the C from the program or if you very tightly limited condom education say to bars and prostitutes?

Ms. MONICO. My quick response would be no, it would not. It takes a comprehensive package of prevention interventions to make it work. And when I hear the Russian story, I think if we talk about sexually transmissional HIV, there is no doubt that it has to be ABC.

Ms. DEGETTE. Let me ask you because I found your testimony intriguing that the faith-based organizations in your country were very effective at the A and B and then the condom education came in too. I'm wondering how that was structured, how Uganda struc-

tured both bringing in faith-based operations to talk about abstinence and about few partners and then how that worked with the condoms. Because I assume the faith-based organizations, most of them did not do the condom education.

Ms. MONICO. You're right. I'll give you an analogy of how we approached it. What we all realized was that it was impossible to change a 2,000 year legacy of what is happening over 17 years, so there was no way we wanted the charge to change their creed that actually you can abstain and you can be faithful and avoid HIV because you can, but at the same time, the charge realized that they cannot go on living in denial about the reality that the context in which we live actually demands that people protect themselves more than just being abstinent and being faithful.

So whereas they did not actually promote condoms, they would refer people to where they can get information about condoms and the condoms themselves. If you go back to what they are talking about, you would be shocked to find that they actually accept condom use within a family setting. You can use a condom if you are married. Just by the mere fact that they accept the use of a condom in a marriage, that shows that they also understand the context in which they are working with and the fact that having extramarital relationships is very possible and getting infected even higher.

Ms. DEGETTE. Dr. Green, do you think that the condom is an important component of the ABC program in Uganda?

Mr. EDWARD GREEN. Yes, I do and just to respond to your last question, the faith-based organizations at the outset said that they would promote the A and the B of the ABC. They didn't want to be forced to promote condoms and so there was at least with the USAID funding there was an agreement that they could do that, but USAID asked that the faith-based organizations not criticize condom use.

What all three faith-based organizations found when they got into AIDS prevention is that there were some people who were already infected or some who wouldn't change their behavior and they quietly promoted condoms to them.

Ms. DEGETTE. And Mr. Smith, I know in your testimony, in your summary points, you say that we should allow faith-based organizations to promote only A and B, without the threat of coercion to promote C and being an old civil libertarian I happen to agree that I don't think we should ever force a faith-based organization to promote something, but on the other hand, if we're spending Federal dollars to put AIDS programs like the ABC program in operation in other countries, I'm wondering what you think of all this. Do you think faith-based organizations should be able to just get Federal funding to do a slight component of it or how is that all going to work in your view.

Mr. SMITH. Sure and you can ask it the other way. If there are people who are really good at C, promoting C and targeting C, should they be able to get money just for that or do they also have to promote abstinence and be faithful.

Ms. DEGETTE. That's an excellent question. If you'd answer my first question.

Mr. SMITH. I'll be happy to.

Ms. DEGETTE. Then maybe we can get to that.

Mr. SMITH. I think that groups that are good at what they're good at and are known for ought to be allowed to do just that.

Ms. DEGETTE. See the problem I have is if what these folks are—I mean what virtually everyone is saying is the ABC program works, so my question is how is it going to work, especially if we're not doing it in a multilateral context to give money to someone just to do A and B?

Mr. SMITH. You've got 600 different AIDS groups in Uganda right now. Some are good at one aspect of this and some are good at another and they aren't all doing the same thing. The problem that you have in many of these countries, we just have people in our office from Nigeria, they can't get funding unless they say they're also going to promote condoms. Why do we put that kind of restriction on them if they aren't good at it and don't want to do it? Why should we make someone promote abstinence if they aren't good at it and don't want to do it.

Ms. DEGETTE. Thank you. Thank you, Mr. Smith.

Mr. BILIRAKIS. A good trial lawyer there. She knows when to quit.

Ms. Barry, as I understand it, the Global Fund would not approve your project in Haiti in the first try, is that right?

Ms. BARRY. No sir, they were approved in the first round.

Mr. BILIRAKIS. They were approved in the first round? Okay. Well, I wanted you not to explain verbally, but in writing why because I wanted to know maybe what kind of problems might exist there.

All right, so it was approved in the first round. That being the case, I'm just going to ask all four of you to first of all, I've already asked all of you to further show us in writing in your own words suggestions, ideas and things of that nature that we might take into consideration here to and to maybe use them in this battle in this fight. But additionally, your willingness to respond to any questions that we might have of you as time goes on in writing and hopefully respond to them in a prompt manner.

