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A MORAL IMPERATIVE: LEADER FRIST'S REPORT ON THE HIV/AIDS CODEL TO AFRICA

JOINT HEARING

BEFORE THE

SUBCOMMITTEE ON CHILDREN AND FAMILIES

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

AND THE

SUBCOMMITTEE ON AFRICAN AFFAIRS

OF THE

COMMITTEE ON FOREIGN RELATIONS

UNITED STATES SENATE

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

ON

A REPORT FROM SENATOR FRIST RELATIVE TO THE HIV/AIDS CODEL TO AFRICA

October 30, 2003

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C O N T E N T S

STATEMENTS

OCTOBER 30, 2003

A MORAL IMPERATIVE: LEADER FRIST'S REPORT ON THE HIV/AIDS CODEL TO AFRICA

THURSDAY, OCTOBER 30, 2003

U.S. SENATE,
SUBCOMMITTEE ON CHILDREN AND FAMILIES, OF THE
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
AND THE SUBCOMMITTEE ON AFRICAN AFFAIRS, OF THE
COMMITTEE ON FOREIGN RELATIONS,
Washington, DC.

The subcommittees met jointly, pursuant to notice, at 3:04 p.m., in room SD–430, Dirksen Senate Office Building, Senator Lamar Alexander (chairman of the subcommittee on Children and Families) presiding.

Present: Senators Alexander, Enzi, Warner, Sessions, DeWine, Coleman, and Frist.

OPENING STATEMENT OF SENATOR ALEXANDER

Senator ALEXANDER. The joint meeting of the Subcommittee on African Affairs and the Subcommittee on Children and Families will come to order. Good afternoon, and welcome to my colleagues and all those in the audience and those who may be watching on C-SPAN.

This is a joint meeting of two of our subcommittees for the sole purpose of letting Majority Leader, Dr. Bill Frist, report on a mission that he led to Africa in late August which focused on HIV/AIDS. Five other Senators, including those who are here in the room, had the privilege of accompanying Dr. Frist. He is a little bit unusual. He is not only a doctor, he has educated the Senate and this country on the importance of the AIDS epidemic. So it was a remarkable experience for all of us.

This meeting of our two subcommittees kicks off, or it begins what we hope will be a series of hearings that focuses on the President's commitment and the Senate and the House's commitment to work on this AIDS epidemic. I believe Ambassador Tobias is in the audience—is he here?—the President's global AIDS advisor. At least he is expected. We welcome him and look forward to working with him.

We will go no later than 4 o'clock. In the interest of time and because we want to hear from Dr. Frist, I will forego an opening statement. We will listen to his presentation and after he is through we will simply go around the table and ask questions. This is more in the nature of a meeting than a hearing. We appreciate your time at this busy season of the Senate and look forward to your report. Our Majority Leader, Senator Frist.

Senator FRIST. Mr. Chairman, thank you, to my colleagues, welcome. Last month I had the privilege of traveling to the southern African nations of South Africa, Mozambique——

Senator ALEXANDER. Is your microphone on?

REPORT OF SENATOR FRIST

Senator FRIST. Last month I had the opportunity to travel to the South African nations which are depicted on the map behind me. That is South Africa, Mozambique, Botswana, and Namibia, with the Senators who are at the table today, notably, Senator John Warner, Senator Mike DeWine, Senator Mike Enzi, Senator Lamar Alexander, and Senator Norm Coleman, and also Dr. Joe O'Neill, deputy coordinator of the global HIV/AIDS office. I have had the wonderful opportunity to have visited Africa many, many times in the past so it was a real privilege for me to be able to join my colleagues as we explored together a part of Africa hat I had not traveled to before.

As with my previous trips, I was struck by the optimism, by the perseverance, by the courage of the people that we had the opportunity to meet with, as well as their warmth, their compassion, their generosity, and their hospitality.

Now the purpose of this delegation going to Africa was unique in many ways in that we had a very specific focus. That focus was to determine how best the United States can coordinate with others in this country and indeed around the world to address the global HIV/AIDS pandemic, which many of you have heard me describe as being the greatest humanitarian moral and public health challenge of the last 100 years. Our team, as you will see, had a productive trip. We met with doctors, patients, nurses, community leaders, government officials, and activists, all of whom are doing the very best they possibly can to fight this pandemic, and thereby bring hope and relief to millions of people.

There is no part of world that has been more greatly affected by HIV/AIDS than the part of the world that we visited and that is southern Africa. Graca Machel, the truly remarkable First Lady of Mozambique, told us very directly that because of HIV/AIDS, "We are facing extinction." We still face the worst of the epidemic, she told us. Let me repeat that. She said, "we are facing extinction." That is her evaluation and that is the challenge that is before us.

