HIV PREVENTION: HOW EFFECTIVE IS THE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF [PEPFAR]

HEARING

BEFORE THE

SUBCOMMITTEE ON NATIONAL SECURITY, EMERGING THREATS, AND INTERNATIONAL RELATIONS

OF THE

COMMITTEE ON GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

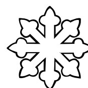
ONE HUNDRED NINTH CONGRESS

SECOND SESSION

SEPTEMBER 6, 2006

Serial No. 109–239

Printed for the use of the Committee on Government Reform



Available via the World Wide Web: http://www.gpoaccess.gov/congress/index.html
http://www.house.gov/reform

U.S. GOVERNMENT PRINTING OFFICE

35–621 PDF WASHINGTON : 2007

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: 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 GOVERNMENT REFORM

TOM DAVIS, Virginia, *Chairman*

CHRISTOPHER SHAYS, Connecticut
DAN BURTON, Indiana
ILEANA ROS-LEHTINEN, Florida
JOHN M. MCHUGH, New York
JOHN L. MICA, Florida
GIL GUTKNECHT, Minnesota
MARK E. SOUDER, Indiana
STEVEN C. LATOURETTE, Ohio
TODD RUSSELL PLATTS, Pennsylvania
CHRIS CANNON, Utah
JOHN J. DUNCAN, JR., Tennessee
CANDICE S. MILLER, Michigan
MICHAEL R. TURNER, Ohio
DARRELL E. ISSA, California
JON C. PORTER, Nevada
KENNY MARCHANT, Texas
LYNN A. WESTMORELAND, Georgia
PATRICK T. MCHENRY, North Carolina
CHARLES W. DENT, Pennsylvania
VIRGINIA FOXX, North Carolina
JEAN SCHMIDT, Ohio
BRIAN P. BILBRAY, California

HENRY A. WAXMAN, California
TOM LANTOS, California
MAJOR R. OWENS, New York
EDOLPHUS TOWNS, New York
PAUL E. KANJORSKI, Pennsylvania
CAROLYN B. MALONEY, New York
ELIJAH E. CUMMINGS, Maryland
DENNIS J. KUCINICH, Ohio
DANNY K. DAVIS, Illinois
WM. LACY CLAY, Missouri
DIANE E. WATSON, California
STEPHEN F. LYNCH, Massachusetts
CHRIS VAN HOLLEN, Maryland
LINDA T. SANCHEZ, California
C.A. DUTCH RUPPERSBERGER, Maryland
BRIAN HIGGINS, New York
ELEANOR HOLMES NORTON, District of Columbia

———

BERNARD SANDERS, Vermont (Independent)

DAVID MARIN, *Staff Director*
LAWRENCE HALLORAN, *Deputy Staff Director*
BENJAMIN CHANCE, *Chief Clerk*
PHIL BARNETT, *Minority Chief of Staff/Chief Counsel*

SUBCOMMITTEE ON NATIONAL SECURITY, EMERGING THREATS, AND INTERNATIONAL RELATIONS

CHRISTOPHER SHAYS, Connecticut, *Chairman*

KENNY MARCHANT, Texas
DAN BURTON, Indiana
ILEANA ROS-LEHTINEN, Florida
JOHN M. MCHUGH, New York
STEVEN C. LATOURETTE, Ohio
TODD RUSSELL PLATTS, Pennsylvania
JOHN J. DUNCAN, JR., Tennessee
MICHAEL R. TURNER, Ohio
JON C. PORTER, Nevada
CHARLES W. DENT, Pennsylvania

DENNIS J. KUCINICH, Ohio
TOM LANTOS, California
BERNARD SANDERS, Vermont
CAROLYN B. MALONEY, New York
CHRIS VAN HOLLEN, Maryland
LINDA T. SANCHEZ, California
C.A. DUTCH RUPPERSBERGER, Maryland
STEPHEN F. LYNCH, Massachusetts
BRIAN HIGGINS, New York

EX OFFICIO

TOM DAVIS, Virginia
HENRY A. WAXMAN, California

R. NICHOLAS PALARINO, *Staff Director*
BETH DANIEL, *Professional Staff Member*
ROBERT A. BRIGGS, *Clerk*
ANDREW SU, *Minority Professional Staff Member*

CONTENTS

	Page
Hearing held on September 6, 2006	1
Statement of:	
Dybul, Mark R., U.S. Global AIDS Coordinator, U.S. Department of State; and Kent Hill, Assistant Administrator, Bureau for Global Health, U.S. Agency for International Development	16
Dybul, Mark R.	16
Hill, Kent	27
Gootnick, David, Director, International Affairs and Trade, Government Accountability Office; Helene Gayle, president and chief executive officer, Care USA; Lucy Sawere Nkya, member of Tanzanian Parliament (MP, Women Special Seats), medical chairperson, Medical Board of St. Mary's Hospital Morogoro, director, Faraja Trust Fund; and Edward C. Green, senior research scientist, Harvard Center for Population and Development Studies	57
Gayle, Helene	85
Green, Edward C.	119
Gootnick, David	57
Nkya, Lucy Sawere	111
Letters, statements, etc., submitted for the record by:	
Dybul, Mark R., U.S. Global AIDS Coordinator, U.S. Department of State, prepared statement of	21
Gayle, Helene, president and chief executive officer, Care USA, prepared statement of	89
Gootnick, David, Director, International Affairs and Trade, Government Accountability Office, prepared statement of	60
Green, Edward C., senior research scientist, Harvard Center for Population and Development Studies, prepared statement of	122
Hill, Kent, Assistant Administrator, Bureau for Global Health, U.S. Agency for International Development, prepared statement of	30
Kucinich, Hon. Dennis J., a Representative in Congress from the State of Ohio, prepared statement of	143
Lee, Hon. Barbara, a Representative in Congress from the State of California, prepared statement of	55
Nkya, Lucy Sawere, member of Tanzanian Parliament (MP, Women Special Seats), medical chairperson, Medical Board of St. Mary's Hospital Morogoro, director, Faraja Trust Fund, prepared statement of	115
Shays, Hon. Christopher, a Representative in Congress from the State of Connecticut, prepared statement of	3
Waxman, Hon. Henry A., a Representative in Congress from the State of California, prepared statement of	8

HIV PREVENTION: HOW EFFECTIVE IS THE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF [PEPFAR]

WEDNESDAY, SEPTEMBER 6, 2006

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON NATIONAL SECURITY, EMERGING THREATS, AND INTERNATIONAL RELATIONS,
COMMITTEE ON GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 1:07 p.m., in room 2154, Rayburn House Office Building, Hon. Christopher Shays (chairman of the subcommittee) presiding.

Present: Representatives Shays, Duncan, and Waxman (ex officio).

Staff present: Beth Daniel, professional staff member; Nicholas R. Palarino, Ph.D., staff director; Robert Briggs, analyst; Naomi Seller, minority counsel; Andrew Su, minority professional staff member; Earley Green, minority chief clerk; and Jean Gosa, minority assistant clerk.

Mr. SHAYS. A quorum being present, the Subcommittee on National Security, Emerging Threats, and International Relations hearing entitled, "HIV Prevention: How Effective is the President's Emergency Plan for AIDS Relief [PEPFAR]" is called to order.

In 1981, scientists diagnosed the first cases of the disease we now call HIV/AIDS, Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome. Today, 25 years later, nearly 40 million people live with HIV/AIDS. Worldwide last year, 4.1 million people were newly infected with HIV, and 2.8 million people died from AIDS, of whom 570,000 were children. A third of these deaths occurred in Sub-Saharan Africa.

A January 2000 U.S. Central Intelligence Agency National Intelligence Estimate warns HIV/AIDS could deplete a quarter of the populations of certain countries. There is no cure for the disease.

The United States has committed massive amounts of foreign assistance to fight HIV/AIDS. After Congress passed the Leadership Act of 2003, President Bush announced a $15 billion, 5-year initiative known as PEPFAR, the President's Emergency Plan for AIDS Relief. PEPFAR fights HIV/AIDS through initiatives in prevention, treatment and care.

By 2010, the goal of PEPFAR is to prevent 7 million new infections, support treatment for 2 million HIV-infected people and provide care for 10 million people affected by HIV/AIDS, including orphans and vulnerable children. Multiple branches of the U.S. Gov-

ernment are engaged in this vast effort, including the Department of State, U.S. Agency for International Development, Health and Human Services, the Department of Defense, and the Peace Corps.

PEPFAR assistance will eventually reach 120 countries, but concentrates the bulk of its funds in 15 hardest hit focus countries, most of which are in Sub-Saharan Africa.

Today, we examine PEPFAR's prevention component. The 2003 Leadership Act, which authorized PEPFAR, recommended and now requires 20 percent of total PEPFAR funds be spent on HIV prevention. The act endorses HIV sexual transmission prevention through the model for Abstinence, Being Faithful and Correct and Consistent Use of Condoms, known for short as ABC, and includes a spending requirement that one-third of prevention funds go to abstinence-until-marriage initiatives. This spending requirement has come under intense scrutiny as a conservative political vehicle rather than a scientifically based policy.

Supporters of ABC contend it is evidence based and shows promising results. Critics assert the spending requirement is an arbitrary figure that ignores human nature and hinders local ability to respond to the epidemic appropriately in each different country. Others argue the key is integration of different prevention methods to create comprehensive initiatives that reach as many as possible, as effectively as possible, and flexibility so local implementers can respond to the specific conditions where they work.

This June, I joined Congresswoman Barbara Lee and others in introducing the Protection Against Transmission of HIV for Women and Youth, referred to as PATHWAY, Act of 2006, which includes a provision to lift the abstinence-until-marriage funding earmark from PEPFAR.

Our witnesses today represent a broad spectrum of opinion and world-class expertise in their respective fields. We welcome Ambassador Mark Dybul, Global AIDS Coordinator at the Department of State, and the Honorable Kent Hill, head of Global Health at the U.S. Agency for International Development.

We also welcome our second panel, including Dr. David Gootnick of the Government Accountability Office, Dr. Helene Gayle from CARE USA, Dr. Edward Green from Harvard University, and a special welcome to Dr. Lucy Sawere Nkya, a member of Parliament from Tanzania and a long time luminary in HIV/AIDS work. I will just say she's one of the most impressive persons I have ever met.

HIV/AIDS is a pandemic that has produced consequences unimaginable 25 years ago. Today, we need to imagine that we can conquer this disease. The world needs PEPFAR and other programs like it to fight HIV/AIDS. We must make sure our funding is responsive, and that the money is being used sustainably and wisely.

That concludes my statement. At this time I would call on Mr. Waxman, the ranking member of the full committee.

[The prepared statement of Hon. Christopher Shays follows:]

TOM DAVIS, VIRGINIA,
CHAIRMAN

CHRISTOPHER SHAYS, CONNECTICUT
DAN BURTON, INDIANA
ILEANA ROS-LEHTINEN, FLORIDA
JOHN M. McHUGH, NEW YORK
JOHN L. MICA, FLORIDA
GIL GUTKNECHT, MINNESOTA
MARK E. SOUDER, INDIANA
STEVEN C. LaTOURETTE, OHIO
TODD RUSSELL PLATTS, PENNSYLVANIA
CHRIS CANNON, UTAH
JOHN J. DUNCAN, JR., TENNESSEE
CANDICE MILLER, MICHIGAN
MICHAEL R. TURNER, OHIO
DARRELL ISSA, CALIFORNIA
JON C. PORTER, NEVADA
KENNY MARCHANT, TEXAS
LYNN A. WESTMORELAND, GEORGIA
PATRICK T. McHENRY, NORTH CAROLINA
CHARLES W. DENT, PENNSYLVANIA
VIRGINIA FOXX, NORTH CAROLINA
JEAN SCHMIDT, OHIO
BRIAN P. BILBRAY, CALIFORNIA

ONE HUNDRED NINTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON GOVERNMENT REFORM

2157 RAYBURN HOUSE OFFICE BUILDING

WASHINGTON, DC 20515–6143

MAJORITY (202) 225–5074
FACSIMILE (202) 225–3974
MINORITY (202) 225–5051
TTY (202) 225–6852

http://reform.house.gov

HENRY A. WAXMAN, CALIFORNIA,
RANKING MINORITY MEMBER

TOM LANTOS, CALIFORNIA
MAJOR R. OWENS, NEW YORK
EDOLPHUS TOWNS, NEW YORK
PAUL E. KANJORSKI, PENNSYLVANIA
CAROLYN B. MALONEY, NEW YORK
ELIJAH E. CUMMINGS, MARYLAND
DENNIS J. KUCINICH, OHIO
DANNY K. DAVIS, ILLINOIS
WM. LACY CLAY, MISSOURI
DIANE E. WATSON, CALIFORNIA
STEPHEN F. LYNCH, MASSACHUSETTS
CHRIS VAN HOLLEN, MARYLAND
LINDA T. SANCHEZ, CALIFORNIA
C.A. DUTCH RUPPERSBERGER,
MARYLAND
BRIAN HIGGINS, NEW YORK
ELEANOR HOLMES NORTON,
DISTRICT OF COLUMBIA

BERNARD SANDERS, VERMONT,
INDEPENDENT

SUBCOMMITTEE ON NATIONAL SECURITY, EMERGING THREATS,
AND INTERNATIONAL RELATIONS
Christopher Shays, Connecticut
Chairman
Room B-372 Rayburn Building
Washington, D.C. 20515
Tel: 202 225-2548
Fax: 202 225-2382

Statement of Rep. Christopher Shays
September 6, 2006

In 1981, scientists diagnosed the first cases of the disease we now call HIV/AIDS—Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome. Today, twenty-five years later, nearly 40 million people live with HIV/AIDS.

Worldwide last year, 4.1 million people were newly infected with HIV, and 2.8 million people died from AIDS, of whom 570,000 were children. A third of these deaths occurred in Sub-Saharan Africa.

A January 2000 US Central Intelligence Agency National Intelligence Estimate warns HIV/AIDS could deplete a quarter of the populations of certain countries. There is no cure for the disease.

The United States has committed massive amounts of foreign assistance to fight HIV/AIDS. After Congress passed the Leadership Act of 2003, President Bush announced a $15 billion, five-year initiative known as PEPFAR, the President's Emergency Plan For AIDS Relief.

PEPFAR fights HIV/AIDS through initiatives in prevention, treatment, and care. By 2010, the goal of PEPFAR is to prevent seven million new infections; support treatment for two million HIV-infected people; and

provide care for 10 million people affected by HIV/AIDS, including orphans and vulnerable children. Multiple branches of the U.S. government are engaged in this vast effort, including the Department of State, U.S. Agency for International Development, Health and Human Services, the Department of Defense, and the Peace Corps.

PEPFAR assistance will eventually reach 120 countries, but concentrates the bulk of its funds in fifteen hardest-hit "focus countries," most of which are in sub-Saharan Africa.

Today we examine PEPFAR's prevention component. The 2003 Leadership Act, which authorized PEPFAR, recommended and now requires twenty percent of total PEPFAR funds be spent on HIV prevention. The Act endorses HIV sexual transmission prevention through the model for "Abstinence, Being faithful, and Correct and Consistent use of Condoms"—known for short as ABC—and includes a spending requirement that one third of prevention funds go to abstinence-until-marriage initiatives.

This spending requirement has come under intense scrutiny as a conservative political vehicle rather than scientifically-based policy.

Supporters of ABC contend it is evidence-based and shows promising results. Critics assert the spending requirement is an arbitrary figure that ignores human nature and hinders local ability to respond to the epidemic appropriately in each different country.

Others argue the key is integration of different prevention methods to create comprehensive initiatives that reach as many as possible, as effectively as possible, and flexibility so local implementers can respond to the specific conditions where they work.

This June, I joined Congresswoman Barbara Lee and others in introducing the Protection Against Transmission of HIV for Women and Youth (PATHWAY) Act of 2006, which includes a provision to lift the abstinence-until-marriage funding earmark from PEPFAR.

Our witnesses today represent a broad spectrum of opinion and world-class expertise in their respective fields. We welcome Ambassador Mark Dybul, Global AIDS Coordinator at the Department of State, and the

Honorable Kent Hill, head of Global Health at the U.S. Agency for International Development.

We also welcome our second panel including Dr. David Gootnick of the Government Accountability Office, Dr. Helene Gayle from CARE USA, Dr. Edward Green of Harvard University, and a special welcome to Dr. Lucy Sawere Nkya, a Member of Parliament from Tanzania and a longtime luminary in HIV/AIDS work.

HIV/AIDS is a pandemic that has produced consequences unimaginable 25 years ago. Today we need to imagine that we can conquer this disease. The world needs PEPFAR and other programs like it to fight HIV/AIDS. We must make sure our funding is responsive and that the money is being used sustainably and wisely.

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

We're here to discuss the progress of prevention programs under the U.S. Global AIDS Program, and I want to thank the chairman for holding this important hearing, and for all of our witnesses for coming here to share their experience and expertise.

The President's Emergency Plan for AIDS Relief has made important progress in some areas. In particular, U.S. assistance has helped bring the number of people getting treatment in the 15 focus countries from a few thousand to over 1 million. I applaud the work of Dr. Dybul and Mr. Hill and all of the in-country staff contributing to this effort.

But worldwide, for each person who gained access to HIV treatment last year, seven more people became infected with HIV. There is no way for the pace of treatment access to keep up with that rate of new infections.

So as we pass the halfway point of this first 5 years of this program, it's time that Congress take a serious look at prevention. We need to examine what's working and what isn't. We need to identify programs that are most effective in reducing vulnerabilities and risk behaviors, and we need to figure out why they work and where they work, and we need to replicate the most successful ones.

Today, we're going to look in particular at the results of a GAO investigation into one element of U.S. HIV prevention policy. It's the requirement that one-third of prevention funds be spent on Abstinence and Be Faithful programs. When the House debated the abstinence requirements, the focus of the debate was the proper balance of abstinence funding, be-faithful funding and condom funding to stop the transmission of HIV.

As depicted in the chart, we had a debate over whether one-third of the funds should be designated for abstinence or if instead we should let the experts determine the right balance. Like several of my colleagues, I felt strongly that we should let the experts decide. But what the GAO report makes clear is that we weren't discussing the right pie, we were focused on three interventions that address sexual transmission. And the behavior changes these programs tried to create, delayed sexual debut, partner reduction and condom use, are crucial elements of HIV prevention, but we didn't discuss all of the other elements of prevention. We didn't talk about antiretroviral therapy to reduce mother-to-child transmission. We didn't talk about blood supply safety. We didn't talk about the medical injection safety. We didn't talk about programs that address the myriad social problems that render people vulnerable to HIV infection. And we didn't talk about the possibility of new types of interventions like male circumcision.

When we look at the full picture, as shown in this second chart, a few things are much clearer. First, when we say that one-third of prevention funds have to go to abstinence programs, we cut into many other types of prevention programs. The administration has determined that the be-faithful message is linked to the abstinence message, and as reported to us, the programs that cover both abstinence and faithfulness will be counted toward the one-third requirement.

But other interventions, like those that save the lives of babies born to women with HIV, have to compete for the rest of the prevention funds. As GAO found, countries have had to restrict funding for many other kinds of prevention programs to meet the abstinence requirement.

What's also clear from this chart is that HIV prevention is extremely complicated. There is no question that determining the right mix for any given country requires an enormous amount of time and expertise. No formula that we try to write in Congress will ever be right for the epidemiology and culture of each country.

It's difficult to overstate the role of the USAIDS program. We are the biggest donor of the world. Our policies carry great weight and very strong sway over countries and individual grantees. We must not shrug off the responsibility we have to pursue the best evidence-based prevention policies.

So it's time for us to stop focusing on arbitrary formulations and have a meaningful discussion of U.S. prevention policy that extends beyond ideology and rhetoric and domestic politics, and I hope we can start this debate today.

Thank you very much.

[The prepared statement of Hon. Henry A. Waxman follows:]

Statement of Rep. Henry A. Waxman
Ranking Minority Member
Committee on Government Reform
Hearing on Global HIV Prevention

September 6, 2006, 1 pm

We're here to discuss the progress of prevention programs under the U.S. Global AIDS program. I want to thank the Chairman for holding this important hearing, and all of our witnesses for coming here to share their experience and expertise.

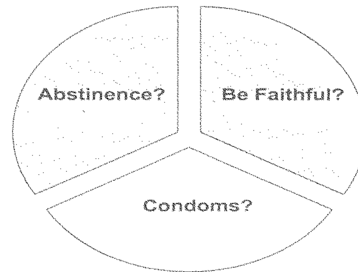
The President's Emergency Plan for AIDS Relief has made important progress in some areas. In particular, U.S. assistance has helped bring the number of people getting treatment in the fifteen "focus countries" from a few thousand to over half a million. I applaud the work of Dr. Dybul and Mr. Hill and all of the in-country staff contributing to this effort.

But worldwide, for each person who gained access to HIV treatment last year, *seven more people* became infected with HIV. There is no way for the pace of treatment access to keep up with that rate of new infections.

So as we pass the halfway point of the first five years of this program, it is time that Congress take a serious look at prevention. We need to examine what's working and what isn't. We need to identify programs that are most effective in reducing vulnerabilities and risk behaviors. We need to figure out why they work and where they work, and we need to replicate the most successful ones.

Today, we're going to look in particular at the results of a GAO investigation into one element of U.S. HIV prevention policy. It's the requirement that one-third of prevention funds be spent on abstinence and be-faithful programs.

When the House debated the abstinence requirement, the focus of the debate was the proper balance of abstinence funding, be-faithful funding, and condom funding to stop the transmission of HIV. As depicted in this chart, we had a debate over whether one third of funds should be designated for abstinence, or if instead we should let the experts determine the right balance.



Like several of my colleagues here, I felt strongly that we should let the experts decide.

But what the GAO report makes clear is that we weren't discussing the right pie. We were focused on three interventions that address sexual transmission. And the behavior changes these programs try to create – delayed sexual debut, partner reduction, and condom use – are crucial elements of HIV prevention. But we didn't discuss all of the other elements of prevention.

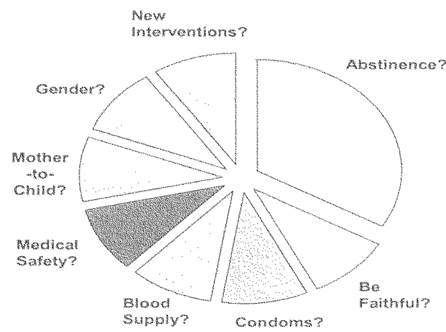
We didn't talk about antiretroviral therapy to reduce mother-to-child-transmission.

We didn't talk about blood supply safety.

We didn't talk about medical injection safety.

We didn't talk about programs that address the myriad social problems that render people vulnerable to HIV infection.

And we didn't talk about the possibility of new types of interventions, like male circumcision.



When we look at the full picture, as shown in the second chart, a few things are much clearer.

First, when we say that 1/3 of prevention funds have to go to abstinence programs, we cut into many other types of prevention programs. The Administration has determined that the be-faithful message is linked to the abstinence message, and has reported to us that programs that cover both abstinence and faithfulness will be counted toward the 1/3 requirement.

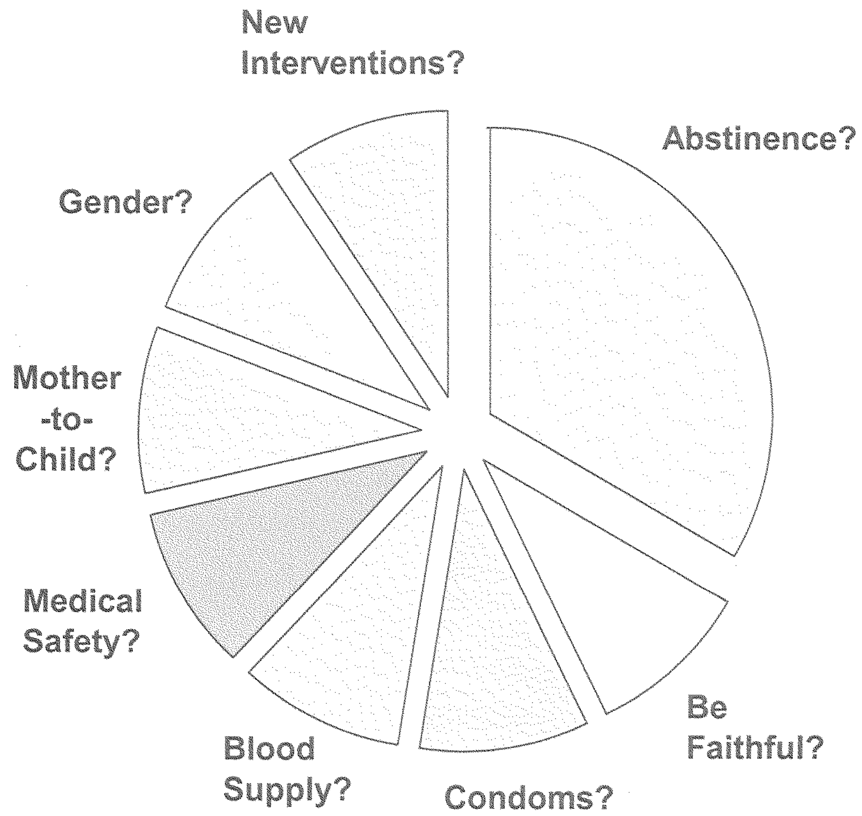
But other interventions – like those that save the lives of babies born to women with HIV – have to compete for the rest of prevention funds. As GAO found, countries have had to restrict funding for many other kinds of prevention programs to meet the abstinence requirement.

What's also clear from this chart is that HIV prevention is extremely complicated. There is no question that determining the right mix for any given country requires an enormous amount of time and expertise. No formula that we try to write in Congress will ever be right for the epidemiology and culture of each country.

It is difficult to overstate the role of the US AIDS program. We are the biggest donor in the world. Our policies carry great weight and very strong sway over countries and individual grantees. We must not shrug off the responsibility we have to pursue the best evidence-based prevention policies.

So it's time for us to stop focusing on arbitrary formulations and have a meaningful discussion of U.S. prevention policy that extends beyond ideology and rhetoric and domestic politics. I hope we can start this debate today.

The Full Prevention Picture



Debating Condoms Vs. Abstinence Vs. Be Faithful

Mr. SHAYS. I thank the gentleman.

At this time, Mr. Duncan.

Mr. DUNCAN. I have no statement, Mr. Chairman, but I do think this is a very important topic, and I'm pleased that you would call a hearing in a continuation of many important hearings in your subcommittee. Thank you very much.

Mr. SHAYS. I thank the gentleman very much.

Let me take care of some business before calling on our first panel.

I ask unanimous consent that all members of the subcommittee be permitted to place an opening statement in the record and that the record remain open for 3 days for that purpose, and without objection, so ordered.

I ask future unanimous consent that all witnesses be permitted to include their written statements in the record, and without objection, so ordered.

And at this time the Chair would acknowledge our first panel. We have Ambassador Mark Dybul, U.S. Global AIDS Coordinator, U.S. Department of State, and the Honorable Kent Hill, Assistant Administrator, Bureau for Global Health, U.S. Agency for International Development. And as you gentlemen know, we swear in all of our witnesses, and if you will just stand, I'll swear you in.

[Witnesses sworn.]

Mr. SHAYS. I'll note for the record that both of our witnesses have responded in the affirmative.

It's truly an honor to have both of you here. You are real experts doing very important work. And I know the committee welcomes you and looks forward to the dialog that we'll have.

At this time, Mr. Dybul—Ambassador, excuse me—we'll ask you to make an opening statement. What we do with the clock, we have 5 minutes, but we roll it over another 5 minutes. So we'll ask you not to be more than 10, but somewhere in between 5 and 10 would be helpful.

Thank you.

STATEMENTS OF MARK R. DYBUL, U.S. GLOBAL AIDS COORDINATOR, U.S. DEPARTMENT OF STATE; AND KENT HILL, ASSISTANT ADMINISTRATOR, BUREAU FOR GLOBAL HEALTH, U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

STATEMENT OF MARK R. DYBUL

Ambassador DYBUL. Thank you, Mr. Chairman, Congressman Waxman, and Congressman Duncan. Thank you for this opportunity to discuss President Bush's unprecedented emergency plan for AIDS relief. We've been grateful for the strong bipartisan support of Congress, including members of this subcommittee.

I'm pleased to be here with Dr. Hill, who leads the U.S. Agency for International Development work toimplement PEPFAR.

Fundamentally, it's the generosity of the American people that has created the largest international health initiative in history dedicated to a specific disease.

In looking at just 15 focus countries of the more than 120 countries where we have worked through bilateral programs in the first 2 years of the Emergency Plan, we've seen remarkable results to

date, as both the chairman and Mr. Waxman have noticed. We supported treatment for over 560,000 people, 61 percent of whom are women, and 8 percent of whom are children. We have supported care for 3 million, including 1.2 million orphans and vulnerable children. We've supported counseling and testing for 13.6 million, 69 percent of whom are female.

And these figures do not include work in other countries with bilateral U.S. Government programs under the Emergency Plan. More importantly, the American people's support for the programs of the Global Fund to Fight Aids, Tuberculosis and Malaria, other bilateral programs and the Global Fund are integral components of PEPFAR.

Yet as was noted, treatment and care for those already infected with HIV/AIDS are not enough. If we do not slow the rate of infections, it will be impossible to sustain the resources, financial, human, institutional, for care and treatment of an ever expanding pool of infected individuals. Ultimately, effective prevention is the only way to achieve the elusive goal of an AIDS free generation.

More than 3½ years ago, President Bush had the vision to insist that prevention, treatment and care be addressed together, an idea that now commands wide respect. The lessons learned from the Emergency Plan are now helping to fuel transformation of the HIV/AIDS responses in nations around the world.

PEPFAR's unparalleled financial commitment has permitted the U.S. Government to support a balanced, multi-dimensional approach, one that was not possible at pre-PEPFAR funding levels. The total annual spending on HIV/AIDS prevention as well as treatment and care has continually increased since the passage of the Leadership Act.

If Congress enacts the President's request for $4 billion for HIV/AIDS in 2007, that will be the fourth straight year of increased funding under the President's plan. In comparison with the fiscal year 2001 total of $840 million for global HIV/AIDS, these PEPFAR funding levels represent a quantum leap.

Even with the massive and highly successful scale-up of treatment and care services with PEPFAR support, PEPFAR preventionfunding in the focus countries has grown substantially from 2004 to 2006, yet there has been a significant constraint on resources in the focus countries, as was noted in the GAO report. Almost $527 million from focus country programs has been redirected to the Global Fund, and other components of the Emergency Plan over PEPFAR's first 3 years.

The effectiveof this trend has been to force country teams to make difficult tradeoffs. In 2007 and beyond, full funding for focus country activities is essential if PEPFAR is to meet its 2–7–10 goals, including the prevention goal.

If I accomplish nothing else today, I hope I will be able to persuade you of the importance of full funding, meeting the President's request for the focus countries to ensure effective prevention.

Now if I could, I'd like to turn briefly to what constitutes effective prevention.

As Mr. Waxman noted, PEPFAR—and effective prevention is a complicated matter. PEPFAR supports the most comprehensive prevention strategy in the world, including interventions for sexual

transmission, prevention of mother-to-child transmission, safe blood, safe medical injections, all the pieces of the pie that are up there. However, prevention must squarely address the reality that the overwhelming majority of cases of HIV/AIDS infection are due to sexual activity, 80 percent worldwide.

Effective prevention must address risky sexual behavior because it is the heart of this epidemic.

The people of Africa have been leaders in developing a prevention strategy that responds to the special challenges that they face, the ABC approach, which stands for Abstinence, Being Faithful and Correct and Consistent Use of Condoms. In fact, the strategies of many nations in Africa and elsewhere included the ABC approach, delivered in culturally sensitive ways, long before the advent of the Emergency Plan.

The past year has been a particularly important moment in the effort for sustainable development. Impressive new demographic health survey evidence from a growing number of nations is expanding the evidence base for the ABC strategy and generalized epidemics such as those in most Sub-Saharan Africa.

Recent data from Kenya, Zimbabwe and urban Haiti show declines in HIV prevalence. A new study has concluded that these reductions in prevalence do not simply represent the natural course of these nations' epidemics, but can only be explained by changes in sexual behavior.

In Kenya, the Ministry of Health estimated that prevalence dropped by 30 percent over a 5-year period ending in 2003. The decline correlated with a broad reduction in sexual behavior, including increased male faithfulness, as measured by a 50 percent reduction in young men with multiple sexual partners; primary abstinence, as measured by delayed sexual debut; and secondary abstinence, as measured by those that have been sexually active but refrained from activity over the past year, and increased use of condoms by young women who engage in risky activity.

In an area in Zimbabwe, the journal Science reported a 23 percent reduction in prevalence among young men, and a remarkable 49 percent decline among young women, also during the 5-year period ending in 2003. Again, the article correlates significant behavior change consistent with ABC with the decrease in prevalence.

Because of the data, ABC is now recognized as the most effective strategy to prevent HIV/AIDS in generalized epidemics. The GAO report notes the consensus among U.S. Government field personnel that ABC is the right approach to prevention.

To the extent any controversy remains around ABC, I believe that it stems from a misunderstanding. ABC is not a narrow one-size-fits-all recipe, it encompasses a wide variety of approaches through a myriad of factors that lead to sexual transmission. For example, the Emergency Plan recognizes the critical need to address the inequalities among women and men that influence behavior change necessary to prevent HIV. PEPFAR-supported ABC programs address gender issues, to include violence against women, cross generational sex and transactional sex. Such approaches are not in conflict with ABC, they are integral to it.

Some of the most striking data presented at our recent implementers meeting in Durban concerned behavior change by men, the

B, or being faithful element of the ABC strategy. In a number of places men have begun toreduce their number of sexual partners through ABC interventions.

The ABC programs also address the issue of prevention for HIV positive people, helping infected people to choose whether to abstain from activity, to be faithful to a single partner whose status is known, and use of condoms. ABC programs offers people information on how alcohol abuse can lead them into risky sexual behavior, and work with HIV positive injecting drug users so they can avoid sexual transmission of HIV/AIDS.

And ABC programs link people to counseling and testing because we know people who know their HIV status are more likely to protect themselves and others from infection.

Now of course we also support national strategies to prevent mother-to-child transmission and transmission through unsafe blood and medical injections, in addition to programs that teach ABC messages to injection drug users. The Emergency Plan supports programs that work with drug users to free them from their addiction through prevention and education, and through substitution therapy, an approach that has been scientifically proven to reduce HIV/AIDS infection while providing clinical treatment for addiction.

I'd like to address the effect of the congressional prevention directive. The authorizing legislation recommends that 20 percent of funds in the focus country be allocated for prevention, and directs that at least 33 percent of prevention funding be allocated to abstinence-until-marriage programs. As has been noted, we count programs that focus on abstinence and faithfulness for this purpose, and this 33 percent requirement is applied to all countries collectively, and PEPFAR has met it.

The legislation's emphasis on ABC activities has been an important factor on the fundamental and needed shift in U.S. Government prevention strategy from a primarily C approach prior to PEPFAR to a balanced ABC strategy. PEPFAR has followed Congress' mandate that it is possible and necessary to strongly emphasize A, B and C.

The congressional directive, which itself reflects an evidence-based public health understanding of the importance of ABC, has helped to support PEPFAR's field personnel in appropriately broadening the range of prevention efforts. The directive has helped PEPFAR to align itself with the host nations, of which ABC is a key element.

PEPFAR does offer each focus country team the opportunity to propose and provide justification for a different prevention funding allocation based on the circumstances in that country. To date, all such justifications have been approved without requiring other countries to make offsetting judgments to their proposed prevention allocations.

It is also important to remember that the U.S. Government is not the only source of funding in-country, and that partners can seek funding from other sources to balance their mix of prevention interventions if they find that necessary. In fact, money does not always follow the evidence. As the Minister of Health in Namibia noted in a recent letter to the editor of the Lancet, PEPFAR support for AB

is needed to ensure the balanced ABC approach that Namibia seeks, and this is because other international partners primarily support C interventions.

Last, let me address the issue of how we are monitoring and evaluating our prevention efforts. We strongly believe that we need to focus not only on the inputs but on results, the number of HIV infections averted to PEPFAR interventions.

Obviously we cannot measure directly the number of infections that would have occurred without U.S. Government support. One area for prevention for which we are using a model to estimate infections averted is prevention of mother-to-child transmission, or PMT CT.

Through March 2006, we supported PMTCT services for more than 4.5 million pregnancies. It is noteworthy that the number of women served grew dramatically from 821,000 in the first half of 2005 to almost 1.3 million in the first half of 2006, a 57 percent increase. This is clearly related to the 59 percent increase in PMTCT funding managed in the focus countries over the course of PEPFAR, from $44 million in 2004 to $71 million this year. And these numbers do not include HIV positive pregnant women who receive other PEPFAR supported services, including treatment, care, counseling and testing, and other prevention interventions.

In over 342 pregnancies, the women were identified as HIV positive and given antiretroviral prophylaxis to prevent infections of their children. Using an internationally agreed model, we estimate that this intervention averted approximately 65,100 infant infections through March of this year.

For prevention as a whole, including sexual and medical transmission, we are working to develop the best possible models to allow us to estimate the numbers of infections that PEPFAR supported programs have averted.