Having said that, I want to again thank you on behalf of Mr. Brown, myself and all of the subcommittee and thank you, particularly for your patience and your understanding as a result of the delays we had this morning.

Thank you very much.

[Whereupon, at 1:55 p.m., the hearing was concluded.]

[Additional material submitted for the record follows:]

THE ALAN GUTTMACHER INSTITUTE  
March 20, 2003

The Honorable W.J. "BILLY" TAUZIN, *Chairman*  
*Committee on Energy and Commerce*  
*House of Representatives*  
2125 Rayburn House Office Building  
Washington, DC 20515

DEAR MR. CHAIRMAN, on behalf of The Alan Guttmacher Institute (AGI), a not-for-profit corporation that conducts research, policy analysis and public education on matters related to sexual and reproductive health, I appreciate the opportunity to submit written testimony for the official record of the March 20, 2003 full committee hearing on global HIV/AIDS programs, and specifically on the importance of maintaining a comprehensive approach to HIV/AIDS prevention.

Uganda's experience with sharply declining HIV prevalence rates in the 1990s has drawn worldwide attention as public health experts seek to understand what accounted for Uganda's success and whether that success can be replicated elsewhere. There is both much information and much misinformation about 1) what behavior changes took place in that country during the period and 2) the nature of the government HIV prevention program that was, and is, in place there.

With regard to behavior changes, a detailed analysis conducted by AGI in 2002 found that reductions in the risk of exposure to HIV in Uganda during the 1990s resulted from *all three* of the following behaviors: delayed sexual initiation among young people (increased abstinence), reductions in the number of individuals' sexual partners (increased monogamy) *and* safer sex practices (increased condom use among people engaging in sexual intercourse). Indeed, increased abstinence by itself may have made the smallest contribution to reduced HIV prevalence; condom use and reductions in the number of people's sexual partners both increased substantially more than did the proportion of young people abstaining from sex.

With regard to the nature of the Ugandan government's HIV prevention program, it is worth remembering that to whatever extent that program (among the myriad other societal factors also at play during the period) was responsible for the observed behavior changes, *including the increase in abstinence*, the program was an "ABC" program ("*abstinence, be faithful, and use condoms*"), which employed a comprehensive, not an "abstinence-only" approach.

I am submitting a copy of AGI's detailed analysis "The Role of Behavior Change in the Decline of HIV Prevalence in Uganda," ([http://www.guttmacher.org/media/uganda\\_memo02.pdf](http://www.guttmacher.org/media/uganda_memo02.pdf)) along with an article from AGI's *The Guttmacher Report on Public Policy* entitled "Flexible but Comprehensive: Developing Country HIV Prevention Efforts Show Promise," (<http://www.guttmacher.org/pubs/journals/gr050401.html>), which places the data in a policy context.

In conclusion, Mr. Chairman, there is nothing in the Uganda experience that justifies an "abstinence-only" approach to HIV prevention, nor is there reason to believe that such an approach would be any more successful than a "condom-only" approach would be. Rather, common sense and responsible public health practice would dictate an approach that ensures people's access to full and accurate information on *all* the ways to reduce exposure to HIV, one that at a minimum, does not disparage any of the available HIV prevention strategies in its zeal to promote another.

Sincerely yours,

CORY L. RICHARDS, *Senior Vice President*  
*Vice President for Public Policy*

GLOBAL HEALTH COUNCIL  
*April 23, 2003*

The Honorable MICHAEL BILIRAKIS  
*Chairman, Subcommittee on Health*  
*Committee on Energy and Commerce*  
*US House of Representatives*  
*Washington, DC 20515*

DEAR MR. CHAIRMAN; Thank you very much for the opportunity to elaborate further on my testimony before your Subcommittee. At this critical time in the development of the US government response to the global AIDS pandemic, I am pleased to offer my views on how the US government could expand its support for programs that seek to halt the spread of the global AIDS pandemic.