I would like to organize my comments, not as a travelogue as we go through, but really in lessons that we as a group took away and lessons learned.

Lesson number one, an effective, comprehensive response to HIV/AIDS requires the strong and the dedicated commitment of the national leaders. It has to start at the very, very top or no matter how much money you spend, how much money you invest, without that commitment at the top you simply, I believe, are not going to have the impact that we know that we can have. We met with the African leaders. We saw what an effective, comprehensive response to HIV/AIDS can result in if you have that national leadership. The leadership commitment has to start at the top with the leader of that country and then extend vertically all the way down to community leaders, all the way down to that local tribal leader.

In South Africa, we met with the leaders in the local community who had been struggling with the political leaders in that country over the development of the appropriate treatment plans. I will come back to treatment here shortly. Treatment plans developed at the community level would save thousands of lives, but the people at the very top had not yet fully bought into the national commitment for treatment.

Now that is changing. It was changing about the time that we were there, but until recently, very recently, the political leadership had failed at the top to adequately, I believe, address the reality of the virus. I believe it played a role in the fact that there are 5 million people in South Africa today who are infected with the HIV virus that causes AIDS. A virus for which there is no cure.

In sharp contrast to that, in Gabarone, Botswana we met with President Festus Mogae, who in an effort to reduce the stigma and encourage nationwide testing, stood up and on television announced his HIV test results before the people of Botswana. Such unambiguous messages to the people have an impact.

We have learned that. Again it is important because with every national leader that we see, not just in Africa but all around the world, we must look that leader in the eye and ask, what is your commitment, and encourage them to make that commitment. As a result, in Botswana we saw notable progress in fighting the pandemic, and in bringing understanding and security and the hope that we all know is so important.

Lesson two, prevention, care and treatment. Those are the three building blocks, and people in public health understand that. But what is new is that the prevention and care must be linked to treatment. In HIV/AIDS, up until really pretty recently people said, no, we can leave the treatment off and let us just look at prevention and care. As you look at prevention, care and treatment, treatment must be preceded by testing so that the diagnosis can be made.

What is not so intuitive, I think, is that testing, getting the test itself and knowing the results is the cornerstone of prevention. So if you just do prevention it is insufficient to have an impact unless you have a very strong testing program. The testing only takes 15 minutes. I say this as somebody who has been involved in public health and somebody who is a physician. The testing process gives what we refer to as a teachable moment that otherwise you just do not have. It is called a teachable moment because you have that 15 minutes that the test is taking place, that time where trust can be established, and in that teachable moment you have the opportunity to open people's eyes to the facts and to the hope of being able to address this disease.

Now I say that because, and most people do not know this, in the world today of every 10 people who have the HIV virus, nine do not know it. So for every 10 people in this room today only one of those 10—assuming they were all infected, only one would know that they had HIV/AIDS. Now if you do not know you have it, you have the potential for spreading it and you are less invested in educating your own family or the people around you.

In Kasane, Botswana we had the opportunity to look at these wonderful centers, Voluntary Counseling and Testing or "VCT" cen-

ters. In Kasane, Botswana and Namaacha, Mozambique we saw how using two simple tests a person could be tested in 15 minutes while receiving counseling on how to avoid coming into contact with HIV/AIDS, and, if you happen to test HIV positive, how to prevent spreading that virus to others.

The VCT test period takes overall typically one hour, about 15 minutes on the test and the rest in counseling. You get the results of the test and then you go through further counseling. A person is encouraged to share that information with other people. If you test positive at that sitting, you can go into care, peer groups, and treatment if it is available. And if you are negative, through that teachable moment, you can learn how to educate your family and other people in your neighborhoods. Also it helps destigmatize. I will come to the stigma component in just a bit. This process is called VCT, voluntary counseling and testing.

Lesson number three, we need to develop the medical infrastructure. This is very important, because there is this perception that if we just put money into buying drugs that we are going to be able to treat people with HIV/AIDS, prevent HIV/AIDS, or cure HIV/AIDS. What is obvious when you are in Africa, is that it is important to have that infrastructure itself to deliver treatment.

President Bush's emergency plan for global HIV/AIDS calls for 2 million people to be on treatment by the year 2008. It is an ambitious goal, but we can meet that ambitious goal if we focus on ensuring that every taxpayer dollar that we invest, and we must be practical because we are talking about a total of $15 billion, we need to make sure it is invested wisely and at the appropriate time.