Mr. Chairman, there has been a sense of fatalism about HIV prevention in many quarters; it is long past time to discard that attitude. The world community must come alongside governments, civil society, faith-based organizations and others to support their leadership in the sustainability of the HIV prevention programs through effective prevention. The U.S. Government, for our part, considers it a privilege to do so.

The initial years of the Emergency Plan have demonstrated that prevention can work in many of the world's most difficult places. Through PEPFAR, the American people have become leaders in the world effort to turn the tide against HIV/AIDS.

Mr. Chairman, thank you very much, and I'd be happy to address your questions.

[The prepared statement of Ambassador Dybul follows:]

Statement of
Ambassador Mark Dybul
U.S. Global AIDS Coordinator

Before the
Subcommittee on National Security, Emerging Threats, and International Relations
Committee on Government Reform
United States House of Representatives

Washington, DC
September 6, 2006

Mr. Chairman, Congressman Kucinich, Members of the Committee, thank you for this opportunity to discuss President Bush's unprecedented Emergency Plan for AIDS Relief, or PEPFAR. We have been grateful for the strong bipartisan support of Congress, including members of this Committee.

I am pleased to be here with Dr. Kent Hill, who leads the U.S. Agency for International Development's work to implement the Emergency Plan. The people of USAID, as well as those of the Department of State, the Department of Health and Human Services, the Department of Defense, Peace Corps and other implementing agencies, are a true interagency team, and their commitment has been a key part of the success of this initiative.

Fundamentally, it is the generosity of the American people that has created the largest health care initiative in history dedicated to a specific disease. What the President's Emergency Plan has accomplished in partnership with the people we are privileged to serve is – in a word – breathtaking.

Looking at just the 15 focus countries of the more than 120 countries where we have worked in the first two years of the Emergency Plan, we have seen remarkable results to date.

In addition to the prevention work that is the focus of today's discussion, we have supported **treatment** for over 560,000 thousand people – 61 percent of whom are women and 8 percent of whom are children.

We have supported **care** for three million, including 1.2 million orphans and vulnerable children. We have supported counseling and testing for 13.6 million – 69 percent of whom are female.

And these figures do not include work in the other countries with bilateral U.S. Government programs under the Emergency Plan, nor PEPFAR's support for the programs of the Global Fund to Fight AIDS, Tuberculosis and Malaria. Other bilateral programs and the Global Fund are both integral components of the Emergency Plan. The success of the Global Fund is important to ensure a truly global response, by providing nations with few or no bilateral programs with a mechanism to contribute to what must be a world-wide effort.

Yet treatment and care for those already infected with HIV are not enough. Only a vigorous and comprehensive prevention approach will turn the tide against the global HIV/AIDS pandemic – the mission of the Emergency Plan. In addition to the humanitarian imperative to avoid suffering whenever possible, if we do not slow the rate of infections, it will be impossible to sustain the resources – financial, human, institutional – for the care and treatment of an ever-expanding pool of

infected persons. Ultimately, effective prevention is the only way to achieve the elusive goal of an HIV/AIDS-free generation.

Since President Bush's announcement of the Emergency Plan, the United States has demonstrated historic leadership in implementing the most diverse HIV/AIDS prevention strategy of any international partner. More than three and a half years ago, President Bush had the vision to insist that prevention, treatment and care be addressed together to ensure a comprehensive and effective response – an idea that now commands wide acceptance. The lessons learned from the intensive application of the Emergency Plan in the 15 focus countries are now being extended to over 120 countries, helping to fuel transformation of HIV/AIDS responses in nations around the world.

This unprecedented initiative dwarfs the pre-PEPFAR baseline levels of prevention spending and has allowed for a wide-ranging portfolio of high-quality, sustainable, evidence-based prevention programs.

PEPFAR's unparalleled financial commitment has permitted the USG to support a balanced, multi-dimensional approach – one that was not possible with pre-PEPFAR spending levels. The total annual spending in the areas of HIV/AIDS prevention, as well as treatment and care, has continually increased since the passage of the Leadership Act.

If Congress enacts the President's request for $4 billion in HIV/AIDS funding for FY 2007, that will represent a total increase of $740 million from that appropriated in fiscal year 2006 ($3.3 billion), and almost $1.3 billion from that appropriated in FY 2005 ($2.7 billion). In comparison with the FY 2001 total of $840 million for global HIV/AIDS, these PEPFAR levels of funding represent a quantum leap.

Before the advent of PEPFAR, the U.S. Government was supporting very few programs in care and treatment. Even with the massive and highly successful scale-up of these services with PEPFAR support, the USG commitment to global HIV/AIDS prevention is now clearly stronger than it has ever been. PEPFAR prevention funding in the focus countries increased from $214 million in FY 2004, to approximately $294 million in FY 2005, to $396 million in FY 2006.

Even so, there has been a significant constraint on prevention, treatment and care resources in the focus countries. Almost $527 million from focus country programs has been redirected to the Global Fund and other components of the Emergency Plan over PEPFAR's first three years. The President's FY 2007 budget request for the focus countries is, in part, a response to that history, in an attempt to mitigate the effects on focus country programs of the redirection of resources.

The effect of this trend has been to force country teams to make difficult trade-offs among prevention, treatment, and care. Within prevention, there have been similar trade-offs, and we appreciate the GAO Report's candor about these challenging decisions. In FY 2007 and beyond, full funding for focus country activities is essential if PEPFAR is to meet the 2-7-10 goals, including the prevention goal.

To be candid, if I accomplish nothing else today, I hope I will be able to persuade you of the importance of full funding for the focus countries to ensure effective prevention.

Now let me turn to what constitutes effective prevention. Prevention programs can only achieve results when they are community-led. Local management and participation means that programs are responsive to local culture and tailored to local circumstances. Locally-led programs can make full use of the passion and commitment of women and people living with HIV/AIDS, and help to build the

capacity of the non-governmental sector to contribute to a truly multi-sectoral response. And local leadership is required for effective prevention to be sustainable for the long haul – as it must be.

Effective prevention must squarely address the reality that the overwhelming majority of cases of HIV infection are due to sexual activity. Worldwide, far more than 80 percent of HIV infections are sexually transmitted. In sub-Saharan Africa, where HIV is generalized throughout the population rather than concentrated in easily-identified groups, the percentage is even higher. PEPFAR has a major focus on prevention of mother-to-child transmission, infection due to unsafe blood and medical injections, and infection due to injecting-drug use. Yet many of these infections can be traced back to earlier cases of sexual transmission. Truly effective prevention must address sexual risky behavior – it is at the heart of this pandemic.

The people of Africa have been leaders in developing a prevention strategy that responds to the special challenges they face – the "ABC" approach, which stands for "abstinence," "being faithful," and "correct and consistent use of condoms." In fact, the strategies of many nations in Africa and elsewhere included the ABC approach, delivered in culturally-sensitive ways, long before the advent of the Emergency Plan.

The past year has been a particularly important moment in the effort for sustainable prevention. We have long had evidence of large-scale behavior change in Uganda and Thailand, at the time when those nations were engaged in intensive behavior change efforts in the 1990s. Recently, however, impressive new Demographic Health Survey evidence from a growing number of nations is expanding the evidence base for the ABC strategy in generalized epidemics, such as those in most of Sub-Saharan Africa.

Recent data from Kenya, Zimbabwe, and urban Haiti show declines in HIV prevalence. A new study has concluded that these reductions in prevalence do not simply represent the natural course of these nations' epidemics, but can only be explained by changes in sexual behavior. This demonstrates the power of behavior change to save lives – and the importance of support for effective behavior change interventions.

In Kenya, the Ministry of Health estimates that HIV prevalence dropped by 30 percent over the five years that ended in 2003. This decline correlates with a broad reduction in sexual risky behavior including: increased male faithfulness, as measured by a 50 percent reduction in young men with multiple sexual partners; primary abstinence, as measured by delayed sexual debut; and secondary abstinence, as measured by those who had been sexually active but refrained from sexual activity over the past year; and increased use of condoms by young women who engage in risky activity.

In an area of Zimbabwe, the journal ***Science*** reported a 23 percent reduction in prevalence among young men, and a remarkable 49 percent decline among young women – also during the five years that ended in 2003. Again, the article correlates significant behavior change, consistent with the ABC approach, with the decrease in HIV prevalence.

Dr. Peter Piot, the Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS), remarked with respect to these two countries, "[T]he declines in HIV rates have been due to changes in behaviour, including increased use of condoms, people delaying the first time they have sexual intercourse, and people having fewer sexual partners." Put another way, each of the ABC behavior

changes took place in these countries, and the combination added up to a significant reduction in the spread of the virus.

Among the most encouraging developments in many years in the global fight against HIV/AIDS is this growing body of evidence demonstrating that ABC behavior change is possible – and that it can reduce HIV prevalence on a large scale. Because of the data, ABC is now recognized as the most effective strategy to prevent HIV in generalized epidemics. One of the most striking findings of the GAO Report is the consensus among U.S. Government field personnel that ABC is the right approach to prevention.

To the extent any controversy remains around ABC, I believe it stems from misunderstanding. ABC is not a narrow, one-size-fits-all recipe. It encompasses a wide variety of approaches to the myriad of factors that lead to sexual transmission. The interventions that help people to choose to avoid the risk of HIV infection entirely, or to reduce their risk, vary according to the circumstances of their lives.

For example, the Emergency Plan recognizes the critical need to address the inequalities among women and men that influence behavioral change necessary to prevent HIV infection. While gender equity does not directly reduce HIV transmission, ABC is crucial for the protection of women. Within our ABC Guidance, it is clear that ABC programs should address gender issues including violence against women, cross-generational sex and transactional sex. Such approaches are not in conflict with ABC – they are integral to it.

Some of the most striking data presented at our recent Implementers' Meeting in Durban concerned behavior change by men – the "B," or "being faithful" element of the ABC strategy. In a number of places, men have begun to reduce their number of sexual partners – and the populations doing so include even some of the men at highest risk, such as long-distance truck drivers. As we seek to empower women for HIV prevention, reaching men with effective interventions is one of the most important things we can do – and this too is part of ABC.

ABC programs also address the issue of prevention for positives – helping infected people to choose whether to abstain from further sexual activity, or to be faithful to a single partner whose status is known and use a condom. ABC programs offer people information on how alcohol abuse can lead them into risky sexual behavior. ABC programs work with HIV-positive injecting-drug users so they can avoid sexual transmission of HIV.

And ABC programs link people to HIV counseling and testing, which is critical for prevention. Studies have shown that people who know their HIV status are more likely to protect themselves and others from infection.

Clearly, the ABC approach is a crucial foundation for our efforts. Of course, there is more to effective prevention. The U.S. Government supports the most diverse range of prevention approaches of any international partner. In addition to ABC, we support national strategies to prevent mother-to-child transmission of HIV and to prevent the transmission of the virus through unsafe blood or medical injections. The Emergency Plan also supports national strategies to address the risks posed by injecting-drug use, as well as many other issues.

As we look at the role of sexual transmission in the larger prevention context, I'd like to address the effect of the Congressional prevention directive. The authorizing legislation recommends that 20

percent of funding in the focus countries be allocated for prevention, and directs that at least 33 percent of prevention funding be allocated to abstinence-until-marriage programs. In 2004, we notified Congress that we count programs that focus on abstinence and faithfulness for this purpose, as A and B messages should always be delivered together except in programming for young children. This 33 percent requirement is applied across all the focus countries collectively, and PEPFAR has met it.

The legislation's emphasis on AB activities has been an important factor in the fundamental and needed shift in U.S. Government prevention strategy from a primarily C approach prior to PEPFAR to the balanced ABC strategy. The Emergency Plan has implemented this more comprehensive strategy, one that reflects the growing body of data that validate ABC behavior change. PEPFAR has followed Congress' mandate that it is possible and necessary to strongly emphasize A, B, and C, while also seeking to support prevention of mother-to-child transmission and other critical prevention interventions.

The Congressional directive, which itself reflects an evidence-based, public health understanding of the importance of ABC, has helped to support PEPFAR's field personnel in appropriately broadening the range of prevention efforts. Solid policy guidance from PEPFAR on prevention has helped to address many issues of concern. In addition, the directive has helped PEPFAR to align itself with the strategies of host nations, of which ABC is a key element.

The Emergency Plan recognizes the importance of tailoring prevention efforts to the particular epidemic of each country, consistent with the requirement that 33% of prevention funding support AB activities. As the GAO Report notes, PEPFAR offers each focus country team the opportunity to propose, and provide justification for, a different prevention funding allocation based on the circumstances in that country.

To date, all such justifications have been approved. PEPFAR has been able to approve these while continuing to ensure that the focus countries as a whole continue to comply with the Congressional directive – and has done so without requiring other countries to make offsetting adjustments to their proposed prevention allocations.

It is important to remember that most focus countries have generalized epidemics, for which the ABC approach is the most effective, data-based strategy. Every country has the opportunity to submit a justification, but in those with generalized epidemics for which ABC has been proven to be so effective, the justification for a different allocation must be particularly strong. It is also important to remember that the U.S. Government is not the only source of funding in-country, and that partners can seek funding from other sources to balance their mix of prevention interventions if they find that necessary.

In fact, while many now recognize that the evidence supports a balanced ABC approach, money does not always follow the evidence. As the Minister of Health of Namibia noted in a recent letter to the editor of the Lancet, PEPFAR support for AB is needed to ensure the balanced ABC program that Namibia seeks. This is because other international partners support primarily C interventions.

Although the ABC approach reflects existing practice in many host nations, it has clearly represented a change in U.S. Government practice, and change always involves a period of transition. Yet we have asked some of the country teams that did not submit justifications if they wanted to do so and the answer was, emphatically, no. As country teams have become more experienced in the ABC approach and familiar with the data that supports it, they have become more comfortable implementing it.

Lastly, let me address the issue of how we are monitoring and evaluating our prevention efforts. We strongly believe that we need to focus not only on inputs but on results – the number of HIV infections averted due to PEPFAR interventions. Estimating the number of cases averted is challenging, because a case averted is a non-event. We are looking at the difference between something that is – the current level of HIV prevalence – and something that merely *would have been* – the level of HIV prevalence we'd be seeing today if the U.S. Government had not stepped in with massive scale-up of HIV prevention activities.

Obviously, we cannot measure directly the number of infections that would have occurred without U.S. Government support. One area of prevention for which we are using a model to estimate infections averted is prevention of mother-to-child transmission. Through March 2006, we supported programs that provided women with these services, including voluntary HIV counseling and testing, during more than 4.5 million pregnancies. It is noteworthy, by the way, that the number of women served with activities to prevent mother-to-child transmission grew dramatically from 821,000 in the first half of FY05 to almost 1.3 million in the first half of FY06.

In over 342,000 pregnancies, the women were identified as HIV-positive and given antiretroviral prophylaxis to prevent infection of their children. Using an internationally-agreed model, we estimate that this intervention averted approximately 65,100 infant infections through March of this year.

For prevention as a whole – including sexual and medical transmission -- we are working to develop the best possible models to allow us to estimate the number of infections that PEPFAR-supported programs have averted. These models will greatly enhance our ability to evaluate our progress toward our goal of 7 million infections averted by 2010.

Mr. Chairman, there has been a sense of fatalism about HIV prevention in many quarters. It is long past time to discard that attitude. The world community must come alongside governments, civil society, religious organizations, and others to support their leadership and the sustainability of their HIV-prevention programs through effective prevention. The U.S. Government, for our part, considers it a privilege to do so.

The initial years of the Emergency Plan have demonstrated that high-quality prevention programs can work – and are working – in many of the world's most difficult places. Through PEPFAR, the American people have become true leaders in the world's effort to turn the tide against HIV/AIDS.

Mr. Chairman, thank you very much. I would be happy to address any questions.

Mr. SHAYS. Thank you very much. Dr. Hill.

STATEMENT OF KENT HILL

Dr. HILL. Mr. Chairman, and members of the subcommittee, as Assistant Administrator of the Bureau for Global Health at USAID, it is my privilege to testify on the importance of prevention in the President's Emergency Plan for AIDS, and to testify with my friend, Ambassador Dybul.

This discussion is particularly timely as only 3 weeks ago the 16th International AIDS Conference came to a close in Toronto, Canada. Against the backdrop of that conference, I returned to Washington with three overarching themes dominant in my thinking.

First, the United States is recognized as a global leader in the fight against HIV/AIDS. The sheer magnitude of the resources the United States has committed to this single disease is unprecedented beyond that of any other nation in the world.

Second, the fight against HIV/AIDS is far from over. Four million new infections every year means that we must markedly scale up and strengthen the prevention of new HIV infections globally.

And third, although opinions can and do diverge regarding the relative importance of various prevention interventions, we must differentiate between legitimate debate and the much more common misinformation so often associated with discussion of the U.S. endorsement of ABC, the abstinence or delay of sexual debut, the be faithful or at least the reduction of partners, and the correct and consistent use of condoms.

As Ambassador Dybul said, the ABC approach is an evidence-based, flexible approach and common sense based strategy which plays a major role in stemming the tide of HIV/AIDS pandemic.

It is too important to be bogged down in the politics of passion, too much is at stake, too many lives hang in the balance, too many children are vulnerable to become orphans if we fail in our prevention efforts. And it should be noted that one way to raise the quality of the discussion of ABC prevention intervention is to absolutely insist that it take place in the context of gender issues. After all, many of the problems associated with the spread of HIV are intimately connected with the absence of gender equity, the presence of gender-based violence and coercion typical of transactional and transgenerational sex. For all too many young girls, abstinence is not about being morally conservative, it is about having the right to abstain. The double standards of men who are unfaithful while their wives are is a gender equity issue. In short, AB interventions much be seen as fundamentally linked to gender and equality issues, a topic which can unite left and right, liberals and conservatives. We need to focus on the common ground.

The ABC approach to HIV prevention is good public health, based on respect for local culture. As has been stated, is it an African solution developed in Africa, not in the United States, and it has universally adaptable themes. To amplify this point, in May 2006 the Southern Africa Development Community, an alliance of several countries in southern Africa, convened an expert think tank meeting to identify and mobilize key regional priorities of HIV prevention. The media report characterized multiple and concurrent

sexual partnerships as essential drivers of the HIV/AIDS epidemic in the southern Africa region. They recommended in light of this fact that priority be given to the interventions that reduce the number of multiple and concurrent partnerships, address male behavior involvement, increase consistent and correct condom use, and continue programming around delayed sexual debut. Clearly these are African derived interventions that address ABC behaviors.

In the field, we are taking steps to find out how well our programs are working. In addition to our normal evaluation of program effectiveness, USAID is leading U.S. Government agencies in an independent evaluation, one not done by USG folks, of some PEPFAR supported ABC programs. An expert meeting was convened to develop new evaluation tools to measure program implementation and strengths. This will be followed by a longer term program evaluation that will be multi-country in nature, and will provide important information on program strengths and outcomes. We're excited about this progress and look forward to the findings which will be used to improve program performance.

One promising, yet overlooked aspect of the Emergency Plan, is its increased attention to issues of male behavior, which lie at the heart of women's sexual vulnerability and sexual coercion. I'd like to give you some examples of what I'm talking about here.

In South Africa, the Emergency Plan works with the Institute For Health and Development Communication's Soul City, the most expansive HIV/AIDS communication intervention in the country, reaching about 80 percent of the population. Soul City emphasizes the role of men in parenting and caring. It challenges social norms around men's perceived right to sex, sexual violence, and intergenerational sex. There is statistical correlation between exposure to Soul City programming and improved norms and values amongst men.

Also in South Africa, the Emergency Plan supports a very successful male involvement program known as Men As Partners. In addition to dealing HIV/AIDS prevention issues that include masculinity, stigma, domestic violence, men are encouraged to assume a larger share of responsibilities for family and community care by spending more time with their children, mentoring young boys in the community, and visiting terminally ill AIDS patients.

Or take for example, Zambia. The United States is working with the Zambian Defense Force to train peer educators and commanding officers to raise awareness among men in the military about the threat posed by HIV/AIDS and to enlist their support in addressing it. Training workshops cover basic facts about HIV/AIDS and its impact, including transmission, prevention, stigma, sexuality, gender, positive living, counseling, testing and care.

I'm going to skip Uganda. A lot has been said about that before, but there are a lot of good things that can be said here, and go on to Namibia.

The Lifeline Childline program addresses the root causes of gender violence. It uses age-appropriate messages to teach boys—as well as girls—about HIV/AIDS sexual abuse, domestic violence, and the resources available to vulnerable children through specialized counseling and other services.

And I'd like to conclude by underscoring the 2004 Lancet commentary on finding common ground. This was a piece signed by 150 AIDS experts, some in this room, from around the world, noting that the ABC approach can play an important role in reducing the prevalence in a generalized epidemic, and that partner reduction is of central epidemiological importance in achieving large scale HIV incidents reduction, both in generalized and in more concentrated epidemics.

Through partnership with host nations, effective programs for HIV prevention are possible even in the most difficult places. We will continue to support this common ground as we continue our massive response to HIV and AIDS.

Congressional commitment to a comprehensive HIV prevention strategy is the correct approach, and one clearly supported by the evidence. Thank you.

[The prepared statement of Dr. Hill follows:]

Testimony of
Kent R. Hill, Ph.D.
Assistant Administrator of the Bureau for Global Health
U.S. Agency for International Development

Before the
Committee on Government Reform
Subcommittee on National Security, Emerging Threats and International Relations
U.S. House of Representatives

"HIV Prevention: How Effective is the President's Emergency Plan for AIDS Relief?"

Washington, DC
September 6, 2006

Mr. Chairman, Ranking Member Kucinich, and Members of the Subcommittee: As Assistant Administrator of the Bureau for Global Health at the U.S. Agency for International Development, it is my privilege to testify on the importance of prevention in the President's Emergency Plan for AIDS Relief (PEPFAR/Emergency Plan). I will also address the broader topic of the fundamental importance of prevention addressing the HIV/AIDS pandemic.

This discussion is particularly timely, as only three weeks ago the 16th International AIDS Conference came to a close in Toronto, Canada. The International AIDS Conference is intended to be a scientific meeting, but it offers an opportunity to spotlight the HIV/AIDS epidemic on a global stage. Both Ambassador Dybul and I had the opportunity to engage conference participants in robust, frank dialogue about the critical interventions needed to accelerate the prevention of HIV. Against the backdrop of the conference, I returned to Washington with three overarching themes dominant in my thinking:

- **One**. The United States is recognized as the global leader in the fight against HIV/AIDS. The sheer magnitude of resources the U.S. has committed to this single disease is unprecedented, and beyond that of any other nation in the world. In both public comments and in the press, the Emergency Plan is repeatedly cited as the single greatest contributor to the fight against HIV/AIDS.

- **Two**. The fight against HIV/AIDS is far from over. In fact, I don't believe we've yet even turned the corner. Despite impressive achievements in the expansion of treatment numbers, four million new infections every year threaten to dwarf the global resources available to meet the treatment requirements in the years ahead. This simple arithmetic fact means that we have no alternative but to scale up significantly and strengthen the prevention of new HIV infections globally. And since the vast majority of new infections occur through sexual transmission, we must focus particularly on that area.

- **Three**. Although opinions can and do diverge regarding the relative importance of various prevention interventions, we must differentiate between legitimate debate and the much more common misinformation so often associated with discussion of the U.S. endorsement of ABC – "abstinence or delay of sexual debut," "be faithful and at the very least partner reduction," and "correct and consistent use of condoms." The ABC approach is an evidence-based, flexible, and common-sense based strategy which plays a major role in stemming the tide of the HIV/AIDS pandemic. It is too important to be bogged down in the politics of passion. Too much is at stake, too many lives hang in the balance, too many children are vulnerable to become orphans if we fail in our prevention efforts.

It should be noted that one way to raise the quality of the discussion of ABC prevention interventions is to insist that it take place in the context of gender issues. After all, many of the problems associated with the spread of HIV are intimately connected with the absence of gender equality, the presence of gender-based-violence and coercion typical of transactional and transgenerational sex. For all too many young girls, abstinence is not about being morally conservative, but about having the "right" to abstain. The double-standards of men who are not

faithful while their wives are is a gender equity issue. In short, AB interventions must be seen as fundamentally linked to gender inequality issues – a topic which can unite Left and Right, liberals and conservatives. We need to focus on such common ground.

PEPFAR Reflects the New Direction of U.S. Foreign Assistance

Ambassador Dybul has spoken on Emergency Plan funding and the rationale behind its allocations. In addition, I'd like to offer a complementary perspective on why the U.S. commitment to HIV/AIDS is so important. Currently, USAID is distinguished to have at its helm the first U.S. Global AIDS Coordinator, who is now serving concurrently as the first Director of U.S. Foreign Assistance and as Administrator of USAID. Ambassador Randall Tobias has said he believes the early success of PEPFAR is due to its overall strategic framework, which reflects the new transformational nature of U.S. foreign assistance.

True transformational development requires far-reaching, fundamental changes in governance and institutions, human capacity and economic structure, so that countries can sustain further economic and social progress without permanently depending on foreign aid. To make a real difference, the resources of the U.S. **must** be focused on transformational initiatives that are owned over time by the developing nations themselves. Therefore, U.S. foreign assistance now centers resources around five overarching objectives: peace and security, governance and democratic participation, investing in people, economic growth, and humanitarian assistance. The ravages of HIV/AIDS threaten and undermine all of these inter-related elements of transformational development. PEPFAR's high-impact, strategic approach to comprehensive HIV/AIDS prevention, care and treatment serves as a basis for alleviating the suffering of those infected and affected by HIV/AIDS. In addition to implementing currently validated programs, PEPFAR is assessing potential new technologies and approaches, such as microbicides and male circumcision. In addition, U.S. foreign assistance supports a multi-sector approach to HIV/AIDS -- ensuring coordination between HIV programs and family planning, food security, agriculture, and education programs.

The Effectiveness of the ABC Approach to Prevent Sexual Transmission of HIV

The ABC approach to HIV prevention -- Abstain, Be faithful, correct and consistent use of Condoms – is good public health, based on respect for local culture. It is an African solution, developed in Africa, not in the United States, and has universally adaptable themes. Three qualities of the ABC strategy are important to understand its central role in the Emergency Plan's emphasis on prevention of sexual transmission of HIV.

- The ABC approach is a balanced strategy that, in its application, is adaptable to diverse epidemic circumstances;
- ABC has a proven and impressive track record, well beyond the most famous example of Uganda. There is a clear and compelling body of scientific study supporting its effectiveness. It also has the benefit of being firmly rooted in common sense;

- Also, the ABC strategy's effectiveness has been affirmed by other leaders in the international community as the most effective way to prevent sexual transmission of HIV.

At the International AIDS Conference in Toronto, I hosted a USAID session called *Refining the Prevention Paradigm: Exploring the Evidence and Programmatic Models for Behavior Change.* The discussion provided further acknowledgment that the appropriate mix of A, B, and C is absolutely essential in the fight against AIDS. In particular, the adaptability of this strategy allows responses to be tailored according to local epidemic circumstances. For instance, in places like Kenya, Uganda, and Zimbabwe, most new infections result from chains of overlapping sexual partnerships in the general population – fueling what we call a generalized epidemic. Through community mobilization efforts, education and awareness activities, the data indicated increased adoption of ABC behaviors, and pointed particularly to a reduction in multiple partners. Furthermore, the data showed associated declines in HIV. By contrast, epidemics such as those in Thailand and Cambodia are primarily associated with commercial sex work, and are therefore concentrated in identifiable population groups. In these instances, we also see the adaptation of certain ABC behaviors – particularly the B and C portions: vigorous correct and consistent condom use, as well as a decline in the proportion of men visiting prostitutes, thus decreasing the risk of HIV transmission to themselves and their spouses. In the cases of Thailand and Cambodia, although it is the C aspect of ABC that is the most well-known factor, other behavior change has clearly led to an associated decline in HIV.

More recently, as Ambassador Dybul has described, impressive new Demographic Health Survey evidence from a growing number of nations is expanding the evidence base for the ABC strategy in generalized epidemics, such as those in most of sub-Saharan Africa. These new data are only a snapshot of the undeniable success associated with the adoption of ABC behaviors around the world. This growing body of evidence paints a powerful picture: simply put, ABC works.

To amplify this point, in May 2006, the Southern Africa Development Community – an alliance of several countries in Southern Africa -- convened an expert, think-tank meeting to identify and mobilize key regional priorities for HIV prevention. The meeting report characterized multiple and concurrent sexual partnerships as central drivers of the HIV/AIDS epidemic in the Southern Africa region. They recommended that priority be given to interventions that:

- reduce the number of multiple and concurrent partnerships;
- address male involvement;
- increase consistent and correct condom use;
- and continue programming around delayed sexual debut.

Clearly, these are African-derived interventions that address ABC behaviors.

In the field, we are taking steps to find out how well our programs are working. In additional to our normal evaluation of program effectiveness, USAID is leading U.S. Government agencies in an independent evaluation of some PEPFAR-supported AB programs. An expert meeting was convened to develop new evaluation tools to measure program implementation and strengths. This will be followed by a longer term program evaluation that will be multi-country in nature

and will provide important information on program strengths and outcomes. We are excited about this progress and look forward to the findings, which will be used to improve program performance.

Because it is a remarkably simple and easily translated message, ABC is often portrayed as simplistic, and even as a superficial approach to addressing much tougher issues underlying sexual transmission of HIV in a generalized epidemic, particularly in the developing world. One promising yet overlooked aspect of ABC's role in the Emergency Plan and in prevention efforts globally is its relevance to effectively address gender issues, including power relationships, women's sexual vulnerability, and destructive male sexual behaviors.

Critics of the Emergency Plan argue that the ABC does not speak to a woman's ability, or inability, to negotiate within a sexual relationship. But, in fact, central to the ABC strategy are parallel efforts to address the vulnerability of women and girls. In addition, within the ABC strategy there is very specific and growing attention to issues of male behavior, which of course lies at the heart of gender inequality and sexual coercion. This past June, there was a particularly interesting article that ran in the Boston Globe. The story highlighted the Emergency Plan's significant efforts to target HIV prevention in men. I will briefly discuss those efforts now, in light of how male behaviors can and often do affect women, particularly the women of sub-Saharan Africa.

The Emergency Plan is based on the firm belief that it is impossible to stem the spread of HIV without addressing the unbalanced power relations between men and women. Working with boys and men is and must be an ever greater integral focus of the Emergency Plan's HIV prevention programs, especially since male behavior is a prominent root cause of female vulnerability to HIV/AIDS. Among the many factors that help fuel the HIV epidemic, putting both men and their partners at risk are:

- Socially-structured norms and expectations related to men's behavior and roles;
- the acceptance of casual sex and multiple sexual partnerships;
- the encouragement of older men to have sexual relations with much younger women;
- viewing men in the household as the sole decision-maker;
- the likelihood that males will engage in risky sexual behavior – often made even more likely because of lowered inhibitions related to alcohol use; and
- use of illegal drugs, which often results in the spread of the disease through dirty needles, unprotected sex, and the descent into prostitution to acquire drugs.

Furthermore, men's reluctance to seek health services limits their ability to learn their HIV status, and limits the likelihood that they will be challenged to change their risky sexual behavior and adopt preventative behaviors. Through a variety of programs, the Emergency Plan is tackling these issues:

- **In South Africa**, the Emergency Plan works with the Institute for Health and Development Communication's Soul City, the most expansive HIV/AIDS communication intervention in the country, reaching more than 80 percent of the population through mass and interpersonal communication programming. Soul City

emphasizes the role of men in parenting and caring. It challenges social norms around men's perceived right to sex, sexual violence, and transgenerational sex. There is a statistical correlation between exposure to Soul City programming and improved norms and values amongst men.

- **Also in South Africa**, the Emergency Plan supports a very successful male involvement program known as "Men as Partners." In addition to dealing with HIV/AIDS prevention issues that include masculinity, stigma, and domestic violence, men are encouraged to assume a larger share of responsibilities for family and community care by spending more time with their children, mentoring young boys in the community, and visiting terminally ill AIDS patients.

- **In Zambia**, the U.S. is working with the Zambian Defense Force to train peer educators and commanding officers to raise awareness among men in the military about the threat posed by HIV/AIDS, and to enlist their support in addressing it. Training workshops cover basic facts about HIV/AIDS and its impact, including transmission, prevention, stigma, sexuality, gender, positive living, counseling and testing, and care.

- **In Uganda**, the Empowering Africa's Young People Initiative includes a focus on masculinity and gender norms. Community advocacy and sensitization meetings are conducted for both younger and older males. For younger males, the focus is on challenging norms about masculinity, challenging the acceptance of early sexual activity and multiple sexual partners for boys and men, and challenging the dangerous and abusive practice of transactional sex. As for older males, the focus is on supporting counseling, peer education, community interventions, and the ending of the dangerous and abusive practices of transactional and cross-generational sex.

- **Also in Namibia,** the Lifeline Childline program addresses the root causes of gender violence. It uses age-appropriate messages to teach boys – as well as girls – about HIV/AIDS, sexual abuse, domestic violence, and the resources available to vulnerable children through specialized counseling and other services.

Prevention of Mother-to-Child Transmission: A Cross-Cutting Initiative

The area of Prevention of Mother-to-Child Transmission, or PMTCT, is one of the most dynamic and multidimensional interventions under the Emergency Plan. While PMTCT is budgeted under "Prevention" in PEPFAR country operational plans, not all PMTCT funding is captured in its line item in the PEPFAR budget. In fact, PMTCT is actually a cross-cutting program area that involves prevention, care, and treatment. The setting for PMTCT is often an entry-point for other services, including treatment with antiretroviral therapy. To view PMTCT as one-dimensional is to lose sight of the overall, strategic nature of the Emergency Plan.

In 2005, almost one-third of Emergency Plan-supported HIV counseling and testing was conducted in PMTCT settings. To put this in perspective, several health centers in Rwanda have initiated highly successful programs to engage men in PMTCT services. Partners are invited to accompany women to prenatal visits and receive voluntary HIV counseling and testing. They

participate in the prenatal counseling, provided to their partners. Associated community services work to change male attitudes and behaviors that compromise their own health, as well as the health of women and children. In Uganda, Kenya, and South Africa, programs have begun to initiate partner testing within PMTCT settings.

Similarly, psychosocial support groups for pregnant women and mothers in the postnatal period are highly valued activities often budgeted under PMTCT. In addition, infant follow-up, which is necessary to minimize transmission during breastfeeding and to diagnose infants, is part of comprehensive PMTCT programs. Other PMTCT activities entail technical assistance to strengthen local PMTCT systems, training personnel in the provision of services, and building strong referral networks for children born to HIV positive mothers.

Preventing 7 Million HIV Infections: How USAID Fits into the Emergency Plan's Function of Strategic Information

Earlier I alluded to the Demographic Health Survey, or DHS. Data from the DHS, which collects behavior and HIV prevalence data at the population level, contribute to PEPFAR's work of calculating infections averted. USAID has supported such population-based surveys since 1982, and now continues to be the primary supporter of DHS under PEPFAR.

USAID's Office of HIV/AIDS makes important contributions to the design and successful implementation of PEPFAR's Strategic Information and Reporting system. The Office of the U.S. Global AIDS Coordinator has organized four interagency Technical Working Groups to manage PEPFAR's Strategic Information and Reporting system. USAID co-chairs each of these Technical Working Groups, along with HHS/CDC, and offers critical feedback on surveillance and surveys, health management information systems, capacity building with regard to monitoring and evaluation, as well as indicators and reporting. In addition, a number of USAID staff serve as Strategic Information Advisors to PEPFAR country teams overseas. Since the late 1980s, USAID has administered an interagency agreement with the Census Bureau to produce occasional reports on the state of the HIV epidemic and its effects on overall health status and social institutions.

Conclusion

I'd like to conclude by underscoring the 2004 *Lancet* commentary on finding common ground. This piece was signed by 150 AIDS experts from around the world noting that, "the ABC approach can play an important role in reducing the prevalence in a generalized epidemic"...and that "partner reduction is of central epidemiological importance in achieving large-scale HIV incidence reduction, both in generalised and more concentrated epidemics."

Congressional commitment to a comprehensive HIV prevention strategy is the correct approach, and one that is supported by the evidence. Through partnership with host nations, effective programs for HIV prevention are possible – even in the most difficult places. We will continue to support this common ground as we advance our massive response to HIV and AIDS.

Thank you -- I'm glad to respond to your questions.

Mr. SHAYS. Thank you very much.

Mr. Duncan, we'll have you start off.

Mr. DUNCAN. Well, thank you very much, Mr. Chairman.

Let me ask this. We have a GAO report that says that the PEPFAR prevention budget is $322 million, and that's 20 percent of the total PEPFAR budget, which would mean the total PEPFAR budget would be approximately $1.6 billion; is that close to being correct?

Ambassador DYBUL. Yes, sir, that is correct, in terms of the 15 focus countries that were mentioned by the chairman. The entire PEPFAR budget encompasses other bilateral programs, it encompasses international research on HIV/AIDS, and it also encompasses our contribution to the Global Fund for AIDS, tuberculosis and malaria, which is substantial. So it would be $1.6 of $3.2 billion, approximately.

Mr. DUNCAN. According to CRS, it says we're giving about $350 million, roughly, to the Global Fund over the last couple of years, each year.

Ambassador DYBUL. Correct.

Mr. DUNCAN. So the total PEPFAR budget is $3.2 billion.

Is there any other country that is contributing figures like that to fight AIDS outside of their own country that you know of?

