

**U.S. INVESTMENTS IN HIV/AIDS: OPPORTUNITIES
AND CHALLENGES AHEAD**

HEARING
BEFORE THE
SUBCOMMITTEE ON AFRICA AND GLOBAL HEALTH
OF THE
COMMITTEE ON FOREIGN AFFAIRS
HOUSE OF REPRESENTATIVES
ONE HUNDRED ELEVENTH CONGRESS
SECOND SESSION

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MARCH 11, 2010
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Serial No. 111-104
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Printed for the use of the Committee on Foreign Affairs



Available via the World Wide Web: <http://www.foreignaffairs.house.gov/>

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U.S. GOVERNMENT PRINTING OFFICE

55-398PDF

WASHINGTON : 2010

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U.S. INVESTMENTS IN HIV/AIDS: OPPORTUNITIES AND CHALLENGES AHEAD

THURSDAY, MARCH 11, 2010

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON AFRICA AND GLOBAL HEALTH,
COMMITTEE ON FOREIGN AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:39 a.m. in room 2172, Rayburn House Office Building, Hon. Donald M. Payne, (chairman of the subcommittee) presiding.

Mr. PAYNE. We will bring the meeting of the Subcommittee on Africa and Global Health to order.

Let me first apologize for the tardiness of the hearing. There was a mandatory caucus meeting held on healthcare, which I had to at least attend for a few minutes. It is still going on, and that is why members over here are not present.

I understand Mr. Smith was here, and I was waiting to see if he could return, since he was here on time initially. But we do have time constraints, so I am going to officially open the meeting. And when Mr. Smith comes, I will allow him to give an opening statement, even after we begin with the witnesses.

So good morning again. Let me thank you for joining the subcommittee here today—the Subcommittee on Africa and Global Health. It is a critically important hearing, entitled U.S. Investments in HIV and AIDS, Opportunities and Challenges Ahead.

In 2003, Congress passed the United States Leadership Against HIV and AIDS, Tuberculosis and Malaria Act, authorizing, at that time, an unprecedented \$15 billion for global HIV/AIDS, TB, and malaria programs. This landmark legislation laid out ambitious goals: Prevention of 7 million new HIV infection, treatment of at least 2 million people, and care for 10 million people affected by HIV and AIDS, including orphans and vulnerable children.

With courageous bipartisan leadership, PEPFAR quickly became the world's largest effort to combat a single disease in the history of mankind. In 7 years since Congress passed the original legislation authorizing the President's Emergency Plan for AIDS Relief, or PEPFAR, it has become a historic program.

The word PEPFAR is known throughout Africa. This program will be remembered as probably the most significant achievement of former President George Bush.

Prior to PEPFAR, the United States did not support any type of AIDS treatment abroad. Officials in the administration said that treatment was not feasible in Africa. One excuse that was used, as many of us remember, was said because Africans could not tell

time, and therefore they would be unable to use the medication, and that we should simply limit our activities to the prevention of the spread of the disease.

Then in 2008, Congress went even further, and PEPFAR won, to the amazement and surprise of many Members of Congress and the administration, and the world, when it reauthorized the program for another 5 years, at the additional level of \$48 billion, to prevent 12 million new infections, treat 3 million people living with HIV and AIDS, and care for 5 million orphans and vulnerable children.

The bill also provided \$4 billion to treat tuberculosis and \$5 billion to treat malaria over the next 5 years. And it incorporated new and improved policy and programming mandates, including increasing the number of health workers in Africa, providing medicines for opportunistic infections, supporting nutritional programs, and removing some of the restrictions on funding to allow doctors and scientists to direct programming.

PEPFAR programs have had a remarkable international impact. As of December 2008, approximately 4 million people in low- and middle-income countries were receiving anti-retroviral therapy (ART), about 10 times more than just 5 years ago.

The number of new HIV infections among children has declined as a result of expanded access to medicine for the prevention of mother-to-child transmission (PMTCT). About 45 percent of HIV-positive pregnant women worldwide had access to PMTCT services in 2008. This is a significant improvement from the 10 percent that we saw back in 2004.

Increasingly, we are seeing the benefits of our AIDS response in other areas of the health sector, including improving vaccination coverage, family planning, strengthening laboratory and health systems, as well as decreasing infant and maternal mortality.

Despite tremendous efforts made by the United States and the international community, AIDS is still among the biggest infectious killers the world has ever seen.

Sub-saharan Africa remains the region most severely impacted by HIV and AIDS. Over 22 million people were living with HIV in Africa in 2008, and 1.9 million of whom contracted the virus during that year. About 1.4 Africans died of AIDS in 2008, accounting for 72 percent of all the AIDS-related deaths worldwide.

Although the rate of new infections is slowly declining, the number of people living with the virus continues to grow, due, in large part, to greater access to anti-retroviral medications.

While coverage rates have improved across Africa, mother-to-child transmission continues to account for a substantial portion of the new HIV and AIDS cases. It is unconscionable that children continue to be born with the virus, when we have the tools to prevent transmission. We must make it our goal to eliminate mother-to-child transmission of HIV.

I am deeply concerned about the reports that the fight against HIV/AIDS is faltering and continued rapid rollout of AIDS treatment is endangered in Africa. The economic crisis that has hit our nation and the world has also devastated the countries receiving our health aid, and calls for us to renew our efforts. And we must make sure that we don't start to decline.

I certainly applaud President Obama's announcement of a broad Global Health Initiative (GHI) with a pledge of \$63 billion over 6 years. That includes \$51 billion for PEPFAR, a \$4 billion increase over the 2008 authorization, and \$11 million for maternal and child health, neglected tropical diseases, and an overall focus on building capacity of health systems.

I look forward to working with the administration to make this vision a reality. I am especially pleased with the GHI emphasis, a focus on building the capacity of healthcare systems. I know that Dr. Goosby will ensure this initiative, and he will certainly continue to be a strong advocate in the fight against HIV and AIDS. And I don't think a more qualified person could have been selected for the very important position.

At the same time, let us all remember that the advances in funding levels and reach of U.S. programs can be greatly leveraged through investment in national health systems. And we have seen that, but we have to know that we are strengthening health systems in other countries, so that when we do decrease funding, perhaps in the distant future, there will be strong health systems in those countries.

In his 2010 State of the Union, President Obama addressed the reason for our efforts to fight HIV and AIDS: "America takes these actions because our destiny is connected to those beyond our shores. But we also do it because it is right."

Despite our economic challenges, we must continue to reach out to other countries in need, not just because it is in our best interest, but because it simply is the right thing to do.

I look forward to the continued evaluation of our efforts to combat this devastating disease, and I sincerely thank the panel of esteemed witnesses for testifying before us today and sharing their insights on what we, as a nation, should be doing and what more we can do to address this issue.

Before I turn to the ranking member for his remarks, let me allow him to catch his breath. And let me also state that we look forward to having Dr. Goosby, the U.S. Global AIDS Coordinator, before this committee. Chairman Berman would like him to testify before the full committee at a later date, and ask that we hold off until he is able to do that. Therefore, this panel will only have a private panel. And at a future hearing, we will have administrative officials.

And now I will turn back to Mr. Smith. I appreciate him being here earlier. I mentioned there was an emergency meeting that was called. I stayed just to be checked in, and came over then. But I am glad you are here again. Thank you.

Mr. SMITH. Thank you very much, Mr. Chairman. I want to thank you for calling this very important and very timely hearing to explore the future of the President's Emergency Plan for AIDS Relief, or PEPFAR.

As you know, the Leadership Act originally passed with the sponsorship of Henry Hyde and Tom Lantos, and you and I and several others, but they were the lead; and was signed into law by President Bush, who initiated this historic health initiative in 2003, with very strong bipartisan support.

It has been extraordinarily successful in countering the devastating toll that the HIV/AIDS pandemic was taking on, and is continually impacting women, men, and children throughout the world, most particularly in Africa.

The United States' bilateral funding has provided lifesaving anti-retroviral treatments for over 2.4 million individuals—over half of the nearly 4 million persons receiving treatment in low- and middle-income countries. It has directly supported care for almost 11 million people affected by HIV/AIDS, including 3.6 million orphans and vulnerable children.