The single largest challenge, perhaps, to meeting the HIV/AIDS crisis in Africa through prevention, care and treatment is to develop this infrastructure to make sure that whatever is provided actually works. Medications must be stored properly and delivered properly. The infrastructure is necessary so that the patient can receive medical care over time. You need more than a diagnostic kit. You need more than medicines on the shelf. You need ways to deliver these drugs in a way that we know will be effective. The distribution, the storage, and ways to administer them.

One message we heard again and again is the need for expertise and training. That is a way the United States can specifically help. In Botswana, Vice President Seretse Ian Khama and Minister of Health Lesego Motsumi stressed that their first priority is the recruiting and the retaining of qualified medical staff. All of our delegation will remember the images of the overworked staff who were dedicated and hard-working, but tired. You could see on their haggard faces their commitment. At the Chris Hani Baragwanath Hospital in Soweto, South Africa, my colleagues will remember the exhaustion on the faces of the staff as they stood into their busy HIV/AIDS ward with things coming and going and people being treated.

We listened to the nurses, the doctors, and the social workers, of the desperate need for more and better trained social workers, for counselors to teach how to avoid and to cope with HIV infection, for technicians who are experts in the storage and disposal of medical waste, and for administrative staff. The United States can play

a tremendous role in providing that medical expertise and in helping to create peer training.

Lesson number four, we must provide care for the dying—the care component of care and treatment—and support for the living. Palliative care is an issue that came up often. What is palliative care? The Health Resources and Services Administration, HRSA, defines palliative care as patient and family-centered care that strives to optimize quality of life by anticipating, preventing, and treating suffering. Focusing on the continuum of illness, this care addresses not only the patient's physical needs, but also intellectual, emotional, social, and spiritual needs.

So we asked, why is palliative care so important? It is important because HIV is a chronic disease that is fatal over time. It is a deadly illness that extracts not just a physical toll but also a spiritual toll, a psychological toll, on those people who are affected. And not just the people affected, AIDS impacts the families around them. As a physician I can tell you that HIV takes a toll, as I implied earlier, on health care workers as well. We have got to keep that morale up for health care workers or they will not stay in this palliative framework. We have got to keep the morale of the patient up, of the health care providers up, of the caregivers up, of the family up, of the loved ones. All of this will strengthen the health care system as a whole.

Orphans. It is an issue that we have addressed in this very room in the past. Senator Jesse Helms really focused on the issue. He was almost the first to do so in our Government, and he made this link between HIV/AIDS and orphans. Graca Machel, who I referred to earlier, told our delegation of meeting an 83-year-old grandfather in Uganda. I remember it so vividly when she said it. This 83-year-old grandfather had two wives, one 73 years of age, one 76 years of age. They were taking care of 30 grandchildren under the same roof because all eight of their children had died, had passed away leaving 30 grandchildren. So caring for children left behind by AIDS is and must be a critical challenge in our response to HIV/AIDS.

In South Africa we visited the Salvation Army's Carl Sithole Center. The center cares for 120 abused and 36 abandoned HIV orphans, has a school right there that teaches 225 children. The center is divided into Zodwa House for young children ages two through eight, and Bethany House for older children ages 8 to 18. The Carl Sithole Center accepted its first HIV positive child in 1993. That child's name was Copso which is the Sotho word for day of peace. Copso died at 4 years of age. Twenty-seven children have been buried in the memory garden of the last 10 years. Of the 128 children living in Bethany House, a third, one out of three, are HIV positive, and all, every one of the younger children at the Zodwa House are HIV positive.

Windhoek, Namibia. We visited the Bernard Noordkamp Center run by the Catholic Church. It provides care and nutritional support and counseling to hundreds of orphaned children.

Lesson number five, we must develop an approach to the AIDS crisis that is comprehensive and creative. There is no cure. We do not have that answer yet, and thus we need to develop more, not

just comprehensive but innovative ways to respond to this pandemic.

In South Africa we met with Dr. Fareed Abdullah, an exceptional health care professional with the vision to imagine a plan to bring universal treatment to those infected with HIV in the Western Cape area. Now this is almost an overwhelming task as you listen to him paint this picture, considering the Cape can expect a substantial health care burden within 7 years with an estimated 300,000 HIV-positive persons just living in this area of the Western Cape. Dr. Abdullah stressed that the AIDS pandemic has got to be tackled head-on and that nobody should view HIV/AIDS as a problem separated from traditional health care. He said we have got to make a virtue out of necessity. We can strengthen the failing health care system to fight HIV/AIDS only if we can think creatively and innovatively in terms of the approach. Otherwise it is simply overwhelming. We have got to find ways to leverage our ability to treat not just HIV/AIDS but HIV/AIDS within the overall health challenges a system must deal with.