Ambassador DYBUL. Tragically, no. According to a recent analysis by the Kaiser Family Foundation, the American people are providing approximately half of all global partner resources for HIV/AIDS. No one is in the category of the United States. In fact, the United States provides as much as all other international what is called donors,a word I really don't like because we're talking about donors/recipients, we're talking about partners—but yes, we provide as much as everyone else combined.

Mr. DUNCAN. You know, I think that's very important because I think some of these are really good things for us to do, but so often the American taxpayers just don't get nearly the credit that they deserve because we're doing far more in this area than any other country. No other country, even developed nations, are coming close. And this money for the most part is being spent in countries where the cost of medical care is far, far cheaper or far less than it is in this country; is that correct?

Ambassador DYBUL. Yes, sir. It would be true that the cost per person for nearly every intervention is lower in the countries in which we're working than it would be in the United States.

Mr. DUNCAN. Let me ask you this, a later witness apparently will testify, or part of his statement says, now PEPFAR and USAID lead the world in AIDS prevention, promoting a balanced and targeted set of interventions that include abstinence, being faithful and condoms for those who cannot and will not follow A or B behaviors. This is in spite of formidable and continuing institutional resistance to change. As a senior USAID officer commented not long ago, "USAID is in the condom and contraceptive business, that is our business."

Do either one of you, are you finding this formidable and continuing institutional resistance to change that this later witness refers to?

Ambassador DYBUL. Well, sir, let me begin, and then Dr. Hill, I'm sure, will want to comment on that.

I think one of the important pieces of the GAO report that has not been commented on often is that in three or four places it states that there is now a consensus by American government personnel in the field that ABC is a balanced approach as what is needed. Now that doesn't mean there aren't people who are still attached to older philosophies. I actually come to HIV/AIDS as a therapeutic scientist and researcher, and it's become very clear, if you look at prevention data—which I've done, I didn't enter this with any particular dog in the race, I just wanted to look at the data as a scientist—that the data for ABC are overwhelming. There is no example of a decline in HIV prevalence in a generalized epidemic such as Africa without all three components, without all three ABC components.

But most of the initial prevention work that was done was not in generalized epidemics, it was in what's called concentrated epidemics, places where identified populations are at high risk, prostitutes, men having sex with men, truck drivers, and much of the initial work was done in those populations. And they're more of a BC message, which is shown to be highly effective. Unfortunately what's happened is some people tried to transfer data from a concentrated epidemic—because that's the work they were familiar with—to a generalized epidemic, and we still have people holding on to the old data set, not moving to the new data set. But that is increasingly becoming less and less of an issue as the data are overwhelming. But we see this unfortunately in any circumstance. In treatment we still have people who want to use two instead of three drugs because they haven't caught up with the data. So we do have to continually educate and provide the data, and the data base is growing substantially.

I think we've largely overcome some of those earlier prejudices as the data become available, but it's a constant effort and we're still working on it.

Mr. DUNCAN. Before Dr. Hill comments, let me, before my time runs out—and maybe Dr. Hill will want to comment on this—that's a very good answer, Mr. Ambassador, that you've just given me, but also another later witness will mention the point about where women do not have the power to refuse unprotected sex and it says that's the problem, not the presence of abstinence or faithfulness per se. Now maybe one or both of you might want to comment about that, in addition to these other comments or answers.

Ambassador DYBUL. Again, if I could start and then Dr. Hill could answer both of those two pieces.

You know, in the case of gender equality or violence against women, negotiating A, B or C is a very difficult endeavor. So as Dr. Hill mentioned, we need to deal with some of the entrenched gender issues, and we are, in fact, dealing with those. We're dealing with those in terms of transactional sex, transgenerational sex, we're teaching young men a lot of important lessons about respecting women. We're tying our programs to issues of gender violence, including the President's initiative on women's empowerment. All of those are important, but I think it is also important that the ABC message is relevant for gender inequality; if men learn ABC,

if men practice ABC, gender issues become easier to deal with because the men themselves will allow for the negotiation of an A, B or C intervention. We've seen over and over again the data for young men radically changing their B behavior, becoming faithful, reducing their partners as a major reason for declines in prevalence, and that is very much affecting the gender issue.

So I think as in most things related to HIV/AIDS, any time we begin with this or that, we're making a mistake, it's generally everything and all and more. And so we need all of these approaches to deal with gender. But ABC is very relevant for gender, particularly if you target the men, and we have a lot of programs to do that, particularly young men.

Mr. DUNCAN. Plus some of that training for men on teaching respect for women and so forth would help curb this program in the future. You can't solve this problem immediately or all at once.

Dr. Hill, I didn't mean to cut you off. I'd be interested in your comment.

Dr. HILL. Congressman Duncan, let me begin with your first question as to whether in fact there is resistance among career people to a comprehensive ABC approach and if there is a favoritism toward the C.

I think if you talk to career people about this, they will be the first to acknowledge that the international approach, including much the of the U.S. approach, in the initial years did tend to view condoms as a kind of silver bullet that might have a huge impact on this. But as the evidence begin to mount that condoms were not going to be enough, and as the evidence mounted as to how prevalence rates were going down in Uganda precisely by using a comprehensive approach, a lot of talk about what they would refer to as zero grazing or partner reduction or monogamy within marriage, etc., faithfulness within the sexual partnerships, when the evidence began to come in that it was this behavior change that was having a dramatic impact on the lowering of prevalence, career people, it didn't matter if they were Democrat or conservative, religious or non-religious, they could see the facts, they could tell that these interventions had a lot more potential than they at first perhaps thought. And so I feel very strongly that the core team of professionals with whom I work with at USAID—and I think this is true of the other Federal agencies—have really had a remarkable shift toward understanding the importance of a comprehensive approach. I feel very good about that.

Now, internationally, we have a long ways to go to have won that battle. And in fact, I really honestly believe that the battle is there. And Ambassador Dybul is absolutely right to point out that one of the reasons is so critical that the United States spend sufficient attention on AB is because you're not likely to find it anywhere else. It's not going to be there yet because people don't yet believe that it's going to be that effective.

And so what I really think we've got to do is two things. We have simply got to focus the world's attention on the fact that this is an evidence-based approach, that all the data suggests that it can be very, very effective. What I find fascinating is that even in a place like Asia where we focused on condoms, AB behaviors changed as well. The percentages of young men that were having their first

sexual experience with sex workers or prostitutes went down. The number of police that were visiting sex workers or prostitutes went down. Throughout many parts of Africa, the evidence suggested people could change their behavior, even to the point of changing to abstinence or to partner reduction if they were sexually experienced. So the evidence is very strong.

The second thing that I think will help get this out of what I call the culture wars debate is to emphasize the connection to gender issues. This is a winner of an approach that will affect gender issues. You cannot affect gender inequality issues or equality issues without doing AB interventions, they're critically important to it.

Your last point about—I'm trying to remember what your last point was—had to do with——

Mr. DUNCAN. It was about the women who——

Dr. HILL. Right. Whether it's realistic—and I think there have been two myths that have been perpetrated. One is that abstinence is not realistic with the young. They simply aren't capable of it. Their hormones are too strong. And the second of course is that be faithful programs don't work when the husband is not faithful. The latter point of course is absolutely obvious. That's why you have to focus on male behavior and not just female behavior. But the evidence is also overwhelming that young people are quite capable of moderating their behavior as well.

So I think what's really needed is for more than ABC, it's gender programs, it's working with pregnant women, it's treatment programs so that people when they get tested and change their behaviors have some hope for the future. It's all connected, and we've got to never treat it in an isolated fashion.

Mr. DUNCAN. Thank you, Mr. Chairman.

Mr. SHAYS. Thank you. Mr. Waxman, you have the floor.

Mr. WAXMAN. Thank you, Mr. Chairman.

Ambassador Dybul, there are several countries where overall prevalence rates have come down significantly. They include Uganda, Kenya and Zimbabwe; is that correct?

Ambassador DYBUL. That is correct, those three; there are many others, actually.

Mr. WAXMAN. Well, experts have identified multiple reasons for these declines. Some factors have nothing to do with behavior change. For example, when young people who have high infection rates leave the country for economic reasons, average prevalence goes down; and sadly, prevalence also goes down when death rates are high. But we do know that in these countries there have been some positive behavior changes. Can you give us some of the examples?

Ambassador DYBUL. Yes, I'd be glad to. And I think you raise a very important point about other factors. There's no question there are other factors, and this is a very complicated scientific approach. However, the recent report from Zimbabwe, for example, looked very specifically at whether or not death contributed to the decline in prevalence, and they looked very scientifically at that in Science Magazine. Only 6 percent of the decline in prevalence was due to death or other factors, only 6 percent. And the report, I mentioned in my testimony where a group looked across the board at multiple countries, about 10 actually, they determined that the decline in

prevalence was in fact substantial behavior change. While these other things contributed, it was substantial behavior change.

A couple of the examples that we can give, whether it's Uganda, Kenya or Zimbabwe, which probably have the most up to date solid data in this respect—we're still looking at some of the other countries—as I mentioned, 50 percent decline in young men who had multiple partnerships. Increase in age of first sexual activity by a year or so, and in fact this overall survey determined that, as in Uganda, was probably one of the most substantial reasons why we saw a decline in prevalence because just that shift in a year remarkably shifts the epidemiology of the infection as less people become infected early who then infect less people. That's a very significant impact.

Importantly, secondary abstinence, building on what Dr. Hill just said, Kenya actually looked in their demographic health survey at people who had previously been sexually active versus those who had been sexually active in the last year; secondary abstinence, people who have been active sexually and no longer were, and saw remarkable progress there, 50 percent.

We also saw, both in the Zimbabwe data and in the Kenya data, as in the Uganda data, some increase in condom use particularly among young women, now a doubling of the use of condom use among young women. Unfortunately we didn't quite see a commensurate change among the young men.

So it is a complex picture, but the data are repeated over and over again supporting A, B and C.

Mr. WAXMAN. My understanding of the epidemiology is that we can link these behavior changes to lower prevalence rates, but what we generally can't do is say this program led to that behavior change, resulting in lower prevalence. Can you explain that?

Ambassador DYBUL. Yes, and this gets to the complicated nature of behavioral science. Aristotle once said you can only be as precise as your subject matter allows, and unfortunately that is the case with behavioral science. Unlike treatment, where you can follow someone's CD–4 cell count or follow their viral load, behavior signs is a much different thing. So what we do is look at prevalence rates, as we've talked about, and we look at behavior change that has occurred over that same time period. You can then link and say this program led to this effect. You can look to see where programs were introduced and whether or not they were introduced largely, and whether or not—you can basically guesstimate that those programs in fact led to the change in behavior that was correlated with the decline in prevalence. It's a much more complicated matter than most sciences.

Mr. WAXMAN. I think that's an important point to highlight because there's a tendency to get bogged down in arguments over exactly which kind of program got results at a national level, but we can't make that kind of claim. We can only know that in certain countries that did implement comprehensive programs, significant behavior changes have led to decreased prevalence. While it's important to clarify the limits of our current knowledge, we do need to get more precise information on how specific interventions impact behavioral change. What are we doing to study this?

Ambassador DYBUL. And that's an important point because that is something you can do in a scientific way is look at programs and see what impact they've had on behavior change. We actually do this in a variety of ways. Many partners do it themselves, and in fact we just had a meeting in Durban, South Africa where 700 scientific abstracts were presented, including quite a few on this topic, where, for example, in Nigeria they introduced what's called the zip-up campaign, and during the time that the zip-up campaign—which was an abstinence campaign—was in play, they saw a dramatic increase in abstinence activities. We have looked at programs on college campuses where we've introduced such ABC programs and looked at the change among those participants.

We have done a number of what we call targeted evaluations to look at this approach. These take a long time. They generally take a couple of years. Dr. Hill talked about a couple that USAID is doing. We're also shifting the way we're doing things, moving from a targeted evaluation approach to public health evaluation approach so that we can do more and more of these efforts, and they are ongoing——

Mr. WAXMAN. Ambassador Dybul, I have a lot of other questions, but I appreciate your answer to that. And I think these evaluations are extremely important. I also think that country teams should have the flexibility to refine their prevention programs based on the evidence we glean from these studies in the coming years.

Your office has turned the one-third requirement into two parts; countries must spend at least 50 percent of prevention funds on sexual transmission; then they must spend 66 percent of those funds on AB programs. I understand that a number of countries were able to get exemption from one or both of these requirements; isn't that correct?

Ambassador DYBUL. That's correct.

Mr. WAXMAN. Now for the countries that didn't get exemptions, the formula means that if they spend more than 50 percent on sexual transmission, they must spend more than 33 percent on AB programs; is that right?

Ambassador DYBUL. That's correct. And that makes some sense. I'd be happy to explain that.

Mr. WAXMAN. In response to the GAO report, the administration said that—you asked those countries that didn't apply for exemptions if they wanted to, and you wrote that the answer was a resounding no. I'd like to read into the record what U.S. guidance is to these countries.

Both in 2006 and 2007 guidance state, "please note that in a generalized epidemic a very strong justification is required to not meet the 66 percent AB requirement." The 2006 guidance also said, "we expect that all focus countries, and in particular those with budgets that exceed $75 million, will meet these requirements."

In addition, both years guidance state, "in any case, no country should decrease from 1 year to the next the percent of sexual transmission activities that are AB. There will be no exceptions to this requirement."

I think that it's difficult to know what country would really have deferred, absent this strong language from their biggest donor.

Ambassador Dybul, I'd like to ask you a few questions about male circumcisions. I understand that four of these studies have indicated male circumcision decreases the risk of a man contracting HIV, and one randomized control study showed that male circumcision lowered the risk by about 75 percent. Lower rates of HIV among men will mean fewer risks for women in the population. Can you tell us what the United States is doing to assess the appropriate role of male circumcision in HIV prevention?

Ambassador DYBUL. I'd be happy to. I'd first like to get back to some of the difficult issues you raised with behavioral data.

Mr. WAXMAN. Excuse me, Ambassador Dybul. My problem is that in another second or two the light is going to switch, so I really do have to move on.

Ambassador DYBUL. I would just say in a sentence that most of those studies——

Mr. WAXMAN. The chairman said I can have as much time as I want, so please feel free to go back. And we'll stay here all day.

Mr. SHAYS. No. The bottom line is that we don't have a lot of members, but if Mr. Waxman wants you to answer another question, he has the privilege to ask you to go to the next one.

Ambassador DYBUL. Most of those studies just showed an association between people who were circumcised and the protection. There are now a couple of studies that were just presented in Toronto that showed that in fact isn't holding up. That one randomized control target you mentioned looked at the actual intervention; programmatically if we proactively did circumcision, would there be a benefit. One trial has shown a benefit, a 60 to 70 percent reduction to men, it said nothing about the women. It also showed an increase in sexual activity by the young men, and there's actually a mathematical model that shows if men think they're fully protected and have more activity, you can actually offset the benefit of the circumcision.

Mr. WAXMAN. Let's take that first part. If men don't get HIV because they're circumcised, it does help the women because if they do have sexual activity——

Ambassador DYBUL. The problem is that they do, they just get a lower rate. It's a 60 to 70 percent reduction. So that's why you can actually mathematically show that if men increase their activity by a certain percent it will offset the benefit of the circumcision. We don't know that. That's a guesstimate.

There are two other randomized controlled trials, large trials that are underway right now, they're ongoing. The Data Safety Monitoring Board has twice not stopped the studies; in other words, allowed them to continue. We don't know what that means. We are expecting data in the next 6 to 12 months, depending on whether they get to their end points.

These studies look a little more carefully at some of the other issues involved. In anticipation of those studies, because we don't know the results and it would not be responsible, no one in the world right now is advocating—no major international organizations are advocating active programmatic use of circumcision, but what we have done is given countries flexibility—and several have through our resources—to do preliminary work, to do preparatory work. Unfortunately, as you know, circumcision does have cultural

connotations to many people, and so we're doing some of the cultural sensitivity work, just like we have to do for vaccines and other work. Should circumcision be proven to be effective and have normative guidance, one implementing agency, not a scientific agency, that's NIH and other people's business, should there be normative guidance on the use of circumcision, it is something we would fund, but we will do it carefully because you need to provide the ongoing ABC behavior change with the circumcision or you can actually offset the benefit.

Mr. WAXMAN. I appreciate that answer. I certainly hope—and we're going to have to look at the evidence—that this can help in reducing HIV transmission. I also hope that if and when the time is right program staff will have the funding and flexibility to implement it, and I see you shaking your head.

Mr. Hill, I'd like to ask you about the role that the one-third earmark has played in the policy. There are some who say before the President's program started there was too much emphasis on condoms. And I gather that was your view as you expressed it earlier; is that correct?

Dr. HILL. I think that's what my career folks tell me; they tell me that there was a tendency to focus on condoms, yes.

Mr. WAXMAN. And do you think things have changed since PEPFAR started?

Dr. HILL. Yes. Both because of the evidence, because we were forced to look at the evidence closely. So no, I think it's quite a different situation now. The best empirical studies on this are given by career people, not by political appointees.

Mr. WAXMAN. If the legislative earmark were to be removed or modified, would USAID and its partner agencies still work to ensure that abstinence and be faithful programs play an appropriate role in country's HIV prevention programs?

Dr. HILL. I'd like to think we would. As an implementer, you know that all implementers like flexibility, they like the options of making their own decisions on how to do things. But I do think it's appropriate and right for Congress to insist that we have a comprehensive strategy, but I'd like to believe we would do the right thing anyway.

Mr. WAXMAN. Well, Dr. Dybul's office has the authority to approve or reject a country team's plans each year, and I trust that if the arbitrary quota for abstinence programs is removed, you both, along with our health experts in the field, would maintain AB programming where it is supported by evidence and by local needs.

Ambassador Dybul, you noted in your testimony the U.S. continues to support condoms and condoms programs. While many believe that we are not doing enough to promote and fund condom use, you clearly agree that condoms are a crucial component of an effective prevention program.

I have a question about appropriations language that has been referred to as the condom nondisparagement provision. It says, "information provided about the use of condoms as part of projects or activities that are funded from amounts appropriated by this act shall be medically accurate and shall include the public health benefits and failure rates of such use."

Well when used consistently and correctly, condoms reduce HIV transmission by 85 percent to 95 percent. But there have been disturbing reports of programs that teach that condoms have holes or that they don't block HIV.

What is the administration doing to ensure that U.S.-funded programs do not spread false information about condoms?

Ambassador DYBUL. Thank you for that question because it is an important one. Because we do have a full ABC approach as is evidenced by our funding distribution and by our guidance. We would take that provision of the law as seriously as any other provision. And so we make clear to everyone, and have done so on multiple occasions, that should anyone be aware of such activity occurring, such medical misinformation occurring, in a PEPFAR-funded program, we need to know about that, and we need to intervene either at the level of the cognizant technical officer and, if that is not successful, higher than that.

Dr. HILL. There is actually in the USAID contract, for example, a very specific provision which requires any recipient of funds, even if all they are doing is AB programming, if they mention C, they have to mention it in a medically accurate way. If a report reaches us that they are not, that is a breach of what they signed.

Mr. WAXMAN. I appreciate that answer.

Thank you, Mr. Chairman.

Mr. SHAYS. In answer to almost every question, there was the word "evidence." And I am not quite sure how to take the word "evidence." I am more inclined to want to say there are indications that. What scientific evidence is available that says that one-third should be for abstinence as opposed to two-thirds or as opposed to one-sixth? Why one-third?

Ambassador DYBUL. Well, there is certainly no randomized controlled clinical trial that gives a percent of a program that should be dedicated to one or the other. What we do have are data that suggests very clearly that you need all three components, A, B and C, and 33 percent gives us a very balanced program.

So you can't find a randomized controlled trial to give you that number, but you can find an interpretation or application of available data for a balanced approach that would get you to 33 percent for AB.

Mr. SHAYS. Dr. Hill, how would you answer the question?

Dr. HILL. Well, I think the experience of PEPFAR in practice illustrates that, in fact, it is not viewed as rigid. There has been enough flexibility, Congress has allowed enough flexibility, that when it was appropriate to not spend that amount, exceptions have been made. In some cases it would be appropriate to have a higher percentage.

So, in fact, the way the program has been implemented shows a fair amount of flexibility.

Mr. SHAYS. When would it make sense to have it higher than one-third?

Dr. HILL. If it was a generalized epidemic, it is very possible that the messages to the general public that have to do with behavior and the behavior of young people and the behavior of sexually active people could have the biggest impact on lowering the prevalence rate. If it is not primarily being spread by truck drivers or

by sex workers or prostitutes or in the high-risk groups, that it is a very good possibility the behavior change messages in AB are the things that will likely bring the prevalence rates down the fastest.

Ambassador DYBUL. In addition to that, Mr. Chairman, if I could add, again, we are not the only player. While we are as much as everyone else in the world combined, there are others. And so we ask our country teams to look at the circumstance in their country, getting to the comment by the Minister of Health in Namibia that he needs us, the United States, to provide substantial support for AB because no one else is doing it.

Mr. SHAYS. Briefly describe three or four abstinence programs to me.

Ambassador DYBUL. I can describe some of the ones I have seen. I can give you a couple from different age groups, and, again, we have very few abstinence-only programs except for young kids. What we have are AB programs and ABC programs once you got above 15. So an example of an A only program would be a 10-year-old school program where for 10-year-olds in schools, the teachers have sessions on a daily basis. And this is a program in Uganda where the kids in the morning learn about the importance of HIV-AIDS in their community and how they as a 10-year-old can avoid it through abstinence.

As you get older, the message changes to AB messages. So we have programs in older kids, but still under 14, where they talk about the importance of HIV-AIDS in the community, but also abstinence and fidelity overall. And this is in the school.

Mr. SHAYS. So abstinence and fidelity in what terms?

Ambassador DYBUL. People use different terms, and, again, it is culturally sensitive. In many countries being faithful means go to church. So they use different terms such as zero grazing. In some countries the term abstinence doesn't resonate——

Mr. SHAYS. I can see you explaining to someone that maybe they don't want to smoke because they will get cancer. That would have a huge impact.

Ambassador DYBUL. Absolutely. And that is——

Mr. SHAYS. But it is more than just explaining that abstinence will protect you from getting HIV-AIDS. It is into more than just that, correct?

Ambassador DYBUL. If I understand the question correctly, it begins with the danger, the risk to you for HIV-AIDS.

Mr. SHAYS. Let me say it this way: I think being honest with people is essentially important. Being able to tell someone that if they don't protect themselves, they will get—and are involved in sexual activities, the risk is very high they will get HIV-AIDS.

That seems like an honest thing to tell people. It seems like an honest thing to tell people that a lot of people are dying because of it. Those—if that is an abstinence program, it seems pretty logical.

If you get into issues about, you know, about lifestyles, and how you might go to hell because you are not abstaining, and you are choosing the wrong direction, then I am just wondering about that. And is that part of the program?

Ambassador DYBUL. Our program is based in public health and in public health evidence, and different people come to that from

different perspectives. The majority of, vast majority of, our programs—in fact, all the ones I have ever seen—begin with what you began with, which is that HIV-AIDS is a risk to you, and you need to protect yourselves so that you can live a healthy, productive life, and that is where most of them begin, nearly all of them begin.

Mr. SHAYS. Do you have the scientific evidence to know which kind of abstinence program works better? Because I keep hearing the word "evidence." I will tell you this: If you told me I would get AIDS, that gives me religion real quick.

Ambassador DYBUL. Well, it might, but unfortunately that is not always the case. Some of the most disturbing data I have seen are that children who are orphaned from AIDS, they watched both of their parents die from AIDS—they know they died from AIDS—still don't necessarily practice safe sex, still don't abstain, be faithful, or correct and consistent condom use. So even that immediate experience did not alter their behavior.

On the other hand, I think there is general agreement that the data are not particularly good on this, but the fear of death has driven behavior change, whether it be in this country or in Africa, and perhaps one of the reasons we are starting to see an uptick in infection rates in this country and in Europe and in some parts of Africa might be fatigue with that message, that you hear it so many times, you don't respond to it. And there are some data on that as well.

So the problem with behavior change is it is a long-term thing. If you keep telling the people the same thing for 5 years, eventually it is going to go over their heads. And that is why behavior change is so difficult, why behavior medicine, why behavior science is so difficult, because it is finding messages that link to and lead to changes in behavior.

And that is fundamentally what we do, culturally appropriate messages that resonate with people, which is why Nigerians talked about zip up and Ugandans talk about zero grazing. People look at what will be the best message. Sometimes that message is within your cultural context, within your religious context, in addition to the HIV-AIDS practices and the effect of HIV-AIDS within your culture, there are other reasons that you should practice safe sex.

Sometimes it is because of the tribal system. One of our most effective is Massai warriors. Massai warriors become warriors when 13 or 14, I can't remember which. They are collected together as young men and are taught to go out and abuse women. Well, the program we intervened with was to teach them that it is actually manly to actually becoming a warrior to refrain and to respect women; that is, in fact, a manly action within that tribal tradition.

So you have to find the right messages which will lead to behavior change. The Minister of Health——

Mr. SHAYS. Let me comment on that last point.

I have no problem with the logic of what you just said. I have a problem with saying that one-third goes toward this program. And, you know, what I am hearing, being very candid with each other, basically what I believe is that when we appropriated the dollars, frankly, it was—one way to get it done was to win over some who don't want condoms as—their dollars being spent on condoms so that they then say, at least I can justify that we are

spreading the word of God to folks through abstinence and so on and feel comfortable. And what I then feel is that both of you have to step up to the plate and justify why we have done that.

And so when I hear the word "evidence," I have a hard time knowing the definition of evidence, but the program you just described, teaching a different behavior, I think there is logic to that. But there is no logic to me that says, that one-third should go that way.

Dr. Hill, as well, would you be able to just tell me some more examples of abstinence programs?

Dr. HILL. Yes. The point I alluded to in my oral comments about Soul City in South Africa is probably one of the best I have heard about recently. They produced a whole series of films that were shown on prime-time television which all address different values, different responsible behavior, etc. It wasn't heavy hitting, always talking about HIV, but it set the context for how men should treat women, etc.

And the initial evidence of this suggests that people are reconsidering behavior that, in fact, is problematic, that leads to the spread of HIV-AIDS. That's a good example of a very sophisticated behavior change program using medium.

But if I might, I would like to just address this question of what reasons we give——

Mr. SHAYS. I will give you a chance. I want to know more programs. So if either one of you want to tell me others.

Dr. HILL. Other examples? A lot of what we do in countries is that we will fund youth clubs, so after-school activities where kids get together anyway to do sports or just get together to get help with respect to certain things, we find ways; we have implementers that will introduce topics that will bring up sexual conduct, etc. They can ask questions. We try to be age appropriate, etc. I met with some of these groups, had discussions with these kids, and there is every reason to believe that kind of discussion can be useful. And there is a lot of countries in which we fund those kind of youth clubs.

Ambassador DYBUL. A specific example of that would be in Kenya. I just visited a program where college kids became concerned about the pressures, the peer pressures. College kids themselves were concerned about the pressures that they saw themselves and their classmates under to engage in sexual activity. They conducted a survey which showed that only 20 percent of the entering freshman had engaged in sexual activity in college, but 80 percent thought that their friends had. So you can see kind of the peer pressure and the disconnect between what people are actually doing and what they thought was going on.

As a result of that, they put together a program that we are supporting to teach people that it is OK, in fact it is a good thing, both for public health and your own self-worth and respecting yourself, to remain abstinent, or, if you had been sexually active, to become abstinent. And these are the students themselves that put this program together.

Dr. HILL. And these programs are called life skills programs in which they will set up drama, set up scenarios in which a young person might encounter, for example, an older man, some other

generation offering a girl tuition or books or something in exchange for sexual services. This explains or this shows them, demonstrates for them, how they could say no, why they should say no.

It addresses other questions where they are being coerced: How do you say no? How do you make sure that what you want is respected? You have to model that, and we often do that through drama.

Ambassador DYBUL. Another example of these types of programs which I think are important ones and get missed are ones that target men specifically. There are actually programs in Namibia that say sometimes stigma is a good thing to stigmatize older men who prey on younger women.

Mr. SHAYS. We call them, what, sugar daddies.

Ambassador DYBUL. Exactly. So to stigmatize them, basically drive men out of the community who engage in and who participate in such activity, that is an ABC program.

In a similar way the program Dr. Hill mentioned in South Africa, a wonderful young man started on his own when he was 14 or 15, his father was an alcoholic, and he drew on the program because he saw the same thing, that his friends were abusing women. He started the program to go around from his own personal experience to explain why young men shouldn't behave that way toward women, why young men should respect women, why they are equal to each other, why you would have a healthier life as you move forward, and it has grown into now he is a national representative for a national program to target young men to teach them to respect women in an ABC way and to give ABC messages. So——

Mr. SHAYS. Finish your sentence.

What did you want to say, Dr. Hill, when I wanted to——

Dr. HILL. I think you were onto something when you were probing the question of about sort of what are acceptable reasons to sort of pursue a behavior change. And there is this fear out there, I have heard it a lot internationally, I have heard it sometimes in this country, if it can be demonstrated that somebody used a moral argument for behavior change, that somehow we may be dangerously close to crossing some line that USG dollars should not be spent for. And I just want to suggest that I think as important the health reasons are, it would be counterproductive to misunderstand that human beings are far more than just material creatures. They don't just respond to motivations that have to do with their appetites. They often respond to motivations that have to do with doing the right thing, whether it is treating another person with respect. They get nothing out of it, they certainly don't get sex out of it, and yet people, young people, repeatedly demonstrate that they can respond to stimuli which says, you know, be a man, do something that shows that you are more than just an animal that is going to follow your sexual urges.

One of the reasons that we like to work with faith-based groups is that they often approach people at that deeper level. And you can sometimes get young people to respond to moral pushing and prodding as easily or more easily and with more passion than just the health issues.

So I think the tent has to be big enough to include people making all sorts of arguments. We tell the faith-based folks, use health

arguments as well. And I tell the folks who just want to use faith arguments, be sensitive to your culture. And if these folks are from a Muslim culture or an orthodox culture or whatever the culture is, if there is something there which stresses monogamy or faithfulness or not lying, for goodness sakes use those arguments as well. We he have to stop the spread of HIV.

Mr. SHAYS. I have absolutely no problem with there being an abstinence problem. I have a problem with stating that it needs to be one-third. That is my problem, and because some places maybe it should be two-thirds. I don't know.

I doubt it. But I would think—and part of it, admittedly it is not based on a wide experience, but when I was in Tanzania and Uganda to hear people describe using condoms more than once because then they weren't available is pretty gross. To hear people describe having sex without condoms because they couldn't get it was pretty gross. To see people waiting in clinics to learn if they had HIV-AIDS—and I will tell you, it was—there were hundreds in every place we went, and we got to interview them. And we got to ask them—you know, here I am thinking they are waiting to learn if they are going to die. They are willing to answer questions about whatever I wanted to ask them.

And what I was struck with was it would be an absolute outrage if someone could have had a condom and didn't, but somehow they weren't available because we were diverting money in a different direction.

If you had a choice of teaching someone abstinence, and they weren't going to abstain, is it better that we did that, or is it better that we make sure that they have a condom?

Dr. HILL. It is why you made a great case for a comprehensive approach. You can't do any of these interventions alone. There is a place for A. There is a place for B. There is a place for C.

Mr. SHAYS. Let's agree with that, provided that the other two get what they need before abstinence gets what it needs.

Dr. HILL. If you look at the statistics on condoms over the last 8 or 10 years, during the PEPFAR years we provided more condoms than in the previous years. So it is not that condoms are actually going down in terms of the number that we are providing. That is a robust and major part of our prevention. So we are not arguing that it should go down. It should be a big part of what we do.

It also should be the case, and, as you know, it is not abstinence that is one-third, it is allowed to be interpreted as AB. And that is a very important part of the message, just as C is.

Ambassador DYBUL. If I could build on what Dr. Hill said, we, in fact, have had substantial increase in support for condoms under the emergency plan, 130 percent increase, and 110 percent increase for AB. So we have had substantial increases across the board for A, B and C.

Unfortunately it is not enough. We cannot, with the resources of the American people, cover everything, which is why we need the rest of the world to be doing a lot more they are doing.

Mr. SHAYS. That we agree, but what I think I heard you say is that some people are not getting condoms because we simply can't provide them.

Ambassador DYBUL. And some people aren't getting AB messages yet because we can't them get to them. And some people are not getting PMTCT because we don't have——

Mr. SHAYS. So what comes first?

Ambassador DYBUL. What comes first is what makes you avoid infection, which is A and B and, if you can't do that, C.

Mr. SHAYS. What happens if you are trying to convince someone to abstain, but, guess what, they are going to have sex? Because as much as you both may not want them to for their own good, they are still going to do it.

Ambassador DYBUL. And that is precisely why when you are above the age of 14 the message is an ABC message. It is not one or the other. It is the public health information to allow people to have a choice. It is giving them the information that abstinence or fidelity to an HIV-negative partner is a 100 percent way to avoid HIV infection, and there may be tribal and other messages that come into play with that. But if that isn't possible, if someone doesn't choose to do that, they have the information available through some vehicle that condoms will protect them. But we can't cover everything because we don't have the money.

Mr. SHAYS. Let me ask you, if countries were allowed to decide for themselves whether to put one-third toward abstinence, would countries still decide to do it, or would they choose not to?

Ambassador DYBUL. I have little doubt that they would.

Mr. SHAYS. Would what?

Ambassador DYBUL. Would support full ABC and put considerable resources toward AB, or more.

Mr. SHAYS. Why require it?

Ambassador DYBUL. Because it is coming from the U.S. Government and not from those countries. If you look at the national strategies——

Mr. SHAYS. That is the problem I have. If your answer to us is that they prove their worth to these countries, why do we just have—why do—in the only area why do we set aside one-third for abstinence?

Ambassador DYBUL. It is actually not the only area. There are a number of congressional directives for other resource requirements of the emergency plan besides the 33 percent. There is treatment, there is orphans and vulnerable children, there are other directives. The national strategies of virtually every country in Africa where they have them lists ABC as their approach, not C. ABC.

The Minister of Health of Namibia was very clear in his response in the Lancet report saying, I need the American people to be doing heavy AB because no one else is doing it. We get C from other folks. We don't get AB from anyone else. We need a direction that allows us to provide the full balanced message, not a single message.

Mr. SHAYS. You kind of turned my question on end. I wasn't saying you would limit it. I would say if they want to spend two-thirds they could spend two-thirds. So I don't really think you were answering the question. The question was, why require it? And your answer, I guess, in the end is not based on science; based on the fact that Congress has required it, that is why we have it.

You have done a very good job—I am interrupting you but you have done a very job of putting the best case forward I think you can do. But it still doesn't answer the question why it is one-third.

Ambassador DYBUL. I think you are right. Maybe it should be more than a third. I don't know, but the law is at least a third if not——

Mr. SHAYS. I never said it should be nothing. I am saying if a country wants to spend more, that it could spend more. We are going to hear from other people in the second panel, but in my brief visit to Uganda and Tanzania, it was—I was struck by this fact. I was struck by the fact that when I spoke to college kids, they were telling me if they don't have condoms, they are still going to have sex, and so are their friends. That is what they said.

And what they said is kids back in villages are still going to have sex no matter what you think about—however, you know, effective your abstinence programs are, they are still going to have sex. So you can decide to let them have sex without condoms, or you can let them decide to have sex with condoms. They are still going to have sex.

Ambassador DYBUL. Mr. Chairman, I think it gets back to your point on evidence. The evidence is that people are changing their behavior. The evidence is that we are seeing a reduction in partnerships and sexual activity.

Mr. SHAYS. But the evidence is not clear if they are changing their behavior because we have an abstinence program that tells them the truth, by the way, you may get AIDS, or we have an abstinence program because it is better for your soul and you will grow up to be a better person. We don't have evidence as to what, why and which programs work.

Ambassador DYBUL. I think that is true, and I have stated that we don't know that yet. We do have some data on some programs; for example, the Zip Up Program in Nigeria. We do have data from some other programs, Soul City and a few others, and we are still working on those.

The fact of the matter is that we need to have a broad-scale ABC message to everyone in every place that condoms should be available to all those who need them. But the issue of priority of just providing condoms without AB we know is wrong, too.

Unfortunately, and again this gets somewhat to the President's request, were the President's request met for the focused countries, we could increase AB and C. Would the rest of the world step up to its responsibility to match the United States, we could do enough AB and C.

I don't think it has to do with the lack of availability of condoms to college kids any more than it has to do with lack of AB messages. It is a problem of resources and the rest coming from the rest of the world and the President's full budget being supported. But we have increased AB and C. We would like to increase it more, and we will increase all three of those more with additional resources.

Mr. SHAYS. Is there any other comments you want to make before we get to the next panel? Is there anything we need to put on the record?

Dr. HILL. I think I would just add that one way or another, whether it is by congressional directive of some sort which instructs us to make sure that we do a comprehensive approach—because the basic message of ABC is critically important, it is going to vary little from country to country—one way or another, whether that prodding comes from you or comes from the Office of Global AIDS Coordinator or from central authorities in Washington, it is like any other guidance. It is given because you want to ensure that you get a balanced program that does as much as possible. Having some flexibility is fine, but we have to make sure that we push hard on this because, in fact, in the past it wasn't a balanced program, and this was an effort to try to make it more balanced.