Almost 340,000 babies have been born without HIV, even though their mothers were HIV-positive, thanks to PEPFAR's mother-to-child transmission prevention programs; and an incredible 29 million people have received PEPFAR-supported HIV counseling and testing.

To achieve these results, as well as to make annual contributions to the Global Fund to fight AIDS, TB, and malaria, and related programs to treat tuberculosis, the U.S. has dedicated over \$32 billion since 2004. The African people, who have been the prime beneficiaries, are well aware of the American taxpayers' generosity. During my travels to Africa I have been repeatedly overwhelmed with gratitude from people of all ages and walks of life, who credit George Bush and the American people and the Congress with saving their lives, their families, and their communities.

However, Mr. Chairman, it is critical that we take this opportunity to step back and examine the best way to move ahead. As the title of this hearing indicates, there are significant challenges, as well as opportunities.

One challenge is in respect to how treatment will be provided to new patients over the coming years. Estimates of the rate of new HIV infections, compared to those obtaining treatment, range from between two to one and five to one.

While Congress authorized \$39 billion in the 2008 reauthorization, for 2009 to 2013, even this amount cannot fully cover the growing need. It is apparent that our country cannot carry this increasing burden, alone. I look forward to hearing our distinguished witnesses' proposals for resolving that dilemma.

At issue with respect to PEPFAR, and I find this particularly disturbing, is the administration's proposed implementation of the so-called Prostitution Pledge. The purpose of this pledge, created to ensure compliance with PEPFAR, a PEPFAR mandate, is to prevent PEPFAR funding from being misdirected to those who refuse to oppose prostitution and sex trafficking as a matter of policy.

Prostitution and sex trafficking exploit and degrade women and children, and exacerbate the HIV/AIDS pandemic. Yes, despite a clear statutory mandate based on an equally clear U.S. Government policy opposing prostitution and sex trafficking, the Department of Health and Human Services has issued a proposed rule that would substantially undermine that law and policy.

It would create loopholes to allow not only affiliation, but shared facilities, staff, legal status, and bank accounts, as determined on a case-by-case basis between PEPFAR funding entities and entities that support prostitution and sex trafficking.

As the prime author of the Trafficking Victims Protection Act of 2000, 2003, and 2005, I find this unconscionable.

It would also significantly reduce the assurance that USAID is supposed to have that a PEPFAR-funded organization is in compliance with the relevant provisions of the PEPFAR legislation.

Unfortunately, HHS has not yet posted, on the official regulations Web site, the comments that I have submitted strenuously opposing this proposed rule. And without objection, Mr. Chairman, I would ask that we make my comments a part of the record.

Mr. PAYNE. Without objection.

[The prepared statement of Mr. Payne follows:]

"U.S. Investments in HIV/AIDS: Opportunities and Challenges Ahead"
Chairman Donald M. Payne
Subcommittee on Africa and Global Health
Thursday, March 11, 2009
10:00AM in 2172 RHOB

Remarks

Good morning. Thank you for joining the Subcommittee on Africa and Global Health for this critically important hearing entitled "U.S. Investments in HIV/AIDS: Opportunities and Challenges Ahead."

In 2003, Congress passed the U.S. Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act authorizing an unprecedented \$15 billion for global HIV/AIDS, TB and malaria programs. This landmark legislation laid out ambitious goals: prevention of 7 million new HIV infections, treatment of at least 2 million people, and care for 10 million people affected by HIV/AIDS, including orphans and vulnerable children. With courageous bipartisan leadership PEPFAR quickly became the world's largest effort to combat a single disease.

In the seven years since Congress passed the original legislation authorizing the President's Emergency Plan for AIDS Relief, or PEPFAR, it has become an historic program. The word PEPFAR is known all across Africa.

This program will be remembered as probably **the** most significant achievement of former President Bush. Prior to PEPFAR, the United States did not support any type of AIDS treatment program abroad.

Officials in the administration said that treatment was not feasible in Africa because Africans could not tell time, and that we should limit our activities to preventing the spread of the disease.

Then in 2008, Congress went even further than PEPFAR I when it reauthorized the program for another five years and provided an additional \$48 billion to prevent 12 million new infections, treat 3 million people living with HIV/AIDS and care for 5 million orphans and vulnerable children.

The bill also provided \$4 billion to treat Tuberculosis and \$5 billion to treat malaria over the next five years, and it incorporated new and improved policy and programming mandates, including increasing the number of health workers in Africa, providing medicines for opportunistic infections, supporting nutritional programs, and removing some of the restrictions on funding to allow doctors and scientists to direct programming.

PEPFAR programs have had a remarkable international impact. As of December 2008, approximately 4 million people in low and middle income countries were receiving antiretroviral therapy (ART)—about 10 times more than just five years ago.

The number of new HIV infections among children has declined as a result of expanded access to medicine for the prevention of mother-to-child transmission (PMTCT). About 45% of HIV-positive pregnant women worldwide had access to PMTCT services in 2008. This is a significant improvement from 10% in 2004.

Increasingly we are seeing the benefits of our AIDS response in other areas of the health sector, including improving vaccination coverage, family planning, strengthening laboratory and health systems, as well as decreasing infant and maternal mortality.

Despite tremendous efforts made by the United States and the international community AIDS is still among the biggest infectious killers the world has ever seen. Sub-Saharan Africa remains the region most severely impacted by HIV/AIDS. Over 22 million people were living with HIV in Africa in 2008, about 1.9 million of whom contracted the virus during that year.

About 1.4 million Africans died of AIDS in 2008, accounting for 72% of all AIDS-related deaths worldwide.

Although the rate of new infections is slowly declining, the number of people living with the virus continues to grow, due in large part to greater access to antiretroviral medication. While coverage rates have improved across Africa, mother-to-child transmission continues to account for a substantial portion of new HIV cases.

It is unconscionable that children continue to be born with the virus when we have the tools to prevent transmission. We must make it our goal to eliminate mother-to-child transmission of HIV.

I am deeply concerned about the reports that the fight against HIV/AIDS is faltering and continued rapid roll out of AIDS treatment is endangered in Africa. The economic crisis that has hit our nation and the world has also devastated the countries receiving our health aid and calls for us to renew our efforts.

I applaud President Obama's announcement of a broader Global Health Initiative (GHI) with a pledge of \$63 billion over 6 years that includes \$51 billion for PEPFAR – a \$4 billion increase over the 2008 reauthorization – and \$11 billion for maternal and child health, neglected tropical diseases, and an overall focus on building capacity of health systems. I look forward to working with the Administration to make this vision a reality. I am especially pleased that the GHI emphasizes a focus on building the capacity of health systems. I know Dr. Goosby will ensure this initiative supports our efforts to fight AIDS.

At the same time, let us all remember that the advances in funding levels and reach of U.S. programs can be greatly leveraged through investments in national health systems.

In his 2010 State of the Union, President Obama addressed the reason for our efforts to fight HIV/AIDS, "America takes these actions because our destiny is connected to those beyond our shores. But we also do it because it is right." Despite our economic

challenges we must continue to reach out to other countries in need, not just because it is in our best interests but because it is the right thing to do.

I look forward to the continued evaluation of our efforts to combat this devastating disease, and I sincerely thank the panel of esteemed witnesses for testifying before us today and sharing their insights on what we as a nation are doing and what more must be done to address this issue.

Before I turn to the Ranking Member for his remarks, let me state that we look forward to having Dr. Goosby, the U.S. Global AIDS Coordinator, before the committee. Chairman Berman would like him to testify before the full committee at a later date and asked that we hold off. Therefore, this hearing will have only a private panel.

With that, I turn to Mr. Smith for opening remarks.

Mr. SMITH. I appreciate that. My office is attempting to correct this omission, and I invite those concerned about the negative impacts of prostitution and sex trafficking in general, with respect to HIV prevention in particular, to read it. And we will have it at the desk, on the left, today.

The HHS proposed rule is unacceptable, and should be rejected. If the proposed rule is promulgated, I can guarantee you this: I will leave no stone unturned in fighting it.

I must also express my grave reservations with respect to certain aspects of the President's Global Health Initiative, which is otherwise an outstanding initiative.

When the reauthorization of PEPFAR was being debated in 2008, references to integrating and providing explicit funding authorization for reproductive health in relation to HIV programs in initial drafts were rejected. The term does not appear in the final legislation.