Senator ALEXANDER. Excuse me, Senator. We have a vote that started at 3:16. I would assume that we could leave now and come back, or we could go another three or 4 minutes and come back.

Senator FRIST. What time is it right now?

Senator ALEXANDER. It says 25 after.

Senator FRIST. We have got to vote within 20 minutes.

Senator ALEXANDER. I thought you might want to be there.

Senator FRIST. How far are we into the vote?

Senator ALEXANDER. We are at 10 minutes into the vote.

Senator FRIST. Why don't I go for about three more minutes and then we will take a break.

Senator ALEXANDER. Then will you have time to come back for questions?

Senator FRIST. Absolutely. I just wanted to mention that HIV/AIDS affects the immune system of the body. We have this little virus, only 20 years old, that has killed 23 million people. When I was a resident in 1982 we had never heard of this virus. So it is a new virus that is having this impact. What it does, it knocks down your overall immune system and makes you susceptible to all sorts of other infections. That is why you cannot just treat the virus itself. You have got to have an overall infrastructure, a health care system and a systematic, a comprehensive approach to be able to treat all those infections and not just the little virus itself.

That brings me to one final point, because by having something that makes you susceptible to other infections you need to consider water. There are about one billion people in the world today who do not have access to clean water. If it is not clean water, it can carry bacteria and viruses.

Over 495 million people live in sub-Saharan Africa who do not have access to clean water today. As a result, 35,000 people die every day. Ten thousand people are children who die each day from waterborne diseases. Ten million children die in developing countries before their fifth birthday, many in the first year of life. From all things that people die of, 75 percent of the children are dying of infections of some sort, respiratory infections, diarrhea, malaria,

measles, and malnutrition, or a combination of these conditions related to waterborne illnesses. Many of these deaths can be prevented by basic sanitation, hygiene, and access to clean drinking water.

With that, Mr. Chairman, I think that is a good place to take a break and then we can slip back in. Is that appropriate?

Senator ALEXANDER. Thank you, Senator Frist. The Committee will take a brief recess. We should be able to be back and resume with Senator Frist's comments and then our questions after that.

[Recess.]

Senator ALEXANDER. I think we should go ahead and take advantage of your time, Bill. What I failed to mention in the introduction of the Leader is that he also was the chairman of the African Affairs Subcommittee for a good while, so we especially welcome him for that reason.

Mr. Leader, please continue.

Senator FRIST. Thank you, Mr. Chairman. We left a few minutes ago talking about this relationship between water and waterborne illnesses and HIV/AIDS. The reason this is so important, as we learned while we were in Africa, is it shows that it is more than just anti-retroviral drugs that you need for this pandemic to be reversed. As important as that anti-retroviral drug might be, that you need to have a comprehensive approach. One of the ways you can do that is to make sure that people do have access to clean potable water.

In Mozambique we visited a project to bring clean water to the citizens of Tshalala which is funded by a U.S. nonprofit called Living Water International, which is part of the Millennium Water Alliance. Living Water teaches people how to drill wells to the depth of about 30 meters and equips people with the tools and the knowledge to repair that equipment and to maintain it over time. At the same time, they provide instruction and training on sanitation and hygiene, and the people who learn these skills and techniques can teach them to other people.

In Tshalala we saw a well with a simple hand pump that provides an estimated 300 to 400 people with adequate drinking and bathing water. The cost is about $2,800. The average cost of such a well in Mozambique is about $2,500. If you divide that out it comes down to about $8 per person. Using that $8 per person we can prevent, through clean drinking and bathing water, a number of otherwise life-threatening diseases, and provide a savings for overworked, underfunded national health systems through preventive care.

Lesson six, partnerships. Partnerships, partnerships, partnerships. Partnerships between government which we represent, NGOs that are so critical on the ground. Partnerships with the academies or universities of the world. Partnerships with private sector companies. Partnerships with pharmaceutical companies. Partnerships with faith-based initiatives. The only way, I believe, and I think that we all learned, to meet the immediate so-called capacity needs is to build these strong and effective partnerships. No one group can do it alone.

In Botswana we visited the appropriately named Masa, and that means "new dawn," Clinic. Masa is funded by the African Com-

prehensive HIV/AIDS program, ACHAP. You will see ACHAP a lot, ACHAP also supports the Coping Centers for People Living With HIV/AIDS as well as the Botswana Christian AIDS Intervention program. ACHAP is a unique partnership sponsored—again, partnerships—by the Bill and Melinda Gates Foundation, the Merck Pharmaceutical Company and the government of Botswana. A remarkable program launched in July 2000, now about 3 years ago, ACHAP provides free anti-retroviral treatment, counseling, care—prevention, care and treatment for 600 Africans.