#### THE NEED FOR A COMPREHENSIVE APPROACH TO THE GLOBAL AIDS PANDEMIC

The Global Health Council supports the critical evidence-based strategies that have worked in Uganda and Thailand, and have been endorsed in USAID documents,<sup>1</sup> by UNAIDS, WHO and other organizations<sup>2</sup>. These strategies are comprehensive and recognize the synergism between prevention and care and support. They go well beyond the currently popular "ABC" approach—"abstain, be faithful, and use condoms." While these three elements are clearly important, the evidence base supports the need for much broader prevention efforts accompanied by caring for those already affected with dignity and compassion. Treatment and prevention

<sup>1</sup> e.g., Lamptey, P. Zeitz, P and Larivee, C. (eds.) *Strategies for an Expanded and Comprehensive Response to a National HIV/AIDS Epidemic, A Handbook for Designing and Implementing HIV/AIDS programs*, Family Health International, 2001.

<sup>2</sup> Op cit. 1

of opportunistic infections extend the healthy lives of persons living with HIV and AIDS, increase their economic and social productivity and allow PLWHA to participate more fully in prevention efforts. As rapidly as treatment can become more widely available, voluntary counseling and testing will become less stigmatized, more widely used and more meaningful as a prevention strategy. Furthermore, antiretroviral therapy is expected to reduce viral load, which will decrease the likelihood of transmission and slow the epidemic.

The ABC approach fails to recognize that marriage, rather than being a protective state, is in itself the most significant HIV risk factor for many women<sup>3</sup>. Most would agree that married women are not free to abstain from sex. HIV is spreading most rapidly among adolescent girls ages 15-19 and abstinence-only programs offer no alternative for the majority of sexually active adolescent women in developing countries who are already married.<sup>4</sup>

The ABC approach focuses entirely on changing the behavior of individuals. Behavior change strategies must be supported by policies and programs that protect individuals from non-sexual transmission. These include:

- condom availability, including attention to universal access and cost;
- prevention of mother to child transmission (MTCT);
- sexually transmitted disease management and treatment, including adequate drug supply;
- voluntary counseling and testing (VCT) practices that assure privacy and confidentiality, which lead to early diagnosis of HIV infection and act as an entry point for prevention programs based on behavior change and prompt individuals to seek care;
- blood safety; and
- safe injection and harm reduction for IV drug users.

Prevention and treatment serve overlapping but not identical goals. For this reason no nation's health policy strictly enforces trade offs between prevention and care. Prevention and care efforts are not simply additive as each strategy increases the impact on the other through synergistic effects. Outcomes are therefore, not linear. Further, prevention and treatment involve different sectors and constituencies. It is therefore advisable to invest in both simultaneously to achieve more than would be accomplished by investing in either alone.

We also recommend that when allocating funds for prevention efforts, Congress encourage strategic planning, decentralization and autonomy to allow local development and implementation of culturally appropriate and equitable programs and services. Imposing restrictions on funds is contrary to the principles of ownership and political engagement that are necessary to successful prevention efforts.

Care and treatment programs must include the prevention and treatment of sexually transmitted infections and opportunistic infections as well as treatment with anti-retrovirals. But, these prevention, care and treatment programs will not be enough alone to halt the pandemic. We must also provide funding to support the development of support systems for those infected and affected by the HIV/AIDS pandemic to ensure on-going systemic assistance after one has been diagnosed as positive. This support system should include:

- psychosocial support;
- on-going issue specific counseling;
- programs that provide education about HIV/AIDS in order to address stigma and discrimination issues; and
- social welfare support for the affected families.

#### FURTHER DISCUSSION OF THE SUCCESS IN UGANDA

I would like to expand upon my testimony and talk about my personal impressions of what worked in Uganda. Success was achieved in Uganda because there was strong leadership from the President. But, strong support from the President was not enough—he worked very closely and diligently with the resilient citizenry of Uganda as a whole. We were openly cognizant of the enormous fatal danger that we were confronting and regardless of who we were—we acknowledged that we must work together to address this risk. We adopted new strategies that had never been tried before and we tried to creatively develop programs that would fit our culture and situation. Over time, it was determined that some strategies were appropriate while others were found not to work and we did not continue them. But, most importantly, the community developed and owned the process of building a strong

<sup>3</sup>S. Clark, Early Marriage and HIV Risks in Sub-Saharan Africa, University of Chicago, 2003 draft report cited with permission

<sup>4</sup>UNAIDS, 2002.

prevention, care and treatment program. Early in the process, we realized that we needed outside donor support for these activities and countries, such as the United States joined our efforts. Most importantly, they built capacity within the country to support the effort but they did not run the programs for us.