However, the new GHI emphasizes the integration of HIV/AIDS programming with family planning, as well as various health programs. This is being undertaken—and this is the important point—undertaken in the context of a family planning program due to President Obama's rescission of the Mexico City policy that now includes foreign non-government organizations that provide and support and seek the expansion of abortion.

When one considers that this involves over \$715 million in family planning funding alone in the 2011 proposed budget, the ability of abortion groups to leverage this funding in relation to HIV/AIDS under the GHI is deeply disturbing. This integration priority in my opinion is wrong.

We are trying to prevent HIV/AIDS, not children. It is time to recognize that abortion is child mortality. Aborting dismembers, poisons, and starves to death a baby, and wounds their mothers.

Let me remind members as well that goal number four of the Millennium Development Goals of the U.N. calls on each country to reduce child mortality, while at the same time pro-abortion activists lobby for an increase in access to abortion.

It is bewildering, to me, how anyone can fail to understand that abortion is, by definition, child mortality. Abortion destroys children.

Let me also point out that at least 102 studies show a significant psychological harm, major depression, and elevated suicide risk to women who abort. At least 28 studies, including three in 2009, show that abortion increases the risk of breast cancer by some 30 percent to 40 percent or more; yet the abortion industry has largely succeeded in suppressing these facts.

Breast cancer in Africa, in many parts of Africa, is a death sentence. So-called safe abortion also inflicts other deleterious effects on women, including hemorrhage, infection, perforation of the uterus, and sterility.

A woman from my own state of New Jersey recently died from a legal abortion, leaving behind four children. At least 113 studies show a significant association between abortion and premature births. That is so under-focused upon, it is appalling.

One example by Shah and Zao show that a 36 percent increased risk for preterm birth after one abortion, and a staggering 93 percent increased risk after two. And what does this mean for her children? Preterm birth is the leading cause of infant mortality in the industrialized world, after congenital abnormalities.

Preterm infants have a greater risk of suffering from chronic lung disease, sensory deficits, cerebral palsy, cognitive impairments, and behavioral problems. Low birth weight is similarly associated with neonatal mortality and morbidity. Those facts are so under-reported upon, and I invite the press to look at those studies, and Members of Congress and members of our panel. Because we have, in Africa and elsewhere, as we have seen in the United States, designated or imposed on subsequent children born to women who abort a significant risk factor for a disability because of prematurity and low birth weight.

So Mr. Chairman, the future of PEPFAR, and particularly in the context of the Global Health Initiative, has many, many challenges. And I look forward to exploring them with you. We have a consensus on PEPFAR. We have a consensus on so many aspects of global health, hopefully it does not get undermined by this emphasis on child mortality called abortion.

Mr. PAYNE. Thank you very much. At this time we will, I am going to condense the biographical information I have before me. Normally I would go through much of the outstanding achievements, but I will, because of time, cut them short.

I would like to introduce Dr. Peter Mugenyi, who is the director and founder of the Joint Clinical Research Center in Kampala, Uganda, where he has served since 1992. In that role he leads the largest treatment initiative in Africa, funded through the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). He cer-

tainly has collaborated with World Health Organization, National Institute of Health; has written books, including *Genocide by Denial*, and has a very outstanding resume.

Next we will hear from Dr. Joanne Carter. She is executive director of the Educational Fund at RESULTS. She also serves as the board representative at the Global Fund to Fight AIDS, TB, and Malaria. Dr. Carter has worked with many of the world organizations, also. She is really one of the top advocates and does a tremendous amount of communicating throughout the world regarding the issue, and is a founding board member of the Global Acts for Children.

Ms. Debra Messing is, of course, known for her role as Grace Adler, NBC's Emmy-Award-winning comedy series, *Will and Grace*. She won the 2003 Emmy Award, has earned a total of seven Golden Globe nominations. She is currently the Global AIDS Ambassador for Population Services International, and has done much travel, recently to Uganda, and does a fantastic job in advocacy.

Finally, we have Dr. Norman Hearst, who is a professor of family and community medicine and epidemiology and biostatistics at the University of California, San Francisco. He has published many articles—over 70. Dr. Hearst has done a tremendous amount of research, and is one of the most respected professors in our nation.

With that, we will start with Dr. Mugenyi. We will have your testimony. Thank you.

**STATEMENT OF PETER MUGYENYI, M.D., DIRECTOR AND
FOUNDER, JOINT CLINICAL RESEARCH CENTER**

Dr. MUGYENYI. Thank you, Chairman Payne and Ranking Member Smith, for giving me the opportunity to address this meeting.

PEPFAR has saved millions of lives in Africa. It started at a time when the AIDS crisis in sub-Saharan Africa had reached a catastrophic stage, because timely action was not taken, and the African countries were too overwhelmed by the sheer magnitude of the disaster.

Before PEPFAR, less than 100,000 in Africa had access to life-saving anti-retroviral drugs, and millions were dying from what had become a preventable death in rich countries.

Today there are 4 million people on ARV treatment in low- and middle-income countries. These people, and their mothers, husbands, wives, and children, got a chance to live, more than half of whom have benefitted from the U.S. Government's contributions, PEPFAR and Global Front.

Beyond treatment, support for current prevention efforts has helped ease the carnage that I and my fellow healthcare providers used to witness on a daily basis.

Recently, recent evidence has shown that HIV programs, where they have reached community-wide coverage, have been among the most effective interventions, having impact well beyond the AIDS epidemic.

Studies in Uganda have shown the increase in services for HIV/AIDS was accompanied by reduction in non-HIV infant mortality of 83 percent, as parents not only lived, but thrived. The DART study, which I co-chaired, found a 75 percent reduction in malaria associated with anti-retroviral therapy.

These programs have also strengthened our health systems beyond addressing HIV/AIDS. For instance, PEPFAR assisted my institution to build the seven laboratories that support nearly all of the public clinics, and trained several thousand healthcare providers now providing crucial services to both the public and private sectors in Uganda.

This success has been coupled with re-excitement and new evidence that reaching all of those in need of ARVs could help us stop new infections, and beat the epidemic for good. New data from the Conference on Retroviruses a few weeks ago, CROI, which I attended in San Francisco, show that HIV transmission between heterosexual couples in Africa reduce by 90 percent, if the HIV-positive partner is on treatment. This gives credence to the recent modeling by the World Health Organization that shows some of the first good news on prevention in several years, that we could truly end the AIDS crisis within a generation.

Today, however, the crisis threatens to reverse. Today, however, the funding crisis threatens to reverse these highly positive changes, and we could miss the opportunity to defeat the epidemic.

AIDS in much of Africa is still an emergency. It continues to be the biggest killer of women of reproductive age. In Uganda we have come very far, but we are less than halfway there.

Unfortunately, over the last 2 years PEPFAR funding has flatlined. New PEPFAR contract awards emphasize treatment for only those already on it, and only very limited slots for new patients.

Currently my institution, which pioneered anti-retroviral therapy in Africa and treats the largest proportion of AIDS patients in Uganda, is not taking all new patients, due to lack of funding. We are forced to turn away desperate patients daily, often 15 to 20. And most of those who come to us would have been turned away from a number of other clinics.

When I say new, it is important to note that most of these are not truly new. Thousands of Ugandans, and millions throughout Africa, heard the message from PEPFAR that knowing the HIV status was important to protect yourself and others, and that treatment would be available to those who required it.

Even though we have put thousands of patients on PEPFAR-supported care today, my program and numerous others across the country cannot deliver on the promise of treatment. I have witnessed many desperate patients unable to access therapy, including pregnant women, resorting to desperate and dangerous measures, including sharing out drugs with their family members, ignoring the good counseling advice they receive advising against this dangerous practice.

Recently, an HIV-infection woman, who was breastfeeding her HIV-negative child because she could not afford formula milk, came to our clinic, having been turned away from other clinics in Kampal because they had no slots. She knew that every day she breastfed her baby without being on treatment greatly increased the chances of her child getting infected, but she had no alternative.

We, out at JCRC in Uganda, led the ARV-resistant testing studies, which found that treatment interruption, including sharing of drugs, which is becoming increasingly widespread, result in drug

resistance. This will result in large numbers of patients failing on simpler and low-cost first-line drugs, and needing more expensive and more sophisticated second-line therapy.