What is fascinating to me as a physician is that patients in the Masa program have a compliance rate of around 90 to 100 percent in following the prescribed drug regimen. Again this is important because in Africa you have heard it said, people are not going to comply. I can tell you that is higher than most every western country. The western country average is probably about 20 percent less than that in terms of compliance.

In South Africa we also visited a company called Anglo-Gold Mining. The Anglo-Gold Mining's anti-retroviral treatment program was established to bring anti-retroviral treatment to HIV-infected employees. The natural question is, how many employees is that? In this huge, huge country it is estimated that about one out of three employees are HIV positive, one out of three.

In Rehoboth, Namibia we visited St. Mary's Hospital which is preventing new infections through President Bush's initiative. It was wonderful for our delegation to see these initiatives on the ground playing out in action. This initiative is the prevention of mother-to-child transmission program. It uses nevirapine, an inexpensive drug, which using a single dose, has a huge impact. But it was great to see that program on the ground implementing President Bush's initiative.

Lesson seven, we have got to reach people where they live. Most Africans live outside of the urban areas. They do not have access to hospitals, clinics, or health care facilities. We saw a lot of creative responses to the problem.

In Carletonville, South Africa we saw mobile clinics. The mobile clinics are vans which have trained personnel and medical equipment. They go out into the bush throughout that region in Africa and bring basic care to treat persons in these communities that are a long way from the nearest health care facility.

In Kasane, Botswana we saw a mobile rapid testing lab which travels through the Kasane region. That is in the north part of Botswana. By closing the gap between people and health care providers we are able to strengthen the capacity to deliver health care to cope with HIV/AIDS. It provides that structure through which HIV/AIDS can be adequately, appropriately, and effectively addressed.

Lesson eight, we must take steps to reduce the stigma—I mentioned the stigma earlier of HIV—through all sorts of means. Through messages, through communication tools. We know which communication tools work today. Let me just say up front, stigma is a universal barrier. The stigma of HIV/AIDS is prevalent in this country today. This is a universal challenge that we have. As we look to reach out to people, remember nine out of 10 people in the world who are HIV positive do not know they are positive. Why? Much of it has to do with the stigma.

Because of stigma and the fear of discrimination, African women told us again and again, they are afraid of getting tested out of the fear of retribution. From who? The person next to them, their husband. Some men are afraid to be tested out of fear of being shunned by who? People who they work with, or shunned by their neighbors. Stigma, obviously makes people reluctant to come forward for testing. It makes people reluctant even to talk about the HIV/AIDS virus. In this country it is the same thing. How many parents really sit down and talk to their children today about HIV/AIDS? So it is a universal challenge that we have.

I mentioned earlier the importance of political leaders. Political leaders need to get out front on the issue. Obviously President Bush has done that in a bold, creative way. He stood up before the American people and, indeed, the world community saying that this is something that we as leaders in this country must and will address.

You can eliminate or reduce stigma by giving the appropriate message. In Mozambique, again former First Lady Graca Machel told us of the difficulty in addressing HIV/AIDS. She has a foundation set up to address this called Foundation for Community Development. She told us how her foundation works with faith-based organizations to reduce that stigma of HIV/AIDS. She said that one of the more effective ways that she found was to use individual Bible verses to connect with people, church-going, faithful people, spiritual people. By using these Bible verses, FDC was able to connect in a unique way and reduce that sense of what she described as shame. Again, it is a technique which she says is working well.

She also reminded us of the importance of creating tactical ads to appeal to men very specifically on the dangers of sexual promiscuity. She shared her thoughts as well on the multiple media sources, the use of radio and billboards and hotlines, all of which she has incorporated into her program. The knowledge of HIV/AIDS and all the science that we have and the ability to help does little good unless we can get it out to people around the world so that they hear it and so that they understand it.

One of the more meaningful interactions we had was with the traditional healers. You know I am a doctor and I am trained in western medicine. I do heart transplants and heart and lung surgery. All that is good, but the people who are trusted in communities on the ground throughout Africa and other parts of the world are the traditional healers. They are the people who are the leaders in the community. They are the people who are actually trusted. In Botswana we were informed that as much as 85 percent of the population will visit those traditional healers, the spiritualist, the herbalist, the diviners, and other practitioners of traditional medicine. In Mozambique we met with traditional healers from 10 different villages. They are trusted local healers and that is to whom people turn for treatment, for counseling. What was exciting to us is that these traditional healers are reaching out to know more about that little tiny virus that has killed 23 million people. That linkage with those traditional healers I am very excited about, especially with those healers reaching out for an understanding of this virus, because it comes down to trust, and that is the way to best destigmatize this virus.