Mr. SHAYS. You wanted to say something?

Ambassador DYBUL. I would say I think this has been a very important hearing. I would just want to state that the American people through PEPFAR are supporting the broadest comprehensive HIV-AIDS prevention strategy in the world beyond question.

I think we may do all of ourselves a disservice by concentrating too much on various percents when we know ABC is the proper message, and stick to supporting things and expanding programs and having that comprehensive base shifting as we go, should male circumcision, microbicides or other things become more available, but sticking to the basic sense that ABC is the foundation. Gender is something we need to deal with, alcohol, all of the things we are supporting, and try to focus more on what we can do going forward rather than focusing too much on a percent that isn't radically affecting things in the field in a negative way at all and, in fact, had some very positive——

Mr. SHAYS. Let me put on the record my own view that you both are very dedicated people. You are taking a law that has been passed by Congress, and you are seeking to implement it. I know this is a morning, noon and night effort on your part and the people that work with you.

I happen to be a very proud American of what we have done, and I know the President is criticized for a lot of things, some of which I have been, you know, out there criticizing him for. But I am very proud of our country's focus on this issue. As a former Peace Corps volunteer, I know that we are doing so much more than any other country, and so while we are asking you these questions, and we might have some disagreements, we don't have any disagreements over the importance of this issue and the dedication of your people, and we do appreciate your being here.

I do want to recognize Barbara Lee. We are going to get on to our next panel, but I would just note that she has unanimous consent to participate in these hearings, and she is a real leader on this issue. Maybe you would like to just address these two gentlemen before they get on their way, and if you would like——

Ms. LEE. Let me just first thank you. Forgive me for being late. I will definitely, though, review testimony, and appreciate everything that you are doing. And, Mr. Chairman, I just thank you for giving me the opportunity to sit in on this very important hearing.

As you know, I helped write the PEPFAR legislation, and we want it to work. And I think today's hearing will let us know if it is working, if it is not working, what the abstinence-only policies

mean in the field, and what to do about them if they are not working.

And I thank you very much, Mr. Chairman.

[The prepared statement of Hon. Barbara Lee follows:]

Congresswoman Barbara Lee
Gov't Reform Subcommittee on National Security, Emerging Threats, & International Relations
HIV Prevention: How Effective is the President's Emergency Plan for AIDS Relief?
September 6, 2006

Thank you Mr. Chairman.

Let me first begin by thanking you and the Ranking Member Mr. Kucinich, and Mr. Waxman for holding this important hearing today on the effectiveness of our global HIV/AIDS prevention programs. I appreciate the opportunity to participate in this hearing even though I am not a member of the committee.

The issue before us today is a critically important one.

Do we neglect evidenced based public health prevention strategies in order to satisfy an arbitrary ideological prevention policy?

Do we put AIDS funding towards meeting the local needs and priorities of people in Africa, the Caribbean and the developing world, or towards meeting the priorities of politicians in Washington D.C?

The answers should be obvious. But the unfortunate truth today is that our global AIDS prevention policy is being driven in large part by the need to fulfill an arbitrary funding earmark that has no basis in science, and that according to the GAO, may be hindering the overall battle against the global HIV/AIDS pandemic.

Let me be clear, as a co-sponsor and a co-author of the original legislation which established PEPFAR in 2003, I believe very strongly in the power and the promise of our global AIDS programs. I very much appreciate the work being done by Ambassador Dybul (Die-Bull) and his office here in Washington, along with the work of all US personnel and NGO's in the field who are working on this issue.

They are doing critical, lifesaving work every day in difficult conditions and their work should be applauded.

But at the same time I believe very strongly that we should not be tying their hands by requiring them to meet an unproven abstinence-only-until marriage earmark.

I know our first two panelists will assert, as they must, that the earmark is not burdensome and that US prevention programs still fund a range of activities beyond abstinence as part of the ABC (Abstain, Be faithful, use a Condom) approach.

But according to GAO, the evidence says otherwise.

The very fact that the Office of the Global AIDS Coordinator allows US country teams to seek an exemption from complying with the earmark indicates that they recognize it is a burden.

It is time for us to end this earmark once and for all, and I have introduced H.R. 5674, the PATHWAY Act to do just that.

My bill would also address the growing toll that HIV/AIDS is taking on women and girls throughout the developing world by requiring the President to develop a comprehensive, integrated and culturally appropriate HIV prevention strategy to address the key factors that contribute to gender disparities in the rate of HIV infection.

Such factors include, for example: empowering women and girls to avoid cross-generational sex and early or child marriage; increasing access to female condoms; addressing gender-based violence, rape and sexual coercion; supporting the development of micro-enterprise initiatives, job training programs, and income generating programs; encouraging the creation and effective enforcement of legal frameworks that guarantee equal rights and protection for women and girls; and promoting gender equality and the development of civil society organizations focused on women.

I want to thank Chairman Shays, Ranking Member Waxman and Ranking Member Kucinich for their co-sponsorship of the PATHWAY Act.

I hope that today's hearing can shed further light on how this abstinence-only earmark is actually being implemented in the field, and I look forward to continuing to work with the administration and colleagues on both sides of the aisle to strengthen our HIV/AIDS programs.

Thank you.

Mr. SHAYS. Thank you.

Gentlemen, thank you both so very much. Appreciate your being here.

Mr. SHAYS. We will ask the next panel to come in just 1 minute.

Our next panel is Dr. David Gootnick, Director, International Affairs and Trade, U.S. Government Accountability Office; Dr. Helene Gayle, president, chief executive officer, CARE USA; and Dr. Lucy Nkya, member of Tanzania Parliament, medical chairperson, Medical Board of St. Mary's Hospital, director, Faraja Trust Fund, to which I have denoted $100 since she shook me up for it; and Dr. Edward C. Green, senior research scientist, Harvard Center for Population and Development Studies, director, AIDS prevention and research project at Harvard University.

Now that you have sat down, Dr. Gootnick, we are going to ask you to rise and—we will ask you to rise, and we will swear you all in.

[Witnesses sworn.]

Mr. SHAYS. What we do is we swear in all our witnesses. You can swear or affirm, but raise your right hands.

In 10 years as a chairperson, there is only one person we have never sworn in, and that was the good Senator in West Virginia. I chickened out, Dr. Green, I just couldn't do it.

We will start with you, Dr. Gootnick, and then we will go to you, Dr. Gayle.

Welcome. Let me explain, we didn't do too good a job last time, but we have a green light there on both ends. We leave them on for 5 minutes, and then we allow you another 5 minutes if you need it. But we have four on the panel, so it would be good not to go beyond the 10 minutes. I will interrupt you after that certainly. So welcome.

STATEMENTS OF DAVID GOOTNICK, DIRECTOR, INTERNATIONAL AFFAIRS AND TRADE, GOVERNMENT ACCOUNTABILITY OFFICE; HELENE GAYLE, PRESIDENT AND CHIEF EXECUTIVE OFFICER, CARE USA; LUCY SAWERE NKYA, MEMBER OF TANZANIAN PARLIAMENT (MP, WOMEN SPECIAL SEATS), MEDICAL CHAIRPERSON, MEDICAL BOARD OF ST. MARY'S HOSPITAL MOROGORO, DIRECTOR, FARAJA TRUST FUND; AND EDWARD C. GREEN, SENIOR RESEARCH SCIENTIST, HARVARD CENTER FOR POPULATION AND DEVELOPMENT STUDIES

STATEMENT OF DAVID GOOTNICK

Dr. GOOTNICK. Thank you, Mr. Chairman. Mr. Chairman, Congresswoman Lee, members of the subcommittee, thank you for the opportunity to discuss GAO's recent report on prevention funding under PEPFAR.

As you know, the May 2003 leadership authorized PEPFAR; established the Office of the Global AIDS Coordinator, or OGAC; and established the GHAI account as the primary funding source for PEPFAR. The act also endorsed the ABC approach, recommended that 20 percent of the funds under the act support prevention, and requires starting in fiscal 2006 that one-third of prevention funds be spent on activities promoting abstinence until marriage.

Our report reviews PEPFAR prevention funding, describes PEPFAR strategy to prevent sexual transmission of HIV, and examines key challenges associated with the strategy. In addition to document review and analysis, we present the results of structured reviews with key U.S. officials or country teams in each of the focus countries who are responsible for implementing PEPFAR programs.

Regarding our findings, PEPFAR prevention funding in the focused countries rose by more than 55 percent between fiscal 2004 and 2006, increasing from roughly $207 to $322 million. I note that our figures differ somewhat from those presented by Ambassador Dybul and would be happy to discuss that in the Q and A.

During this time the prevention share of focused country funding fell by about one-third, bringing it into alignment with the act's recommendation that 20 percent of PEPFAR funds support prevention.

The PEPFAR preventing strategy for preventing sexual transmission is largely shaped by the ABC approach, Congress's one-third abstinence-until-marriage spending requirement, and local prevention need. OGAC adopted broad principles associated with the ABC model.

Mr. SHAYS. Doctor, why don't we move the mic a little to the left because you pronounce Ps very well.

Dr. GOOTNICK. OGAC adopted broad principles associated with the ABC model, directing country teams to employ best practices coordinated with national strategies and focused countries, integrate across A, B and C activities, and be responsive to the key drives of the epidemic and local cultural norms in each country.

To meet the spending requirement for fiscal 2006, OGAC directed that each focus country team, amongst other things, direct at least half of their prevention funds to the prevention of sexual transmission and within that spend $2 on AB programs for every dollar spent on what OGAC refers to as condoms and related prevention activities. Of note, activities that support IV drug, alcohol reduction and others are considered under condoms and related prevention activities. Seven focus country teams, primarily those with smaller PEPFAR budgets, received exemptions from this requirement.

Regarding key challenges, although several teams noted the importance of promoting abstinence, more than half of the focus country teams reported that the spending requirement limited their ability to design prevention programs that were integrated across A,B and C, and most teams reported that fulfilling the spending requirement challenged their ability to respond to the local conditions and social norms in their countries.

Between fiscal 2005 and 2006, funding in the focus countries for abstinence-until-marriage programs rose from $76 to $108 million. During the same interval, condoms and related activities and prevention of mother-to-child transmission programs in these countries had roughly level funding. These program shifts allowed OGAC to project that it will meet Congress's one-third abstinence-until-marriage spending requirement. However, to meet the requirement for fiscal 2006, seven countries planned declines in PMTCT funding that ranged from roughly 5 to over 60 percent and seven projected cuts to programs aimed primarily at high-risk ac-

tivities in vulnerable populations. These cuts ranged from 7 to over 40 percent.

Finally, as a matter of policy, OGAC also applied the spending requirement to certain USAID and HHS funds despite its determination that by law the requirement applies only to funds appropriated to the GHAI account. These non-GHAI funds are a small part of the focus country prevention budgets; however, they represent more than 80 percent of U.S. prevention dollars for five additional countries, India, Russia, Zimbabwe, Malawi and Cambodia were also held to OGAC's policies on the spending requirement. This decision could especially challenge these country teams' ability to address local prevention needs.

Our report recommended that OGAC collect and report information on the effects of this spending requirement on its programs and ask Congress to use this information to assess how well the requirement supports the act's key goals.

GAO also recommended that OGAC use this information to reassess its decision to apply the spending requirement to PEPFAR funds in the nonfocus countries as previously mentioned.

In commenting on our report, OGAC acknowledged that countries face difficult tradeoffs with their prevention programs, and Dr. Dybul reiterated that this afternoon. They agreed with our recommendation to collect and report information on the spending requirement; however, they did not agree that the requirement should be applied only to the GHAI account.

Mr. Chairman, this concludes my statement. I am happy to answer any questions you or members of the subcommittee may have.

Mr. SHAYS. Thank you very much, Dr. Gootnick.

[NOTE.—The GAO report entitled, "Global Health, Spending Requirement Presents Challenges for Allocating Prevention Funding Under the President's Emergency Plan for AIDS Relief," may be found in subcommittee files.]

[The prepared statement of Dr. Gootnick follows:]

United States Government Accountability Office

GAO

Testimony

Before the Subcommittee on National Security, Emerging Threats, and International Relations, Committee on Government Reform, House of Representatives

For Release on Delivery
Expected at 1 p.m. EDT/EST
September 6, 2006

GLOBAL HEALTH

Spending Requirement Presents Challenges for Allocating Prevention Funding under the President's Emergency Plan for AIDS Relief

Statement of David Gootnick, Director
International Affairs and Trade

GAO-06-1089T

Highlights

Highlights of GAO-06-1089T, testimony before the Subcommittee on National Security, Emerging Threats, and International Relations, House Committee on Government Reform

Why GAO Did This Study

The U.S. Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 authorizes the President's Emergency Plan for AIDS Relief (PEPFAR). It promotes the ABC model (Abstain, be faithful, or use Condoms); recommends that 20 percent of funds appropriated pursuant to the act be spent on prevention; and requires that, starting in fiscal year 2006, 33 percent of prevention funds appropriated pursuant to the act be spent on abstinence-until-marriage activities. The Office of the U.S. Global AIDS Coordinator (OGAC) oversees PEPFAR and administers the Global HIV/AIDS Initiative (GHAI) account, the main repository for PEPFAR funds. For our April 2006 report, GAO reviewed PEPFAR prevention funding trends; described the PEPFAR strategy to prevent sexual transmission of HIV; and examined related challenges.

The report recommended that the Coordinator collect and report information on the effects of the abstinence-until-marriage spending requirement and use it to, among other things, assess whether the requirement should apply only to the GHAI account. OGAC agreed to collect information but disagreed with applying the requirement only to certain funds; GAO modified the recommendation. GAO also suggested Congress use the information to assess how well the requirement supports the Leadership Act's endorsement of both the ABC model and strong abstinence programs.

www.gao.gov/cgi-bin/getrpt?GAO-06-1089T

To view the full product, including the scope and methodology, click on the link above. For more information, contact Gootnickd@gao.gov.

GLOBAL HEALTH

Spending Requirement Presents Challenges for Allocating Prevention Funding under the President's Emergency Plan for AIDS Relief

What GAO Found

As GAO reported in April 2006, PEPFAR prevention funding in 15 focus countries increased by 55 percent between fiscal years 2004 and 2006, rising from about $207 million to $322 million. During this time, the prevention share of PEPFAR funding in these countries fell by about one-third, in accordance with the Leadership Act's recommendation that 20 percent of funds appropriated pursuant to the act support prevention.

The PEPFAR strategy for preventing sexual transmission of HIV/AIDS is largely shaped by three elements—the ABC model, the abstinence-until-marriage spending requirement, and local prevention needs. In addition to adopting the ABC model, OGAC developed guidance for applying it—for instance, that prevention interventions should be integrated and responsive to local needs and cultural norms. To meet the 33 percent spending requirement, OGAC mandated that country teams (PEPFAR officials in the field) spend at least half of prevention funds on sexual prevention and two-thirds of those funds on abstinence/faithfulness (AB) activities. OGAC permitted certain country teams to seek exemptions from this policy. OGAC also applied the spending requirement to all PEPFAR prevention funding as a matter of policy, although it determined that as a matter of law it applies only to funds appropriated to the Global HIV/AIDS Initiative account.

GAO also reported in April 2006 that OGAC's ABC guidance and the abstinence-until-marriage spending requirement, while valued by country teams, have presented challenges to most teams. First, two-thirds of focus country teams told us that ambiguities in some parts of the guidance led to uncertainty about implementing the model; OGAC officials commented they were clarifying the guidance for country teams. Second, although several teams indicated that they value the ABC model and noted the importance of AB messages, some teams also reported that the spending requirement can limit their ability to design programs that are integrated and responsive to local prevention needs. Most country teams reported, either in structured interviews or exemption requests, that fulfilling the spending requirement, including OGAC's policies implementing it, presents challenges to their ability to respond to local needs. Seven focus country teams—primarily those with smaller PEPFAR budgets—received exemptions from the requirement, allowing them to dedicate less than 33 percent of prevention funds to AB activities. In general, the nonexempted teams are spending more than 33 percent of prevention funds on AB activities, and OGAC should just meet the overall spending requirement for fiscal year 2006. However, to meet the abstinence-until-marriage spending requirement, teams have in some cases reduced or cut funding for certain prevention programs, such as those to deliver comprehensive messages to certain populations. OGAC's decision to apply the spending requirement to all PEPFAR prevention funds may further challenge country teams' ability to address local prevention needs.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss HIV prevention efforts funded under the President's Emergency Plan for AIDS Relief (PEPFAR).

In January 2003, citing the need "to meet a severe and urgent crisis abroad," President Bush announced PEPFAR, a $15 billion, 5-year initiative to combat the global HIV/AIDS epidemic through prevention, treatment, and care interventions. The U.S. Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003[1] (Leadership Act), which authorizes PEPFAR, endorses using the "ABC model" (Abstain, Be faithful, or use Condoms) to prevent the sexual transmission of HIV. The act also provides for the establishment of an HIV/AIDS coordinator within the Department of State (State) to lead the U.S. response to the HIVAIDS epidemic and oversee all U.S. efforts to combat HIV/AIDS abroad, including administering an account—known as the Global HIV/AIDS Initiative (GHAI) account—containing funds appropriated pursuant to the act. The act recommends that 20 percent of the appropriated funds be dedicated to HIV/AIDS prevention and requires that, beginning in fiscal year 2006, at least 33 percent of these prevention funds be spent on abstinence-until-marriage programs. State's Office of the U.S. Global AIDS Coordinator (OGAC) has defined five HIV/AIDS prevention program areas—abstinence/faithfulness (AB), "other prevention," prevention of mother-to-child transmission (PMTCT), safe medical injections, and blood safety—and defined abstinence-until-marriage programs as AB activities.

My remarks will focus on three areas, as discussed in our report issued on April 4, 2006:[2] (1) trends and allocation of PEPFAR prevention funding, (2) the PEPFAR strategy for preventing the sexual transmission of HIV, and (3) key challenges associated with applying this strategy.

My observations are based on the work of our GAO team over the previous year. For this project, our team conducted structured interviews with U.S. agency officials responsible for managing PEPFAR in all 15 PEPFAR focus

[1]Pub. L. No. 108-25.

[2]GAO, *Global Health: Spending Requirement Presents Challenges for Allocating Prevention Funding under the President's Emergency Plan for AIDS Relief*, GAO-06-395 (Washington, D.C.: April 4, 2006).

countries[3] (focus country teams). This structured interview tool was designed, tested, and reviewed in consultation with our methodologist to ensure the validity and reliability of our analysis. Our team also reviewed key PEPFAR documents, such as country teams' operational plans, and interviewed U.S. based officials from the key agencies responsible for implementing PEPFAR—State, the U.S. Agency for International Development (USAID), and the Centers for Disease Control and Prevention (CDC)—as well as representatives of several nongovernmental organizations based in Washington, D.C. In July 2005, the team visited four PEPFAR focus countries—Botswana, Ethiopia, South Africa, and Zambia—that it had selected using a set of objective criteria, such as level and focus of PEPFAR funding. Finally, the team reviewed information from five additional PEPFAR country teams that receive at least $10 million in U.S. government funding for HIV/AIDS.[4] We conducted this work in accordance with generally accepted government auditing standards.

Summary

As we reported in April 2006, PEPFAR prevention funding[5] in the 15 focus countries rose significantly between fiscal years 2004 and 2006, while the proportion of total PEPFAR funding dedicated to prevention declined. PEPFAR funding in these 15 countries rose from $207 million in fiscal year 2004 to $322 million fiscal year 2006.[6] At the same time, prevention funding as a share of total PEPFAR funding in the 15 focus countries declined from 33 to 20 percent, consistent with the Leadership Act's recommendation

[3] The 15 PEPFAR focus countries are Botswana, Cote d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Vietnam, and Zambia. Officials in these countries spoke with us with the understanding that individual respondents and the countries where they serve would not be named in our discussion of the structured interviews.

[4] These countries are Cambodia, India, Malawi, Russia, and Zimbabwe. Each of these teams is required to submit an operational plan to OGAC each fiscal year, starting in fiscal year 2006.

[5] For the purposes of this testimony, and in our April 2006 report, PEPFAR prevention funding is defined as funding appropriated to four accounts in the 15 PEPFAR focus countries, as well as bilateral HIV/AIDS funding in the five additional PEPFAR countries. Funding data for fiscal years 2004 and 2005 are actual, while funding data for fiscal year 2006 are planned funding as of March 15, 2006.

[6] Data that OGAC reported to Congress in April 2006 regarding fiscal year 2006 planned PEPFAR prevention funding differ from these figures, primarily because OGAC's reported prevention funding included costs not reported in previous fiscal years as program area funds. These costs include, in part, certain strategic information and management and staffing costs.

that 20 percent of funds appropriated pursuant to the act be spent on prevention. For fiscal year 2005, focus country teams reported allocating varying amounts for prevention programs, including those designed to prevent sexual transmission of HIV—AB and "other prevention." We found that challenges and inconsistencies in country teams' categorization of funding for certain ABC programs and some broad sexual transmission prevention activities, such as programs aimed at reducing stigma associated with HIV, result in some limitations in the reliability of reported allocations for sexual transmission prevention.

The PEPFAR strategy for preventing sexual transmission of HIV is largely shaped by three elements—the ABC model, endorsed by the Leadership Act; the Leadership Act's abstinence-until-marriage spending requirement; and local prevention needs in the PEPFAR countries.

- *ABC model.* OGAC adopted the model and identified key principles to guide country teams' implementation of it—stating, for example, that prevention interventions should be responsive to characteristics of the epidemic of the country. OGAC's guidance regarding the ABC model also outlined the types of activities that can be funded through PEPFAR and directed country teams to emphasize different components of the ABC model for various target populations.
- *Abstinence-until-marriage spending requirement.* The PEPFAR sexual transmission prevention strategy reflects the Leadership Act's requirement to reserve at least 33 percent of prevention funds appropriated pursuant to the act—starting in fiscal year 2006—for abstinence-until-marriage programs. To ensure compliance, OGAC established policies in August 2005 directing 20 PEPFAR country teams[7] to dedicate at least 50 percent of prevention funding to sexual transmission prevention activities (50 percent policy) and 66 percent of that amount to AB activities (66 percent policy). OGAC also allowed country teams, especially those with smaller budgets or more concentrated epidemics, to request exemption from these policies. Finally, OGAC applied the spending requirement to all PEPFAR prevention funding as a matter of policy, although it determined that, as a matter of law, the requirement applies only to funds appropriated to the GHAI account.

[7]These 20 teams are the 15 focus country teams and the 5 additional teams that receive at least $10 million annually in U.S. government HIV/AIDS funding.

- *Local prevention needs.* Working within the parameters of the ABC model and the abstinence-until-marriage spending requirement, country teams design prevention programs that respond to the countries' prevention needs.

OGAC's ABC guidance and the Leadership Act's abstinence-until-marriage spending requirement have presented several challenges to country teams.

- Lack of clarity in the ABC guidance has created challenges for a majority of focus country teams. Although a number of teams told us that they found the guidance clear or easy to implement, 10 of the 15 focus teams cited instances where elements of the guidance were ambiguous and confusing, leading to difficulties in its interpretation and implementation. We reported in April that OGAC officials told us they were working to clarify confusing components of the guidance, including distributing to country teams a document to address concerns teams had identified.

- Satisfying the Leadership Act's abstinence-until-marriage spending requirement presents challenges to most country teams. Several focus country teams indicated that they value the ABC model as an HIV/AIDS prevention tool and noted the importance of AB messages, particularly for certain populations. However, about half of the focus country teams told us that meeting the spending requirement can undermine the integration of prevention programs. Further, 17 of the 20 PEPFAR teams required to meet the requirement, absent exemptions, reported either in structured interviews or exemption requests that it presents challenges to their ability to respond to local epidemiology and cultural and social norms. Ten of these 17 teams (including 7 focus country teams) requested and received exemptions, citing a variety of constraints related to meeting the requirement, such as reduced PMTCT spending and limited funding for prevention messages to high-risk groups. The remaining 7 teams, which did not meet OGAC's proposed criteria for submitting exemption requests, also identified specific program constraints related to meeting the requirement, such as reduced funding for prevention programs aimed at HIV-positive individuals. Having approved 10 requests for exemption, OGAC should just meet the Leadership Act's 33 percent requirement for fiscal year 2006 by effectively requiring teams that do not request exemptions to, in most cases, spend more than 33 percent of prevention funds on AB activities. However, these teams must sometimes reduce or cut funding for certain prevention programs, such as programs to deliver comprehensive ABC messages to populations at risk of contracting HIV. The analysis in our April report showed that nonexempted country teams' allocations of planned prevention funds to "other prevention" declined by approximately $5 million—from about 23 percent in fiscal year 2005 to

about 18 percent in fiscal year 2006. At the same time, exempted country teams' allocations of planned prevention funds to "other prevention" increased by approximately $700,000 between fiscal years 2005 and 2006, remaining at about 21 percent of their total prevention funding in each fiscal year. Finally, OGAC's decision to apply the spending requirement to all PEPFAR prevention funding, rather than only to prevention funding in the GHAI account, may further constrain some country teams' ability to respond to local prevention needs.

In our April 2006 report, we recommended that the Secretary of State direct the U.S. Global AIDS Coordinator to collect and report to Congress information from the country teams about the spending requirement's effect on their prevention programming and use that information to, among other things, consider whether the Leadership Act's abstinence-until-marriage spending requirement should be applied only to funds appropriated to the GHAI account. We also suggested that, in light of this information, Congress should assess the extent to which the spending requirement supports the Leadership Act's endorsement of both the ABC model and strong abstinence-until-marriage programs. In responding jointly to a draft of our report, State, USAID, and the Department of Health and Human Services accepted our recommendation to collect information from the country teams regarding the spending requirement's effects on their HIV sexual transmission prevention programming. They disagreed with our draft recommendation to consider whether the Leadership Act's spending requirement should be applied solely to funds appropriated to the GHAI account. We modified the second recommendation to recommend that they consider this policy change after collecting information on the effect of the spending requirement.

Background

Each day, an estimated 13,400 people worldwide are newly infected with HIV; more than 20 million have died from AIDS since 1981. HIV is transmitted both sexually (through sexual intercourse with an infected person) and nonsexually (through the sharing of needles or syringes with an infected person; unsafe blood transfusions; or the passing of the virus from mother to child through pregnancy, childbirth, or breastfeeding). The majority of HIV infections worldwide are transmitted sexually. About two-thirds of the estimated 40 million people currently living with HIV/AIDS are in sub-Saharan Africa where, according to the Joint United Nations

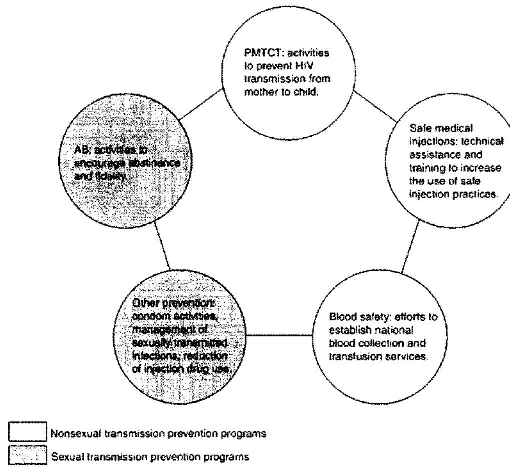
Programme on HIV/AIDS, adult HIV prevalence averaged 7.4 percent in 2004.[8]

As the entity responsible for developing the U.S. global HIV/AIDS strategy and administering PEPFAR, OGAC has defined five prevention program areas—abstinence/faithfulness (AB), "other prevention," prevention of mother-to-child transmission (PMTCT), blood safety, and safe medical injections. These areas are divided into two groups: those aimed at preventing sexual transmission—AB and "other prevention"[9]—and those aimed at preventing nonsexual transmission—PMTCT, blood safety, and safe medical injections. (See fig. 1.)

[8]HIV prevalence represents the percentage of the adult population that is estimated to be HIV positive. Estimates of HIV prevalence are often based on surveillance of pregnant women in prenatal clinics or population-based surveys.

[9]In its Second Annual Report, released to Congress in February 2006, OGAC began referring to these activities as "condoms and related prevention activities."

Figure 1: PEPFAR Prevention Program Areas



Source: GAO analysis of OGAC's fiscal year 2006 Country Operational Plan Guidance.

AB activities encourage abstinence until marriage, delay of first sexual activity, secondary abstinence,[10] faithfulness in marriage and monogamous relationships, reduction of sexual partners among sexually active unmarried persons, and social and community norms related to the above practices. "Other prevention" activities include the purchase and promotion of condoms, management of sexually transmitted infections (if not in a palliative care setting), and messages or programs to reduce injection drug use and related risks.

[10] According to OGAC, secondary abstinence activities encourage abstinence for youths who have already engaged in sexual intercourse.

In fiscal year 2004, the U.S. Congress appropriated $2.4 billion for global HIV/AIDS efforts, directing $865 million of this amount to four accounts: (1) the GHAI account, which received most of the funding; (2) the Child Survival and Health account; (3) the Prevention of Mother to Child Transmission account; and (4) CDC's Global AIDS Program.[11] In our April 2006 report, PEPFAR funding refers to funds appropriated to these four accounts[12] for the 15 focus countries, as well as bilateral HIV/AIDS funding for the five additional countries that receive at least $10 million in U.S. government HIV/AIDS funding. Each year, to receive country-level funding for the coming fiscal year, country teams submit budgets, or "operational plans," to OGAC outlining planned activities and the organizations that will implement them (implementing partners). These plans are subject to OGAC's review and approval. Focus country teams also receive central funding—multicountry awards that are managed by U.S. agency headquarters in Washington, D.C. For fiscal years 2004 and 2005, PEPFAR funding figures are central and country-level appropriations allocated by OGAC. For fiscal year 2006, PEPFAR funding consists of planned allocations of central and country-level appropriations.[13]

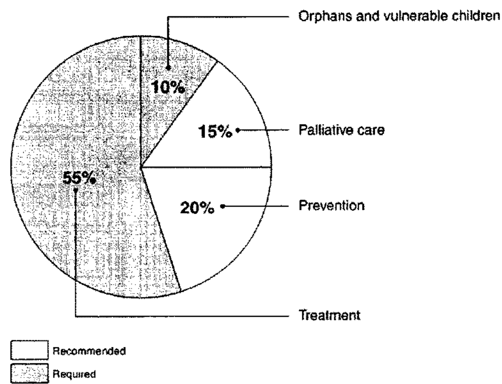
The Leadership Act specifies the percentage of PEPFAR funds to be allocated for HIV/AIDS prevention, treatment, and care for fiscal years 2006-2008. The act recommends that 20 percent of funds appropriated pursuant to the act be spent on prevention and 15 percent on palliative care for those living with the disease. The act also requires that, beginning in fiscal year 2006, at least 55 percent of funds appropriated pursuant to the act be spent on treatment and at least 10 percent on orphans and vulnerable children. (See fig. 2).

[11]The remaining $1.5 billion was appropriated for, among other initiatives, the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria—a multilateral public-private mechanism—and international HIV/AIDS research through the National Institutes of Health.

[12]The Prevention of Mother to Child Transmission account expired at the end of fiscal year 2004, but some country teams carried over funds from this account from fiscal year 2004 to fiscal year 2005. Therefore, for fiscal year 2006, PEPFAR funding is defined as funds appropriated to the remaining three accounts.

[13]Fiscal year 2006 funding figures change slightly throughout the fiscal year, as country teams make adjustments to their funding allocations.

Figure 2: Selected Spending Requirements and Recommendations for Fiscal Years 2006-2008 Contained in the 2003 Leadership Act



Source: GAO analysis of 2003 Leadership Act.

The Leadership Act further requires that at least one-third of prevention funding appropriated pursuant to the act be spent on abstinence-until-marriage programs, starting in fiscal year 2006. (The act also recommended this spending distribution for fiscal years 2004 and 2005.) In June 2004, OGAC notified Congress that it defines abstinence-until-marriage activities as programs that address both abstinence and faithfulness.[14]

The Leadership Act states that "behavior change, through the use of the ABC model, is a very successful way to prevent the spread of HIV." The model, which the Leadership Act defines as "'Abstain, Be faithful, and use Condoms,' in order of priority," is based in part on the experience of Uganda, which implemented an ABC campaign in the 1980s and observed

[14]Office of the U.S. Global AIDS Coordinator, *Appendix 2: The Emergency Plan for AIDS Relief: Fiscal Year 2004 Prevention Expenditures and Program Classification Criteria* (Washington, D.C.: U.S. Department of State, 2004).

a decline in HIV/AIDS prevalence by 2001.[15] Although substantial debate exists about the extent to which each component of the model is responsible for reducing HIV prevalence in individual countries, there is general consensus that using the ABC model can have a positive impact in combating HIV/AIDS. In November 2004, a key consensus statement authored by leading public health experts and endorsed by more than 125 prominent figures and world leaders observed that "all three elements of [the ABC model] are essential to reducing HIV incidence, although the emphasis placed on individual elements needs to vary according to the target population."[16]

The PEPFAR prevention goal is to avert 7 million infections in the 15 focus countries by the year 2010. This goal is cumulative; that is, infections averted in 2004 through 2009 will count toward the final total of infections averted by 2010. In addition, this goal is to be reached both through PEPFAR activities and through interventions by other donors and host nations. OGAC plans, over time, to estimate progress toward this goal by using a statistical model of epidemiological trends developed by the U.S. Census Bureau. This analysis will compare "expected" HIV incidence rates in particular countries with "actual" incidence rates, using those comparisons to estimate the number of infections that have been averted through PEPFAR and other prevention programs. However, it cannot attribute this change to any specific intervention or to the success of particular types of programs. The approach involves substantial challenges and the reliability of the estimates is not known, according to Census officials. Key challenges include a lack of data on prevalence rates in many developing countries and the fact that impacts of behavioral change programs can occur over a period of time. OGAC initially considered using a different methodology—the Goals model[17]—that links estimates of

[15]In 1986, the Ugandan government launched a nationwide information, education, and communication tour to encourage Ugandans to abstain from sex until marriage, remain faithful to one partner (termed "zero-grazing"), and use condoms when necessary. According to the U.S. Census Bureau and UNAIDS, national HIV/AIDS prevalence in Uganda fell from about 15 percent in the early 1990s to 5 percent in 2001.

[16]Cates, Willard,et.al. "The Time Has Come for Common Ground on Preventing Sexual Transmission of HIV," *Lancet*, vol. 364 (Nov. 27, 2004).

[17]The Goals model is based on published research studies of the effectiveness of various prevention strategies and on conversion factors that translate dollars spent on a given prevention intervention into the number of infections averted. The model was developed by the Futures Group—a privately held company that designs and implements public health and social programs for developing countries.

infections averted to specific types of prevention programs carried out under PEPFAR and their spending levels. However, OGAC concluded that this model could yield misleading results and was not the best method to adopt. To acquire information about the effectiveness of specific PEPFAR prevention programs, especially in the AB area, OGAC plans to fund targeted evaluations on a very limited scale.

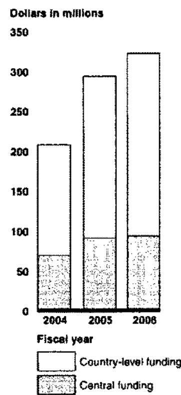
PEPFAR Prevention Funding in the Focus Countries Grew Significantly during First 3 Years

PEPFAR prevention funding increased significantly between fiscal years 2004 and 2006, while the proportion of total PEPFAR funding dedicated to prevention declined. Country teams reported varying allocations among the five prevention program areas. We found that challenges and inconsistencies in country teams' categorization of funding for certain ABC programs and broad sexual transmission prevention activities resulted in some limitations in the reliability of reported allocations for sexual transmission prevention.

PEPFAR prevention funding[18] in the 15 focus countries increased by more than 40 percent, from $207 million in fiscal year 2004 to $294 million in fiscal year 2005. It further increased by about 10 percent, to $322 million, in fiscal year 2006. (See fig. 3.)

[18]OGAC officials were unable to provide data on PMTCT central funding for prevention. While they estimated that $6.5 million in central PMTCT funding went to prevention in fiscal years 2004 and 2005, these rough estimates are not included in our funding figures.

Figure 3: Total PEPFAR Prevention Funding in the 15 Focus Countries, Fiscal Years 2004-2006

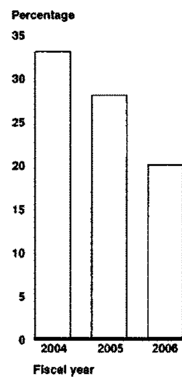


Sources: GAO analysis of fiscal year 2004 budget data provided by OGAC; OGAC's Country Operational Plan and Reporting System database; and OGAC Central Awards database.

Note: Fiscal year 2006 funding is planned funding as of March 15, 2006. Data that OGAC reported to Congress in April 2006 regarding fiscal year 2006 planned PEPFAR prevention funding differ from these figures, primarily because OGAC's reported prevention funding included costs not reported in previous fiscal years as program area funds.

At the same time, the proportion of PEPFAR funding dedicated to prevention in the 15 focus countries declined from 33 percent in fiscal year 2004 to 20 percent in fiscal year 2006, consistent with the Leadership Act's recommendation that one-fifth of funds appropriated pursuant to the act be spent on prevention. (See fig. 4.) OGAC's fiscal year 2004 operational plan predicted this decline, noting that the proportion of total PEPFAR funding allocated to prevention would likely begin to decrease relative to the proportion allocated to care and treatment.