We must end the forced dichotomy between the prevention and treatment. If we choose one over the other, we will fail. We must invest more strenuously in treatment, while also scaling up prevention programs, including male circumcision, combination prevention and services targeting high-risk groups.

Let us also not forget that strengthening the health system and getting AIDS treatment to those who need it are not contradictory goals. We know from our experience in the 1990s that if treatment isn't there, people will not come to the health centers, and doctors will not stay.

We know from our long experience that it is virtually impossible to have successful public health sector and AIDS programs, where some people get therapy and others in dire needs don't.

The news of President Obama's new Global Health Initiative was received in Africa with great appreciation and enthusiasm. However, to ensure maximum health benefits, we must build in past successes, and ensure sufficient new money is available for successful integration of serious health issues. Otherwise we risk going back to the failed approaches of the 1990s that do not prioritize provision of lifesaving drugs.

In conclusion, Mr. Chairman, allow me to refer to repeated commitments by United States universal access AIDS services in U.N. declarations, which caused great excitement and expectation in Africa.

U.S., as the world's friend, came to the rescue of Africa at the time of our greatest need. It is our hope that current efforts can be strengthened, so that one day we can achieve our shared goal of a world free of AIDS.

Thank you again, Mr. Chairman, for this opportunity, and the American people for their compassion and generosity. Thank you.

[The prepared statement of Dr. Mugenyi follows:]

Testimony to Congress: House Committee on Foreign Affairs, Subcommittee on Africa and Global Health, Thursday, February 11, 2010.

Peter N. Mugenyi M.D.

Executive Director of Joint Clinical Research Centre, Kampala, Uganda.

SUCCESS OF PEPFAR

PEPFAR has saved millions of lives in Africa. PEPFAR started at a time when the AIDS crisis in Sub-Saharan Africa had reached a catastrophic stage because timely action was not taken, and the African countries were too overwhelmed by the sheer magnitude of the disaster. Before PEPFAR, less than 100,000 thousand in Africa had access to life saving antiretroviral drugs, and millions were dying what had become preventable deaths in rich countries. Today, there are four million people on ARV treatment in low- and middle-income countries who would not be alive without the treatment scale-up only possible with donor support. More than half of them have benefited from the U.S. government's contributions to PEPFAR and the Global Fund. These people – and their mothers, husbands, wives and children – got a chance to live. This is a chance they simply would not have had without the humanitarian global AIDS program, backed strongly by the American people.

During the first 7 years of PEPFAR, the carnage that I and my fellow health care providers used to witness on a daily basis faded as the situation changed from that of despair and misery to hope. PEPFAR did more than treat people—nearly 4 million AIDS orphans and vulnerable children have been assisted because of it. By keeping parents alive, PEPFAR has prevented millions of others from becoming orphans. It has also allowed more than 300,000 babies of HIV-positive mothers to be born HIV-free. In the area of prevention, millions have been tested for HIV, and preventive initiatives based on the Abstinence, Be faithful, and Condoms--otherwise known as ABC strategy for AIDS prevention—have been supported.

OPPORTUNITIES TO END THE EPIDEMIC & AFFECT OTHER HEALTH AREAS

Recently, excitement has built around the potential to both reverse the pandemic and to have a major impact on overall health through effective AIDS programming.

Evidence has shown significant strengthening of health systems by AIDS programming. For instance, PEPFAR assisted my Institution, the JCRC, to establish diagnostic and clinical facilities. It has also helped us improve our standards of care by supporting our training programme, which has so far trained thousands of health care providers who are now providing crucial services to both the public and private sectors in Uganda.

There is also significant evidence that AIDS programming, where it has reached community-wide coverage, has been among the most successful interventions for broader health. Studies in Uganda have shown the increase in services for HIV/AIDS was accompanied by a reduction in

non-HIV infant mortality of 83% as parents not only lived but thrived.¹ The DART study, which I co-chaired, found that of 300 HIV-positive pregnant women with very low CD4 counts, ARVs prevented their children from being infected 100% of the time. Essentially, it also found a 75% reduction in Malaria associated with anti-retroviral therapy.

Most recently, there has been considerable excitement coming out of the CROI conference—held a few weeks ago in San Francisco. Evidence there showed that reaching all those in need with anti-retroviral therapy could have a major impact on preventing new infections. A study of HIV transmission between heterosexual couples in Africa found that the chance of transmission is reduced by at least 90% if the HIV-positive partner is on antiretroviral therapy. This gives credence to recent modelling by the World Health Organization and experts in South Africa that shows some of the first good news on prevention in several years: that we could truly end the AIDS crisis within a generation if we can reach all those in need with testing and treatment, combined with rolling out new, important prevention technologies.

FUNDING CRISIS UNDERMINING PROGRESS

Today, however, the twin realities of the economic crisis and flat-lining of funding for PEPFAR threaten to reverse these highly positive changes and miss opportunities to defeat the epidemic.

PEPFAR responded to a crisis of immense magnitude that is still devastating. AIDS in much of Africa is still an emergency. In Uganda, only 170,000 adults out of estimated 350,000 in immediate need of life-saving ART, and 12,000 children out of estimated 60,000 who also need treatment, are receiving it now.

And every year, the number of patients who need treatment but who have no access will increase—in fact, the numbers in need of treatment are projected to increase to over 14 million worldwide in the next 10-15 years.

Over the last few years, data from research made it clear that the CD4 level of 200 cells used in Africa to determine when to start therapy was late and was predisposing patients to poor treatment outcome and increased mortality. Accordingly, WHO has revised the when-to-start recommendation to a CD4 of 350, as already established in developed countries. The possibility of starting treatment at even higher CD4 level for better treatment outcomes and as a preventive strategy is currently being researched. However, Africa is currently unable to implement the new recommendation for the simple reason that a majority of countries are not able to treat even half of the patients in need at the old CD4 level. It has been estimated that, by using this criteria, the numbers in immediate need of ART in Africa would double, further compounding the already dire situation.

¹ Mermin J, Were W, Ekwaru JP, et al. *The Lancet*, 2008; Ndirangu J, Bland R, Newell M-J. IAS 2009, abstract WEAD105; Stoneburner R, Montagu D, Pervilhac C, et al. *16th International AIDS Conference*, Toronto, abstract THLB0507

There are other unmet needs that are vital for successful control of the raging HIV epidemic in Africa. Many rural areas, where the majority of people live, remain without services. Most laboratories are in a miserable state, and the available few are not accessible to the majority of patients. The epidemic is still spreading at an alarming rate, calling for robust preventive interventions. Data from UNAIDS has indicated that for every 2 patients who started therapy, 5 new ones—mainly females—were infected. The epidemic in Africa is increasingly becoming feminized because of gender inequity. There were 1.9 million new infections in Sub-Saharan Africa in 2007, and since then there has been no significant decline in rates. This situation underscores the urgent need for strengthening of preventive initiatives incorporating new strategies, like male circumcision, and targeting emerging vulnerable groups who are most at risk for HIV/AIDS, including men who have sex with men, drug users, sex workers, and women.

Unfortunately, over the last two years, PEPFAR funding has flat-lined. A decrease in budget neglects the clinical and economic analyses that survival, overall cost of care, and even new infections are linked to getting people into care as soon as possible. Decreased spending now will increase costs in the future; that is the essence of responding to infectious diseases with a growing infected population and increasing burdens over time. It will also increase mortality: patients in need of treatment cannot wait for the international AIDS treatment budgets to increase.

SENDING PATIENTS HOME TO DIE AGAIN

This brief glimpse of a grim and still deteriorating AIDS situation in Africa is not commensurate with a frozen budget. On the contrary, it clearly calls for urgent intervention by increasing funds for treatment and prevention of HIV. The effects of the current flat-lined budget have already demonstrated some worrying trends. Currently, my institution, which pioneered antiretroviral therapy in Africa and treats a big proportion of AIDS patients in Uganda, is not taking on any new patients. We are forced to turn away desperate patients daily. Most of those who come to us will have been turned away from a number of other clinics. A majority of these patients are already receiving care and have been waiting years to receive drugs. Those that still have a few slots have a long waiting list of very sick patients—some of them staring death in the face—jostling to jump the queues.