Uganda like all other countries with HIV infections is implementing a comprehensive package of services. Overall, strategies in Uganda<sup>5</sup> were implemented in the context of:

- strong political will and leadership, emphasizing a “matter-of-fact” approach to condom use and VCT, and constant media attention to these issues;
- the involvement of government and other stakeholders from outside government including community organizations and business in a social mobilization movement;
- open and candid discussion of HIV and AIDS, sexual behavior and personal risk;
- relevant and sensitive transformation of values and behavior change that emphasized not judging or stigmatizing those living with AIDS;
- strong educational programs for in and out-of-school youth and adults promoting AIDS awareness and safe sexual practices as “patriotic duty;”
- broad decentralization and community mobilization involving and caring for persons living with HIV and AIDS;
- strong emphasis on the empowerment of women and girls to engage in decision-making and policy formation;
- comprehensive counseling to reinforce prevention strategies for those who tested negative as well as those who are positive; “post-test clubs” provide long term support for sustained behavior change;
- reduction in the number of non-regular partners and significantly increased condom use with non-regular partners and among high risk groups; and
- use of innovative behavior change strategies including drama, music, and involvement of popular public figures to demystify the disease and reduce stigma and discrimination against HIV positive persons.

Our experience in Uganda strongly suggests that successful prevention efforts are based on comprehensive behavior change strategies that address stigma, promote open dialogue and accurate assessment of personal risk. These should be led and supported by high level political commitment and diverse community participation in prevention and care and support efforts. Mother to child prevention programs were critical to our success but it must be recognized that even with confidential testing and treatment, women fail to access this safe and effective treatment due to stigma and fear of exposing their HIV status to a partner. Providers were forced to implement this program in a sensitive manner as they anticipate that women may face personal risk of violence and ostracism when their HIV positive status is determined and providers must deal with these risks in a sensitive and protective manner.

Unlike the experience of Uganda, most countries have not been able to attain the ideal HIV/AIDS response because of discrimination, stigmatization of high-risk groups and denial by the community that there is a problem. In addition, the access to support services is limited and systems are not in place to support voluntary counseling and testing programs, which are the entry point for behavior change programs as well as services that provide care and treatment. Finally, budgetary constraints have led countries to make the hard choice between investment in prevention interventions and care and support, especially ARVs.

#### ADDITIONAL RESOURCES REQUIRED

There is wide global recognition that AIDS spending in low and middle income countries needs to increase. We are very encouraged by President Bush’s call for \$15 billion over the next five years and look forward to working with Congress and the Administration to make this pledge a reality. Other studies have examined this issue more specifically and have found that in order to contain and ultimately reverse the broadening HIV pandemic, efforts must be expanded as quickly as possible. A recent mathematical modeling exercise jointly published by UNAIDS, WHO and the CDC<sup>6</sup> illustrates the impact of scaling up prevention, care and support efforts, and contrasts the effect of doing so earlier as opposed to later. With global expansion of the strategies that led to the successes achieved in Uganda and Thai-

<sup>5</sup>Hogle, J., (ed) What Happened in Uganda, Declining HIV prevalence, behavior change and the National Response, USAID, 2002.

<sup>6</sup>Stover, J, Walker, N, Garnett, GP, Salomon, JA, Steneck, K, Dhys, P, Crassly, N, Anderson RM, and Schwartzlander, B. Can we reverse the HIV/AIDS pandemic with an expanded response? *The Lancet*, 2002: 360: 73-77.

land, 29 million new HIV infections could be averted by 2010. A delay of three years in full implementation of these strategies will reduce this number by half. Fifteen million lives hang in the balance between an ambitious but feasible program to assault the virus and a delayed response.

The key to a successful US government program to address the global AIDS pandemic is that it must be comprehensive. Just like combination therapy has been proven to be the solution to HIV treatment, so too combination prevention is the key to stopping the spread of HIV. There is no one size fits all solution. The US government was one of the first industrialized countries to recognize the scope of this pandemic and responded effectively. It is critical that we continue these efforts by empowering communities to determine the most culturally appropriate solutions for themselves.

Thank you again for this opportunity to expand upon my testimony and I am happy to answer any additional questions at your convenience.