Figure 4: Share of PEPFAR Funding Dedicated to Prevention in the 15 Focus Countries, Fiscal Years 2004-2006

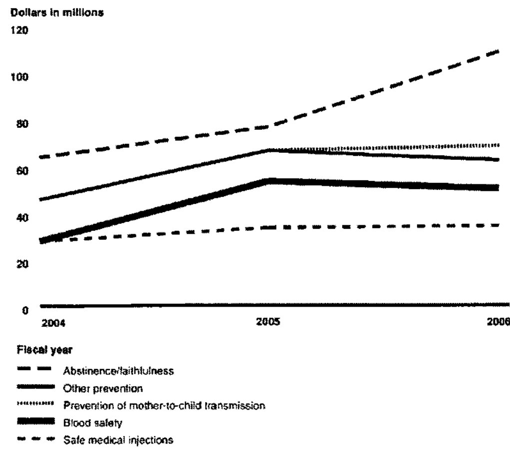


Sources: GAO analysis of fiscal year 2004 budget data provided by OGAC; OGAC's Country Operational Plan and Reporting System database; and OGAC Central Awards database

Note: Fiscal year 2006 funding is planned funding as of March 15, 2006. Data that OGAC reported to Congress in April 2006 regarding fiscal year 2006 planned PEPFAR prevention funding differ from these figures, primarily because OGAC's reported prevention funding included costs not reported in previous fiscal years as program area funds.

The total proportion of PEPFAR prevention funding that the 15 focus country teams reported allocating to each of the five prevention programs varied to some extent across fiscal years 2004-2006. (See fig. 5.)

Figure 5: Reported PEPFAR Prevention Funding in Focus Countries, by Program Area, Fiscal Years 2004-2006



Source: GAO analysis of fiscal year 2004 budget data provided by OGAC, OGAC's Country Operational Plan and Reporting System database, and OGAC Central Awards database.

Note: Fiscal year 2006 funding is planned funding as of March 15, 2006. Data that OGAC reported to Congress in April 2006 regarding fiscal year 2006 planned PEPFAR prevention funding differ from these figures, primarily because OGAC's reported prevention funding included costs not reported in previous fiscal years as program area funds.

Challenges and inconsistencies in country teams' categorization of funding for certain integrated ABC activities and some broad sexual transmission prevention activities cause some limitations in the reliability of the allocations reported for AB and "other prevention." For example, in their country operational plans, some teams categorized integrated ABC programs entirely as "other prevention," while others divided some or all of these programs between the AB and "other prevention" categories. In addition, certain broader components of sexual transmission prevention programs that are not clearly defined as AB or "other prevention," such as activities to prevent substance abuse, may appear in either program area in the teams' operational plans. The lack of a standardized method for categorizing these programs means that, to some extent, the varied

numbers of funding reported across fiscal years may reflect the variations in categorization methods rather than actual differences.

PEPFAR Sexual Transmission Prevention Strategy Is Driven by ABC Approach, Abstinence-Until-Marriage Spending Requirement, and Local Prevention Needs

The PEPFAR strategy for preventing sexual transmission of HIV is shaped largely by three components: the ABC model, the abstinence-until-marriage spending requirement, and local prevention needs.

In adopting the ABC model, OGAC identified the following key principles that country teams should consider in developing and implementing ABC programs:

- The model should be applied in accordance with local prevention needs.
- Prevention activities should be integrated.
- Prevention activities should be coordinated with the HIV/AIDS strategies of host governments.
- Prevention interventions should be driven by best practices.

OGAC's guidance to the field states that "the optimal balance of ABC activities will vary across countries according to the patterns of disease transmission, the identification of core transmitters (i.e., those at highest risk of transmitting HIV), cultural and social norms, and other contextual factors."[19] The ABC guidance also specifies the components of the ABC model that should be targeted to certain populations and sets parameters on the prevention messages that may be delivered to youths. For example, although PEPFAR funds may be used to deliver age-appropriate AB information to in-school youths aged 10 to 14 years, the funds may not be used to provide information on condoms to these youths. When students are identified as being at risk, they may be referred to out-of-school programs that provide integrated ABC information and that provide condoms. Under these rules, PEPFAR funds may be used to give integrated ABC information to youths older than 14. Other rules include the following:

[19]Office of the U.S. Global AIDS Coordinator, *Guidance to In-Country Staff and Implementing Partners Applying the ABC Approach to Preventing Sexually-Transmitted HIV Infections within the President's Emergency Plan for AIDS Relief* (Washington, D.C.: U.S. Department of State, March 2005).

- PEPFAR funds may not be used in schools for marketing efforts to promote condoms to youths.
- PEPFAR funds may not be used in any setting for marketing campaigns that target youths and encourage condom use as the primary intervention for HIV prevention.
- PEPFAR funds may be used to target at-risk populations with specific outreach, services, comprehensive prevention messages, and condom information and provision. At-risk groups include, among others, sexually active discordant couples and those who have sex with one whose HIV status is unknown.

To meet the 33 percent abstinence-until-marriage spending requirement, OGAC issued policies in late August 2005 instructing each of the 15 focus country teams and 5 additional teams to spend at least 50 percent of their prevention funding on sexual transmission prevention and at least 66 percent of that amount on AB activities. To show compliance with the spending requirement, country teams' operational plans must isolate the amount of funding dedicated to AB activities. OGAC allows country teams to request exemption from its 50 percent and 66 percent policies. However, the guidance cautions that, in a generalized epidemic, a very strong justification is required for not meeting the 66 percent policy and adds that OGAC expects all focus country teams, particularly those with total PEPFAR funding exceeding $75 million, to adhere to the policies.[20] Finally, OGAC directed country teams to apply the spending requirement to all PEPFAR prevention funding (about $357 million in fiscal year 2006), although it determined that, as a matter of law, the requirement applies only to funds appropriated to the GHAI account (about $322 million in fiscal year 2006).

[20]In its fiscal year 2007 Country Operational Plan Guidance, OGAC dropped the language regarding focus teams, particularly those with total PEPFAR funding exceeding $75 million.

ABC Guidance and Abstinence-Until-Marriage Spending Requirement Present Challenges for Country Teams

As our April 2006 report discusses, country teams face challenges related to both the ABC guidance and the Leadership Act's abstinence-until-marriage spending requirement. Two-thirds of focus country teams reported that a lack of clarity in aspects of the ABC guidance has led to interpretation and implementation challenges. About half of the country teams indicated that adherence to the spending requirement can undermine the integrated nature of HIV/AIDS prevention programs. In addition, most country teams required to meet the requirement, absent exemptions, reported either in structured interviews or exemption requests that the requirement challenges their ability to allocate prevention resources in accordance with local HIV/AIDS prevention needs. Finally, OGAC's policy of applying the spending requirement to all PEPFAR prevention funding, including funds not appropriated to the GHAI account, may further constrain country teams' ability to address local prevention needs.

Challenges Related to ABC Guidance

We reported in April 2006 that, although many focus country teams told us that they generally found the ABC guidance to be clear and several said that it did not present implementation challenges, 10 of the 15 focus teams cited instances where components of the guidance were ambiguous and caused confusion. First, 6 focus country teams expressed uncertainty regarding the populations that should be considered at-risk in accordance with the guidance, and 5 of these teams expressed concern that certain populations that need ABC messages in their countries might not receive them because they do not fit the ABC guidance definition of at-risk. Second, teams reported that the ABC guidance does not clearly delineate permissible condom-related activities, causing confusion about proper use of PEPFAR funds. For example, 5 focus country teams reported that, in their understanding, PEPFAR funds may not be used for broad condom social marketing, even to adults in a generalized epidemic. Third, the ABC guidance does not discuss how the age cutoff for providing condom information should be applied to groups that include youths younger and older than 15. We reported in April that OGAC officials told us they were working to clarify confusing components of the guidance, including distributing to country teams a document with some additional clarification on how to apply the ABC guidance.

Challenges Related to Abstinence-until-Marriage Spending Requirement

In several of our structured interviews, focus country teams endorsed the ABC model and noted the importance of AB messages. For example, one team told us that, because of the country's high HIV/AIDS prevalence rate, abstinence is an appropriate message for both youths and adults.

However, the abstinence-until-marriage spending requirement presented challenges to country teams' ability to implement integrated prevention programs. Because the abstinence-until-marriage spending requirement requires them to segregate AB funding from funding for "other prevention," 8 of the 15 focus country teams reported that the spending requirement can undermine their ability to design and implement programs that integrated the components of the ABC model. For example, one focus country team told us that artificially splitting programs for the military (traditionally considered an at-risk group) between AB and "other prevention" disaggregates activities that should be integrated and potentially lowers effectiveness.

In addition, 17 of the 20 PEPFAR country teams required to meet the abstinence-until-marriage spending requirement, absent exemptions, reported that the requirement presents challenges to their efforts to respond to local prevention needs. Ten of these 17 teams requested exemptions, citing a variety of concerns, such as reduced spending for PMTCT, limited funding to deliver appropriate prevention messaging to high-risk groups, lack of responsiveness to cultural and social norms, cuts in medical and blood safety activities, and elimination of care programs. The remaining 7 teams, which did not meet OGAC's proposed criteria for requesting exemptions, also identified a variety of constraints related to meeting the requirement, including difficulty in reaching certain populations with comprehensive ABC messages, limited or reduced funding for programs targeted at high-risk groups, reduced funding for PMTCT services, and difficulty in funding programs for condom procurement and condom social marketing.

The analysis in our April 2006 report showed that, with the approval of all 10 exemption requests, OGAC should just meet the overall 33 percent target for AB activities for fiscal year 2006 by effectively allowing exempted teams to spend less than 33 percent on AB programs and requiring nonexempted teams to spend more than 33 percent. Our report found that all but one of the exempted teams planned to dedicate less than 33 percent of funds to AB activities—about 23 percent on average—while,

on average, each of the nonexempted country teams planned to spend around 37 percent.[21]

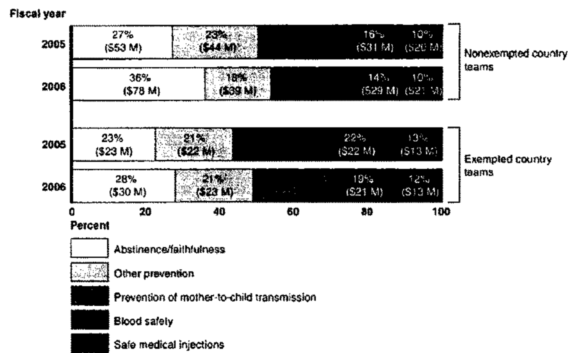
In allocating funds to meet the spending requirement, country teams are primarily limited to shifting resources among three prevention program areas—AB, "other prevention," and PMTCT. (This limitation occurs because the overwhelming majority of funds spent on safe medical injections and blood safety are centrally awarded funds, over which the country teams have no budgetary control.) If, for example, a country team's planned funding has less than a 2-to-1 ratio of AB funds to "other prevention" funds, the team can increase AB funding to reach the required ratio by reducing funds in "other prevention," PMTCT, or a combination of the two. The team can also consider taking funds from the treatment and care program areas and placing them in the AB category.

Our analysis found that nonexempted country teams' allocations for "other prevention" funding declined between fiscal year 2005 and fiscal year 2006.[22] For the nonexempted focus country teams, total funding for "other prevention" declined by about $5 million from fiscal year 2005 to fiscal year 2006, falling from about 23 percent to about 18 percent of total prevention funding, while total funding for AB activities increased by about $25 million, rising from about 27 percent to about 36 percent of total prevention funding. By contrast, in the focus country teams that received exemptions, total prevention funding for "other prevention" increased slightly, by about $700,000, remaining at around 21 percent of total prevention funding, and total prevention funding for AB activities increased by about $7 million, from about 23 percent to about 28 percent of total prevention funding. Figure 6 shows the allocation of prevention funds by nonexempted and exempted focus country teams for fiscal years 2005 (actual funds) and 2006 (planned funds).

[21]Because of challenges and inconsistencies in country teams' categorization of funding for certain integrated ABC programs and some broad sexual transmission prevention activities, data on prevention allocations may reflect the variation in categorization methods rather than actual differences.

[22]Some of the decline in "other prevention" funding may be due to varying methods of categorizing sexual transmission prevention programs and changes in categorization methods across fiscal years. However, the data demonstrate a common trend across the nonexempted country teams.

Figure 6: Prevention Allocations for Nonexempted and Exempted Focus Country Teams, Fiscal Years 2005 and 2006



Sources: GAO analysis of fiscal year 2005 country operational plans and OGAC's Country Operational Plan and Reporting System database.

Note: Fiscal year 2006 funding is planned funding as of March 15, 2006. Data that OGAC reported to Congress in April 2006 regarding fiscal year 2006 planned PEPFAR prevention funding differ from these figures, primarily because OGAC's reported prevention funding included costs not reported in previous fiscal years as program area funds. These percentages are reliable for understanding general trends in data rather than for precise percentage differences in program areas, because of potential differences in categorization methods.

As figure 6 shows, overall levels of PMTCT funding stayed relatively constant for both nonexempted and exempted focus country teams. Overall, the proportion of funding dedicated to PMTCT in the focus countries was about 23 percent in fiscal year 2005 and about 22 percent in fiscal year 2006. Focus countries' total PMTCT funding was $66.3 million in fiscal year 2005 and $67.5 million in fiscal year 2006.

Finally, OGAC's decision to apply the spending requirement to all PEPFAR prevention funding—although OGAC had determined that, as a matter of law, the requirement applies only to funds appropriated to the GHAI account—may further challenge some teams' ability to address HIV prevention needs at the local level. For fiscal year 2006, non-GHAI prevention funds amounted to about $35 million (10 percent) of PEPFAR prevention funding—that is, about $6 million (2 percent) of the focus country teams' planned PEPFAR prevention funds and about $29 million (82) percent of the five additional country teams' planned PEPFAR

prevention funds. Because of OGAC's policy, some country teams are constrained from allocating non-GHAI funding to meet local needs if the allocations do not comply with the spending requirement.

Concluding Observations

In conclusion, our analysis of HIV/AIDS prevention efforts funded under PEPFAR reported in our April 2006 report showed that, although country teams consistently value the ABC model as a useful tool for preventing HIV, the Leadership Act's 33 percent abstinence-until-marriage spending requirement has presented challenges to their ability to adhere to the PEPFAR sexual transmission prevention strategy. In particular, it has challenged their ability to integrate the components of the ABC model and respond to local needs, local epidemiology, and distinctive social and cultural patterns. OGAC's application of the spending requirement to $35 million in funds not appropriated to the GHAI account may further hamper some country teams' ability to develop locally responsive prevention programs. OGAC may be able to address some of the constraints country teams face by reconsidering this policy, but the amount of non-GHAI funding is relatively small and the underlying challenges that country teams face in having to reserve a specific percentage of their prevention funds for abstinence-until-marriage programs would remain.

Because meeting the 33 percent abstinence-until-marriage spending requirement can challenge country teams' ability to allocate prevention resources in a manner consistent with the PEPFAR sexual transmission prevention strategy, our April 2006 report recommended that the Secretary of State direct the U.S. Global AIDS Coordinator to take the following actions:

- Collect information from the country teams each fiscal year on the spending requirement's effects on their HIV sexual transmission prevention programming. This information should include, for example, the justifications submitted by country teams requesting exemption from the spending requirement.
- Provide this information in an annual report to Congress.
- Use the information collected to, among other things, assess whether the spending requirement should be applied solely to funds appropriated to the Global HIV/AIDS Initiative account, in line with OGAC's legal determination that the requirement applies only to these funds.

In commenting jointly on a draft of our April 2006 report, the Department of State/OGAC, HHS, and USAID reiterated their strong commitment to fight HIV/AIDS and also noted the importance of the ABC model in preventing sexual transmission of HIV. The agencies agreed with our recommendation to collect information regarding the effects of the Leadership Act's abstinence-until-marriage spending requirement. They disagreed with a draft recommendation regarding applying the abstinence-until-marriage spending requirement only to funds appropriated to the GHAI account, citing concerns about the effect on a unified budget approach and noting the small amount of non-GHAI funding that the focus countries receive. We modified our recommendation to recommend that they consider this policy change after collecting information on the effect of the spending requirement. However, we noted that the five additional countries required, absent exemptions, to meet the spending requirement received more than 80 percent of their funds through non-GHAI accounts.

Matters for Congressional Consideration

Given the challenges that meeting the abstinence-until-marriage spending requirement presents to country teams attempting to implement locally responsive and integrated HIV/AIDS prevention programs, our April 2006 report also suggested that Congress, in its ongoing oversight of PEFAR, should review and consider the information provided by OGAC regarding the spending requirement's effect on country teams' efforts to prevent the sexual transmission of HIV and use this information to assess the extent to which the spending requirement supports the Leadership Act's endorsement of both the ABC model and strong abstinence-until-marriage programs.

Mr. Chairman and members of the committee, this concludes my prepared statement. I will be happy to answer any questions you may have at this time.

Contacts and Acknowledgments

For information on this statement, please contact David Gootnick, Director, International Affairs and Trade, at (202) 512-3149. You may also reach him by email at gootnickd@gao.gov. Other individuals who made key contributions to this testimony include Celia Thomas (Assistant Director), Elizabeth Singer, Chad Davenport, and Reid Lowe.

GAO's Mission

The Government Accountability Office, the audit, evaluation and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's Web site (www.gao.gov). Each weekday, GAO posts newly released reports, testimony, and correspondence on its Web site. To have GAO e-mail you a list of newly posted products every afternoon, go to www.gao.gov and select "Subscribe to Updates."

Order by Mail or Phone

The first copy of each printed report is free. Additional copies are $2 each. A check or money order should be made out to the Superintendent of Documents. GAO also accepts VISA and Mastercard. Orders for 100 or more copies mailed to a single address are discounted 25 percent. Orders should be sent to:

U.S. Government Accountability Office
441 G Street NW, Room LM
Washington, D.C. 20548

To order by Phone: Voice: (202) 512-6000
TDD: (202) 512-2537
Fax: (202) 512-6061

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Web site: www.gao.gov/fraudnet/fraudnet.htm
E-mail: fraudnet@gao.gov
Automated answering system: (800) 424-5454 or (202) 512-7470

Congressional Relations

Gloria Jarmon, Managing Director, JarmonG@gao.gov (202) 512-4400
U.S. Government Accountability Office, 441 G Street NW, Room 7125
Washington, D.C. 20548

Public Affairs

Paul Anderson, Managing Director, AndersonP1@gao.gov (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, D.C. 20548

PRINTED ON RECYCLED PAPER

Mr. SHAYS. Dr. Gayle.

STATEMENT OF HELENE GAYLE

Dr. GAYLE. Thank you, and thank you very much, Mr. Chairman, Congresswoman Lee, and thank your subcommittee for the opportunity to join today to consider issues related to HIV prevention programs funded by the President's Emergency Plan for AIDS. We clearly feel that ensuring PEPFAR achieve its success in reducing HIV rates while we continue to focus on equitable treatment and humane care for those already infected is a key critical challenge for U.S. policymakers.

Organizations like CARE who implement programs at the country level share your commitment to make sure that we use these resources in the most effective way as possible. We feel we owe that to the people in those countries and clearly to the U.S. taxpayers who make these resources available.

We applaud the focus on prevention because clearly while treatment is critical, we can't treat our way out of this epidemic, and we really do need to think about how we are using the resources to keep people from getting infected to begin with. And we know that without effective prevention strategies, the numbers of infected individuals will continue to grow.

We are here because we feel strongly that PEPFAR and the U.S. Government have shown real leadership and have contributed major resources and critical momentum to prevention, treatment and care, and we know that the program has already saved countless lives and provided much-needed support to communities, and we strongly support the continuation of this vital initiative beyond 2008. And so we are here today because we believe in the program, believe that it has a strong role, and want to provide instructive feedback.

I would just say—and that feedback, that comes, from our experience, at the field level so that this program can be strengthened.

Just say from the outset there was a lot of discussion, the first panel, about the ABC approach and whether this is the right approach. And I think we would go on record saying that we strongly believe that a behavioral approach, approach that changes people's risk of acquiring this infection or avoids it altogether, is the right approach. And so ours is not an argument about the merits of an ABC approach, but rather a look at how the current legislation may be construed in ways that don't allow for a balanced approach to the use of an ABC and behavioral change approach.

And I also say this as somebody who worked in the U.S. Government for 20 years and was responsible for developing program guidance, and understand that what may be written at one level has huge implications in how it actually gets translated at the country level. So it is with that perspective that I want to talk about some things that we think would really help and make more effective the current program and make a bigger difference in lives.

So I want to talk about, first of all, the importance of being able to more flexibly implement the current guidance to best respond to the needs at the country level; that we feel that the issue of—as a result of vulnerability of women and girls must be even more strongly focused on; that it is important that a focus on engaging

other highly vulnerable populations is incorporated; look at the better need to integrate efforts to address underlying determinants that drive or compound vulnerability to HIV; and then finally to look at a greater commitment to look at the impact and the evaluation and long-term sustainability of this program.

So I will try to be brief. I have a written statement that goes into much more detail. But our first point, that in our experience on the ground and resources for countries throughout the developing world, the PEPFAR country teams responsible for interpreting program guidance have articulated prevention policies and programs with a strong AB preference, leaving little room and funding for integrated local responses, HIV-AIDS prevention programs. And again, we understand that this may not be the intent, but the experience on the ground suggests that this is a real issue.

Let me just give you one example from our many conversations with CARE field staff in preparation for this hearing. In one of the PEPFAR focus countries with a generalized epidemic, our country office approached the PEPFAR country team with an innovative proposal to work with sexually active youth who were exchanging sex for money. Our proposal would have provided treatment for sexually transmitted diseases, training for alternative livelihood so that youth would not have to exchange sex for livelihood and for money, and a variety of—a more comprehensive approach to address these issues.

This proposal was turned down for AB prevention funding because it was seen as not having a focus on those two elements, and I think highlights the fact that there is a real difficulty and a bias that works against having a comprehensive approach in the way that programs are actually implemented in the field because the funding categories of AB and other often end up being applied in a very rigid fashion.

We have other examples of how this interpretation of the need to partition funding works against a more comprehensive approach, and as I stated in the beginning, our strong feeling is that all of those components are important, and it is only through having a comprehensive approach, a truly comprehensive approach, that the prevention efforts can be most effective.

We believe that countries left to make the decisions, that have the freedom to make their own decisions that meet the needs of their country's circumstances, will, in fact, apply the funds in a way that provides for a balanced approach, and that countries don't need to be dictated to about the percentage of resources that are used for any particular strategies. So we believe that countries left to their own wisdom will, in fact, make good use and make—and use a balanced approach in their effort.

Second, in sub-Saharan Africa, women represent 60 percent of those infected with HIV and 75 percent of infections between the ages of 15 and 24.

Women and girls in Africa are well served by the ABC model only when they are free to make choices about abstaining from sex, or choosing to remain in a relationship where faithfulness is meaningful, or to access condoms and negotiate their correct and consistent use.

But wherever women cannot control the sexual encounters they engage in, either for reasons of rape, abuse, gender disempowerment, economic dependency and cultural practices, ABC in its current formulation is significantly more problematic. And we have a lot of examples from countries that have high rates of rape and sexual exploitation where girls report that they feel compelled to exchanges sex for food.

So clearly a message that focuses on abstinence and being faithful misses the point of the circumstances of these women and their lives. And so having a focus that really addresses the needs of women and the circumstances in which they find themselves is critical.

I just give one quote, a predicament of one African woman interviewed by CARE which is all too widespread. She said, I am a widow and have no family around me except my small children. People in the community know I am poor and alone and thus more vulnerable. As I have no one to protect me and no money, I am often forced to provide sexual favors to officials, military and even my brother-in-law.

We know that the OGAC has given more support to the issue of including gender issues, but we feel that needs to be a much stronger focus, recognizing that the ABC approach alone does not take into consideration the entrenched cultural and social norms that drive women's vulnerability. But we know that a difference can be made, and particularly when more focus is placed on changing male behavior.

Again, to illustrate, an African man recounted the following to CARE field staff: My wife was raped, and I threw her out of out of the house. A neighbor helped her and talked to me, but I refused to listen to that woman. Later the men from the association came to talk to me. They explained what had happened, and it wasn't my wife's fault. They encouraged me to take her back into the home, and I did.

So we know that, in fact, that by focusing on men's behavior at the same time, that we can have an impact on making a difference in the circumstances that affect the lives of women.

Third point, the risk of HIV infection is significantly higher among certain vulnerable populations, including sex workers, injection drug users, men who have sex with men, and prisoners and sexually active adolescents. In many countries CARE HIV-AIDS and reproductive health programs reach sex workers and those engaged in transactional sex through interventions designed to reduce the risk of infection or identify activities to expand livelihood activities. PEPFAR's funding is often supporting too little and too little innovation in prevention programs among vulnerable populations.

And in view of the time, I won't go into a lot of detail other than to say that I think the focus on vulnerable populations has to be included in that regard. And we think that the antiprostitution pledge is particularly counterproductive in the fight against HIV-AIDS.

Our fourth point is that as we look toward PEPFAR reauthorization——

Mr. SHAYS. Is this your final point? Because we need to conclude here.

Dr. GAYLE. Yes.

It is important to learn from experience to date and begin to articulate components of a truly comprehensive HIV prevention policy that looks beyond the ABC formula and also addresses the broader underlying issues linked to HIV vulnerability and related issues.

In that regard we look at issues of poverty, gender inequality and livelihood, understanding that all of that can't be funded through PEPFAR, but a better approach to integrating sources of U.S. funding, like food, nutrition, agriculture and economic growth resources so that those components can be integrated with prevention will clearly make a huge impact on the effectiveness of prevention programs.

And I won't go into detail in the final one only to say that evaluation of this program and looking at the long-term impact of sustainability is also going to be critical.

So I will just close there and look forward to your questions.

Mr. SHAYS. You will have plenty of time to elaborate on any point in your statement and questions.

[The prepared statement of Dr. Gayle follows:]

STATEMENT OF HELENE GAYLE, MD, MPH
PRESIDENT AND CHIEF EXECUTIVE OFFICER
CARE USA

BEFORE THE U.S. HOUSE COMMITTEE ON GOVERNMENT REFORM
SUBCOMMITTEE ON NATIONAL SECURITY, EMERGING THREATS
AND INTERNATIONAL RELATIONS

***

September 6, 2006

Subcommittee Hearing on "HIV Prevention: How Effective is The President's Emergency Plan for AIDS Relief (PEPFAR)?"

WRITTEN STATEMENT

Mr. Chairman, Congressman Kucinich, Congressman Waxman, thank you for this opportunity to join you today to consider the President's Emergency Plan for AIDS Relief or 'PEPFAR' as we've all come to know it. CARE has a long history of implementing HIV and AIDS projects with funding from the United States Government and other governmental and institutional sources. CARE is a nonprofit, nongovernmental humanitarian organization fighting poverty through long-term development projects and emergency relief during natural disasters and conflict. CARE works in 70 countries with more than 12,000 staff worldwide – the vast majority of whom are from the countries in which we work. CARE works in 11 of the 15 PEPFAR focus countries and in four of the five non-focus countries receiving more than $10 million annually from PEPFAR. Our total current PEPFAR budget is $44.5 million. CARE's HIV and AIDS program began with one project in 1987 and by 2005 we had more than 150 projects in 40 countries addressing HIV and AIDS. Our objectives are primarily focused on reducing the number

of new HIV infections, especially among the most vulnerable; mitigating the impact of HIV and AIDS on economic development and community well-being; and increasing access to high quality care and support for affected families. CARE's HIV and AIDS projects are typically community-based, comprehensive, and multi-sectoral.

PEPFAR represents an unprecedented investment and long-term commitment by the U.S. government to the fight against HIV and AIDS. In turn, American funding has allowed CARE and other global health and civil society organizations to design and implement a diverse spectrum of promising approaches to prevention, treatment and care that have positively affected the lives of millions around the world. CARE looks forward to working with Congress and the Global AIDS Coordinator to ensure that this critical investment is sustainable, that we achieve maximum results in the fight against HIV and AIDS, and that the strategies employed in this fight are based on sound, evidence-based public health practices.

In CARE's experience, PEPFAR has contributed energy, resources, and critical momentum to prevention, treatment and care programs in resource-poor countries that have shown tangible results, saved countless lives and provided much needed support in communities with a heavy burden of HIV and AIDS. PEPFAR has also demonstrated crucial leadership, political will and lasting commitment from the United States, all key ingredients in the broader fight to stem the tide of HIV/AIDS. CARE strongly supports the continuation of this valuable program and we are here today to offer our support and our constructive suggestions, drawn from our field experience, to further strengthen the program. Given the critical nature of this initiative, we take seriously the opportunity to help ensure that it can exert the greatest possible impact over the long run.

Today, I would like to raise several issues based on CARE's experience implementing PEPFAR-funded programs, particularly in the prevention area given the focus of today's hearing.

First, there is a crucial need for a more balanced and flexible approach to HIV prevention policy, one that integrates the strengths of A, B, and C programming and enables local decision-making on how best to achieve and maintain that balance.

Second, U.S. prevention efforts need to give far higher priority to activities that reduce gender inequity and the acute vulnerabilities of young women and girls.

Third, PEPFAR prevention programming should intensify its focus on populations at greatest risk, such as sexually active youth, commercial sex workers and injecting drug users (IDUs) among others.

Fourth, PEPFAR should more systematically leverage other development resources and programs that can strengthen the position of women and girls and reduce their vulnerabilities and those of other high risk groups.

Finally, adjustments are needed to strengthen PEPFAR's measurement framework and project timelines.

More Integrative Programming is Needed

The HIV sexual transmission prevention strategy of the U.S. Government centers on the ABC model. The elements of the ABC model are, of course, **A**bstaining from sex, **B**eing faithful to one sexual partner, and correctly and consistently using **C**ondoms. ABC provides individuals with simple, understandable messages on how they can avoid HIV infection. CARE strongly supports PEPFAR and its important work on behalf of

individuals who are or who may become infected with HIV, and in particular, we support and implement each element of the ABC model as appropriate in our global HIV and AIDS prevention work. Much has been written about the 2004 *Lancet* commentary on finding common ground for optimal prevention policy. As co-author of that statement, I firmly believe that "the ABC ... approach can play an important role in reducing the prevalence of HIV in a generalized epidemic, as occurred in Uganda. *All three elements of this approach are essential* to reducing HIV incidence, although the emphasis placed on individual elements needs to vary according to the target population."[1]

However, in our experience on the ground in resource-poor countries throughout the developing world, OGAC and the country teams responsible for interpreting program guidance have articulated prevention policies and programming with a strong AB preference that leaves too little space or funding for meaningful, integrated HIV and AIDS prevention programming. Our specific concerns include the following:

- *Issuing unclear guidance.* CARE concurs with the finding of the Government Accountability Office (GAO) that OGAC guidance explaining the ABC approach lacks clarity. In our experience with country office teams, OGAC's lack of specific, understandable guidance on its primary prevention approach results in uncertainty of scope and overly conservative interpretations by PEPFAR country teams about what prevention interventions can be included in implementing partners' programs.
- *Defining program content narrowly.* Too often, PEPFAR has emphasized the narrower interpretation of appropriate programming, ignoring meaningful

---

[1] The time has come for common ground on preventing sexual transmission of HIV. *Lancet* 364, 1913 (2004).

comprehensive programming in favor of a more basic AB message. Our country offices express deep concern that messages about abstinence or faithfulness, de-coupled from the broader reality that most individuals in resource-poor countries face every day, are not effective in influencing high-risk behaviors or promoting safer practices over the long term.

- *Counting AB dollars separately.* For reporting purposes, the program refuses to count funds devoted to comprehensive ABC programming toward the earmark even when the programs contain abstinence or delay-of-debut components, requiring that its AB programs exist in isolation. We know from our work in the field that isolated interventions are rarely successful—accounting for AB resources separately reinforces the 'island effect' of U.S. prevention programming and ignores the synergistic value of more balanced, integrated approaches.
- *Isolating 'high-risk' populations.* By requiring that condom outreach, distribution, and marketing programs be focused only on 'high risk' groups, PEPFAR ignores the sound public-health premise that 'integrated' means integrating A, B, *and* C. In particular, U.S. programming should support truly integrated programming in generalized epidemics (all PEPFAR focus countries in sub-Sahara Africa) where those who are sexually active should all be considered at risk of infection.

CARE's experience, confirmed by the Government Accountability Office's (GAO) recent analysis, is that the ABC approach is interpreted and applied inconsistently across PEPFAR focus countries by USG country teams. In some countries, CARE has

observed that country teams are able to find ways to make A, B and C accessible in a more balanced, integrative way. In other countries, the guidance we receive is more rigid, and fosters the perception that condoms are an undesirable "only if-all-else-fails" option. The variability and uncertainty at the country-team level regarding permissible programming with AB funding is created in Washington but transmitted to CARE and other implementing partners in the field, constraining our ability to design and implement interventions that best respond to local circumstances.

In our conversations with CARE field staff in preparation for this hearing, one experience in particular stands out. In a CARE project in one of the PEPFAR focus countries with a generalized epidemic, our country office approached USAID with an innovative proposal to work with sexually-active youth engaging in transactional sex for money. Our proposal would have provided treatment for sexually-transmitted diseases and training for alternative livelihoods to reduce the economic dependence of these desperately poor children. Unfortunately, OGAC turned down our request for AB funding but suggested country office staff resubmit the proposal for OVC care and support funding to pursue the same objectives. Ultimately, though after considerable delay, this innovative proposal was accepted and funded with OVC funds. But think about the implications here. Why does programming designed to treat STDs and draw children out of transactional sex work, a high-risk activity for HIV infection, not qualify for U.S. prevention funding? The answer, regrettably, is simply because U.S. policy has compartmentalized prevention funding into arbitrary categories, "AB" and "Other Prevention", with simple deliverables that must be 'rolled up' to the national (and global)

level every year. The result is unfortunate: a rigid interpretation results in significant delay while bold and innovative programming becomes harder to fit and harder to fund.

We recognize that this is as a result of the underlying statutory requirement included by Congress in the Global AIDS Act that requires U.S. prevention programming to devote at least one-third of its funding to abstinence-until-marriage programming. Unfortunately for implementing organizations like CARE, the statutory restriction constrains OGAC's ability to support the design and implementation of more comprehensive and flexible programming. We are encouraged by recent legislative initiatives in both the House and the Senate to modify or eliminate this restrictive requirement. Though A and B programming are both important in certain settings for specific populations, as we've said before, an integrated approach that balances all three elements and addresses the complicated realities of individuals living in resource-poor countries is strongly preferable to an arbitrary formula with no basis in public health evidence or practice. CARE urges Congress to consider modifying or repealing the AB set-aside to substantially increase the ability of PEPFAR country teams and implementing partners to respond to local circumstances.

Fully Address Gender as a Determinant of Vulnerability

In sub-Saharan Africa, women represent 60% of those infected with HIV and 75% of those infected between the ages of 15 and 24. Young women age 15-24 in South Africa, Zambia and Zimbabwe are three to six times more likely to be infected than are young men. One in four women in South Africa is HIV-infected by the age of 22.[2] In our experience, women and girls are disproportionately infected by HIV because they are

[2] Quinn T, Overbaugh J. HIV/AIDS in Women: An Expanding Epidemic. *Science* **308**, 1582 (2005).

less able to negotiate sexual relations, they are more prone to sexual violence, they are often married at an early age to older men and they are more susceptible to pressure to engage in transactional and inter-generational sex.

Women and girls in these countries are only meaningfully engaged by the ABC model when they are free to choose to abstain from sex, or to choose to enter or to remain in a relationship where their own faithfulness is reciprocated and thus truly protective, or to avail themselves of condoms where they can negotiate correct and consistent use. In those instances, ABC as a preventive strategy—including AB for appropriate target populations—is an effective intervention. But wherever women cannot control the sexual encounters they engage in, either for reasons of rape or abuse, gender disempowerment, economic dependency, or cultural practices, ABC in its current formulation is significantly more problematic. Worldwide, thousands of women and girls are infected with HIV daily in settings where saying no to sex or insisting on condom use is not an option because of cultural factors, lack of financial independence, and even the threat of violence."[3] The following predicament of a young African woman, as conveyed to a member of CARE's field staff, is all too common: "I am a widow and have no family around me, except my small children. People in the community know I am poor and alone and thus more vulnerable. As I have no one to protect me and no money, I am often forced to provide sexual favors to officials, military and even my brother-in-law."

In CARE's experience, many women and girls are unable to choose to remain abstinent due to the high prevalence of rape and gender-based violence (GBV) in far too many countries. In Burundi, CARE found that 15 percent of men admitted to raping someone at least once in their lives. It is clear that we must do more to change men's

[3] Fauci, A. Twenty-Five Years of HIV/AIDS. *Science* 313, 409 (2006).

behavior. We must find ways to engage men more fully so that they are equal partners in the fight against HIV and AIDS. Moreover, rape and GBV all too often go hand-in-hand with conflict and instability. For example, in the Great Lakes region of Central Africa, a woman told CARE staff, "I was raped two years ago by a man in uniform . . . Fifteen hours after he committed this ignoble act he told me, 'I got AIDS by paying for sex. You are lucky; I gave it to you for free.'" Darfur and eastern Congo are two current, terrible examples where unthinkable numbers of women and girls have been raped or coerced into sex. In countries where the costs of going to school are high, too many young girls participate in transactional sex, often with older men and sometimes with their own school teachers, in order to be able to cover the costs of school or simply to contribute to meeting their family's basic needs. One African woman told CARE, "I was one of the few lucky to go to school. However, my teacher kept harassing me when I arrived. I asked a friend about this and she said, 'If you want to pass the exam, you have to agree to his sexual demands.'" Women may also enter into such relations so that they and their families can survive. CARE and others' assessments in Rwanda point to an alarmingly high rate of young women and girls who are or who have been sexually abused or engaged in "survival sex".

