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U.S. Investments in HIV/AIDS: Opportunities and Challenges Ahead

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Good afternoon, Mr. Chairman and members of the subcommittee. I am honored to join you today, representing PSI, a leading global health organization. I thank Chairman Donald Payne, Ranking Member Chris Smith, the distinguished Members of the subcommittee and their staff members for organizing today's hearing.

In 1993, at age 41, Paul Walker, my dear friend and acting teacher, died of AIDS-related complications. Paul's loss was devastating to me and my husband, and Paul's many friends and family. My son Roman Walker is named for Paul. A day does not pass where I don't think of Paul. Today, especially, he is in my thoughts.

After Paul's death, I was moved to learn more about the epidemic and, for a number of years, I've been quietly supporting AIDS efforts in the United States, which has led to further opportunities to learn about the impact of HIV/AIDS in developing countries. Two months ago I traveled to Zimbabwe with my colleagues from PSI and with staff from UNAIDS to learn more about the HIV pandemic in Sub-Saharan Africa. PSI has programs targeting HIV in 55 countries, as well as programs in malaria, reproductive health, and child survival. In Zimbabwe, PSI has a staff of 220 and 218 are Zimbabwean, which helps ensure that PSI's programs are country-led, locally developed and culturally appropriate.

What I saw in Zimbabwe was that the investment and strong support from PEPFAR, the Global Fund to Fight AIDS, Tuberculosis, and Malaria, and other donors is paying off in dramatic ways. For example, Zimbabwe has experienced a reduction in HIV prevalence among adults from 29 percent in 1999 to 14 percent in 2009. Think of all the lives that have been saved.

But it also became heartbreakingly clear to me that resources still fall short of what is needed to reach everyone at risk for HIV. In particular, I learned that further gains can be made through a combination of proven biomedical, behavioral and structural HIV prevention tools and strategies available to us. I would like to tell you today about two prevention tools that could make a difference if there is continued investment: male circumcision and HIV testing and counseling.

First, voluntary adult male circumcision. There is now strong evidence that male circumcision reduces the risk of heterosexually-acquired HIV infection in men by about 60 percent, yet only about one in ten Zimbabwean adult men are circumcised. PSI and its partners run circumcision clinics in Zimbabwe and other countries, with support from PEPFAR and other donors.

I was invited to observe the procedure, which is free to the client, completely voluntary and according to the young man I spoke with who underwent the procedure, painless. The cost of the procedure at that clinic—including follow-up care and counseling—is about $40 U.S. dollars.

UNAIDS and the World Health Organization have issued guidance stating that male circumcision should be recognized as an important intervention to reduce the risk of heterosexually-acquired HIV infection in men.

Even with no demand creation, the clinic I visited serves upwards of 35 clients per day. It is estimated that if male circumcision is scaled up to reach 80 percent of adult and newborn males in Zimbabwe by 2015, it could avert almost 750,000 adult HIV infections—that equals 40 percent of all new HIV infections that would have occurred otherwise without the intervention—and it could yield total net savings of $3.8 billion U.S. dollars between 2009 and 2025.[1] Male circumcision programs get robust support from the U.S. government in Zimbabwe and other countries, but greater resources would yield greater results.

Many of the clinic's patients learn about male circumcision when they receive HIV counseling and testing at PSI's New Start centers and through its mobile outreach teams operating in every district in Zimbabwe. Testing and counseling is the next area I'd like to discuss.

An estimated 72 percent of Zimbabweans with HIV are unaware that they are infected.

To better understand the HIV counseling and testing process, I was tested for HIV at a PSI New Start center in Harare that is funded by PEPFAR, the Global Fund and the British government. Despite the fact that I was confident of the results, I still felt anxious.

Upon entering the center, I was given a number by the receptionist to maintain my anonymity. I then joined about 10 people, who were also waiting to be tested, for a pre-testing session. The counselor talked to us about how HIV is transmitted, how to reduce risk, what happens if you test negative, what happens if you test positive. All bases were covered and I felt my anxiety lessen, and I could see the same thing happening for those around me.

Knowledge is power.

A lab technician gave me the confidential test, a tiny pin prick to the finger that turned out to be painless.

Then, I waited for about 15 or 20 minutes for my results.

In a private room, with a trained counselor, I was given my results and felt a great sense of relief. I was counseled on staying negative. Had I tested positive, I would have been counseled on what that means and I would have been referred to a post-test center where I would receive additional counseling and referral services for anti-retroviral treatment. 35,000 Zimbabweans go through this HIV counseling and testing experience

[1] John Stover, Lori Bollinger et al, 2009

every month just as I did, emerging with a greater awareness of measures they can take to protect themselves and others.

New Start centers also integrate family planning services, provide screening for tuberculosis and offer other health services.

This level of implementation requires effective partnership between donors and the partner country. During my time in Zimbabwe, I came to understand the importance of government leadership in addressing HIV. The Ministry of Health and Child Welfare in Zimbabwe has shown strong leadership and support for HIV prevention, care, treatment and support, including male circumcision and HIV testing and counseling. PSI Zimbabwe works closely with the Government of Zimbabwe and provides technical support in HIV prevention.

I was also impressed to see the depth of local capacity-building. PSI Zimbabwe is working with 12 local non-governmental organizations, community-based organizations, and faith-based organizations in the provision of counseling and testing services, for example.

Mr. Chairman, thank you again for bringing attention to HIV/AIDS programs by holding this hearing. I saw firsthand that the U.S. government's investment in HIV/AIDS is working, and we can all be proud that the U.S. government's support for programs like male circumcision and HIV counseling and testing is very strong in Zimbabwe and elsewhere. But although we have and utilize effective HIV prevention tools and strategies, data from UNAIDS indicates that the epidemic continues to grow, so we need to broaden the use of those tools and strategies, and we need to invest in learning and doing more of what works.

Every day, 7,400 people become newly infected with HIV worldwide, and there are five new HIV infections for every two people put on treatment.[2] I know that prevention remains the paramount challenge of the HIV epidemic, and a major priority for the next five years of PEPFAR. Treatment and care needs are growing as well. More resources are needed. I urge your ongoing robust support for PEPFAR and the Global Fund so that we can halt the spread of HIV and comprehensively expand access to HIV prevention, care, and treatment.

I am grateful for the opportunity to brief you, Mr. Chairman, Honorable Members, and colleagues. Thank you.

[2] UNAIDS, 2009, http://www.unaids.org/learnmore/en/prevention.html and http://www.unaids.org/learnmore/en/index.html#