Sincerely,

SOPHIA MUKASA MONICO, *Senior AIDS Program Officer*  
*Global Health Council*

---

INSTITUTE FOR YOUTH DEVELOPMENT  
*April 14, 2003*

The Honorable MICHAEL BILIRAKIS  
*Chairman, Subcommittee on Health*  
*Committee on Energy and Commerce*  
*U.S. House of Representatives*  
*2125 Rayburn House Office Building*  
*Washington, DC 20151*

DEAR CHAIRMAN BILIRAKIS, in response to your letter requesting what we feel are key elements of a successful HIV prevention model, I will be brief and to the point. The biggest predictor of a sexually transmitted disease is number of lifetime partners. The greatest influence on that is age of sexual debut. The younger an individual has sexual relations, the more likely they are to have a large number of lifetime partners. Delaying sexual debut becomes of primary importance to any prevention campaign.

This means the promotion of abstinence. It should be promoted in a way that says it is the only way to avoid risk, and there should not be an option for risk reduction for young people. We offer no options for reduction with alcohol, drugs, tobacco, and violence for youth. The message is unequivocal, "do not participate in this behavior." We need to be consistent with sexual activity as well.

In respect to limiting partners, the second message as seen in the Uganda ABC model is "be faithful." We must let people know that the more partners they have the more risk they entail. The goal for everyone should be one lifetime sexual partner, period. Lastly, we should discontinue any broad social marketing of condoms. There is no instance in any country we have studied where the broad social marketing of condoms has reduced infection rates. If anything, there seems to be a correlation with increased infection rates with increased broad social marketing of condoms.

We need to be very targeted in any promotion of a risk reduction or harm reduction message. People in discordant relationships where one is positive and one is negative, should not first be offered condoms. They should first be offered the opportunity not to infect the other individual by avoiding intimate sexual activity where body fluids are exchanged. Condoms should be the last resort not a first offer in these circumstances. Targeting those who have multiple partners with condoms may make a small difference in an HIV epidemic, but we need to recognize that they should be targeted to very limited high-risk populations.

In respect to disbursing funds, the United States has an incredible infrastructure in all the countries we visited in Africa to adequately distribute both treatment and prevention dollars. We have not been impressed by some of the maneuverings regarding the Global Fund. We should continue to give resources to the Global Fund, but with the condition that it prove itself effective before we give any increases at all. The United States needs to direct the President's international effort, and if done properly we can make a significant difference in the world, and ultimately will receive recognition for doing so.

Lastly, we have visited those parts of Africa that have promoted condoms broadly. They have increasing HIV infection rates. We have also visited Uganda that has a declining HIV infection rate, which heavily promotes "Abstinence" and "Be Faithful." In one area young people all too frequently will have dramatically shortened

lives, and in the other there is increasing hope among youth for brighter futures. The differences are striking. We need to take note and we need to take action.

Thank you, again, for the opportunity to testify before your committee, and to respond to your questions.

Sincerely,

SHEPHERD SMITH  
*President*

PARTNERS IN HEALTH  
*April 3, 2003*

Mr. Michael Bilirakis, *Chairman*  
*Subcommittee on Health*  
*Committee on Energy and Commerce*  
*2269 Rayburn House Office Building*  
*U.S. House of Representatives*  
*Washington D.C., 20515-6115*

DEAR CHAIRMAN BILIRAKIS, Thank you for the opportunity to testify before the Subcommittee on Health on March 20 during the hearing on HIV/AIDS, TB and Malaria: Combating a Global Pandemic. I very much appreciated the chance to present our views on how best to allocate the funds for the new initiative. Per your request, please find below written recommendations based on my testimony and on some issues that were raised during the hearing, to which there was no time to respond orally. These views reflect the position of Partners In Health, the organization for which I work, based on our deep commitment to providing health services to persons living in resource-poor settings.