Worldwide, 80 percent of women newly infected with HIV are practicing monogamy within a marriage or long-term relationship. Sadly, their husbands and partners are not. Under AB programming, CARE country offices have encouraged couples to be faithful to each other despite the reality, in many cases, that many couples either do not know each other's status or at least one partner is or may be infected and discordant. Certainly for women who faithfully respect the sanctity of their marital bonds

but who are unknowingly exposed to the HIV virus by a discordant husband, PEPFAR's current approach is of little or no value at reducing the likelihood that they will contract HIV and AIDS.

CARE's experience shows that no single approach can effectively prevent HIV infection. For instance, married women in sub-Saharan Africa have one of the highest HIV prevalence rates. Promoting abstinence or fidelity will not protect them from HIV, since it is often their husbands who infect them. If we're emphasizing faithfulness in this context, it has to focus as much or more on men than women, and it has to recognize that relationships of economic or cultural dependency where women do not have the power to refuse unprotected sex *are* the problem, not the presence or absence of faithfulness per se. OGAC has rightfully acknowledged that working with men in peer groups is essential to transforming underlying gender norms that endanger women. CARE has found that such interventions are critically important and should be encouraged. As one African man recounted to a member of CARE's field staff, "My wife was raped and I threw her out of the house. A neighbor helped her and tried to talk to me, but I refused to listen to that woman. Later, the men from the association came to talk to me. They explained what had happened and that it was not my wife's fault. They said she was neither seropositive nor pregnant. They encouraged me to take her back into the home." Men, alongside women, must be leading the fight against sexual violence and PEPFAR can do even more to help make that happen.

Too often in our conversations with field staff in preparing for this hearing, we heard that despite the critical importance of gender as a determinant of vulnerability for people at risk of contracting HIV and AIDS, gender inequity still is not a sufficient focus

of PEPFAR nor an area that PEPFAR is especially effective at addressing. Too many women and girls are becoming infected with HIV and dying from AIDS. We have to do better.

Engage Vulnerable Populations

The risk of infection is significantly higher among certain vulnerable populations, including sex workers, injecting drug users (IDUs), sexually active adolescents and children, prisoners, men who have sex with men (MSMs) and other individuals whose activities or practices put them at higher risk of contracting or spreading the HIV virus. In many countries, CARE's HIV and AIDS and reproductive health programs reach sex workers and others engaged in sex in exchange for food, money or other resources through interventions designed to reduce the risk of infection or activities to expand livelihood opportunities.

CARE's vision places human dignity at the very center of our work. We seek to protect and advance the dignity of all people, especially those who are living in poverty and at the margins of broader society. CARE is committed to addressing the underlying causes of poverty and vulnerability, and helping poor communities become empowered to seek the fulfillment of their rights. In the countries in which CARE works, many people are marginalized and vulnerable for many different reasons, including gender, poverty, age, caste, religion, occupation and ethnicity. Although individuals in resource-poor countries are entitled to the same basic human rights as people in more privileged positions, they are often not able to avail themselves of those rights. Their access to health care, education, housing and employment is limited, their personal security is

constantly at risk, and they are prevented from realizing their full potential as human beings.

CARE seeks to advance our vision by working alongside marginalized and vulnerable people, helping them to claim their rights and fulfill their responsibilities. We also help to hold people and institutions with duties to protect and uphold those rights accountable. CARE works with vulnerable and marginalized groups in a wide variety of settings: examples include low-caste and tribal groups in India, child soldiers in the Democratic Republic of Congo, girls subjected to female genital cutting in Ethiopia, indigenous populations in Bolivia, and people subjected to gender-based violence and exploitation throughout the world. In each case, CARE stands in solidarity with such groups to enhance their most basic human rights and positions in society.

In our HIV and AIDS and reproductive health programs, CARE works with many groups that are vulnerable, including sex workers, injecting drug users, men who have sex with men, and women and girls engaged in transactional sex among others. Because of gender disparities, cultural norms and socio-economic pressures, these groups exist on the margins of society. They are especially vulnerable to violence, unplanned pregnancy and sexually transmitted infections, including HIV. If these groups are not effectively reached by HIV and AIDS programming, they can be disproportionately infected by HIV and become significant drivers of the epidemic.

CARE works with vulnerable groups as a service provider, facilitator, and partner. Our evidence base demonstrates that addressing vulnerability and reducing stigma are essential elements of effective strategies to fight HIV and AIDS, and must underpin successful prevention, treatment and care efforts. Medically-focused interventions alone

directed toward these groups are insufficient to address the HIV and AIDS pandemic. Vulnerable groups must be willing and able to access these services, and use the information they receive. This cannot happen as long as these groups are pushed "underground" or shunned by society.

CARE's programs seek to facilitate the empowerment of individuals in these groups, so that they can secure their basic needs and human rights, and expand their range of choices and opportunities. We understand that vulnerability stems from social, economic and cultural factors, and our activities seek to address these underlying factors, for example, by providing alternative vocational training, counseling and legal referrals, building leadership and negotiation skills, and creating networks of peer educators for condom distribution, management of clinics and prevention communication.

Currently, PEPFAR is funding and supporting too little vulnerable-populations prevention work. In one especially telling example, a CARE field staff member in a high-prevalence PEPFAR focus country told us that the USG country team had specifically suggested that they should seek other – non-PEPFAR – funding for addressing vulnerable populations. To improve its effectiveness at reaching these important but marginalized populations, PEPFAR must significantly increase its investments in well-established interventions that reduce stigma around HIV and AIDS and discrimination and abuse of vulnerable populations; encourage safer sex among sex and transport workers; harm reduction strategies and effective treatment for IDUs and other vulnerable populations; structural interventions to positively affect the social, political, or cultural environment in which infection and transmission occur; and more comprehensive, engaged programming directed at sexually active youth. In CARE's

experience, not enough PEPFAR funding for 'other prevention' is supporting work with vulnerable populations, nor is PEPFAR funding the more creative, highly responsive interventions that can meaningfully engage these populations and reduce their likelihood of contracting or transmitting the HIV virus. These populations are at significant risk; we must do a better job.[4]

In this regard, we are also concerned about the U.S. prostitution pledge requirement. To effectively prevent HIV and AIDS, CARE works with vulnerable groups who exist on the margins of society. Sex workers represent an especially high-risk population that we must reach in order to strengthen prevention efforts worldwide. Because they are often shunned by society and pushed "underground," sex workers are not able to receive the information and health services necessary to protect them from HIV and AIDS and other sexually transmitted diseases. Even when they have access to information and services, sex workers are often not able to protect themselves effectively because they don't have the power to negotiate safe sex. CARE works to help vulnerable individuals, including sex workers, to better protect themselves against HIV and to cultivate a broader range of economic options for themselves and their families.

CARE believes the U.S. prostitution pledge requirement is counterproductive in the fight against HIV and AIDS and supports the legal efforts currently underway to overturn the requirement. In our view, the pledge requirement threatens to drive a wedge between implementing organizations like CARE and the vulnerable populations whose trust and respect we must preserve in order to combat HIV and AIDS effectively. CARE is also concerned that the application of the current pledge requirement to non-U.S. non-

[4] *See e.g.*, Report on the Global AIDS Epidemic. Geneva: UNAIDS; 2006: 106 ("In China, it is estimated that sex workers and their clients account for just less than 20% of the total number of people living with HIV" (Ministry of Health, People's Republic of China/UNAIDS, 2005)).

governmental organizations adversely affects their work on behalf of poor, marginalized people. We stand with our partners and urge Congress to consider repealing this provision in its entirety as it looks for new opportunities to strengthen PEPFAR and to increase the effectiveness of U.S. HIV prevention policy.

Comprehensive Programming is Needed

As we look toward PEPFAR reauthorization in 2007-08, it is important to begin to articulate the components of a truly effective U.S. prevention policy. From CARE's perspective, we have to integrate A, B, and C wherever appropriate and in whatever configuration is most likely to increase the effectiveness of meaningful prevention over the long term, but we must go beyond the simple ABC formula to recognize that access to education for young girls, economic and gender empowerment, public health infrastructure, protection from sexual violence, and food security and livelihood options for desperately poor people are the ultimate foundation on which an effective prevention strategy in resource-poor countries must be built.

PEPFAR could be considerably stronger in addressing vulnerability if it took a broader health and development approach to combating HIV and AIDS. PEPFAR's work is often too clinical, disease-specific and narrowly medical in focus. Despite its medical and public health context, HIV and AIDS is not a health issue alone. The underlying causes of the spread of HIV and AIDS reflect a combination of many non-health factors such as poverty, gender inequality, stigma and social and cultural norms. As one African woman told CARE staff, "I received more than once, nightly visits from the local chief harassing me and I had to give in so that I could feed my children. It is

difficult to escape what is linked to survival." Additionally, the impact of HIV and AIDS on families, communities, and societies goes well beyond health alone. Congress should consider expanding U.S. HIV and AIDS programming beyond medically-focused prevention, treatment and care to more effectively leverage its HIV and AIDS funding and other foreign assistance resources.

Appropriate, carefully targeted food aid, community gardening to enhance food and nutritional security, inheritance and property rights protection, and small scale economic development through microfinance and microenterprise are program areas that PEPFAR should actively embrace to better address food and nutritional insecurity and to relieve chronic economic pressures that increase vulnerability to HIV infection in poor countries. In one troubling example confirmed by several CARE country offices, CARE staff raised the issue of inadequate nutrition for people living with HIV and AIDS on ARV therapy. Despite the critical need, CARE staff have not been able to secure resources to address the problem because, they were told by USAID, "PEPFAR does not have the mandate." All too often, there are no other agencies, even within the USG, stepping up to fill PEPFAR's gaps. A colleague from another of our PEPFAR-supported country offices reported that, recently, the USAID Health Team in country passed her to their colleagues in the Economic Growth Team (down the hall) to seek food and economic strengthening resources for the most HIV and AIDS-affected families. Shortly thereafter, CARE was informed by the Economic Growth Team that such resources were not available and that what was needed was more money for food and economic security interventions from PEPFAR! The lack of communication and agreement on a coordinated approach to address such a major priority was hard to swallow, and our

impression is that this was not an isolated case – USG coordination and complementarity appear to be lacking in all PEPFAR countries.

Several CARE offices have developed innovative, multi-sectoral interventions with communities affected by HIV and AIDS but only after struggling to mobilize alternative, non-PEPFAR resources. While we recognize that PEPFAR resources must focus on HIV/AIDS and cannot bear the burden of engaging the totality of U.S. development assistance, encouraging examples of focused multisectoral programs are emerging across the developing world and should be carefully examined – and more robustly supported – by PEPFAR administrators and USG country teams. Better coordination with other USG development and food and nutrition funding sources must be operationalized on the ground in order to ensure an effective and sufficiently resourced multi-sectoral approach.

Another serious concern of CARE country offices is focused on programs designed to prevent mother-to-child transmission of HIV (PMTCT). Many PEPFAR PMTCT projects are simply too narrow and fail to incorporate the full range of services that women in resource-poor countries need and want. First, PMTCT is significantly strengthened by ensuring that women can prevent unplanned pregnancies. In our experience, many PMTCT services are utilized by women who would have preferred not to become pregnant. An integrative PMTCT regimen should ensure that HIV-positive women who prefer not to become pregnant are able to access the full range of family planning and reproductive health services. Secondly, for HIV-positive women seeking to have children, PMTCT programs should focus on both appropriate anti-retroviral therapy *and* child survival. In too many instances, CARE staff have witnessed tragic outcomes

when mothers who are successful at preventing antenatal HIV transmission lose their infants to diarrheal illnesses that are easily preventable through access to safe water or low-cost interventions like oral rehydration therapy (ORT). On other occasions, young mothers are given information on the risk of passing HIV to infants through breastfeeding, but do not receive assistance to allow them to access infant formula.

Several CARE country offices have raised these concerns with USG country teams and asked for help at finding additional funding for a more comprehensive PMTCT approach. Unfortunately, on most occasions they were told that integrated PMTCT could not be supported. All U.S. PMTCT programs should incorporate reproductive health and family planning services for women who prefer to avoid pregnancy and provide integrated programming to protect newborn infants from HIV and other readily preventable illnesses. This is another area where better coordination with other USG foreign assistance funding sources, including child survival and reproductive health funding, could strengthen PMTCT programming.

Although, there is general support for the so-called wraparound approach requiring strong and regular "coordinat[ion] with and leverag[ing of] resources from other agencies and sectors, such as nutrition and education, to promote comprehensive and effective responses,"[5] PEPFAR in its current configuration has largely failed to adequately address the broader health and development causes and consequences of HIV and AIDS. Beyond OVC care and support programs, relatively few PEPFAR-supported programs address economic and social issues related to HIV and AIDS. These programs are often neglected, apparently in the hope that other agencies – whether USG or

[5] "Action Today, A Foundation for Tomorrow: The President's Emergency Plan for AIDS Relief: Second Annual Report to Congress." Page 13. http://www.state.gov/documents/organization/60598.pdf

otherwise – will 'wrap around' PEPFAR's mainly clinically-focused work to achieve a multi-sectoral, holistic response. To work effectively, this wrap-around approach entails real, ongoing, on-the-ground coordination, planning, and resource pooling with other agencies. The reality remains far removed from the ideal and leaves the goal of comprehensive programming largely unfulfilled.

Operational Challenges

CARE appreciates PEPFAR's commitment to accountability and we agree completely that it is essential to systematically monitor and meaningfully assess program outcomes to ensure the maximum return on the U.S. and host governments' investments in the fight against HIV and AIDS. That said, after conducting many conversations with CARE and partner staff implementing PEPFAR interventions around the world, the manner in which PEPFAR's results measurement and evaluation framework has been implemented requires attention by policy makers. Above all, PEPFAR's ambitious 2-7-10 targets are driving a single-minded pursuit of highly specific results, producing an excessive focus on quantitative process outputs without sufficient attention to program sustainability, impact evaluation and continuous learning.

Sustainability in particular can be jeopardized when narrowly-focused U.S. programming emphasizes meeting numerical targets over engaging the underlying causes and consequences of HIV and AIDS. In one especially hard-hit PEPFAR focus country, for example, CARE's model OVC care and support program was criticized as too expensive on a cost-per-OVC basis. To meet OGAC targets for numbers of orphans and vulnerable children "reached," CARE was pushed to scale back key investments in

support of local ownership and community capacity building. According to field staff, the pressure was enormous to reduce or eliminate planned investments in community support networks and promotion of food and income security. In CARE's long experience in community development, we have learned that such interventions are key to ensuring program sustainability and to improving, in the long run, the quality-of-life and well-being of vulnerable children. As this and other CARE experiences illustrate, Congress and the Administration must find a more productive balance that ensures sustainability and durable change from U.S. investments in the fight against HIV and AIDS. Effective measures have to assess the degree to which PEPFAR programming encourages economic, social and cultural transformation that can take root locally and be sustained over the long term.

In addition, in assessing PEPFAR program evaluation and learning, CARE urges greater, more systematic attention to the crucial question of impact measurement. Are the individuals who receive information or education about abstinence, faithfulness, or condoms actually modifying behaviors to reduce risk, and do we know the ultimate impact in averted infections? It is certainly challenging to measure behavioral outcomes successfully, but crucial investments in impact evaluation and continuous learning should not be sacrificed to PEPFAR's "full speed ahead" emergency mindset. In the long run, we have to be sure that we are doing the best job possible with PEPFAR resources. Or as one of my colleagues with extensive, on-the-ground PEPFAR implementation experience wondered recently, "Are we building a bunch of straw houses here?"

Finally, in addition to its excessive focus on numerical targets, PEPFAR programming tends to involve short contracting periods. The short-term nature of

PEPFAR programming makes it difficult to address one of the key goals of the U.S. Five-Year Global HIV/AIDS Strategy to "develop sustainable HIV and AIDS health care networks" and to build local capacity for the long term.[6] From CARE's long and extensive experience in building local capacities to address HIV and AIDS, we have learned that it takes time to build trust and truly enable meaningful, effective, and sustainable community-based interventions. Small community-based or faith-based organizations operating in developing countries generally do not have the ability to absorb large amounts of funding, conduct effective programming, and measure results on six-month or one-year contracts. They need to be accompanied and supported over a multi-year period to enable analysis of HIV and AIDS' causes and consequences and engender community solidarity and action planning to respond. Enabling women's participation and creating a climate in which the potential of women's leadership can bear fruit is an especially lengthy effort, since it must go hand in hand with a profound process of social change in order to be truly sustainable. CARE shares OGAC's commitment to devolving more HIV prevention, care and treatment service delivery to local organizations and local government entities. But let us be clear that longer-term investments are needed to ensure that local organizations and government entities will be capable of continuing to provide – responsibly and effectively – these crucial services in the future.

[6] "The President's Emergency Plan for AIDS Relief: U.S. Five-Year Global HIV/AIDS Strategy." Page 8. http://www.state.gov/documents/organization/29831.pdf

Conclusion

Let me close by saying that we welcome the opportunity to work with this committee and with our partners at the Office of the Global AIDS Coordinator to strengthen U.S. prevention practices and to reduce, wherever possible, the likelihood that any individual worldwide will contract HIV and AIDS.

I look forward to answering your questions Mr. Chairman, Congressman Kucinich, Congressman Waxman. Thank you

Mr. SHAYS. Dr. Nkya, you are most welcome here. And the only thing that concerns me is when I saw you in Africa, you had a smile on your face. You look too serious to me. I need to see that smile.

This is a wonderful opportunity for us to have you here, and I just want to say before you speak, I don't want to put pressure on you, but our visit to Africa was made very special by getting to meet you. You are a remarkable person, and you honor us with your presence, and it is lovely to have you here.

STATEMENT OF LUCY SAWERE NKYA

Dr. NKYA. Mr. Chairman, Congresswoman Ms. Lee, members of the subcommittee, I am honored to be here to speak on behalf of the African continent, and more specifically for my people from Tanzania.

Mr. Chairman, before I discuss or give the evidence of what is happening with PEPFAR funding in Tanzania, I would like to give a few statistics of information about the epidemic in Tanzania.

The AIDS Tanzania epidemic was first recognized in Tanzania in 1983 with three cases from the northwestern part of Tanzania called Kagera region. Within 3 years, the epidemic had spread throughout the whole country. That means it assumed a disaster proportion, and that is why in the year 2000 our President, when launching the AIDS policy, announced that AIDS was a national disaster in Tanzania.

Mr. Chairman, I would like to bring to the attention that there is only 1 case out of 14 of AIDS cases in Tanzania who are reported to the nationalized control program, which is charged with the following of the money that are in the epidemic in Tanzania. That means that the statistics which are released are really, you know— and the reporting, and they are downplaying the epidemic and the proportion of the epidemic in the country.

Out of all the cases reported, they referred that the peak of the epidemic is between 20 and 49 years that contributes 73 percent of all the AIDS cases in the country, which means that this age group has been infected during adolescence or during their youthful years; that is, between 15 and 20 years of age. Then 10 years later that is when the epidemic starts showing up.

Another point to take, to note, is the, you know, preponderance of——

Mr. SHAYS. Let me ask you to put the mic a little closer to you. Just a little.

Dr. NKYA. Is the early age of infection in women. The peak is between 20 and 29 years. That means women are infected at a very young ages compared to male counterparts, and that married people contribute 56 percent of all the cases of AIDS which are reported in the country as compared to the 32 percent of the singles.

And the currently AIDS infection in Tanzania now is 7.7 percent. This does not mean that the prevalence rate has gone down, but it is because it is based on blood donor, surveillance reports, which have proved that people now who are going go to donate blood have known about HIV-AIDS, so a person who suspects himself as being infected will not go. So this has brought down the infection rate.

Let me tell you that we aimed at treating only 1,200 people out of 2,000 who are infected, but this is only in urban areas, and the legality is if your city or county is less than 200 percent—200, that means a lot of people infected who could be healthy and lead a meaningful life—are denied opportunity for treatment. I don't know who brought in this cut point, but it is there.

Let me say that the initial response is good, and I do have a very good HIV prevention strategy which includes ABC, plus other contributing factors like using the same instruments, ear-piercing and injections, and more on cultural behaviors and beliefs which contribute to the, you know, spread of the HIV-AIDS.

Now, what about my experience now with PEPFAR fund. And I am going to talk in relation to for trust fund.

Mr. SHAYS. Your experience with what?

Dr. NKYA. With PEPFAR funding program, the AB program.

I am going to talk about my experience with FARAJA Trust Fund, which is an agency which I am directing. Before I started working with Deloitte through a program called ISHI—ISHI means live. It was a campaign which was targeting young people in Morogoro municipality with one message, that you should wait until marriage, and if you cannot, you can use a condom and engage in dialog.

Dr. NKYA. Yes. The message is this: It means wait, don't be afraid. You know, engage him in a dialog or her in a dialog, or abstain. If you cannot, use a condom.

That was the message. And you know, we produced a lot of teachers with the message. And it was all over the radio program, television programs, even the national television. Unfortunately during the last session of the Parliament, this message was banned from being transmitted through our television programs in Tanzania.

Dr. NKYA. It was a successful program, it was a 1-year program. We had more than 7 million shillings from Deloitte. And it give the youth an opportunity to discuss openly about HIV/AIDS, to get access to condoms, the few condoms which I had because we could not access new condoms through the ministry because they were not available, there were no funds.

And then the second message came in 2005, 2006 through Family Health International. Now the message changed, it was now AB, that was abstain or change your behavior. That was the message that was being given to the young people. Now what was the reaction? The reaction was very confusing. The young people would come to us and ask us, are you going mad? It was a bit embarrassing. You have been advocating condom use, behavioral change and abstinence where it is applicable, but now you change and say OK guys, it is time to be more realistic, abstain from sex until you get married—as if everybody's going to get married—or change your behavior, be faithful in marriage.

So several questions came up. The first question was, what will happen to the sexually active young people who are HIV positive? What will happen to the couples who are HIV positive if free condoms—because many people in Tanzania are poor—if no free condoms are available? They're asking me, you know, have you changed the behavior and the culture of the people whereby, you

know, rich men, especially affluent men, in the community that they are rich and influential, the number of concubines or sexual partners they're going to have, they came to ask me, you know, don't you know, mom, that the problem here is poverty, not even, you know, we being promiscuous.

And this brought me back to the project which we started in the brothels. It is one of the biggest brothels where a lot of young women were in the 1990's, and I talked with one and asked her what is your problem, why do you have to leave your home and come to this place, which is filthy and they're being abused by men. She said, look here—they used to call me mother-in-law—mother-in-law, look here, it is better to die slowly than to die of starvation to death, and better off dying 10, 20 years to come if the message is this, rather than dying today because the 10 years will give me time, first of all, to work and build a house for my children, and give enough time for my children to grow up and to become self-reliant, and also be able to purchase a farm. And then very slowly given enough time to repent of my sins, that's what they told me.

Then probably, if I would give another example, another example is about a young girl who is 15 years old and she has a child. This woman, this girl asked how come she have a child. She told me that she was forced into marriage by her father, and that is, you know, perfectly in order, depending on the culture of our people in Tanzania, to marry a man as his official wife, and when this man died, she was forced to be inherited by the older brother of the dead man that she managed to run away and escape.

Now what was her refugee? How could she leave with two children? So she had to engage in commercial sex work in order to live. And now I'm talking to her, telling her now, you see, if we check you—you come for physical, and we refer to you as either negative or positive, you should be abstaining from sex. Then she asked me, what am I going to do? How am I going to feed my children? My mother also expects me to support her from where I am now.

That's the issue, Mr. Chairman. Let me say that the approach and the policy of AB does not take into consideration the culture of the people in the developing countries. It does not take into consideration the socioeconomic situations, things like poverty.

Let me tell you that even empowering women or gender empowerment will never succeed if we don't address the issue of poverty, especially among women. This is evidenced by a program I conducted in a brothel whereby I was able to empower those woman economically, and we managed to remove more than 67 percent of those women from prostitution, they are living, and their children are now going to school.

Mr. Chairman, I have a lot of testimony, but——

Mr. SHAYS. Well, maybe we'll get some of your testimony from the questions, but I remember your conversation with us, and as you—this brothel, as I remember, had literally hundreds of women, didn't it?

Dr. NKYA. There were about 450 women, and we managed to rescue 270 women who were HIV negative to stop prostitution, and they moved back into their homes. The remaining, we were able to give them some money so that they could take care of themselves. Although they were positive, they could do some work, ideas to get

food, to meet their present medical requirements and to feed their children. And eventually, as I'm talking today, Mr. Chairman, the brothel has been demolished, and these women now are living, they are respected and they're living.

So that is a living example which has been by many people and organizations in Tanzania and some organizations from the countries that empowering women should complement economic empowerment because poverty is the basis of HIV. HIV is epidemic in our countries. Whether you are infected or not infected, you are in the rural area or in the urban area, if you are poor, you are going to engage into behavior which is going to put you into risk of getting infected. I'm not forgetting that.

44 percent of our population is young people. That means these young people, as we have seen in the statistics here, they are more vulnerable than the others. So let's say that they're all vulnerable to getting HIV infection. So telling them to abstain, that is not really going to hold water, and backed by the fact that we did the survey in Morogoro in year 2000 and year 2003, whereby we found that the minimum age of sexual activity started from 10 years, and for some were 9 years of age.

So given that basic fact, and I think, you know, it would be better off if HIV prevention strategies, that means including AB plus the other cultural factors, and economic factors which are contributing to this plague of HIV/AIDS.

Mr. SHAYS. Well, we will get into some of this in the questions that Ms. Lee and I will be asking. So thank you for your testimony.

I'm struck by the memory that as you went to this brothel to deal with these women, as I recall, your husband, who traveled, got a note from one of his friends saying your wife has become a prostitute. He didn't quite understand the role you were playing. You are obviously a magnificent lady.

[The prepared statement of Ms. Nkya follows:]

HIV PREVENTION: HOW EFFECTIVE IS THE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF (PEPFAR)? TANZANIA'S EXPERIENCE

Dr. Lucy Nkya

Introduction

AIDS epidemic in Tanzania was first recognized in 1983, when the first three cases were recorded in Kagera region. Three years later 21 regions of Tanzania mainland reported AIDS cases in hospitals. This signified fast spread of the disease making it a potential national disaster. Consequently, the president of Tanzania declared AIDS a national disaster in 2000 when launching National AIDS Policy.

NACP report of 2004 indicated that there were 16,430 new cases reported from 21 regions of Tanzania mainland leading to a cumulative total of 192,532 cases since 1983. The statistics were obtained from hospitals and few HIV care facilities mostly found in urban areas. Based on Estimation and Projection Package (EPP) and spectrum model developed by WHO, only one out of fourteen cases of AIDS are reported in Tanzania. Based on the EPP, therefore, the total number of AIDS cases for 2004 was 1,840,000 leading to cumulative number of 2,675,448 since 1983. The highly affected age group is between 20 – 49 years (73%). Females between ages 20 and 29 are more affected than males while married people form 55.6% of PLHA as compared to 22% of singles. Current HIV infection prevalence rate in Tanzania is estimated at 7.7% which is based on blood donors (NACP, 2004).

In year 2004 the Government of Tanzania planned ARV treatment to an estimated number of 500,000 AIDS patients, most of which were in urban areas. Only those with CD4 count less than 200 were eligible for treatment. This means that a large numbers of HIV cases are not getting ARV treatment. Nutritional support is not part of the treatment package due to lack of funds.

Tanzanian government response to the AIDS epidemic is robust. The National AIDS Policy spells out prevention approaches which include; care, treatment and support to those affected by HIV/AIDS. Education on the use of condom and distribution to high risk groups is one of the approaches. Free access to condoms is no longer possible, however, due to shortage of funds. Abstinence and faithfulness drive is still limited to faith based organizations.

This testimony provides a general overview of PEPFAR in relation to HIV/AIDS situation in Tanzania with reference to Faraja Trust Fund.

What is Faraja Trust Fund?

Faraja Trust fund (referred to as FARAJA) is a community based non-governmental organization with integrated activities on HIV/AIDS prevention, care and treatment. The organization was established in 1991 in response to HIV/AIDS epidemic in Morogoro region of Tanzania.

The mission of FARAJA is to alleviate suffering among the HIV/AIDS vulnerable people and affected individuals through counseling, care and coping support, income generation activities and preventive health education. The vision of FARAJA is to see communities free from suffering arising from the scourge of HIV/AIDS and to become the foremost competent and effective service provider in alleviating suffering through care and support of HIV/AIDS affected individuals in Morogoro Region. The Motto of FARAJA is to *alleviate suffering through building self-help capacity.*

FARAJA started with Commercial Sex Work Resocialization program in 1991 when 270 Commercial Sex Workers were enabled to switch from risky behaviour to other socially acceptable income generating activities. Strategies employed included HIV/AIDS/STI education, information about condom use and distribution and economic empowerment through small grants. As the organization grew, strategies expanded to include HIV/AIDS peer education, counseling and home based care, OVC support, human rights and legal aid, school health program and out of school youths program.

Faraja Experience with PEPFAR

Experience through ISHI Campaign (2004-2005)

Through the agency of Deloitte and Touché FARAJA was provided with $ 7,000 for the 'ISHI' Campaign targeting youth in Morogoro Municipality. The aim of the project was to promote youth's behavioral change, abstinence until marriage, condom promotion, and promotion of voluntary counseling and testing (VCT).

This program was highly successful because many youths turned for VCT and attended youth behavioral change "Wednesday" debates. There was also increased demand for STI treatment and increased demand for condoms. Feedback from beneficiaries confirmed that knowledge about HIV/AIDS/STI was increased by about 90% among youth in the intervention while information about condom and condom use increased by 80%. Those treated for STI'S reported high rate of condom use after treatment. Sex workers acquired skills of negotiating condom use with their beneficiaries who were also interested in knowing their HIV status. Youth living with HIV/AIDS became more willing to disclose their HIV status and joined the campaign against spread of HIV/AIDS as witnesses to the reality of HIV/AIDS epidemic.

Experience through Family Health International (2005-2006)

FARAJA continued with second phase of ISHI Campaigns funded through Family Health International (FHI) where a total of $7000 was provided to target youth in Morogoro Municipality with a focus on abstinence until marriage, behavioral change, promotion of VCT and "no condom" promotion. Sex workers (prostitution) were not part of the programme. In this second phase the campaign style changed and results were mixed.

A number of youths reported that they were confused by the new approach where Faraja seemed to have abandoned their previous focus of advocating behavioral change, abstinence and condoms, and switched to a new moralistic approach of encouraging youth to abstain until marriage, no condom use, and family planning.

Several questions were been asked by beneficiaries of the program, including:

- What will happen to the sexually active youth and adolescents who are living with HIV/AIDS?

- What about the sexual rights of PLHA youths? (The issues at stake here were re-infection, unwanted pregnancies leading to giving birth to HIV+ children and forced early marriages.

Faraja Assessment of the ISHI Campaigns

The concept of AB approach as compared to ABC approach did not take into account the following realities:

- The issues of culture, such as polygamy, parents not discussing reproductive and sex education with their children, behavior of men when they have money, behaviors during folk festivals (initiation ceremonies, witchcraft, raping the young for cleansing and wealth).

- The role of poverty in the spread of HIV/AIDS and its impact on communities in which young women, single mothers and widows are predisposed to HIV.AIDS infection.

- Increased unemployment in developing countries exposes youths to risky behaviours i.e. sex work and drug abuse.

The *bottom-line outcome* arising from the complexity of the HIV/AIDS is that the traditional family support system is rapidly weakening due to rapid urbanization, deaths of parents caused by AIDS and family breakdown. This is contributing to the rapid increase of children and youth living in streets and are exposed to greater risk of contracting STI's and HIV infections due to many reasons.

Mr. SHAYS. Dr. Green.

STATEMENT OF EDWARD GREEN

Dr. GREEN. Thank you. Mr. Chairman, members of the Government Reform Committee, thank you for inviting me to participate in this important hearing on AIDS prevention and PEPFAR. I'm a senior research scientist at the Harvard Center for Population and Development Studies.

For most of my career I have not been an academic. I've worked in less developed countries as an applied behavioral science researcher and as designer and evaluator of public health programs, mostly under funding of USAID. I've worked extensively in Africa and other resource-poor parts of the world. I've worked in AIDS prevention since the mid 1980's, at which time I was working in the field of family planning and contraceptive social marketing in Africa and the Caribbean, and I've served on the Presidential Advisory Council for HIV/AIDS since 2003.

I might add that I worked with Dr. Nkya in 1984 in Morogoro in that very project for sex workers. We were helping them not get infected or pass on infections, treat their STDs, and provide income generating skills if they wanted to get out of sex work, which the great majority did.

I would say that obviously abstinence is not the very relevant message if you're an active sex worker, but then neither are condoms and clean syringes, the primary message that you would bring to primary schools.

Since my time too is very short, let me just cut to the chase. And I feel that amending the 2003 act that requires that 33 percent of PEPFAR prevention funds be spent on abstinence and fidelity programs, moving this would be a bad move, removing this earmark would remove the essential primary prevention foundation from the U.S. Government response to the AIDS pandemic. It would leave only risk reduction, which is different in intent and effectiveness from true prevention.

A risk reduction approach assumes that behavior contributing to morbidity and mortality cannot be changed; therefore, the best we can do is to reduce risk. And this was our strategy with those sex workers in Morogoro. Risk reduction alone has never brought down HIV infection rates in Africa. This conclusion was reached by three separate studies under the rubric of the USAID funded ABC study in 2003, and later. It was also reached by a U.N. AIDS study of a 2003 study condom effectiveness review by Herston Chen, and it was the conclusion implicit in the UN/AIDS multi-site African study published in 2003.

Prevention based on risk reduction had some early success in Thailand, and later in Cambodia, but never in Africa, or at least outside of the few high risk groups. Now PEPFAR and USAID lead the world in AIDS prevention, promoting a balanced and targeted set of interventions that include Abstinence, Being Faithful and Condoms for those who cannot or will not follow A or B behaviors. And I'm the person who said this is in spite of formidable and continuing institutional resistance to change, and maybe we can talk more about that.

Removing primary prevention from this mix by removing the present earmark would almost certainly return AIDS prevention to the era when HIV prevalence continued to rise in every country in Africa, with the exception of Uganda and Senegal, the first two countries in Africa to implement ABC programs. Since then, ABC programs and changes specifically in A and B behaviors, especially in B behaviors, as has been said earlier, which is measured in the decline in the proportion of men and women reporting two or more partners in the last year, are credited with reducing HIV prevalence not only in Uganda, but in Kenya, Zimbabwe and Haiti, and possibly in Rwanda. These last three countries' successes were all the more remarkable considering the political and economic devastation they've suffered.

As was mentioned, a consensus statement published for the 2004 World Aids Day special issue of the Lancet proposed that mutual faithfulness with an unaffected partner should be the primary behavioral approach promoted for sexually active adults in generalized epidemics. Abstinence or the delay of age of sexual debut should be the primary behavior approach promoted for youth. This represents a fairly marked departure from many previous prevention approaches which emphasized condom use almost exclusively as the first line of defense for sexually active adults for all types, in other words, regardless of the country, the culture or the type of epidemic. This statement was endorsed by over 150 global AIDS experts, including representatives of five U.N. agencies, the WHO, the World Bank, as well as President Museveni, and two of the authors were myself and Dr. Gayle.

A growing number of public and international health professionals recognized the previously missing AB component of ABC as logical, sensible, cost effective, sustainable, culturally appropriate interventions for general as distinct from high risk populations. Moreover, the evidence is clear that these components work, and that risk reduction alone has not lead to a simple success in generalized epidemics.

I wish I had more time to present more evidence, I thought we were going to be kept on our 5 minutes.

For example, DHS, Demographic and Health Survey data showed that higher levels of AB behaviors—and it's assumed by many that we already see that, including people who work in the AIDS field ought to be familiar with the data. For example, only 23 percent of African men and 3 percent of African women reported multiple sex partners in the last year, according to the most recent DHS surveys. Among unmarried youth 15 to 24, only 41 percent of young men and 32 percent of young women in Africa reported premarital sex in the last year. This means that most African men and women practice B behaviors, or do not have outside sexual partners, and most unmarried African youth do not report sexual intercourse in the past year.

I hate to use the controversial A word, abstinence, but that's what surveys show. And I wish we could take away the word only after abstinence.

Moreover, the trend in Africa is toward higher levels of A and B behavior, it is toward incrementally lower HIV prevalence. HIV prevalence is an average of 7.2 percent for Sub-Saharan Africa in

2005, compared to 7.5 percent in 2003. I mention this because critics of the African ABC model often depict African men in particular as incapable of monogamy or fidelity, which is simply not true. When critics of fidelity and abstinence programs argue that these behaviors sound nice but don't get the reality of Africa, one only needs to look at the available behavioral and epidemiological evidence—this is from DHS, studies by Population and Services International of Family Health International, a number of USAID recipients of funds.