A survey by UNAIDS found that many adult AIDS patients in Africa are still using the highly toxic Stavudine (d4T) based combinations, which WHO removed from the list of recommended first-line treatment because of serious toxicity. The reason why they still use this drug to-date is because it is the cheapest—they have no other choice. Meanwhile, the lack of new funds means clinics are now being forced to stop enrolling patients. All new PEPFAR contract awards emphasize treatment for only those already on it and only very limited slots for new patients—yet the new patients are the majority.

Hundreds of thousands in Uganda, and millions in Africa, responded to PEPFAR's highly successful testing program, but its success was largely due to the promise that treatment would be provided to those found to be in need. Those found positive but not yet at a stage to require therapy were put in PEPFAR-supported care programs where they were provided with Bactrim, a drug that protects against some opportunistic infections. Those in care had regular CD4 checks

and whenever they reached a stage to need therapy, they received it. Nowadays, when new ones reach a stage when they require therapy, which they were promised, they are disowned and abandoned to their fate.

Let me tell you what I have seen: I have witnessed desperate patients unable to access therapy, including pregnant women, resorting to desperate and dangerous measures including sharing drugs with their family members, ignoring the good counselling they receive advising against this dangerous practice. Recently, an HIV-infected poor woman who was breastfeeding her HIV-negative child because she could not afford formula milk came to our clinic, having been turned away from three other clinics in Kampala because they had no slots. She knew that every day she breast fed her baby without being on treatment greatly increased the chances of her child getting infected, but she had no alternative. As we were trying to find her a treatment center that still had a slot, we were repeatedly told that they were turning away similar cases. We have a situation where some people in need of therapy get it, yet their family members in similar need don't. Through our long experience, we learned that it is virtually impossible to have successful public sector AIDS treatment program where some people get therapy and others in dire need don't.

Early resistance testing studies carried out at JCRC in Uganda found that treatment interruptions predispose the development of drug resistance. Inequitable access compromises the quality of ART programs and fuels resistance to ARV drugs because drug treatment interruptions will inevitably increase. This will result in big numbers of patients failing on the simpler and low-cost first-line drugs and needing more expensive and more sophisticated second-line therapy. It would not take long before an increasing number started requiring the ultra-modern, highly expensive third line drugs—which virtually do not exist in Africa.

Such a situation would make the current cost of ART therapy look small by comparison, especially if HIV-resistant strains start spreading within the community. This would make HIV management highly expensive and complicated. However, this unfortunate situation is not inevitable as long as timely action is taken. Therefore, there is urgent need for increased funding to address increased demand by supporting ART programs in order to prevent reversal of gains and a resurgence of mortality on a large scale. Action is needed now in order to minimize emergency resistance while at the same time expanding prevention services.

An AIDS epidemic of this magnitude calls for a long-term commitment to allow sufficient time for resource-limited countries to build capacity. Many nations in Africa realize that they need to play a bigger role in management of AIDS in their respective countries. A partnership between countries, which extends to civil society and faith-based organisations, needs to be strengthened. In building capacity, PEPFAR needs to help Africa address the main constraints of human resource deficiency by supporting training and salary top-ups for public sector workers, especially those in hard-to-reach and underserved rural areas.

However, almost all African governments and ministries of health systems are still too weak to undertake the enormous task alone. They need continued support and adequate time to build up the necessary capacity in the public sector to eventually take over the work established by

PEPFAR. Hurried hand-over, without allowing time for systematic capacity-building, will break the system instead.

And it is imperative that treatment and prevention together must remain a priority. Without tackling HIV/AIDS, which is the most devastating disease on the African continent, it is extremely difficult to successfully strengthen health systems to a level where they would function well and be sustainable.

The Global Health Initiative

The news of President Obama's new Global Health Initiative—which has added attention to Neglected Tropical Diseases, maternal health, and sexual and reproductive health—was received in Africa with great appreciation.

There are some innovative ways that can be incorporated for cost-effective integration of these diseases into the PEPFAR program. They include funding support for critical facilities like laboratories and clinics that can be shared for diagnosis, monitoring, logistics, and treatment of these and as many of the other diseases and conditions as possible. This envisions widening the scope of training syllabuses for health care providers and community support groups to cover the whole spectrum of diseases. In consideration of deficiently trained manpower in Africa, multi-tasking of staff is important, as the same staff would provide care and treatment for all diseases—especially in rural areas, where most of the people live.

However, the main requirement for successful integration of these serious health issues is to ensure sufficient funding, with new money. It should not be at the expense of HIV/AIDS, which needs increased support.

In this regard, Uganda's Minister of Health sent a letter to Secretary of State Hillary Clinton last September, in which he stated, and I quote, "concerns in growing across the African continent about a slowdown in U.S. assistance via PEPFAR and the Global Fund. I urge that you maintain the pace of assistance as envisioned in the Lantos-Hyde U.S. Leadership Act Against HIV/AIDS, Tuberculosis and Malaria of 2008 so that we do not lose crucial momentum."

Finally, I glance back to 1993 when the AIDS carnage was ravaging my country, Uganda. My institution, the JCRC, was facing a serious crisis. We were losing our staff members, and the rest were spending all their time attending burial ceremonies of their colleagues, siblings, parents, and close relatives. Our trained staff continued to dwindle. The turning point was brought about by PEPFAR. The sick staff members and their relatives who needed treatment got it. My institution gradually recovered and started working smoothly. We have not had any staff deaths due to AIDS in the last 3 years.

Nothing could have done more for health systems strengthening at that critical time than getting AIDS treatment. By treating AIDS, some of the critical elements of health systems strengthening were addressed. Treating AIDS does not contradict health systems strengthening, and it is not one or the other—they go together. What would be the use of training and building human resources only to lose them to AIDS if treatment is not provided when they need it?

In conclusion, allow me to refer to repeated commitments to universal access to AIDS services in UN declarations and G8 communiqués, which caused great excitement and expectation in Africa. But today, with such a dramatic slowdown in funding, we the United States risks jeopardizing the progress toward these goals, which would tarnish the current high esteem Africa has of the U.S. as a redeemer and the world's friend.

Mr. PAYNE. Thank you very much. Thank you.
Dr. Carter.

STATEMENT OF JOANNE CARTER, D.V.M., EXECUTIVE DIRECTOR, EDUCATIONAL FUND, RESULTS (ALSO BOARD MEMBER OF THE GLOBAL FUND TO FIGHT AIDS, TB AND MALARIA)

Ms. CARTER. Chairman Payne and Ranking Member Smith, thank you so much for inviting me to discuss the opportunities and challenges ahead for U.S. investments in HIV/AIDS program.

The House Foreign Affairs Committee, and particularly the members of this subcommittee, have been instrumental in crafting and supporting our U.S. AIDS response, with results that were almost unimaginable only a few short years ago. Both you and Dr. Mugenyi referred especially to the massive treatment scale-up.

And despite the clear bipartisan mandate of the Lantos Hyde Act, which, as you said, authorized \$48 billion over 5 years, both to build on what has been achieved and to ramp up the response, there is unfortunately a significant gap between the vision expressed in that bill and its realization.

So I would like to briefly review the funding situation we currently face, and then turn to some important opportunities to increase the impact of our response.

The administration's Global Health Initiative calls for a more integrated, comprehensive AIDS and health response. It is a welcome intent, but it is only going to work if it is adequately funded.

The President's Fiscal Year 2011 budget request essentially flat funds for our global AIDS programs, with just a 2 percent increase in bilateral AIDS funding, several billion short of what would have been needed to reach the Lantos Hyde authorization levels. And the budget actually proposes a \$50 million cut to the Global Fund to fight AIDS, TB, and malaria, and just a minuscule \$5 million increase for bilateral TB, even though TB is the leading killer of people with AIDS.

And as Dr. Mugenyi has pointed out, flat funding actually means cuts to lifesaving services at the very moment when we built the capacity and the demand to get to the finish line, and at the very moment when the global economic crisis has profoundly exacerbated needs in Africa.

I would like to highlight just three opportunities to fundamentally alter the course of the HIV/AIDS epidemic in the coming year.

The first, again building on what Dr. Mugenyi said, is to continue to scale up treatment, not just as a medical and a moral imperative, but actually as a public health strategy for reducing transmission of HIV. There is a growing body of evidence that widespread access to early treatment can help prevent transmission.