Over the long-term we have got to work toward developing guidelines for medical personnel to make HIV a more routine part of health testing. Last week, I was very pleased to see that President Mogae of Botswana announced a new government policy on routine HIV testing in Botswana.

Let me go through one more lesson, Lesson nine. We have got to envision a future without HIV/AIDS. Remember, this little tiny virus was not known in this country until about 1983, and again, I had the opportunity of training at some very good hospitals in the United States of America with the very best of what we have to offer. We had no idea that this little virus existed and we had not defined it until between 1981 and 1983.

Twenty-three million people have died. Forty million people are infected now. Again, this is around the world. It is likely another 60 million people are going to die unless we act, act as a Nation and as a global community. But we need to envision this future without AIDS. It is overwhelming what is happening. Even if we get the disease under control we have got to think ahead right now, and it is not just vaccine development to imagine a world without HIV/AIDS. In all the countries that we traveled, in each of these countries we were met with a lot of hope and optimism about the future. It was expressed in many ways, hope that we would have better trade agreements to empower people, to empower their economies, hope for a more prosperous life. People with HIV/AIDS or with infected family members, hope for a more prosperous life with their families. In spite of the impact of this terrible and devastating disease, Africans are very hopeful and truly believe in the future. We have a moral obligation to stand by them and to maximize their opportunity for growth and for that posterity.

Mr. Chairman, let me just close, and thank the ambassadors from the United States of America and their staff because they really made it possible to open up their countries for our delegation to visit over this period of time. Ambassador Cameron Hume in South Africa, Deputy Chief of Mission Dennis Hankins in Mozambique, Ambassador Joe Huggins in Botswana, and Ambassador Kevin McGuire in Namibia. They gave us outstanding support and assistance by opening up their homes to our delegation, working overtime to make our trip successful, and for that we are grateful. They are a real credit to the State Department and the United States, and they represent, as we had the opportunity to see on the ground, the American people admirably.

Thank you, Mr. Chairman. That is a quick overview in terms of a fascinating trip. There is so much more to talk about, but I did want to stress these nine lessons so that we can all best figure out how to address this largest and most significant humanitarian challenge of our times.

Senator ALEXANDER. Thank you, Senator Frist. On behalf of all of us I would like to thank you and your staff for that presentation, and for putting together such an effective trip. I rarely spent 10 or 11 days so efficiently and learning as much as we did.

We have a little time. We probably need to end this about 5 after 4:00 because of the Republican Conference, but let us see if we can each get in a question. I will ask one, and then go to Senator Warner, and Senator DeWine, Senator Enzi, Senator Coleman.

You mentioned political leadership at the beginning of your talk, and we saw examples of impressive political leadership in the four countries we visited. We have talked about a lot of problems, but we also saw a lot of good government, and of course in South Africa we saw a political miracle, which is what has happened there in the last 10 years. The surprise of the trip probably was the exchange you had, and others of us had, with some of the political leadership in South Africa which had been slow to respond to the AIDS epidemic. Do you have any reflections on that and have you seen any changes in that since the time we were there?

Senator FRIST. Thank you, Mr. Chairman. What was remarkable was the juxtaposition of leadership that was in the process of changing plus leadership that had already changed at the highest level. South Africa, for the last 5 years—and let me say there have been dramatic changes in the last 3 months, dramatic changes—but for the last several years there has been denial and there have been reasons given in terms of what HIV/AIDS was caused by. With that denial there was not a walking away but a lack of recognition. Unless you say that there is a problem, you are not going to be able to move in with prevention, care and treatment. That has changed, and it has changed at the highest level, with the President of that country. So I am a little hesitant to be critical of the past because I am so delighted to see a huge change there and by the Minister of Health.

Then we saw countries like Botswana where the leadership was out getting that test, saying to the people all across the country that this is a problem and you can see that I am going to be on the forefront to reverse this. Otherwise, we will face the inevitable course of a worsening pandemic.

Senator ALEXANDER. Senator Warner.

Senator WARNER. Thank you, Mr. Chairman. First, I commend you for having this meeting because in my 25 years in the Senate I have been on a fair share of CODELs, and they are misunderstood. It is part of the continuing educational process of the Senate to go out and visit the countries abroad and to come back, as we are doing, and share with our colleagues and others our own observations.

But first, Mr. Leader, a little observation here. You overlooked something that is very important in this report, and that is reference to the fact that each of you brought your wives and they were an integral part, seriously, of this CODEL. They were able to interrelate with others, and particularly some of the females that we met I think in a way that none of us could have done so. So I would hope that you would revise these remarks to include reference to that.