- At least 1 billion dollars should be allocated to the Global Fund to Fight AIDS, TB and Malaria (GFATM). The GFATM is the only organization in the world with the ability to fund the large-scale prevention and treatment programs which are currently needed. These programs should include both non-governmental organizations and government entities, as the extensive networks that are needed to reach all persons at-risk or already infected with these diseases can only be expanded through both private and public facilities.
- We must address HIV and TB in those countries with the highest HIV and TB rates, included in the fourteen countries mentioned in the President's initiative. However, we must not neglect those countries where the next epicenter of TB and HIV will be, including Russia, India and China. If we do, in 5-10 years they will find themselves with infection levels similar to those currently seen in the highest-burden countries.
- As I mentioned during my testimony, the U.S. Centers for Disease Control and Prevention (CDC) have extensive national and international experience in preventing and treating HIV/AIDS, TB and Malaria. The Committee should directly fund the CDC for their international work in TB, rather than channeling the money through the U.S. Agency for International Development (USAID) which adds an extra layer of bureaucracy, thus decreasing the amount of funds available for implementation of actual projects. In addition, USAID projects have not made much progress in controlling any of these diseases over the past 20 years; in this time of limited resources, we must find the most efficacious means for treating and preventing these diseases.
- During the hearing we had very little time to respond to the other presenters' testimonies and I would like to share PIH's views on the Uganda experience.
  - First, while there is no question that Uganda has achieved success in decreasing the prevalence of HIV/AIDS, unfortunately, the statistics that were presented in the charts and written testimony of Dr. Green and Mr. Smith do not show a decrease country-wide (they only show data from 9 urban sights, while 87% of the population live in rural areas). In addition, the 9 sights were antenatal clinics which do not reflect the prevalence in the wider population. In fact, data from antenatal clinics can be very biased and not indicative of the status of the rest of the population.
  - Second, a decrease in prevalence which was shown in the charts does not necessarily reflect a decrease in incidence (new cases). As other African countries are not showing such declines, Uganda must be doing something correct, but the data presented does not explain what that is. This leads to my final point;
  - As I alluded to during my comments, I am very concerned about expanding the ABC model too widely in other countries. The success of the Ugandan experience cannot be attributed to one factor. There were several factors at play during the decrease in Ugandan prevalence rates, including strong govern-



ment commitment, large amounts of foreign aid, raising the status of women, relative political stability, extensive private and public networks involved in prevention efforts, and all three parts of the ABC model. To date, no data has been presented that shows that any one of these factors was more important than the others.

- The ABC model will have little impact in countries where the HIV/AIDS epidemic is being spread through intravenous drug use, such as many countries of the former Soviet Union where HIV/AIDS infection is rising faster than anywhere else in the world.
- During Mr. Allen's testimony and the question/answer session with him, he avoided directly answering how the 2 billion dollars President Bush promised for treatment would be used. He vaguely responded that much of the funding would be channeled through antenatal clinics in the fourteen countries. I am very concerned with this lack of clarity and the suggestion, that by treatment, the Administration will only be spending the funds on preventing maternal-child transmission, rather than beginning life-long treatment for men and non-pregnant women. If the Administration is allowed to substitute preventing transmission to infants, a laudable goal in and of itself, but a very narrow definition of treatment, in an age where 40 million persons are infected with the disease, this would be a serious misuse of funds. I respectfully request that this issue be pursued more intensively by your Subcommittee.
- Finally, we can no longer approach these complicated diseases with simple, one-step solutions. Each disease requires developing the health infrastructure and training local health professionals, as well as providing adequate funding for both prevention and treatment. Once these infrastructures have been strengthened, they will be able to provide services for other serious health problems that many of the countries are facing.

Thank you once again for allowing me to testify and provide you with written recommendations. Please contact me for further clarification.

Sincerely,

DONNA J. BARRY, *N.P. M.P.H., Russia Project Director  
Partners In Health Program in Infectious Disease  
and Social Change, Harvard Medical School*

cc: Ranking Member Sherrod Brown

April 2, 2003

MICHAEL BILIRAKIS  
Subcommittee on Health  
2125 Rayburn bldg.  
Washington DC 20515

DEAR CHAIRMAN BILIRAKIS: Thank you for the opportunity to testify before the Health Sub-committee on March 20. I'm writing in response to your request that those who testified write to you with some suggestions about how the President's Initiative can have the most impact in combating AIDS.

My comments are limited to AIDS prevention rather than treatment. We will save many more lives through prevention than through high-cost programs of treating those already infected.