And Congressman Smith, you raised the issue of, in a sense, the treatment mortgage, and the growing cost. But there is also both evidence and really exciting modeling that shows that if we are aggressive now on universal access to testing and early treatment, within not a very long time you actually break the back of the epidemic, and you start to see the curve going down. It just requires aggressive investment up front to make that happen. And we would be glad to share some more of that data with you.

A second critical lifesaving opportunity is tackling tuberculosis. And both of you have really been leaders on this issue. It is the leading killer of people with AIDS. And as you know, an HIV-positive person who gets sick with TB is dead within a few weeks.

Yet fewer than 4 percent of people with HIV/AIDS are screened for TB. This is the low-hanging fruit when it comes to saving lives, and we have yet to seize it. And people are now quite literally living with HIV because of ARVs and dying of TB.

In just a few weeks the WHO is going to also reveal new data around the growing epidemic of drug-resistant TB. And despite successful pilot efforts, PEPFAR is still failing to take TB/HIV efforts to scale, and is essentially flatlining TB/HIV funding in Fiscal Year 2011.

And the Global Health Initiative, as I said, proposes just a \$5 million increase; but, perhaps more worrisome, it actually proposes targets for TB treatment scale-up that are much lower than actually what was in the Lantos Hyde Act.

We actually know what to do about TB/HIV. We are just not doing it.

And finally, I want to say we just have a tremendous opportunity to accelerate our global health efforts by increasing our support for the Global Fund to fight AIDS, TB, and malaria.

I am honored to serve as the Northern Civil Society Representative to the Fund Board, and I would urge all of you to read the Annual Results Report released by the Fund just this week. Because I believe the Fund is the most effective tool we have in fighting these three diseases.

The Global Fund has supported 2.5 million people on anti-retroviral treatment, 6 million treatments for TB, and the distribution of 104 million bed nets to prevent malaria. These efforts have saved an estimated 4.9 million lives through investments in 144 countries.

I would just say that the success of the Fund is not just what has been achieved, but how it has been achieved; through an innovative, performance-based, transparent, multi-stakeholder process.

One example. By focusing on value for money on all levels, the Fund has identified \$1 billion in efficiency savings. And its impact has gone well beyond AIDS, TB, and malaria.

Ethiopia has trained and deployed over 30,000 community health workers through Global Fund investments, with not only an astounding increase in AIDS treatment, but also rapid improvements in child and maternal health indicators, like measles vaccinations and births attended by health professionals.

Civil society participation, as you know, is a prerequisite for the Fund, and 36 percent of grants are distributed to non-governmental organizations.

And just on the funding issue. Importantly, the U.S. funding for the Global Fund has traditionally been matched two-to-one by other donors. Two-thousand and ten is going to be a critical year in determining the future of the Global Fund. Other donor countries will be making 3-year funding commitments as a part of the Global Fund's replenishment, and the President's proposed \$50 million cut not only underfunds this hugely effective mechanism, but actually fails to exert any leverage on other donors.

And just to, in conclusion, what is at stake. By 2015 we could virtually eliminate maternal-to-child transmission of HIV, eliminate malaria deaths in many endemic countries, and contain the spread of multi-drug-resistant TB. These are things we didn't dream were possible even a few years ago. And the Global Fund estimates that to maximize its impact will require about \$20 billion from all sources for quality programs over the next 3 years. And a U.S. down payment would be about \$1.75 billion for 2011.

If I can just end by saying sometimes it is difficult to articulate the profound impact our investments have had. But I wanted to share a story from my friend, Winston Zulu, who is the first person to go public on his HIV status in Zambia, and who lost all four of his brothers to TB.

When I asked Winston the impact of the Global Fund and PEPFAR, he said something that I first didn't understand. He said now when I visit a village in Zambia, and I don't see a friend or a family member, I ask where they are. He said 10 years ago in Zambia, if you went to a village and you didn't see someone, you never asked, because you assumed they died of AIDS.

So just to say that our investments have done more than deliver drugs and diagnostics, this is nothing short of a transformation of despair into hope in an astonishingly short period.

So I just am grateful for both of your leadership on this, and the leadership of this committee. We have made remarkable progress, and we can't stop now. And I look forward to your questions. Thank you.

[The prepared statement of Ms. Carter follows:]

**Joanne Carter
Executive Director
RESULTS/RESULTS Educational Fund**

**Testimony before the
House Committee on Foreign Affairs
Subcommittee on Africa and Global Health**

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

March 11, 2010

Chairman Payne, Ranking Member Smith, and distinguished members of the subcommittee: thank you for inviting me to discuss the opportunities and challenges ahead for U.S. investments in HIV/AIDS programs.

The results of these investments to-date have been remarkable, and were simply unthinkable only a few short years ago. PEPFAR has provided live-saving anti-retroviral treatment to 2.4 million people, and the Global Fund to Fight AIDS, TB and Malaria has supported treatment for an estimated 2.5 million.

The House Foreign Affairs Committee – and in particular members of this subcommittee – have been instrumental in crafting and supporting our response to the pandemic through the original authorizing legislation for the U.S. AIDS initiative and through leadership and oversight in its implementation. In 2008 Congress voted overwhelming to sustain and accelerate this progress. In fact, it was exactly two years ago yesterday that the Foreign Affairs Committee reported out the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act, which authorized \$48 billion over five years to build on what has been achieved and ramp up the fight against these three diseases.

Despite this clear, bipartisan mandate, there is a significant gap between the vision expressed in Lantos-Hyde Act and its realization expressed in the President's Fiscal Year 2011 budget request and the Global Health Initiative. We have a tremendous opportunity to build on our momentum, but our achievements are in jeopardy unless we act.

Funding Shortfalls

I would like to briefly review the funding situation we currently face before turning to important opportunities to increase the impact of our response.

The Administration's budget suggests a new approach to our global health portfolio in which U.S. funding supports a response to AIDS that is more closely linked to other health priorities. This is a welcome sentiment, but the evidence shows that this approach only works when programs are fully funded. Smart linkages between programs are not free. This approach – to broaden the set of priorities on which we focus without necessarily adequately funding any of them – could have serious consequences for people living with or at high risk of contracting HIV.

The President's Fiscal Year 2011 budget request essentially flat funds our global AIDS programs. The budget includes an additional \$141 million or 2 percent increase in bilateral AIDS funding – this in the face of 7 to 10 percent inflation in Africa. If we were on pace to reach the Lantos-Hyde authorization

levels, the request this year for global AIDS should be \$2.2 billion more.

The budget also proposes a \$50 million cut to the highly effective Global Fund to Fight AIDS, TB and Malaria at the very time when the Global Fund's impact is accelerating, and a miniscule \$5 million increase for bilateral TB, the leading killer of people with HIV/AIDS. As I will discuss in further detail, under-funding these initiatives will prohibit us from seizing major opportunities in our global AIDS response, and undermine efforts to cut deaths due to TB and malaria as well.

My colleagues on this panel are better equipped to discuss the impact on the ground of halting the scale-up of HIV/AIDS funding, but I share their concern that our departure from the vision of the Lantos-Hyde Act will leave too many waiting in line for treatment, prevention and care.

When there are such yawning gaps in access to health services in the developing world, there is no shortage of opportunity to make significant, life-saving impact. I would like to highlight three opportunities to dramatically reduce the burden of HIV/AIDS and fundamentally alter the course of the epidemic in the coming years.

Treatment as Prevention

The first opportunity is to continue to scale up treatment – not just as a medical and human rights imperative, but as a public health strategy for reducing transmission of HIV. There is a growing body of evidence that widespread access to early treatment is an essential component of a comprehensive prevention strategy.

ARV drugs can help prevent HIV transmission by dramatically reducing the viral load in an infected person. The public health potential of this biological fact was re-confirmed in a study released last month. Across seven African countries, researchers closely monitored 3,400 "discordant" couples – couples where one partner is HIV positive and the other negative. Where the positive partner was on AIDS treatment, there was a 92 percent reduced risk of infection for the discordant partnerships. In South Africa researchers are using modeling techniques to investigate the potential impact of "test and treat" strategies, which involve widespread testing and early initiation of anti-retroviral treatment. The models suggest that this strategy, if combined with smart combination prevention, could effectively halt transmission of HIV in five to ten years. Certainly more work needs to be done, but the implications are enormous. And if this seems utopian or unachievable, recall that it was less than a decade ago that we were counting the number of people in Africa on ARVs in thousands rather than millions.