In conclusion, I hope Congress will take no actions that would seriously undercut the one major donor agency in the world that is conducting effective AIDS prevention, the generalized epidemics by in effect removing the very interventions that have been proven to have the most impact. I believe that the simple effect of the African model of AIDS prevention is still so new and different from the old way of doing things that without some direction from Congress, the bureaucracies involved in guiding implementation would probably fall back into old habits and once again limit AIDS prevention to its reduction to condoms, drugs and testing. These three are all necessary, but A and B is the missing part.

If I could just take a moment to answer the question that you were asking the government panel, why not simply leave allocations to the countries themselves. We had an example of that happening in 1998, the Ministry of Health in Jamaica convinced USAID, they said basically we feel we have the expertise in our government and our NGO's, give us the money and we'll give you the results. After 5 years, we'll account for every dollar to see how we do results-wise. And what they did, what Jamaica did is they developed a program very much like that of Uganda or Senegal, it was a balanced ABC program, and I was one of the three American evaluators, and STD rates were coming down, and it seemed like HIV rates were coming down, and it was one of the better programs I've seen in developing countries.

I think where the problem is, Mr. Chairman, is with us, is we technocrats from the United States and Europe, we're used to the American model of AIDS prevention which is focused on MSM and IDU, focused on high risk groups. And so if you come from a family planning background the way I do and you're used to preventing contraception, which I am and USAID is institutionally, and all of a sudden, you find out that Uganda and some other countries are quietly doing something a little bit differently and having results, it takes a while to change your thinking and to change what the bureaucracy does. And when you think of all the grantees, the contractors and what they do, what they do best, it takes some change. So I really think that if the earmark were removed right now, we would go back to the AIDS prevention before 2002, and we wouldn't be having as many successes as we now have. Thank you.

Mr. SHAYS. Thank you, Dr. Green.

[The prepared statement of Dr. Green follows:]

Green, Edward C., "Culture Clash and AIDS Prevention."
The Responsive Community.
Vol. 13(4); 4-9 2003.

While attending a recent international health conference, I sat in on a session on AIDS prevention. Out of the four scheduled presenters, only one, an American, showed up to speak; the other three, all African, could not attend due to travel problems. The American speaker spoke about HIV transmission among gay men, using the word "homophobia" about a dozen times. The audience, mainly from Africa, Latin America, and the Caribbean, seemed unresponsive, and while there was at least 90 minutes left for a Q&A session, no one said a word.
The situation seemed a bit awkward. The session moderator knew me, and perhaps because I was sitting near the front of the room, she asked me if I would like to open up a discussion about AIDS prevention. So I commented on the different patterns and dynamics of transmission between AIDS in America and Africa, and told the audience a little about Uganda's simple, low-cost ABC program, led by President Museveni: Abstain, Be faithful, or use Condoms if A and B are not practiced. The abstinence message urged youth to delay having sex until they were older, preferably married. 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.
Information about AIDS and how to avoid it reached local communities through culturally
appropriate means of communication involving local leaders, indigenous healers, drama, and song. There was AIDS education in the primary schools. Christian and Muslim faith-based organizations were involved from the beginning of the national response, and they were particularly adept at promoting abstinence and faithfulness. The government took concrete steps to empower women so that they could refuse unwanted sex.

The result? Since the program's inception, Uganda has experienced an unparalleled two-thirds reduction in national HIV infection rates, and in 1989, the new infection rate began to decline. Western experts began showing up a few years later.

The audience was immediately full of questions: Why had they not heard more about these interventions? Why don't we involve religious groups and schoolteachers more in AIDS prevention? How can we prevent seduction of schoolgirls by
older men? How can we get husbands to stop running around and then infecting their wives? Just as the audience had no comments about the presentation they had just heard, the American who had made the presentation had no comments about this new topic that so animated the audience.

This illustrates not only the very different types of epidemics found in two regions of the world and therefore the different responses needed to address

them, but also a clash of cultures and values between the West and Africa. Africans and others in the audience thought that promotion of fidelity and abstinence was exactly the right response to AIDS, whereas this is usually thought by Westerners to constitute unwarranted infringement in people's personal lives. Some of my colleagues call this approach "missionary terrorism," designed to interfere with people's right to experience having multiple sexual partners. The American and indeed Western model of AIDS prevention is to leave sexual behavior alone, but reduce risk by promoting condoms and treating the curable STDs (since these facilitate transmission of HIV).

How has the Western risk-reduction model fared in Africa? There is no evidence that mass promotion of condoms has paid off with a decline of HIV infection rates at the population level in Africa, according to a new UNAIDS assessment of condom effectiveness. In fact, countries with the highest levels of condom availability (Zimbabwe, Botswana, South Africa, Kenya) also have some of the highest HIV prevalence rates in the world. Still unknown is the impact of the other relatively expensive AIDS prevention programs we now fund, namely widespread treatment of STDs or voluntary counseling and testing. We know that these programs, along with condom social marketing, had not yet started in Uganda when infection rates began to decline. This does not mean they might not have contributed to HIV prevalence decline in later years. In fact, even though only 8% of Ugandan men and women were using condoms regularly by 2000, those who were using them were exactly the ones that needed them: sex workers and the few men who still had multiple partners.

To understand why the major donors continue to pour millions of dollars into risk reduction while largely ignoring the evidence from Africa, it is useful to review some recent history. Western donor organizations and the groups they fund began implementing "behavior change communications" programs in the Third World in the mid-1980s, soon after American AIDS activists felt they had discovered how to defeat AIDS in San Francisco and New York. Of course, the very term "behavior change" suggests that outsiders know what is best for Africans, that Africans are misbehaving and need to change their behavior, and that outsiders will show them the way to behave. Yet now that we have comparative data, we know that African and American sexual behavior is not very different. There are subgroups of Africans an Americans who have a great many sexual partners, but most people in both populations do not.

When Americans designed interventions for Africans, the only prevention model available was the risk reduction model that had been designed in the United States for special high-risk groups. The model's premise was that we cannot change the behavior of gay men (or drug addicts), therefore the best we can do is reduce risk through condom promotion (and needle exchange for addicts). This model seemed to work realtively well in the 1980s, although infection rates are rising again among gay men in America. Nevertheless, since the mid-1980s, this model has been applied to populations where most of those infected are not

in special high-risk groups but instead in the majority population. In short, we provided American solutions for Third World populations. Once the risk reduction model was launched in Africa and the developing world, it assumed a life of its own and became the unchallenged paradigm for global AIDS prevention.

The risk reduction approach also involves the promotion of "safer sex" practices such mutual masturbation and oral sex, if not male-to-male sex, even though all these practices seem to be comparatively rare in Africa. Some Westerners see this as liberating Africans from outmoded and perhaps repressive sexual norms. What Americans and Europeans forgot when designing these approaches is that African cultures are still largely bound by tradition and religion, and that they have not undergone the general sexual revolution, and certainly not the gay-lesbian revolution, of the West. This should have been Anthropology 101.

In the minds of Western AIDS activists and public health professionals, no one should judge someone else's sexual behavior. This leads to "moralizing" about behavior, and which should not have any place in public health. Yet Ugandans who turned around their AIDS epidemic did not know they were supposed to remain value-neutral. In a BBC interview in August 2002, Museveni recounted how he talked about AIDS at every meeting with the public: "I would shout at themâ€¦ you are going to die if you don't stop this [having multiple sexual partners]. You are going to die."

Forms of sexual behavior highly relevant to HIV transmission, such as rape, coercion, and seduction of minors, take us into the realm of morals or at least ethics, whatever our objections. Issues involving questions of right and wrong may well require an ethical or value-related answer. Ellen Goodman has wondered whether in the American transition from a more religious to a more secular society, we have somehow given ourselves a "moral lobotomy." She asks whether, due to our reluctance to being considered judgmental, "â€¦are we disabled from making any judgment at all?" To avoid a fatal disease fueled by having multiple sex partners, good judgment dictates that people have fewer partners. Common sense should not be dismissed as moralizing.

Apart from Western values and biases, there are economic factors to consider. AIDS prevention has become a billion dollar industry. Under President Bush's global AIDS initiative, the US will spend $15 billion, partially on prevention. It would be politically naÃ¯ve to expect that those who profit from the lucrative AIDS-prevention industry would not be inclined to protect their interests. Those who work in condom promotion and STD treatment, as well as the industries that supply these devices and drugs, do not want to lose market share, so to speak, to those few who have begun to talk about behavior. Put crudely, who makes a buck if Africans simply start being monogamous?

Financial interests aside, it is tempting to rely on quick technological fixes to complex problems involving human behavior. Condoms and STD drugs can be

procured, promoted, and distributed, and all of this can be counted easily. With condoms and pills we have ready-made monitoring and evaluation measurement units, and these units are already familiar from decades of experience with family planning programs. USAID often comments that it has a "comparative advantage" in the condom supply and promotion part of AIDS prevention. Yet other major donors could also make the same claim, leaving no one with a "comparative advantage" in promoting non-contraceptive, non-drug interventions focused on simple behavioral change. In fact, faith-based organizations have exactly this interest and capability, but they are usually excluded from donor-funded participation in AIDS prevention. Western experts, who often have backgrounds in AIDS activism and contraception, are predisposed to be suspicious about religious organizations. There is a long history of antagonism between family planning organizations and certain religious groups, notably the Roman Catholic Church, and more recently, the "religious right" in America. Some of my family planning colleagues fear that raising any question about condom effectiveness for AIDS prevention is evidence of a larger agenda to cut off funding for all contraception and to oppose the advancement of women's rights.

Part of the whole problem is precisely the "ever-increasing polarization between left and right." Some in the religious right have in fact attacked broader contraception and progressive social programs in the same breath as they have attacked the condom distribution (or "condom airlift") solution to AIDS. This has put liberals so much on the defensive that they will simply not listen to logical public health arguments on the need to address risky sexual behavior in a pandemic driven by risky sexual behavior. Partisans on the left and right are currently fighting over how the newly promised billions for AIDS prevention will be spent. The fight seems to have once again been reduced to condoms versus "abstinence," forgetting that the lesson from Uganda is that a balanced, integrated approach that provides a range of behavioral options is what works best.

Rethinking AIDS Prevention
Learning from Successes in Developing Countries

Edward C. Green

http://www.greenwood.com/books/BookDetail_pf.asp?pf=0&dept_id=1&sku=T316

Description:

This is not another book about how AIDS is out of control in Africa and Third World nations, or one complaining about the inadequacy of secured funds to fight the pandemic. Edward C. Green, a member of President's Advisory Committee on HIV/AIDS, looks objectively at countries that have succeeded in reducing

Mr. SHAYS. We're going to start with Ms. Lee.

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

Let me first say once again, thank you for this hearing. It's very important. And as I listen to the testimony, the only thing I can think of is we're talking about saving lives right now, and finding the best way to do that and to help people live longer lives until we do find a vaccine or a cure. And I need to say up front that I think we need to repeal this earmark. I intend to do everything I can do to try to get that repealed.

Dr. Green, now you're at Harvard University, and I appreciate Harvard and know of your good work and Harvard's good work throughout the world. And I have to ask you, though, in one who believes that ABC makes sense, abstinence, be faithful, use condoms, why in the world would you believe that ABC is not what we're talking about when we talk about abstinence, be faithful, use condoms, I mean, we're talking about a balanced comprehensive approach. And with this earmark being what it is, we have seen in and GAO has indicated that this is probably hindering our efforts in the prevention arena. And let me just say, I was at the last AIDS conference in Toronto, the rest of the world, quite frankly, disagrees with what you're saying, Dr. Green, the rest of the world understands and gets it. The rest of the world believes that they know how to develop country-specific plans that come up with their specific ways of addressing prevention, care, treatment. And so why would we not listen to what works in countries and not be as heavy handed in our approach?

Dr. GREEN. With all due respect, that's exactly what I'm doing, my rethinking AIDS prevention in 2003 was looking specifically at the first five or six countries to experience prevalence decline. I also have to say, with all due respect, that the people who attend the global AIDS conference are not a cross-section of Africa, Asia, Latin America—this is not the best of the world.

Ms. LEE. Well, Dr. Green, what countries do you think would not want to see the earmark repealed?

Dr. GREEN. What countries would not want to see it repealed? Who would you ask in those countries? If you put it to a vote of the people, the majority of the population, I'm certain that all of the countries would want to keep the earmark there if they understood that——

Ms. LEE. They knew they could get some money.

Dr. GREEN. No, if they understood that AIDS prevention would go back to risk reduction only.

The head of the National Aids Committee for Kenya 2 or 3 years ago posted a complaint on an AIDS discussion group on line that the ministry—that the government of Kenya had received an additional $10 or $15 million for AIDS prevention. And part of what the government wanted to do was have a program to reach kids before they become sexually active, to promote abstinence or delay of sexual debut, not abstinence only, but to include. And they were told no, this is money from the U.S. Government, it has to be spent on condoms. And he wrote a letter to complain, and I asked if I could put his letter in my book, which I did. I, again, say I think the problem is with we technocrats—and I mean European and American experts who work in AIDS, we're used to thinking in terms of

the American epidemic, the European epidemic, high risk groups—which are some of the first groups we went after in Africa and the Caribbean, I was working in the Dominican Republic in the mid '80's. We went after—we tried to reach sex workers and their clients. But again, if you look at the data, most Africans, most people everywhere are already engaged in primarily B behaviors, and young people are primarily engaged in A behaviors. I don't even like the word "behavior change."

Ms. LEE. Dr. Green, all I'm saying is that the conditionality aspect of this, even telling a country that they must have a strategy that only uses condom as part of their strategy——

Dr. GREEN. I'm glad you agree that's wrong.

Ms. LEE. I'm talking about ABC; I'm talking about allowing countries to come up with their culturally specific, their scientifically specific, their gender specific, their overall approach to how they want to deal with this pandemic. So no, we shouldn't say——

Dr. GREEN. I think we should do that, I think we should find out——

Ms. LEE. I think we shouldn't say if we don't like the way you approach it. What I've heard—and again, I think that we, at the international AIDS conferences and throughout the year we hear from many, many people around the world who want to get rid of this earmark because of one point, they want to be able to be unencumbered by their approach to addressing this pandemic because it's so serious.

And with regard to women, what happens to women? We all know what happens to women. We heard earlier, the empowerment of women, women's equity, gender equity, female condoms, all of these strategies.

Dr. GREEN. That's part of the B strategy. If faithless men are infecting their wives, then it's the men's behavior that needs to change, and that's B.

Ms. LEE. But what about women and the access to condoms? If a country or the United States has precluded the funding for that, what if women——

Dr. GREEN. Well, they shouldn't.

Ms. LEE. Well, the earmark, in many ways, precludes a comprehensive balanced approach.

Dr. GREEN. I don't see it that way. There is a larger pie now to divide up than there was a year ago, 2 years ago, 3 years ago. As I've been saying for some years now, as we have gained more to work with in AIDS prevention, let's not put all of our money into programs that have not worked in Africa and the Caribbean.

Ms. LEE. I'm not talking about putting all of our money into programs that don't work. All I'm saying is why can't we just repeal the earmark and say to countries, develop whatever plan makes sense to address this terrible deadly disease. That's all I'm saying, period, dot dot.

Dr. GREEN. I agree with the intent of what you're saying, but I think in practice what happens is poor countries ask for the program that they know that there is money for.

Ms. LEE. Oh, Dr. Green, come on. You know how you're sounding, very patronizing. Countries have the ability—and I've spent quite a bit of Africa——

Dr. GREEN. I lived there.

Ms. LEE. Countries around the world have many unbelievable people who know how to address epidemics, pandemics, disease if only provided the resources and the support and the technical assistance. I can't believe that in any country at this point, if we didn't help develop and go in and do the things we need to do to support their efforts, that they couldn't be successful. So I can't buy the poor country notion.

Dr. GREEN. Again, I agree with your intent. I wish there was some way to let these countries choose for themselves without imposing our priorities on them.

Ms. LEE. Well, I think we can.

Let me just say to Dr. Gayle, I want to congratulate you on the successful conference in Toronto, it was really quite successful, quite powerful. I've been to four, and intend to go to the next one in Mexico City. And as I was thinking about Toronto today, I said when in the world are we going to have an international AIDS conference in America? And then it dawned on me that we have certain travel restrictions for people living with HIV and AIDS that precludes us from having such an important conference in our own country.

So I'm going to work with others to try to—again, I hate to keep trying to repeal stuff, but we want to get rid of that, too.

You know, I mean, I think that the world is a small place now, and we need to figure out ways to work together. And for us not to be part of this conference and not to be able to have it on our own soil to me is just downright wrong and, quite frankly, it's immoral. I was proud to carry the American flag in a rally in Toronto. I knew I couldn't carry the American flag in a rally here in America at an international AIDS conference. Mr. Chairman, I think that's pretty bad and it doesn't bode well for our standing in the world.

And so I just to want congratulate you and also just to ask you your take on—you heard what Dr. Green said about the conference in terms of who goes and who doesn't go. What is your take on the abstinence only policy, and by the rest of the world, the rest of the world that didn't come to the international AIDS conference.

Dr. GAYLE. Yes, thank you. And we appreciate you and the Chair's leadership in this issue. And I also appreciate your comment about repealing the travel restrictions. We really would love to see an international conference on U.S. soil again and feel that there's a real value to it because I think it goes along with the leadership role that the United States is playing. And that's why we feel so strongly about getting it right because we feel that not only are the resources that the U.S. Government contributes critically important, but the leadership role that the U.S. Government can play and does play is critically important. And so the consistency in that leadership role we feel is extremely important on all these issues.

I would disagree, I think the International Aids Conference, I disagree with Dr. Green that the International Aids Conference is a wide cross section of people working on HIV at a grassroots level as well as the international arena. So while perhaps it isn't perhaps totally inclusive, 24,000 people working on HIV from all dif-

ferent continents I think does speak to a pretty inclusive gathering. And we didn't take a poll on what people thought about the restrictions, but I think it's fair to say that there are concerns because not only does what the U.S. Government do impact U.S. Government funding, but again, the United States plays a strong leadership role. And so I think it does also influence other people's thinking about what is the right way to do things. And so what we do with our funding does influence the world, and I think sending a message to the world that we don't see this in a comprehensive way, that we do have biases, has an impact. And I think all efforts to really allow for countries to make decisions to have an integrated program, just like we talk about combination treatment, we also have to talk about combination prevention. There is no one-size-fits-all, it is by the ability to make programs that fit the country needs and country circumstances that we can have the most effect prevention response.

And I would argue that as somebody who's been doing HIV prevention programs for over 20 years, I don't remember a time when we as public health professionals said that condoms were the only answers. So this idea of going back to that day, I'm not sure where that perception comes from. I think that the understanding and the evidence around what works for HIV prevention has evolved. And so I think it is not legislation that leads to the understanding that a comprehensive approach is right, it is evidence, it's the fact that we have growing evidence that this is the right approach.

So I don't think the clock will be turned back, whether you think that it was there or not. I don't think that it is legislation that keeps people looking at a comprehensive approach, it's the evidence, it's the evidence that says this. And I think whether it's technocrats or whether it's the country level, it is a comprehensive approach that must move forward. And I don't think that it is a need for a proscriptive approach what is what will keep a comprehensive approach on the books and in our policies and in our program, it's the fact that we all know that is the best way to have an impact on prevention by doing it in an integrated fashion, doing it in a comprehensive way. The evidence is there, and I think that stands for itself.

And I would just add that I do think that the issues that were raised around making sure that we address the other issues, the issues of poverty, the issues of gender and equity, we must do that in order to support a behavioral prevention strategy because people's behavior, individual behaviors occur in the context of social realities.

Mr. SHAYS. Let me jump in here, I'd like to take some time.

Dr. Green, first let me say you bring tremendous credibility to whatever position you take based on the work you've done for so many years. So even if Ms. Lee does not agree with you, it's important that we hear exactly what you think, and then kind of wrestle those out.

I would like to know, coming all the way from Africa, what would be the most important thing that you would want us to know about the continent as it wrestles with this disease? And what is the biggest area that you would want, Dr. Nkya, to impress upon us so

that I'm very clear as to the most important thing that you want us to know.

Dr. NKYA. Thank you, Mr. Chairman.

Coming all the way from Africa, I'd like to insist that AIDS is a disease of poverty. And it is compounding on the threat of disease, poverty, it is also compounding on the socioeconomic impact and even the physical well-being of the people, which also in turn compounds the vicious cycle of compounding poverty itself.That is one.

Two; it is unfortunate that we in Africa, especially in Sub-Saharan Africa, we are always the recipients; we totally depend on external support on most of our intervention packages. So whoever comes with assistance in HIV intervention, they come with their own prescription for intervention package. Whether we agree to it or not, we have to adhere because we need the money. And it's unfortunate that we cannot even become a bit flexible to fit into our own, you know, what is really workable in our own environment.

So what I would like to, you know, ask you or request from this package or from the funding is like what Congresswoman Lee was saying, that if countries were given the opportunity to choose and to plan for themselves, could it really have an impact on the spread of the disease? I'm saying yes. Yes, because, for example, in Tanzania, we recognize that women are very vulnerable. We know that when we are addressing ABC, and there are free condoms for those who want to use condoms and have the information, the impact is really good, but now we cannot produce condoms because most of the money for condoms came from the United States of America. So now we do not have access to free condoms.

Money comes for treatment and for prevention for mother to child. It's unfair to just giving the women some medicine to prevent the child from getting infection at birth and while the child is newborn, but after that there is no form of support of counseling. So I would like to see more money being allocated to provide holistic HIV—I would like to see some money being allocated to provide holistic HIV/AIDS prevention package, like for primary schools, very young children we can talk about abstinence and behavioral change. For the grown up children, because we know, whether we want to talk about it or not, they are practicing sex.

We should be able to give them more information about, you know, productive health, more information about behavior changes through life skills training, which is not really widespread in Tanzania and that's why we have so much AIDS.

Mr. SHAYS. What I find myself wrestling with, and I'd like all of you to respond to it, and I'll start with you, Dr. Green, when I heard the first panel talk about basically a holistic approach, looking at all abstinence as well as condoms as well as be faithful and so on, what I'm realizing though is, from the testimony that we've heard from this panel, that we really separate them. And so I'm thinking, is it a crapshoot in a way? Do some students only get abstinence and some students only get condoms, and is it really an integrated program because of that? And you know, you, Doctor, are getting me to think that way, that if that's where the money is—first off, I believe that folks will go wherever the money is, I mean, they're going to design a program, we give them money

they're going to design a program to be able to attract that money. Do you get the gist of my question, Dr. Green?

Dr. GREEN. Did I get the question?

Mr. SHAYS. Do you understand what I'm asking?

Dr. GREEN. Not quite.

Mr. SHAYS. OK, let me ask it this way. If we are mandating that a certain amount be for abstinence—there's going to an abstinence program that's provided, correct?

Dr. GREEN. Yes.

Mr. SHAYS. But I suspect in most instances, the abstinence program is not going to also tell you you can use a condom, and that you're going to see a program in abstinence. And that you might see a program that, you know, is providing condoms, but you don't integrate it. So it's not like what people are suggesting. You know, trying to persuade a young person about abstinence is the best way, but here is a condom if you're not going to go that route, it almost seems like a contradiction.

Dr. GREEN. Well, I agree with your implicit criticism of compartmentalizing, you know, this program is for this and only this, and the B and the C are only for the—and that's not integration and that's not real life and that's not responding to people's actual needs. So I think we're in agreement there.

I think the government panel testified that after the age of 14, that the B and C message are brought in. You know, if there is evidence that children are sexually active at age 10 or 11 and that's their situation, you can't change it—I would try to change it—then you need to bring in condoms earlier. So I'm not in favor of abstinence only.

You know, if we just look at the Uganda model, and we can look at the other models, Senegal and more recently Kenya and so forth, I didn't see much evidence of condoms only. I have pages of teachers books and student books from primary schools in Uganda, and condoms are part of the education. So there should be integration. I don't know that much about how PEPFAR is integrating, but that's the way it should be.

Mr. SHAYS. Dr. Gootnick.

Dr. GOOTNICK. Thank you. I think the particular lens that GAO can bring to this discussion is really two-fold. One, if you offer the U.S. Government implementers in the field, the USAID and CDC staff in the field some degree of candor and ask them how this spending requirement affects their programming, you'll get some interesting information. That's the first thing. And second——

Mr. SHAYS. And the interesting information is?

Dr. GOOTNICK. Well, the interesting information is that more than half of the respondents will tell you that while Office of Global AIDS coordinator will certainly allow an integrated program, an ABC program—and if Ambassador Dybul was here, I think he would tell you that these programs, the vast majority of them are integrated. But if you speak to the implementers in the field, they will tell you that program dollars in these different buckets has consequences, and that there are programs that could be much better integrated but for the spending requirement that the program works with.

The second point is if you look at where the dollars have had to move, and the difference between 2005 and 2006 really is enlightening. And there will never be another set of data like the transition between 2005 and 2006 and that's because 2006 was the first year that the one third abstinence requirement became law.

So looking at what happened in the shift between 2005 and 2006, it is informative that no other data set will be. And as I mentioned in my prepared remarks, if you look at in the aggregate, AB programs went up very significantly whereas prevention mother-to-child transition and condoms and related program activities remain level. If you look at a country level, you see some real tradeoffs that have been made there. If you look at a country like Zambia, you see that there has been nearly a 40 percent cut in condoms and related program activities at the same time that abstinence programs have risen. You see in that country also as you well know that sex workers, migrant populations, and other vulnerable populations are perhaps key to the epidemic there. You see that sexual transmission in discordant couples, in a couple where one individual is positive, the other is negative and may not know it, the rates of transmission in discordant couples are very similar to the rates of transmission in the general population, so——

Mr. SHAYS. I'm not getting the point as to how that relates to my question.

Dr. GOOTNICK. Well, the point is that an integrated program—the U.S. Government implementers will tell you that the counting of the money in the buckets of abstinence, faithfulness and condoms related programs does hamper their integration. And you will see, if you look at the dollars, considerable shifts in program dollars in order to meet the spending requirement.

Mr. SHAYS. OK, thank you. Doctor.

Dr. GAYLE. Yes, briefly to add to that, I would agree our experience at the field level is that while the guidance, strictly speaking, does allow for an integrated approach, the way it's practiced inconsistently and the guidance that is used does bias programs often in an AB category where the preferred program would be to implement an integrated approach so that we do have in the field programs that end up being not integrated, only having one element or the AB approach not being able to integrate condom funding, and again, not because that is necessarily explicit, but the guidance is confusing, and it ends up being interpreted in the field in a very compartmentalized way.

Mr. SHAYS. Does your organization provide all three, ABC, all three?

Dr. GAYLE. Right. But we're in 70 different countries. So at a country level, the guidance is applied differently. As an organization overall, yes, we definitely focus on a comprehensive integrated approach. But by country by country, the way the guidance is interpreted pushes people in one direction or the other, and compartmentalizes programs much more than the original intent would have been.

Mr. SHAYS. OK, thank you.

Dr. NKYA. But Mr. Chairman, my concern is this; whether we talk about ABC, but for poorer countries like Tanzania, you can, you know, violate the rule and talk about ABC. But there are many

people who would like to use the condom, and young people cannot access condoms because they're not there. I go and ask the minister of health what is happening, we don't have condoms, we says we are not getting money from the United States of America to buy condoms——

Mr. SHAYS. Let me ask you this; OK. You're not getting it from the United States, but you're not getting it from anyone either?

Dr. NKYA. We're not getting it from anybody else because the others who are funding something like integration impact, and others have some other interests like working with other organizations, but initially, all the condoms in that country were being funded by the USAID from America. So now we don't access—for the past 5 years—4 years we don't access free condoms for anybody in that country.

Mr. SHAYS. So I make an assumption that if condoms aren't available, we're basically transmitting AIDS. If condoms aren't available, sex—I mean, I have not yet known a society that's decided to give up sex. So what I make an assumption is, from your testimony—and it's pretty powerful because, unlike the others, you're there, you're working with young people all the time, and you're saying and testifying before this committee that condoms are not available. That is a powerful message because we know that is one way to prevent the transmission of AIDS. We could talk long and hard about whatever we want to talk about, the value of abstinence, but if in the end condoms aren't available and young people and older people are having sex, they are at huge risk. And what I'm trying to understand is why would it have to be, Dr. Green and Dr. Gootnick and Dr. Gayle, if we are saying it's an integrated approach, why can't it include all of the above? And why, in the end, are condoms not available? Are they that expensive that—so someone help me out here.

Dr. GAYLE. Well, I guess I would agree with the earlier statements, that in order to have the best chance at having a balanced approach is to let countries develop programs that meet their needs at the country level, and that countries make those decisions about what proportion gets spent on what part of the ABC approach based on what their greatest needs are. So that if condoms and condom shortage was the greatest need for a given country, that they have the ability to use resources for condoms. If, on the other hand, they had other funders that allowed them to use those resources for purchasing condoms, that more focus be put on the other parts of the approach, so that countries have the ability to make those decisions without having arbitrary proportions that need to be spent, and can develop a truly integrated approach.

So I think the lack of funding for condoms is reflected by the inability too use resources to spend it on what countries need it for the most.

Mr. SHAYS. I'm going to react to something—thank you. Dr. Green, I'd like you to react to—I'm going to tell you what I'm hearing and I'd like you to react to it.

What I'm hearing is a better and more powerful message than I thought in support of abstinence programs. I thought that the first panel did a better job than I anticipated. You believe in this program and you carry a lot of weight; you've had tremendous ex-

perience and you do research and so on, so that carries weight with me. But I'm left with the fact that if it's a mutually exclusive issue—in other words, if you go the route of abstinence, you are not providing enough condoms, for instance, as one preventative way, then one, it isn't know an integrated approach. But No. 2, if I had my child—let's not use my child, let's just use any child, if they only had one choice, they were going to have an abstinence program but still have sex, I'd prefer they had a condom instead of an abstinence program and still have sex. I mean, so react to what I'm saying.

Dr. GREEN. It seems like we always fall back into talking about abstinence versus everything else. Keeping in mind that both government panelists and I have reported, which is that it's part of reduction, it's not having—what drives epidemics, sexually transmitted epidemics whether heterosexual or homosexual, what drives these epidemics is having multiple concurrent partners. And what brings prevalence down at the population level is not having multiple concurrent partners.

So I wish I didn't always have to be put in the position of defending abstinence—and we're leaving out the thing that works best. So having said that, how often have I heard African health educators and others say if it was—you know, it's not if it was only one program, they would say if it was only one behavior, I would want my child to abstain and not have sex using a technology that, if used consistently is 80 to 85 percent effective in reducing HIV infection.

The problem is that rarely are condoms used consistently in Africa, in the United States, anywhere in the world. I didn't want to bring this up because it just makes me even more unpopular than I probably already am to talk about uncomfortable data, but there is an unwanted and unfortunate correlation between populations where you find more condoms available and people use them more, and higher infection rates.

The demographic and health surveys, we now have serologic data to go with behavior data, so we can easily cross tabulate those who are—we can look at the sero status of those who are practicing A, B and C behaviors. And the first countries we have evidence from from the demographic and health surveys—and I don't think these have been published yet because there are uncomfortable data—from Tanzania, from Ghana, from Uganda—I think there may be one other country—we see that condom users are more likely to be HIV infected than non-users. This is counterintuitive, it's not what we want, it's not where we put billions of dollars, but it may be because—it's probably because condoms are not used consistently usually, and second, there's a disinhibiting effect. If the message is you can do what you want, be sure to use American brand condoms, then people will probably take more chances than they would if they weren't using condoms. Again, this seems to be counterintuitive.

Mr. SHAYS. One last question. I heard the data is 85 percent; is that because they're not used properly?

Dr. GREEN. 85 percent is about right.

Mr. SHAYS. Basically, what you're saying is so someone is having sex with someone who had AIDS, by one out of ten, you're going

to get AIDS even with a condom. But is that because they're not being used properly?

Dr. GREEN. We don't know the reasons. It's probably more improper use. It's not being consistent; this is when condoms are used consistently, it's probably that they're not used correctly. In poor countries, you don't have good storage, condoms may be the wrong size. How often in Africa I see condoms made in Thailand, wrong size. There's product failure, in part, because they may be old condoms, expired and so forth, especially in poor countries.

So those reasons are—those figures are pretty consistent every time. We knew this from family planning. Before the AIDS pandemic I worked in family planning; the condom was not one of the more effective methods of prevention——

Mr. SHAYS. Let me do this; if any of the panelists want to just respond to any question I asked Dr. Green.

Dr. NKYA. Mr. Chairman, I would like to comment. I would like to ask him, at that particular time when condom distribution was started, was there a survey, you know, a serological test to know who was positive and who was negative? Because when you start giving condoms, you don't know who's positive or who's negative. So when you started giving condoms, that's the majority of those people are already infected, but we are preventing infection. So that is my concern.

And another thing about the storage, and the condoms being made in Thailand being shorter than, you know, the private parts of men in Africa it is true, but that is another aberration which I'm seeing that if someone wants to give us assistance and he goes ahead and orders condoms for us without taking into consideration of sizes of our people, that is another thing that I'm saying that I disagree with completely.

The storage part of it, you know, you give the condoms. You don't give money for logistic support whereby you could be able to transport and store the condoms in the situation whereby they remain, you know, protective, that is another problem, because someone says I'm giving you condoms, I'm ordering them, not to take into consideration about the sizes, the needs and other logistical support which is needed to transport the condoms from where it is manufactured, and to the end point to where, you know, the beneficiary is. That is another problem. And that's why I support the idea that the developing countries should be given the opportunity to plan how to use the PEPFAR funds whenever the funds are available.

Mr. SHAYS. Let me go to Ms. Lee. Oh, I'm sorry——

Dr. GAYLE. I was just going to make an additional comment. I agree with the comment that was made about the shortcomings of the survey which are cross-sectional data, and I think it needs to be put into broader context. It could be that people with condoms were already infected, it could be that by definition, those in the population are already at greater risk, so it's not surprising that the rates would be higher, but I think what it really points to is the fact of what we've been talking about, that it isn't one or the other, even condom use needs to be in concert with a focus on changing risk behavior to begin with. And I think most people in this business believe that it isn't one or the other and that they re-

inforce each other, and it's not just a condom message, it's a condom message that also talks about reducing risk behavior, reducing the number of partners. And it's by doing all of those things together that you have the greatest impact and are synergistic.

So it is not one or the other, and that's, again, why this whole focus on being able to have a comprehensive approach can't be said enough.

Mr. SHAYS. Thank you. Did you want to say something?

Dr. GREEN. Yes.That last statement I completely agree with.

Mr. SHAYS. Thank you.

Ms. Lee.

Ms. LEE. Thank you, Mr. Chairman. I'm not sure who to direct this question to, so whoever can answer it, please do.

Let me ask you this; with regard to the guidance document, abstinence or return to abstinence must be the primary message that youth receive or for youth in PEPFAR countries, and information about consistent and correct condom use is only provided to youth who are identified as those who engage in risky behavior. But I want to ask you just from a practical point of view, in a classroom setting, how do you distinguish between youth who are engaged in risky sexual behaviors and those who are not? And doesn't it make sense to provide again age-appropriate, scientifically medically sound information that includes all aspects of ABC without stigmatizing or segmenting part of that message? And so how is that addressed at this point? Dr. Gayle or Dr. Gootnick.

Dr. GAYLE. I would just agree that I think that the ability to provide the complete message as appropriate at a given age is a—seems to me be more effective than segmenting information by age group. I think that most of us would agree that we would want to have young people abstain from sex as long as possible and that would be desirable. But when you're looking at a population of young people, it is difficult to segregate information based on whether or not somebody's currently abstaining from sex or not. And so having half information, not complete information, seems to be a less effective approach than looking at what's an age-appropriate way of giving people more complete information because somebody who is sexually inactive and are abstaining 1 day may become sexually active the next day, and we want them to have the information that allows them to reduce their risk even if they're not totally avoiding risk. So I think the ability to do that in a comprehensive way at any age would be desirable.

Ms. LEE. So how is one supposed to separate out youth who are high-risk youth in terms of youth who engage in risky sexual behavior being the ones who get the information with regard to correct and consistent condom use versus those who are not identified?

Dr. GAYLE. I think that raises a good point. I think it's difficult. I think it is easier for a group of youth who are at risk and who are currently sexually active to know that. I think it's difficult in a situation of youth who are not specifically at high risk who are in a classroom setting, who are within a civic organization or other settings where there is going to be a mix of young people, to be able to segregate information accordingly in a practical sense.

Dr. NKYA. I would like to add on that. You know, for me, according to my experience, 20 years of working with AIDS, I have come to discover that all young people are at risk. So trying to segregate who is to get it is going to bring some problems. I think our message here should be that we should target all the youth, whether in school or out of school, give them the message and correct information. And more probably, try to make sure that every child has the right health information because the survey which was conducted in Dar es Salaam in high schools in Dar es Salaam, in 1988, zero percent of the girls were infected with HIV, and then only one boy was found to be infected because of transfusion.

Two years later, the infection went up 10 times, it was 8 percent. That means that there is a high, you know, sexual activity taking place among schoolgirls, especially where poverty is a problem.