As I showed in my example of Uganda-and many others agreed with my assessment, including at least one congresswoman-the integrated ABC approach seems to be a good model for combating AIDS in "generalized" epidemics. Another person who testified objected that the ABC approach would have little impact in Russia. This is true, since Russia's epidemic is almost entirely driven by injection drug use. But this is a red herring. The new money for AIDS is going to the generalized epidemics of Africa and the Caribbean, and not to the "concentrated" epidemics of Russia or Ukraine. There is every reason to believe that the ABC approach is suitable for the countries where the new money is in fact going. We see ABC interventions as well as stabilization or reduction of national HIV prevalence not only in Uganda but also in Senegal, Jamaica, and the Dominican Republic, as well as in certain populations in Zambia and Ethiopia.

There is a new global policy at USAID called the ABC policy. To ensure that this policy is implemented, it may be useful or necessary to have some oversight over funds allocated to AIDS prevention. I'm not sure how the CDC sees the new ABC policy. Nor am I sure where the oversight should be coordinated, or exactly who should do it. All I am certain of is that business-as-usual AIDS prevention has had little impact to date, especially in the areas targeted by the president's initiative. Therefore we need to do prevention differently.

I am more than willing to discuss this matter with you or anyone else on your committee or sub-committee, at any time. I would be happy to provide more evidence as well.

Sincerely yours,

EDWARD C GREEN, PHD, *Senior Research Scientist*  
*Harvard Center for Population and Development Studies*

HUMAN RIGHTS WATCH  
March 27, 2003

The Honorable W.J. "BILLY" TAUZIN, *Chairman*  
*Committee on Energy and Commerce*  
*House of Representatives*  
*2125 Rayburn House Office Building*  
*Washington, D.C. 20515*

DEAR MR. CHAIRMAN, I write on behalf of the HIV/AIDS and Human Rights Program of Human Rights Watch to submit testimony for the official record of the March 20, 2003 hearing of the Subcommittee on Health of the Committee on Energy and Commerce, "HIV/AIDS, TB, and Malaria: Combating a Global Pandemic."

Human Rights Watch writes to caution that any failure to provide complete and accurate information about HIV/AIDS prevention to young people, including information about condom use to prevent HIV transmission, violates their rights to information and to the highest attainable standard of health, and may have fatal consequences for them. We would like to emphasize as well that addressing inequalities that put women and girls at added risk of infection from HIV/AIDS must also be an important part of U.S.-funded prevention efforts.

#### PROTECTING THE RIGHT TO INFORMATION ABOUT HIV/AIDS PREVENTION

According to a U.N. study released last July, most of the world's young people have "no idea how HIV/AIDS is transmitted or how to protect themselves from the disease."<sup>1</sup> A recent study of HIV/AIDS education in schools suggests an explanation for such widespread ignorance: many teachers censor information they provide about HIV prevention, omitting information about the role of sex in HIV transmission and about condoms as a means to prevent transmission.<sup>2</sup> In combating HIV/AIDS in the United States and abroad, the U.S. government should make sure that U.S.-funded HIV/AIDS prevention efforts protect the right of all people to the knowledge as well as the skills and services necessary to protect themselves from HIV.

Claude Allen, Deputy Secretary of the Department of Health and Human Services, has characterized the "ABC" educational strategy for HIV/AIDS as follows: "The "A" is for abstinence in young people, the "B" is for being faithful in a mutually monogamous relationship, and the "C" is for condom use in high-risk populations with the knowledge that condoms are highly effective in preventing HIV infection and gonorrhea in men, but not as effective with all sexually transmitted diseases."<sup>3</sup>

Targeting abstinence messages at young people and limiting information about condom use to "high-risk" populations (which we take to mean high-risk persons other than the general population of young people) is at odds with the recommendations of the Centers for Disease Control and Prevention and the National Institutes of Health, and of every major American medical professional association (including the American Medical Association, the American Pediatric Association, the American College of Obstetrics and Gynecologists, the American Public Health Association, the American Psychological Association). All of these groups have endorsed comprehensive sex education programs for young people, including information about the use of condoms to prevent HIV.

Of particular concern is that if Mr. Allen's vision of this strategy is pursued, the "ABC" approach to HIV/AIDS prevention will, in the case of young people, amount to an "abstinence-only" strategy similar to that endorsed by the Bush Administration for domestic AIDS prevention programs. The evidence is clear that comprehensive sex and HIV/AIDS education programs and condom availability programs can be effective in reducing high-risk sexual behaviors. There is, however, no reliable

<sup>1</sup> UNICEF, UNAIDS & World Health Organization, *Young People and HIV/AIDS: Opportunity in Crisis* (2002), p. 13.