Some policy makers have expressed concern about a "treatment mortgage" and the long term cost implications of AIDS treatment. What this new data shows us is that we have a stark choice. We can invest up front in achieving the promise we made to reach universal access to AIDS medicine and break the back of the epidemic. WHO estimates show that within five years, the costs would then begin to fall, becoming manageable for countries in the medium term. Or we can do half-measures, in which case the epidemic will continue to grow and the costs will rise without end as millions of the most productive members of Africa's economy die each year.

"Treatment vs. prevention" is not just a false dichotomy, but a dangerous one. We must certainly expand an array of effective prevention strategies. And we must also continue to scale up AIDS treatment, not only as an urgent lifesaving medical intervention, but as an essential public health

strategy to prevent transmission.

TB-HIV

Another critical opportunity to accelerate our progress in fighting AIDS is to fight tuberculosis – the leading killer of people with HIV/AIDS. Despite being the leading killer, globally less than 4 percent of people with HIV/AIDS are screened for TB. People on anti-retroviral treatment are still dying for lack of \$20 worth of TB drugs. Scaling up our investment in TB is *the* low hanging fruit opportunity to save lives, and we have yet to seize it.

TB preys on those whose immune systems have been compromised by HIV. In some sub-Saharan African countries, the proportion of TB patients living with HIV can exceed 50 percent. TB transmission and the progression from latent to active disease are dangerously accelerated in people living with HIV/AIDS, which is why sub-Saharan Africa has the highest rates of TB in the world. People living with AIDS who develop active TB will die in a matter of weeks without effective treatment, making routine screening for TB, rapid treatment, and infection control urgent priorities. This deadly synergy of TB and HIV threatens to undermine our progress in fighting both diseases.

As the U.S. pursues a global health strategy centered on women and girls, TB control must be strengthened. TB is the third leading killer of adult women on the planet, and women who develop the disease are more likely to die from it than men. The risk of premature birth or having a low birth weight baby doubles for women with TB, and those who receive a late diagnosis are four times as likely to die in childbirth.

With inadequate investment in TB control and decades of neglect of research and development for new and better TB tools, multi-drug resistant (MDR) and extensively drug resistant (XDR) TB have emerged. They demonstrate that we are steadily and surely manufacturing more deadly, difficult and costly strains of this airborne infectious disease. And now the first cases of XXDR or extremely drug resistant TB suggest we are on the way to creating forms of the disease that are completely untreatable. This is a public health failure of the first order.

The deadly synergy of TB and HIV is nowhere more evident than with XDR. In the first reported cases of XDR-TB in Tugela Ferry in South Africa, 52 out of 53 patients died and a number of the first cases were transmitted in a support group for people on anti-retrovirals. As the South African experience shows, drug-resistant TB threatens HIV/AIDS progress and threatens public health overall, including here at home. The Department of Homeland Security has identified XDR-TB as an “emerging threat to the homeland.”

PEPFAR has been a leader in driving an integrated response to the TB and HIV co-epidemic in sub-Saharan Africa, with strong policies and a TB-HIV budget line that increased from virtually nothing in PEPFAR’s first year to \$140 million in FY08. But TB-HIV activities make up only 4.3 percent of PEPFAR’s operating budget, which is simply too little to ensure that PEPFAR meets the basic standards of care for diagnosing and treating co-infection in the programs it supports. To emphasize, this is *the leading killer of people with HIV* in PEPFAR focus countries. Despite successful pilot efforts, PEPFAR has so far failed to take TB-HIV efforts to scale. And now, despite PEPFAR’s commitment to continue expanding its delivery of TB-HIV services, OGAC has proposed flat funding these activities in the next fiscal year. We can’t afford to slow down in this area. We need to build on PEPFAR’s successes to date and take the prevention and treatment of TB-HIV to scale.

Despite some promise within PEPFAR, our investment in bilateral USAID TB programs outside of PEPFAR is grossly insufficient to leverage our investment in HIV/AIDS. Unfortunately, TB is where the President's proposed Global Health Initiative departs most dramatically from the Lantos-Hyde Act. The GHI consultation document proposes TB treatment targets that are inexplicably well below what is mandated in the bill. The President's budget requests \$230 million for TB in FY11 – a \$5 million increase – well short of a path to reach the five-year \$4 billion authorization in the bill and provide investment commensurate with the scale of devastation of this disease.

As a killer of 1.8 million people every year, TB warrants increased investment on its own. And as the leading killer of people with HIV/AIDS, TB control should be an integral part of our AIDS response.

Global Fund to Fight AIDS, Tuberculosis and Malaria

Third and finally, we have a tremendous opportunity to accelerate our global health efforts by increasing our support for the Global Fund to Fight AIDS, TB and Malaria. I am honored to serve as the Northern Civil Society Delegate to the Global Fund Board, and proud of the annual Results Report released by the Fund just this week. This report should be required reading for any policy maker involved in shaping our global health strategy. I believe the Global Fund is *the most effective tool we have* in the fight against HIV/AIDS, TB and malaria.

This Committee should be justifiably proud of the Global Fund's impact, having helped shape its creation and evolution. Since its inception just eight short years ago, the Global Fund has supported 2.5 million people on anti-retroviral treatment, 6 million treatments for TB, and the distribution of 104 million bednets to prevent malaria and some 108 million malaria treatments. The impact of the Fund has gone well beyond Millennium Development Goal 6 to reverse AIDS, TB and malaria, and extends to Goals 4 and 5 on child and maternal health by addressing the biggest killers of women and children. In Africa, AIDS, TB and malaria account for over half of all deaths of women of reproductive age, and malaria alone accounts for up to 18 percent of child deaths. The Global Fund has also provided 790,000 HIV-positive pregnant women with treatment to prevent vertical transmission of HIV to their children.

The Global Fund's impact has been truly global, with investments in programs and efforts catalyzed in 144 countries. These efforts have saved 4.9 million lives – and this is only the beginning. The coming years will bring more results more quickly as half of total disbursements by the Global Fund have been made within the last two years. The full return on our investment has yet to be realized.

The success of the Fund is not just what's been achieved, but in *how* it's been achieved. On a broad range of best practices – transparency, accountability, performance-based financing, country-led development – the Global Fund is on the cutting edge of translating aid effectiveness theory into practice.

Congress is rightfully concerned with stretching our limited foreign aid resources. Every dollar we contribute to the Global Fund goes to support programs in country, and the operating expenses of the Secretariat are covered by the interest earned on contributions. By relentlessly focusing on value for money at all levels – management, implementation, and procurement – the Global Fund has identified \$1 billion in efficiency savings. Here's one example. Global Fund programs are required to procure commodities through a competitive process, and then report price information on key products like anti-retroviral drugs and bednets to a publicly accessible database. This information facilitates cost comparisons, and gives leverage to other programs to negotiate lower prices.

Responding to country demand, the Global Fund has provided resources to strengthen national health systems as countries respond to AIDS, TB and malaria. Sixteen percent of Global Fund financing has gone to health system strengthening priorities like improving supply chain management and increasing the capacity for monitoring and evaluation.

In an effort to strengthen primary health care through investments in HIV/AIDS and malaria, Ethiopia has trained and deployed over 30,000 community health workers. The result is not only an astounding scale of up AIDS treatment, but rapid improvements in broader maternal and child health indicators. Between 2005 and 2008 – just three years – measles immunization rates have increased from 61 to 77 percent, and births attended by a health professional have jumped from 13 to 25 percent.

The Global Fund's flexible but targeted support for Ethiopia is enabled by a country-led approach. For the Fund, "country" means much more than just the central government. In fact, diverse civil society participation in proposal development is a prerequisite for Global Fund grant approval. This process results in funding disbursements that strengthens civil society voices and seeks to reflect who's actually delivering health services on the ground. Thirty-six percent of Global Fund grants are distributed to non-governmental organizations who are using these funds to take community based programs to a massive scale. For example, the Churches Health Association of Zambia (CHAZ), a network of faith-based organizations and a primary recipient of Global Fund financing, provides half of all rural health care services in Zambia.