Senator ALEXANDER. Yes, sir, sure will.

Senator WARNER. On another matter, I felt that—and I have talked to the military leaders in my capacity as Chairman of the Armed Services Committee in the various countries, and I was shocked to learn how AIDS is affecting their ability to conscript and train adequate forces to maintain the political stability as well as the strategic stability of these countries emerging from colonialism and fighting the struggle to become independent and strong nations.

For example, the UN is raising peacekeepers to go into a number of areas. There are about 6 areas where there is open warfare in the African continent today. They go to the various nations and ask for several battalions, and when those nations put the battalions together they have to strip out significant numbers of the trained soldiers because they have HIV, because they do not want to send an HIV to another nation. Often it is difficult to raise the number of troops that they need.

I saw that—as you know, I left you for a day or two to go to Liberia, where at that time our forces had intervened and were continuing to intervene to maintain peace and stability, and they did it in a very successful way thus far in Liberia. There is a nation that is utterly devastated by 12 years of civil war. Superimposed on that are the horrors of the AIDS epidemic.

So I am delighted that you took the initiative that you included all of us, and we commend you.

Senator FRIST. Mr. Chairman, let me jump in real quick because I think that Senator Warner really pointed out the pervasive effect that HIV/AIDS has in the most productive years of a population. When you go to parts of Africa you see very young children running around, and then you see people much older, and whether it is a teacher, military personnel, leaders in civil society, people are losing the people in the most productive years of their lives because of this virus.

Senator ALEXANDER. I think we ought to also add that in the few minutes that Senator Frist allowed us to have free time, Senator Warner often took the Marines who were stationed out to dinner, which impressed me.

Senator DeWine.

Senator DEWINE. Mr. Leader, thank you for leading that trip. It was an excellent trip and a great educational experience for all of us.

Your presentation, I think, outlined a lot of what we learned and outlined many of the challenges that we face and these countries face. It seems to me that we have a long-term challenge and a short-term challenge. The short-term challenge that we have and these countries face is to deal with the crisis as quickly as we can. We are in the process of appropriating money. The first question is how do we get this money out quickly to save as many lives as we can? The second question is, as you have pointed out, we have got a health infrastructure challenge, a medical infrastructure you call it, which is a long-term problem, and how do we deal with that?

I wonder if you could reflect on both the short-term challenge that we face; how do we make sure those dollars are spent correctly to save as many lives as quickly as we can? But also the long-term challenge—the 2-, 3-, 4-, 5-years and beyond—of how we help them with their health infrastructure which in the long run will also save, we hope, hundreds of thousands, maybe millions of lives?

Senator FRIST. Thank you. I think that is a good way to dissect the problem because if you have a dollar to invest, you have to decide how to invest that dollar so that it will have the greatest impact. You cannot think just short-term, because you could take not just $15 billion over 5 years, which is huge, you could take hun-

dreds of billions of dollars, and if you did not invest it wisely, it would be not wasted, but it would not have anywhere near the potential impact.

So challenge number one, short term we need to identify programs that work because there are things that we know work in terms of prevention, care and treatment. We do have a 20-year history. We have places like Uganda and we need to replicate the programs that are developed there, namely, what I talked about, VCT, voluntary counseling and testing. It is a model. They had a curve like the curves in Southern Africa, where things are getting worse, and they now have reversed that curve in Uganda. It is going down. Thus, we need to do what they did.

Chairman Warner is exactly right. The effective use of our time is to go through and see firsthand what works based on models that work, and that is where we need to be investing our money in the short term, not just taking a dollar and spending it by giving it to a group that is not proven. There are unlimited groups who want money. Having Dr. O'Neill with us, who represented the administration, allowed him to see some of those programs.

Longer term, and the continuum itself, we need to even jump further ahead than was in your question because we do not have a cure. This little virus is a cagey virus. It moves about 100,000 times faster than most other viruses. If you develop something we think is going to cure it, it just changes face and becomes something else. We have to figure that out. That means the science in this country must improve, taking the smartest people in the United States of America and around the world, and investing part of that dollar there because no matter how much we do in prevention and care, if you cannot cure it long-term, you are not going to be able to eradicate this virus. We can do it. As you know, smallpox has been eradicated. That killed about 340 million people. So I would jump even further ahead.

That is the spectrum itself, programs we know work all the way to finding an actual cure. In that we are going to have to make decisions throughout, and I am confident we can do that by having the sort of experiences that we all shared together 2 months ago.