<sup>2</sup> Actionaid, *The Sound of Silence: Difficulties in Communicating on HIV/AIDS in Schools* (2003).

<sup>3</sup> Statement of Deputy Secretary Claude Allen before the Subcommittee on Health, Committee on Energy and Commerce, March 20, 2003.

evidence to date supporting abstinence-only programs. For these reasons, the Institute of Medicine has expressed its concern that “investing hundreds of millions of dollars of federal and state funds...in abstinence-only programs with no evidence of effectiveness constitutes poor fiscal and health policy,” and recommended that “Congress, as well as other federal, state and local policymakers, eliminate requirements that public funds be used for abstinence-only education, and that states and local school districts implement and continue to support age-appropriate comprehensive sex education and condom availability programs in schools.”<sup>4</sup>

In many parts of the world, the engine of the epidemic is the subordination of women and girls, which has particularly lethal consequences in a world of HIV/AIDS. Regardless of cultural norms about virginity and marriage, many women and girls are unable to negotiate safer sex, or refuse unwanted sex; and, if they refuse or resist sex, may be physically harmed or shunned from the household, thus risking impoverishment. In this context, it is all the more important to provide girls with complete information about HIV/AIDS prevention, including condom use, while also addressing the underlying gender inequalities that undermine women’s and girls’ control over their sexual lives within and outside of marriage. (Obviously many other measures are needed in addition to education and information programs to ensure basic protections for women and girls from sexual violence and abuse.)<sup>5</sup>

Failure to teach about means of HIV prevention other than abstinence endangers young people who are sexually active and limits potentially life-saving information to all. Depriving young people of life-saving information about HIV prevention violates their right to information<sup>6</sup> and their right to the highest attainable standard of health<sup>7</sup> and places them at needless risk of HIV infection and premature death from AIDS.

A copy of Human Rights Watch research on federally funded abstinence-only-until-marriage programs in Texas, which documents how these programs censor or distort lifesaving HIV prevention, is attached to this testimony.<sup>8</sup>

In conclusion, we believe it important that the government of the United States make explicit, concrete commitments to protecting the right to complete and accurate information about HIV/AIDS in the programs it supports both in the U.S. and overseas. These programs should include information for young people and adults on the use of condoms for HIV prevention (A, B and C). Efforts to combat the subordination of women and girls and to protecting them from sexual violence, abuse and coercion should also be a central part of U.S.-supported efforts to fight HIV/AIDS.

Sincerely,

JOANNE CSETE, *Director*

*HIV/AIDS and Human Rights Program, Human Rights Watch*

cc: Michael Bilirakis, Chairman, Subcommittee on Health

<sup>4</sup>Committee on HIV Prevention Strategies in the United States, Institute of Medicine, *No Time to Lose: Getting More from HIV Prevention* (Washington, D.C.: National Academy Press, 2001), pp. 118-20.

<sup>5</sup>See Human Rights Watch, *Suffering in Silence: The Links Between Human Rights Abuses and HIV Transmission to Girls in Zambia* (2003) (<http://www.hrw.org/reports/2003/zambia/>); Human Rights Watch, *The War Within The War: Sexual Violence Against Women and Girls in Eastern Congo* (2002) (<http://www.hrw.org/reports/2002/drc/>).

<sup>6</sup>Everyone, including children, has the right to “seek, receive and impart information of all kinds.” See International Covenant on Civil and Political Rights (ICCPR), art. 19, and the Convention on the Rights of the Child (CRC), art. 13.

<sup>7</sup>All individuals have the right to enjoy the highest attainable standard of health, a right guaranteed by the International Covenant on Economic, Social and Cultural Rights, art. 12; the CRC, art. 24; and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), art. 12. According to the Committee on Economic, Social and Cultural Rights, the right to the enjoyment of the highest attainable standard of health includes the right to information and education concerning prevailing health problems, their prevention and their control. See Committee on Economic, Social and Cultural Rights, *General Comment 14. The Right to the Highest Attainable Standard of Health*, paras. 12(b), 16 and note 8.

<sup>8</sup>Human Rights Watch, *Ignorance Only: HIV/AIDS, Human Rights and Federally Funded Abstinence-Only Programs in the United States* (September 2002) (<http://hrw.org/reports/2002/usa0902/>).