So we should target the girls together with the boys, although the infection with the boys was not significant, but we should target all the children, even as young as, you know, in primary one, to tell them that there is AIDS, do you know AIDS, and then we start from there. And make it a sustainable program, not just a one-time seminar in school and then you disappear. So that is my concern there.

So that is my concern there, a sustainable program from, you know, primary 1, up to university if it is possible.

Ms. LEE. Thank you very much. I hope the powers that be heard you, Doctor, because I think you make a lot of sense and it makes sense. And, to me, listening to you, I am trying to, again, figure out why the guidance documents instruct—you know, in PEPFAR countries—instruct organizations to have the primary message as being abstinence only, except the youth that they think are identified are at risk in terms of risky behavior.

Doctor Gootnick.

Dr. GOOTNICK. I would say briefly that the guidance document we refer to is used extensively by the program officials in the field and it is valued by them. They cite 3 key issues and key areas where this guidance may be indeed—although clear if you read it word for word—hard to apply in the field; one of which is the case that you mentioned, the issue of how to deal with youth of different age. There are different messages that can't under PEPFAR's guidance be offered to youths less than 14, youths who are older than 14, populations who may be at risk or most at risk, and as a practical matter it is difficult for them to apply the guidance.

The second area of confusion is permissible activity with respect to condom use. There is guidance for different populations that allows you to discuss condoms but not promote condoms, and that becomes very difficult for the program officials to apply in the field.

And the third area where there is some confusion is in high-risk activities or individuals. There is certain programs that PEPFAR may implement for high-risk or most-at-risk populations, but in a generalized epidemic it is often very difficult to determine who indeed is high risk or most at risk, because the fairest way to define that is almost anybody who is having sex outside of a known mutually monogamous relationship with a noninfected partner or someone who is abstinent.

Dr. GREEN. If we go by data, the epidemiologic data, we see that 7.2 percent of subSaharan Africans, if you average all the countries together in subSaharan Africa, about 7 percent of Africans are HIV positive, which means 93 percent are not positive. You don't agree?

Mr. SHAYS. I was shaking my head because I was thinking 7 percent of a population is such a huge number. It blows me away.

Dr. GREEN. Yes it is way too high.

Mr. SHAYS. I think of kids going to school with no teachers, coming home to no parent.

Dr. GREEN. I mention that as an antidote to the thinking that everyone is a current risk and all African men are promiscuous and all African women have no power—African women have more power than we foreigners give them credit for.

I agree with most of the comments I just heard, Dr. Nkya. I feel certain that if we had time to sit down and if you just interviewed me and Dr. Nkya and try to find points of disagreement, there wouldn't be many. And if Africans could choose for themselves, without being influenced by what is on the donor menu not only from the U.S. Government but from the United Nations, AID, and other organizations I think that would be ideal.

I see a lot of of these problems as growing pains. It is as if we were putting billions of dollars into reducing lung cancer and we for some reason, because it might hurt people's feelings, we didn't have don't start smoking or give up smoking if you are already smoking or at least smoke fewer cigarettes per day.

And I have never said that condoms were the only message, but it was the main message before PEPFAR, and the other interventions were and are for all other major donors treating STDs, VCT, voluntary counseling and testing, and treating HIV-infected mothers with nevirapine. And I think it is a great step forward that the U.S. Government for whatever reasons, maybe it was for, I don't know, ideological reasons—Congresswoman Lee, you said you were in on the planning of PEPFAR so maybe you know, but I don't know what the reasons were, but I think it was a genuine positive step forward to include primary prevention, avoid the risk altogether if you can.

But here are the other things you can do if that is not possible. And I think programs should be integrated and not compartmentalized, and if some people in the field are having problems because of the way the earmark is written, nobody likes earmarks. I come from 2 generations of foreign service officers. My father and grandfather always complained about congressional earmarks. I sympathize, but I think it has brought us forward.

Mr. SHAYS. Let me quickly get a quick response. I am surprised that other countries aren't doing more. And am I just misreading it? I am surprised that other countries aren't doing more, and am I misreading what other countries are doing, No. 1? And I am also told sometimes when the United States really steps up to the plate, other countries feel they don't have to.

And so, one, is the United States stepping up to the plate, even if we had this disagreement about where one-third of the prevention dollars go? And No. 2, are other countries doing what they should do? Maybe, Dr. Gayle, I could just ask you that, and Dr. Gootnick.

Dr. GAYLE. Definitely the United States is stepping up to the plate, and, as the earlier panel said, we fund anywhere from one-third to one-half depending on how the numbers come out in terms of funding. I think the difference is that the U.S. Government has always had a strong bilateral program where other countries have not, and more of the countries put their money through the pooled resources, through the global fund. So I think there are a variety of different ways of looking at funding, and a lot of the other countries also put their money either in the global fund or through programs that are not specific sectorial programs and are going to much more combined funding approach where they put it into a pool that then gets used, so it is harder to track it as AIDS funding.

That being the case, clearly the U.S. Government is the largest funder of HIV programs, and the work needs to be done to continue to encourage others to increase their resources.

Mr. SHAYS. Quickly, what is the close second? Maybe there isn't a close second. Who is second?

Dr. GAYLE. England.

Mr. SHAYS. There is certainly not a close second. We take a lot of hits on a lot of things but sometimes we don't pat ourself on the back.

Dr. GAYLE. I think we should pat ourselves on the back. I also think we have to remember that we are the largest economy, and when you start looking at our contribution per capita, we don't have quite as much to be proud of; we still should be proud and we still are the largest contributor, but in terms of per capita funding, if you look at some of the smaller countries per capita, they actually are contributing substantial amounts. So I think we need to look at it in a variety of different ways.

Mr. SHAYS. Fair enough. Dr. Gootnick.

Dr. GOOTNICK. Just to put a couple of numbers to those comments, and while not the subject of our analysis, roughly speaking it is estimated about $8.3 billion was spent on AIDS last year, global spending. About $2.5 billion of that was national spending, spending by the Governments of Tanzania, the so-called recipient nations. And the remainder of that would be donor spending. Of that, OGAC was more than half, about $3.2 billion, with the rest of the two nations combined somewhere in the $2.5 to $2.7 billion range.

Mr. SHAYS. That would suggest our economy at 25 percent of the world's economy, we are doing 50 percent of the contributions.

Dr. GOOTNICK. Yes. The other way to look at it is to look at the percentage, our share of GDP. There is an aspirational notion that donor countries would provide .7 percent of their GDP for development assistance, humanitarian assistance, broadly speaking. Some countries in Europe get closer to that and a few reach it. The United States is about at .1 percent of GDP.

Mr. SHAYS. Let me do this. Is there any closing comment that any of you would like to make, something that we should have brought up that we didn't, something that needs to be put on the record? And we will start with you, Dr. Green.

Dr. GREEN. Just to continue the answer to that question, but it brings out something that I would like to say, that I am not so con-

cerned about the amounts or even the proportions of money; rather, that money is well spent. Daniel Lobier, formerly of Cambridge University, now with the Global Fund for ATM, estimated that between 1986 and 1991 in Uganda, when Uganda turned that epidemic around using its own approach before we donors really moved in there, it was before the U.S. aid, the first bilateral program, Uganda spent about 25 cents per person per year for this highly effective program. It was the first really effective program in the world.

So if money is well spent, we—it is less an issue of how much and—but the other important point I would like to leave the subcommittee with is that there is a perception out there that ABC is something to do with the Bush administration, and like a faith-based initiative and something to appease the religious right. And for that reason the major donors, United Nations, AID, WHO, all the major bilateral multilateral donors pretty much are very suspicious of it and don't support the A and B parts, by and large, and that is what the government panel said.

Mr. SHAYS. Very interesting. Dr. Gootnick.

Dr. GOOTNICK. Just briefly to reiterate what GAO recommended in the aftermath of this study was that Congress—that the Office of Global AIDS Coordinator collect and report information on the downstream implications of the spending requirement report it to Congress, and that Congress use it in its ongoing oversight of the program. And we reiterate that recommendation.

Mr. SHAYS. Thank you for doing that. Dr. Gayle.

Dr. GAYLE. Yes, three very brief points, I think this panel is the first one where all agree that the ABC approach is important and should be the cornerstone of behavioral prevention. I think where we disagree is how do we get to that comprehensive approach.

And I would just like to somewhat differ with some of the comments that before the PEPFAR program there was not a commitment to comprehensive programming. Having run USAIDS prevention programs from the very early days, CDC's programs, that in fact the U.S. Government strategy was behavior change, treatment of STDs and condoms before the PEPFAR. So the idea that the—only by having that earmark will we make—keep a commitment to comprehensive prevention doesn't speak to the facts that a comprehensive approach that includes behavior change, has been part of the U.S. Government program for the last couple of decades.

Second, I think that the issues that have been raised that there needs to be greater flexibility to integrate programs that focus on the other dimensions, the vulnerability that people face, the poverty, gender inequity, food insecurity, that the other issues that put people at risk for HIV to begin with, particularly women, need to be able to be addressed, perhaps not directly through resources from PEPFAR, but a greater flexibility and much greater coordination of U.S. Government funding, so that in fact there is the ability to knit together these other aspects that, after all, if we don't attack the context in which people's behaviors occur, we are not going to be able to change individual behavior, because it is often based on just life survival. And so we have to be cognizant of those issues.

And, third, that the importance of a long-term commitment to sustainability, many of the programs that we are involved in, the

aspects that would allow for community buy-in and long-term sustainability are not allowed, and that we have to recognize that if we are going to commit to these programs being sustainable in the future, we have to look at how we do that and how do we make sure that there is community buy-in, there is capacity development, and that these things go hand in hand with the immediate need to get programs up and running.

Mr. SHAYS. Thank you.

Dr. Sawere Nkya, you have the last word——

Dr. NKYA. Mr. Chairman.

Mr. SHAYS [continuing]. Before I get the last word.

Dr. NKYA. I am the last word at home, too.

Mr. Chairman, I totally agree with what, you know, my fellow testimony givers have talked about. But I would like to emphasize on flexibility and just bring to attention that, you know, empowering women in developing countries is through education. If women are not educated we will never, ever be able to empower them and they will always remain as vulnerable. So probably if there could be some way whereby countries are made accountable into promoting women or female education, like giving them free education, giving free primary school education, because it makes a difference if you are educated or not.

And another thing is that of, you know, trying to remove the component of compartmenting people as risky groups or non-risky groups because that is stigmatizing them. It makes people, even if they know they are at risk, they never go for anything to help them preserve life, because here we are talking about preserving life and as a result also promoting the economies of the developing countries through reduction of morbidity and mortality.

So, Mr. Chairman, I request for flexibility and probably a change of direction of looking into all countries' needs; specifically, you know, to that country, not, you know, the comparison with another country.

Mr. Chairman, thank you very much.

Mr. SHAYS. Thank you very much. And we should pay attention to you. You came all the way, 6,000 miles, to tell us this, and you have been doing this work for decades.

You are a true hero, a true hero, and we really value your testimony. We value the testimony of all our panelists but I particularly want to thank you.

Mrs. Lee, a comment to close.

Ms. LEE. I want to say, Mr. Chairman, thank you for your leadership and for your commitment to address this entire issue in a bipartisan way and in a way that makes sense and it works; because, as I said earlier, this is about saving lives and it is about making sure that people who are living with HIV and AIDS can live longer.

I want to thank all of our panelists. Whether we agree or disagree, I think we have to muddle through all of this together because it is so serious.

And the United States must continue to be out front in terms of leadership, in terms of resources, and in terms of really being committed to allowing countries to do their thing in the way that they know how to do it best. And so I hope that we can get to that point

where we can go back when we do reauthorize PEPFAR, look at your testimony, the suggestions you have made, and try to figure out how we can incorporate some of these very thoughtful suggestions and ideas into what we have to come up with in the future. So thank you again, Mr. Chairman.

Mr. SHAYS. Thank you. I just want to say you are the true leader on this. I eat the crumbs off your table. I thank you for what you have done, and thank you for participating in this hearing and, again, thank both panels, our first and second panel, and just to say to Planned Parenthood that enabled me to take a really good look at what two countries were doing. I went with the expectation I would come back somewhat, frankly, disheartened, and I came back with a tremendous amount of gratitude for the spirit that I saw in both Tanzania and Uganda, particularly among the young people that I met. I thought this is an alive place. And I met so many young kids who just want to have a better future, that were excited about their future, not asking for a lot.

And it made me feel—and I met a lot of people who are running great programs.

So I came back from my visit to Africa with a feeling that it has such unbelievable potential.

And I just kind of feel that Africa is on the cusp, at least in the two countries that I saw, of really turning around, not just their concerns with AIDS, but a whole host of other issues. So I thank you. And with that, we will adjourn.

Thank you very much.

[Whereupon, at 4:22 p.m., the subcommittee was adjourned.]

[The prepared statement of Hon. Dennis J. Kucinich and additional information submitted for the hearing record follows:]

Opening Statement of Rep. Dennis J. Kucinich
Ranking Minority Member
Subcommittee on National Security, Emerging Threats and International Relations
Committee on Government Reform

Hearing on "HIV Prevention: How Effective is the President's Emergency Plan for AIDS Relief (PEPFAR)?

September 6, 2006

Thank you, Mr. Chairman and good afternoon to our distinguished witnesses and experts here today.

It is rare that this Congress holds oversight hearings over truly pressing matters – matters touching the daily lives of citizens around the world, and which are truly life and death decisions.

Today, I am pleased that the Subcommittee can work on a bipartisan basis to examine the Emergency Plan to combat the global HIV/AIDS epidemic.

Across the world, but particularly in the neglected and impoverished communities of sub-Saharan Africa, this disease is killing millions of people, and entire generations are being lost as they succumb to this horrific epidemic. According to the Joint United Nations Programme on HIV/AIDS, an estimated 39 million people are currently infected and living with HIV.

The passionate and emotional dialogue at last month's 16th International AIDS Conference in Toronto reminds us all that the world still has a long way to go in order to defeat this scourge, and that we still need to build consensus on prevention and treatment options. The United States should continue to be at the forefront in providing medical research, availability of low-cost treatment options, prevention advocacy and training, and humanitarian assistance.

Moreover, HIV/AIDS prevention should also be addressed in the larger context of other societal and cultural problems such as gender inequality, global trafficking of women, sex workers, and abuse of illegal narcotics.

While the establishment of the Office of U.S. Global AIDS Coordinator is an important first step in marshaling our financial, health, scientific, private and grass roots practitioner resources, Congress needs to make sure that the $15 billion allocated for the program is spent wisely, and the most effective prevention and treatment initiatives are given the support they need.

Therefore, we must ensure that our programming strategies and priorities reflect the body of evidence showing what works and what does not. The GAO recently found

that half of the focus country teams they interviewed said that abstinence spending requirements were undermining prevention efforts.

Of course, each country also has its own unique situation, and we must be respectful of local epidemiological conditions, cultural customs, and morals. There is no simple answer. Rather, the task is both daunting and extremely complex, and a cookie cutter approach will not work. Many teams reported to the GAO that the abstinence spending requirements ran counter to their efforts to tailor solutions to local needs. However, we should let science, not politics, guide us as we work together to fight HIV and AIDS.

As has been clear for years, a politically driven mandate to spend an arbitrary amount of money on abstinence does more harm than good. Congress should provide the necessary flexibility to each of the 15 focus countries in the Program to address their own needs from year-to-year, and adopt a comprehensive approach that includes each of the ABC strategies as appropriate. I urge my colleagues to support H.R. 5674, the Pathway Act of 2006 as introduced by Rep. Barbara Lee, which would eliminate the one-third requirement for spending on abstinence programs.

I am grateful for the excellent work of the GAO auditors who examined the PEPFAR program, and thank them for their recommendations on how to improve U.S. leadership and coordination of HIV/AIDS prevention programs.

I hope that we will have open and honest testimony today, and hope that we can hear some constructive suggestions to improve the PEPFAR program.

Thank you, and I yield back to the Chair.

September 11, 2006

The Honorable Christopher Shays
Chairman, House Government Reform Subcommittee on National Security, Emerging Threats and International Relations
U.S. House of Representatives
Washington, DC 20515

Re: Testimony in connection with September 6, 2006 hearing entitled "HIV Prevention: How Effective is the President's Emergency Plan for AIDS Relief?"

Dear Mr. Chairman,

Thank you for the opportunity to submit this letter and attached materials for the record pertaining to the hearing you chaired examining the rationale for and effect of the legal requirement that at least 1/3 of all HIV/AIDS prevention funding under PEPFAR be reserved for "abstinence until marriage" programs.

For background purposes, I am including a link to a compilation of brief articles written by our senior staff addressing the politics and policy issues surrounding the "A", "B" and "C" of the ABC approach (*a*bstinence, *be* faithful, use condoms) to prevention. http://www.guttmacher.org/pubs/compilations/agionabc.pdf. I am also including a link to an article highlighting how PEPFAR's emphasis on promoting "A" as the primary intervention for young people is impeding the efforts of providers on the ground to get comprehensive information and services especially to youth who are already sexually active. http://www.guttmacher.org/pubs/tgr/08/3/gr080304.pdf.

In our view, sexually active youth living in high HIV-prevalence countries (a defining characteristic of all PEPFAR focus countries) must be considered at high risk and therefore are deserving of more than only information about abstinence and fidelity in order to protect themselves and their partners. Yet, as you know, the imperative to spend so much on "abstinence until marriage" programs has limited the ability of in-country public health experts to direct sufficient funding towards programs geared more to the realities and that takes into account all the complexities of young people's lives.

As you said at the hearing, calling for the elimination of the earmark does not mean calling for the elimination of programs that increase sexual abstinence among youth. The earmark is not necessary in order to assure continued U.S. support for "A" and "B" programs, as Global AIDS Coordinator Mark Dybul and USAID Global Health Administrator Kent Hill both made clear. Meanwhile, however, the GAO has clearly documented the harm and confusion that the spending requirement is causing in the field, which was attested to further by CARE's Helene

Gayle and Tanzanian physician and parliamentarian Lucy Nkya. Therefore, in the absence of any science-based rationale for continuing to designate "abstinence until marriage" programs as the single most important global HIV/AIDS strategy, and in recognition of its high costs, we applaud your leadership in working towards repealing the spending requirement and allowing PEPFAR prevention funds to be allocated according to public health needs and local epidemiology.

Sincerely yours,
Cory L. Richards
Senior Vice President and Vice President for Public Policy

STATEMENT OF CHARLES MACCORMACK, PRESIDENT AND CEO OF SAVE THE CHILDREN U.S.A. ON THE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF

SUBCOMMITTEE ON NATIONAL SECURITY, EMERGING THREATS, AND INTERNATIONAL RELATIONS OF THE HOUSE COMMITTEE ON GOVERNMENT REFORM

September 6, 2006

There are an estimated 15 million children who have lost one or both parents to HIV/AIDS. As the death rates from HIV/AIDS continue to increase around the globe, the total number of children who will lose one or both parents is expected to climb to approximately 25 million by 2010. Orphans and other vulnerable children (OVC) affected by HIV/AIDS tend to drop out of school early to take care of sick family members or to look for work for income no longer brought in by their parents. These children are increasingly susceptible to abuse, sexual exploitation, criminal activities, and drug use. HIV/AIDS has severely eroded the traditional extended family system in Africa, and communities are staggering under the weight of escalating orphan populations. These children face enormous barriers to staying in school, getting adequate health care and psychosocial support and obtaining skills adequate to find legitimate employment.

Save the Children programs for orphans and vulnerable children in Ethiopia, Haiti, Malawi, Mozambique and Uganda work to address these issues by building the capacity of local organizations, family members, caregivers, and communities to provide for the children orphaned or affected by HIV/AIDS, emphasizing interventions to meet their basic care, psychosocial, educational, and nutritional needs. Congress recognized the importance of supporting these needs and required, in "The United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003" (P.L. 108-25) that at least 10% of all funding for programs to address global HIV/AIDS be dedicated to orphans and vulnerable children, beginning in fiscal year 2006. We urge Congress to work with the Administration to ensure that not less than 10% of HIV/AIDS assistance goes to interventions for orphans and other vulnerable children affected by HIV/AIDS, in order to fulfill the U.S. commitment as required by P.L. 108-25.

Additionally, the Office of the Global AIDS Coordinator (OGAC) has indicated that in some cases funding for pediatric treatment for HIV/AIDS can be attributed to the 10% earmarked for OVC programs under PEPFAR rather than to the 55% earmarked for treatment services. We are concerned that attributing pediatric treatment to the OVC budget rather than the treatment budget reduces the already limited resources available for vital care and support programs for children affected by HIV/AIDS. We call on Congress to work with OGAC to preserve the limited OVC resources and to finance comprehensive programming for children that includes increased resources for pediatric treatment, funded through PEPFAR's treatment allocation.

Finally, Save the Children's experience has demonstrated the need for flexibility to use PEPFAR resources for supporting the hunger and nutrition needs of children, families, and communities impacted by HIV/AIDS. In our efforts to support children affected by HIV/AIDS to attend and complete school, one of the main barriers is the difficulty orphans and other vulnerable children have in finding and acquiring sufficient food. Many children are forced out of school or attend only sporadically because they must search for or work for food.

The current PEPFAR guidance calls for organizations to leverage food and nutrition support from "other international and/or host-country partners." According to Save the Children and other NGOs working in Africa, the hunger and nutritional needs of children impacted by HIV/AIDS is tremendous. Throughout the developing world, hunger and malnutrition contribute to over five million child deaths annually. We ask Congress to work with the Office of the Global AIDS Coordinator to provide greater flexibility to support the immediate hunger and nutritional needs of children. We also ask Congress to work with OGAC and USAID to fund sustainable local, community-driven nutrition and livelihood initiatives to improve the nutritional status of children.

Thank you for your consideration of our requests.

United States President's Emergency
Plan for AIDS Relief

Office of the U.S. Global AIDS Coordinator

Washington, D.C. 20522-2920

September 9, 2006

Dear Chairman Shays,

Thank you for your invitation to testify at the Subcommittee's hearing on the President's Emergency Plan for AIDS Relief (PEPFAR). I am pleased to have had the opportunity to inform the Subcommittee Members on our progress to date in ensuring a comprehensive and balanced approach to HIV/AIDS prevention.

It has been reported to me that a panelist from Tanzania said that (1) the U.S. Government is the only source of condoms in Tanzania and that (2) the U.S. Government is no longer procuring condoms for Tanzania. I request that the following response to these two points be placed in the record of the hearing.

First, with respect to whether the U.S. Government is the only source of condoms in Tanzania, the Global Fund for AIDS, Tuberculosis, and Malaria (Global Fund) and the World Bank Global HIV/AIDS Program are major suppliers of condoms for Tanzania. While it is true that the U.S. Government is by far the largest supporter of the Global Fund and has also provided support to the World Bank program, both are independent of the U.S. Government. In addition, the Government of the Netherlands also has a condom distribution program in Tanzania. From all sources, there are over 150 million public sector condoms either in the country or planned for shipment through June of 2008. Given current and future consumption estimates, the U.S. Agency for International Development (USAID) estimates that this amount will meet distribution needs throughout the country well into 2009.

The Honorable,
Christopher Shays, Chairman,
Subcommittee on National Security,
Emerging Threats, and International Relations
Committee on Government Reform
United States House of Representatives.

Second, with respect to whether the U.S. Government is procuring condoms for Tanzania, USAID reports that the U.S. Government shipped almost 18.6 million condoms to Tanzania in calendar year 2005, and has shipped nearly 24 million to date in 2006. Further shipment of 5.9 million condoms is scheduled before the end of 2006. Of course, the U.S. Government will continue to work with the Government of Tanzania and other international partners to monitor the country's needs and ensure an adequate supply of condoms.

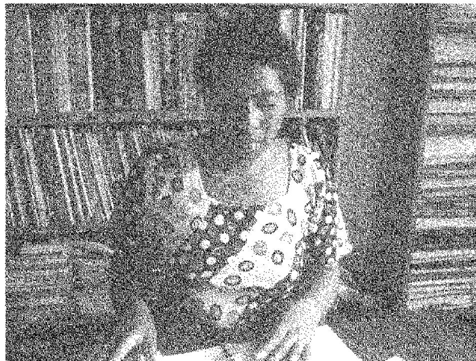
I hope this clarifies the U.S. Government's commitment to ensuring the supply of condoms in Tanzania. Thank you for your support for the President's Emergency Plan for AIDS Relief.

Sincerely,

Ambassador Mark Dybul
U.S. Global AIDS Coordinator

FARAJA TRUST FUND, MOROGORO TANZANIA

TESTIMONIES FROM VARIOUS PEOPLE ON THE EFFECTIVENESS OF PEPFAR FUNDING PROGRAMS



Sept. 2006

VARIOUS TESTIMONIES ON EFFECTIVENESS OF PEPFAR FUNDING PROGRAMS

Currently, PEPFAR Fund offers funds to programs that advocate for abstinence until marriage, and to those that are against modern family planning and prostitution.

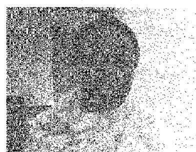
I have gathered different views and various perceptions from different people about the effectiveness of the AB approach

1. **The abstinence-only-until –marriage programs ignores the socio-economic and cultural context of other countries**

"Though abstinence is the best and recommended HIV preventive among youths, there are socio-economical and cultural factors hinder these efforts and thus abstinence has proved failure to majority of them..."

"I agree that the parents, teachers and religious leaders should insist on abstinence for children and the youths and that abstinence should be our message. However, these new conditions of PEPFAR Funding contradict what transpires in their western cultures and media. The western influenced message received via telecommunication like the Internet, television and other sources are a different story. How can African youth abstain while each day they see pornography on the Internet and in the media? What lessons, if any, can be drawn from this western media? In western shows we see youth having sex all the time before marriage, and aren't they using condom? I believe that the abstinence message will be effective only if the western-culture through media coming to Africa controlled. Is the current American administration prepared to limit the media messages put forth by their country in order to limit sexual activity and promote abstinence among youth in different countries?" **Out of school youth, Morogoro, Tanzania**

2. "In my opinion, focusing only on abstinence and faithfulness among married people as the only strategies against HIV in an African context is not enough. In Tanzania, for example, there are many traditional practices that lead to HIV infection. Many tribes practice female genital mutilation and circumcision to girls and boys respectively. The chance of HIV infection is very high when same instruments are used during FGM or circumcision. There are other traditional rituals and rites that involve passing ones blood to another, thus leading to HIV infection. Abstinence and faithfulness is fine, but we should also consider other routes of HIV infections and address them consequently



"Fatuma Mlagha, a widow in Morogoro municipality, Tanzania.

A study conducted in Morogoro Municipality among primary school pupils in 2000, and in Turiani-a rural area in Mvomero district in Morogoro, in 2003 revealed that at the age of ten (class five) some adolescents had already had a sexual relationship. **(Source: Morogoro municipal ,Tanzania)**

3. **Asha's Opinion**

My name is Asha (not her actual). I am 19 years old. I am an orphan and I am taking care of my three young brothers. My father died when I was six years old. We were left with our mother who was also sick and used to prepare local brews as the only activity to support our living. Our house was always

full of drunkard people. Some of them used to sleep with my mother, and that way, she was able to earn extra little money to buy us food. I remember one day when I was ten or eleven years of age, a drunkard beat up our mother because she was too ill to have sex with him. He threatened to kill her unless I slept with him. He grabbed my hand and threw me into the corner of our bedroom. He raped me! I was badly hurt and my private part was full of blood. After one week my wound healed. My mother did not take any action. From that day on, the rapist became my partner. He was paying me, about $ 2 per night. My mother died when I was 15 years old. It was hard, as I had to take the role of caring for my young brothers through sex work. I became pregnant at age 16 and delivered my son. As a young mother, I had to care for my sibling as well as my son; the father of my son ran away. Then life became harder! I had to turn into sex work. I became a sex worker. I thank Faraja peer educators who informed us about sexual reproductive health and safer sex. I now use condoms whenever I have sex. Many of my friends have died of AIDS because they did not use condoms. It is too risky for sex workers, whose living depends on sex. **(Young sex work in Morogoro Municiapality, Tanzania**

4. Ishi campaign Advisors View

"Tanzania for example, there are cultures that initiate boys and girls into man hood and woman hood respectively. After the initiation ceremonies, they are ready for marriage. But the chance of marriage is sometimes very limited; as a result, they are forced to engage into sex before marriage so as to have children, which is a strong value for some tribes. Girls on the other hand are sometimes subjected to rape which results into unwanted pregnancies and thus becoming young mothers. And because of poverty, they opt to sex work so as to earn a living, which means they are further exposed to HIV and eventually AIDS...**(Ishi campaign youth advisor, Morogoro Municipality Tanzania)**

5. Sex Workers Opinion

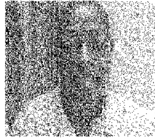
"I was forced by father to marry a rich person, someone as old as my father, when I was only 14 years of age, immediately after my initiation ceremony. I was against the idea, as I wanted to continue with my education (I was in class seven and among the brightest pupils in my class). My father insisted that I should get married so that he could collect dowry, after all I was a girl, and for him education was meant for men. A traditional marriage was arranged and I became the fifth official wife to that man. I became pregnant after two years and delivered a baby girl. A year later my husband died. I became a widow with a responsibility of caring for my daughter at the age of 16. I was forced to run into another village so as to avoid to be inherited by my late husband's elder brother. Life is very difficult. I cannot go back to my father's house because I refused to be inherited. I do sex work so as to earn a living. I have multiple partners and I insist on using condoms with my partners during sexual intercourse". **(A young mother and sex worker at Mtamba in Morogoro rural)**

6. Health workers reaction

"In Tanzania, the rate of HIV infection is higher among married than those are not married. The National AIDS Control program Surveillance Report (2004) revealed that the proportion of cases among the married categories of patients with AIDS is 56%.

If those in marriage are in such rate of HIV infection, then it is meaningless to advise us to abstain till marriage, yes we can, but eventually we end up being infected even in our marriage. And because, some

people cannot abstain or be faithful in their marriage, and because we cannot let them infected by HIV-the virus that cause AIDS, I think condom use should be insisted even in marriage"

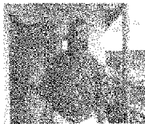


Paulina Rwegayura-nursing officer, Morogoro Tanzania

7. Community Members Reaction

Abstinence-Only-Until -Marriage Funding the administration has not considered other factors that lead to HIV infection among people such as those who inject drugs or men who have sex with men.

"HIV can be transmitted through drug-injection where shared equipment gives HIV a direct route into the blood. On the other hand, the non-injecting drug users are at risky of engaging into other sexual behaviors such as sex work so as earn money for buying drugs.
It is absolutely impossible to advocate only for abstinence-till-marriage as the only intervention in fighting against HIV, we should talk about holistic approach strategies that address also other risk behaviors among people. Drug injectors could abstain, but still get infected through drugs; same as lesbians...I believe that the ABC model should be complemented by other strategy, but not abstinence only..."



Victor Mulimila-HIV/AIDS activist

8. Journalist Reaction

Abstinence-Only-Until -Marriage the funding administration has not considered other factors that lead to HIV infection among people such as poverty.

"I think Tabho Mbeki, the president of Republic of South Africa, was right to address poverty as cause of death among HIV people rather than the virus. I agree that poverty is the major contributing factor of HIV infection. Vulnerable girls are forced into sex work to earn a living, widows in rural areas exchange sex for food or encouraging their daughter to engage in sex work. Not only women but, poverty has driven men to have sex with men on monetary gain. They die within a short period of time because of poverty as they hardly can meet medical expenses, afford nutritious and balance diet or ARVs .If we are really serious about combating HIV/AIDS, we should address the issue of absolute poverty..."**Bujaga Izengo Kadago -Journalist, TV presenter, Sokoine University of Agriculture Television, Morogoro Tanzania.**

9. Sew Workers Reaction (urban based)

"I know there is AIDS, and it has no cure, but you see, I am 20 years old and I have two children and no husband. Besides that, I take care of my four bothers and sisters and our grand mother, and yet I do not have a job. The only source of income is sex work. I rather die tomorrow or after 10 years with AIDS than die of hunger today. I am taking a chance yes, but I am using condoms" **Amina-a sex work in Morogoro Municipality.**

10. Faraja Legal and Human Rights Volunteers Views

Abstinence-only-until-marriage marginalizes sexual rights to some categories of people

such as, young mothers, widows and married couples who are infected with HIV.

"Addressing the ABs, as the only strategies for combating HIV/AIDS it is true that we eliminate and deny the rights of other categories of people like widows, widowers, PLHA and young mothers. I think the focus should not only centre on new prevention but we should consider about re-infection especially for PLHA. It is the right of every one to have sex-and because of AIDS, the message should be protective sex. Now where is protective sex without addressing the use of condoms?

"Dianna Gangata-a paralegal working with Faraja, Morogoro, Tanzania

11. A Stakeholders Reaction

The Global Gag Rule has greatly affected the fight against AIDS in Sub Saharan Africa including Tanzania. Prohibiting the availability of abortion information, modern family planning resources and counseling services by cutting US funding to foreign organizations that offer these services has had nothing but a negative affect in the fight against HIV/AIDS.

"In a poor country like ours (Tanzania) where because of ignorance on sexual reproductive health information education, the birth rate is high, and therefore cutting funding for family planning is very dangerous and almost suicidal. Think social problems like rape cases, unwanted pregnancies, and domestic violence in Tanzania. All victims of these cases need psychosocial counseling and other services, it is unbelievable for USA to cut down such a needed support. I really do not understand...**Victor- Social worker and youth counselor.**

12. Youth from University Reaction

Behavior change is not a quick process. We have seen this in previous attempts to change the lifestyles of high risk community members, and already the change is noted as a very slow one. With the introduction of the new policy, the administration is expecting a full turnaround in people's behavior, and in most developing countries, lack of social and economic development will not warrant this. By applying the new abstinence only policy, it seems that there are many important steps in a positive development process being overlooked. Someone with any knowledge of developing nations, their economic and social problems, should not place such a high expectation/demand on its people (Pam).

13. Pam Continues

The abstinence until marriage policy contradicts everything that has been taught in the past 4 years concerning the ABCs. Finally, condoms and condoms use is not being completely condemned by societies in developing nations and condom campaigns are becoming more successful. Taking away the funding to continue with these and other family planning campaigns devalues all of the hard work previously put into these campaigns. It also gives mixed messages to the youth concerning their own safety and sexual activities, youth that are already confused and scared enough with all of the social and economic problems they are faced with today.

Africa is rich in culture. One of the things I like the best about Tanzania is that two strong religious groups, Christians and

Muslims, live together peacefully. Some of the most traditional beliefs in Tanzania are that of polygamy. The Bush administration, with its new policy, is discriminating against such groups. These people should have the right to their own sexual health and safety that comes, now a day, in the form of protective birth control like using condoms. Its is unjustifiable to expect cultural practices, that date back thousands of years, to change, when there are protective methods available today to save the lives of many people. **Pamela**

14. A Parent reaction

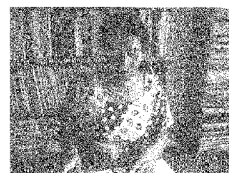
Allowing faith based organizations to exclude information about contraceptives and condemning condom use ignores African culture and traditions, particularly in sub-Saharan countries where by polygamy is part of life. In order to control family size and even the population crisis facing the entire world, modern family planning is crucial.

Because of ignorance on some methods of modern family planning, condoms seem too easy and effective to use. President Bush should understand that with limited knowledge of sexual reproductive health education information, STIs are a major problem in developing countries. Condoms use has significantly reduced the infection of STIs which are routes of HIV infection. **Michael Njohole- Social-economist, Morogoro**

15. Reaction from PLHA

As a youth-community educator and a person living with the virus I have learned that the youth are at a high risk of HIV infection due to a number of reasons which include poverty, ignorance of sexual reproductive health information education and unemployment. I have counseled so many young people who have been suffering from STIs, school drop out because of poverty, those with early pregnancies and those suffering from local abortion complications. There are sex workers who come several times at the centre with repeated STIs infections because they have had several partners. With the provision of sexual reproductive health information education, condoms, economic empowerment and the promotion of sports and games as alternatives to risky behavior, the number of youths with STIs cases dropped. For example data from Faraja out of School youth-user friendly centre indicate that in 2005 a total number of 1531 youth attended VCT of which, eight (8) were HIV positive, and 36 had STI as compared to 962 youths attended VCT of which45 were HIV positive and 84 had STIs in 2003.Therefore, any campaigns against HIV/AIDS should address other contributing factors such as poverty, SRHIE and protective sex through condom use.

Sarfina Dalamsi-youth peer educator, counselor and person living with the virus



Sarafina participated in the two Ishi campaigns conducted by Faraja (2004/2005 and 2005/2006) She compares the STIs/HIV situations before, the first Ishi campaign which advocated condoms as one of the campaign components.

16. Reaction from Freelance Journalists

I am wondering whether a research was done in Africa, particularly Sub-Saharan Africa on the abstinence-till-marriage policy. If the research was done in USA, and the results were used to generalize

developing countries, this should not have been done. These two worlds differ significantly in terms of socio-economic and cultural context. Even how the policy has been effective in the USA is questionable. I think it's the right time now for The Bush Administration to re-evaluate this policy, not only in third world, but also in USA, Devotha Minja, Morogoro Tanzania,