Senator ALEXANDER. We have two more questions. We have a vote with 11 minutes left. That ought to wrap things up neatly. Senator Enzi.

Senator ENZI. Mr. Chairman, I thank you for holding this. I think this itself is an unusual event for one of the trips to pull back together to discuss some of the information that was on it. I thank the Chairman for doing it. It was just an incredible cultural shock for me to go over there. Mozambique has 11 different languages and then each tribe has their own dialect of that, and we wonder how do you communicate under these circumstances? None of them own a TV because they are too poor to own a TV. They would be lucky if they owned a radio. They do not subscribe to a newspaper because you are not going to print a newspaper for a couple of hundred people. So just getting the message out is difficult. I had never appreciated the possibility of the prevention of mother-to-child transmission, which is one of the real hopes that I saw out of the trip. For $2.50 the mother gets a dosage of a drug she takes when she goes into labor. The child gets a liquid dose right after birth.

It prevents 95 percent of the mother-to-child transmission. Of course they have to have that testing that you talked about to be able to do that.

But even more basic than that was that water problem that you showed on your slides. Mozambique hopes that some day everybody will be within 5 miles of water, and in that they are counting ponds that they wash their clothes in, swim in and have their animals drink out of. For $6 million we could solve a water problem over there.

Did we include in anything that we are doing financially—in other words, money that could be utilized to help out on that water problem, which is such a basic thing?

Senator FRIST. The water issue is just fascinating in terms of the prevention of disease by a very small investment over time. I hope it is part of the comprehensive program that the President is developing with Mr. Tobias, who we will have the opportunity to meet with later today. But that planning is under way and that comprehensive approach, not just of getting a medicine, anti-retroviral therapy, but the comprehensive approach indeed should be part of the President's initiative for combating and reversing this pandemic.

Senator ALEXANDER. Senator Coleman.

Senator COLEMAN. Thank you, Mr. Chairman. Mr. Chairman, thank you for pulling this hearing together. It has just been absolutely fascinating. Mr. Leader, I really think we are blessed to have your leadership at this time in this body with your understanding of this issue that is just taking so many lives it is almost mind boggling. But you give us hope by your passion and your commitment.

One of the things I notice about hope—and it was the difference between the doctors at the Krishani facility in South Africa where at that time there were 5 million people HIV positive, 20,000 being treated, I think they just got a letter that said they could do some treatment, but they were tired, their eyes were tired. They were treating people, they were dealing with people who were going to die and there was no treatment. I contrasted that with the look on the face of the healers at the Masa ARV facility in Botswana, who were treating people, and they were lined up, and the backlog was actually in processing some of the testing. I am a passionate believer in treatment, in terms of extending lives, keeping moms alive so that people are not orphaned for many, many years, and what it does to the healers to keep the system going.

Is there a way to set up measurables? Can we go back with the money we have to go back and say, okay, you have been treating this many folks now. We expect over a certain period of time to try to have some standards by which we can measure the kind of growth and the impact because we know how important it is.

Senator FRIST. The measures are critical. Again, if we had the answers now in terms of a cure, it probably would not be as important because basically once you have the medicines all the way to the delivery point, and you knew they were going to have an impact, that the virus was going to go away, then it probably would be less important. The problem is we are in the learning curve. I mentioned Uganda, Senegal. These are the great success stories that we have and we can replicate today.

What the President's initiative does is set out in very specific terms both numbers and accountable measures throughout the program to make sure that the money that is invested, huge sums, unprecedented sums in the history of any nation on earth today, has its outcome measured along the way. So that if we invest two billion dollars this year and a little bit more that next year, a little bit more that next year, we would be able to invest that incremental amount in the most useful way based on what we are learning right now in the program, as has been done in Uganda.

One of the beautiful things about this very targeted initiative, is that instead of saying we are going to throw money at the problem, it is being done in a way that is organized, that is disciplined, that has quantifiable measures in terms of outcome, both in terms of quality as well as quantity as we go forward. That is what I am most excited about, and again, that is why it is important that as we recognize that it is not just the amount of money which is what a lot of people around the country measure. It is also about ensuring that that money is invested wisely in programs that work.

Senator ALEXANDER. Senator Frist, thank you for your leadership. Thank you for your presentation.

These two Subcommittees representing the Health, Education, Labor, and Pensions Committee and the Foreign Relations Committee will continue to meet together. We look forward to hearing from Ambassador Tobias on his plan for the $15 billion that the President has recommended and that the Congress has said it will spend, and we invite you to any of those hearings that you have time to attend. Thank you very much.

The Committee meeting is adjourned.

[Whereupon, at 4:10 p.m., the Joint Committee was adjourned.]

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