2010 will be critical in determining if the Global Fund will be allowed to accelerate its successful efforts or be forced to curb its growth – with dire consequences for AIDS, and TB and malaria. This year other donors will make three-year funding commitments as part of the Global Fund's once-every-three-year replenishment conference. While the U.S. has not historically made a formal multi-year replenishment pledge, as the largest contributor to the Global Fund our FY11 allocation will send an important signal to other donors. Flat or reduced funding will exert no leverage on other countries to increase their contributions, and might even trigger a downward spiral. Increased funding from the U.S. could change the course of the replenishment. The President's proposed \$50 million cut is alarming in light of its potential multi-year impact on other donor countries' commitments, and would leave the U.S. well behind the \$1.75 billion that constitutes our fair share this fiscal year.

Here's what's at stake. The Global Fund estimates that to maximize its impact on achieving Millennium Development Goal 6 and other international health targets, it will need to meet \$20 billion in demand for quality proposals over the next three years, including both scaled up efforts and continued support for successful programs. With this investment the Fund estimates that by 2015 we could virtually eliminate vertical (or so-called "mother-to-child") transmission of HIV, eliminate malaria as a public health threat in many endemic countries, and contain the spread of multi-drug resistant TB. These are audacious goals, but they are worthy of our support and achievable if we are willing to make the right investments.

It is sometimes difficult to articulate how profoundly U.S. investments in HIV/AIDS have affected the lives of millions of people. The numbers never quite tell the whole story. In trying to capture the impact of our efforts, one of the better stories comes from my friend Winstone Zulu, a TB and AIDS activist from Zambia. Winstone was the first person to go public with his HIV status in Zambia and he lost all four of his brothers to TB.

When asked about the impact of U.S. investments in AIDS and TB, Winstone told me that these days when he visits a village, if he doesn't see a friend or family member around, he won't hesitate to ask where they are. Happily, the news is often they've gone off to work somewhere in another town, they're off at school, or away visiting relatives. Ten years ago, he says you never asked that question because if a friend was absent, it was nearly certain that they had passed away from AIDS.

Our investments have done more than deliver drugs and diagnostics, more than shift our perception of how we can deliver health services in resource poor settings. This is nothing short of the transformation of despair into hope, and in an astonishingly short period of time.

Congress has the opportunity to work with Administration to solidify and accelerate this transformation. I am grateful for the leadership of members of this committee to work toward this goal, and I look forward to your questions.

Mr. PAYNE. Thank you very much. We will now hear from Ms. Messing, who I mentioned was in Uganda recently, but I was thinking about Dr. Mugenyi. It was Zimbabwe, I think, for your recent travels. I stand corrected. Thank you.

**STATEMENT OF MS. DEBRA MESSING, GLOBAL AIDS
AMBASSADOR, POPULATION SERVICES INTERNATIONAL**

Ms. MESSING. Good afternoon, Mr. Chairman and members of the subcommittee. I am honored to join you today, representing PSI, a leading global health organization with programs targeting HIV in 55 countries, as well as programs in malaria, reproductive health, and child survival.

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 the age of 41, Paul Walker, my dear friend and acting teacher, died of AIDS-related complications. Paul's loss was devastating. After Paul's death I was moved to learn more about the epidemic.

Three 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. 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, as well as the Zimbabwean Government, 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. But it also became heartbreakingly clear to me that resources still fall short of what is needed to reach everyone at risk for HIV.

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, recognized by UNAIDS and the World Health Organization, that male circumcision reduces the risk of heterosexually acquired HIV infection in men by about 60 percent. Yet only about one in 10 Zimbabwean adult men are circumcised.

P.S.I 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 followup care and counseling, is about \$40.

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 between 2009 and 2025.

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 in Zimbabwe. Testing and counseling is the next area I would 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. In a pre-testing session, a counsellor talked to me and 10 other people 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 pinprick to the finger. In a private room, a trained counsellor gave me my results after 15 or 20 minutes, and I 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 treatments.

Thirty-five thousand Zimbabweans go through this HIV counseling and testing experience every month, as I did, emerging with a greater awareness of measures they can take to protect themselves and others.

I saw firsthand that the U.S. Government's investment in HIV/AIDS is working. But although we have and utilize effective HIV prevention tools and strategies, like male circumcision and HIV counseling and testing, data from UNAIDS indicates that the epidemic continues to grow. 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.

In closing, 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 so grateful for the opportunity to brief you, Mr. Chairman, honorable members and colleagues. Thank you so much.

[The prepared statement of Ms. Messing follows:]

**Statement by Debra Messing
Ambassador
PSI
Washington, DC**

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

**House Committee on Foreign Affairs, Subcommittee on Africa and Global Health
U.S. House of Representatives
Washington, DC**

11 March 2010

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#>

Mr. PAYNE. Thank you. Dr. Hearst.

STATEMENT OF NORMAN HEARST, M.D., PROFESSOR OF FAMILY AND COMMUNITY MEDICINE AND OF EPIDEMIOLOGY AND BIOSTATISTICS, DEPARTMENT OF FAMILY AND COMMUNITY MEDICINE, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

Dr. HEARST. Thank you. Good morning. That is a tough act to follow.

It is an honor to be here. As someone who has worked with AIDS epidemiology and prevention for 25 years, I greatly appreciate this opportunity to share my thoughts about the future of PEPFAR.

In my field, at least, I know that Congress can work together in a constructive and bipartisan way. PEPFAR has made a tremendous difference for many individuals and countries, and has done great things for the reputation of the United States in large parts of the world. Thank you.

Nevertheless, PEPFAR today is at a crossroads, and faces new and difficult challenges. Some of these are results of PEPFAR's success; others are inevitable consequences of the mathematics of the AIDS epidemic.

The last time I testified here was before the full committee, during the PEPFAR reauthorization hearings. The most contentious issue then was earmarks for prevention: Whether to require that a proportion of prevention funds go toward reducing the behaviors that spread HIV, as opposed to things like condoms and testing.

At that time Tom Lantos, who had been my representative and for whom I voted many times, who was chairing the committee, at that time the main emphasis of my testimony was the solid scientific evidence behind the A and B of the ABC strategy for AIDS prevention: That is, abstinence, and be faithful, and to make clear that it wasn't just some sort of plot by the religious right.

I am happy to say that Congress came up with a reasonable compromise on this issue. While ending rigid earmarks of spending for A and B, you required that PEPFAR programs in countries with a generalized AIDS epidemic provide a justification if they spend less than half of their prevention budget on A and B. Such justifications have now been submitted by some countries, and for the most part, they appear reasonable. The system is working.

I don't know if anyone is pressuring you to revisit this compromise. If they are, I don't know what the problem is that they are trying to fix.

But today I am concerned that PEPFAR's prevention efforts soon will be under an even greater threat than unfortunate ideological battles about how much to spend on promoting condoms versus encouraging people to stick to a single partner.

The threat now is that prevention money may be syphoned off for treatment. As I said the last time I testified, we cannot treat our way out of this epidemic. What has happened since? PEPFAR is treating more people. But the number of people entering treatment is far less than the number of people getting infected, by somewhere between a two-to-one and five-to-one margin, depending whose numbers you believe.

So despite all our efforts to rapidly scale up treatment, we are falling farther and farther behind. Funding for treatment cannot keep growing exponentially, and we now have many people on treatment whose virus is developing resistance to first-line drugs. This means they will require more and more expensive alternate drugs.

Remember that we are not curing anyone. The people that PEPFAR treats have a lifetime entitlement to whatever drugs they need, unless we want to cut them off and let them die. So despite all our efforts to enhance efficiency and decrease unit costs, it is going to be increasingly expensive just to maintain the people we have on treatment, let alone to keep adding more.

This is ironic, because we have worked so hard to encourage people to come in for testing and treatment. We have labored to create the demand for anti-retroviral treatment, and now we will inevitably find ourselves unable to satisfy that demand.

Instead of being good guys for keeping millions of people alive, we seem to have set things up so that we will now become bad guys for turning people away.

What we should be learning from the current situation is the paramount importance of prevention. What I am afraid will happen instead is tremendous pressure to divert the minority of PEPFAR funds going for prevention to treatment, so as to briefly postpone the day of reckoning, when we will have to admit we can't treat everyone. This would be a terrible mistake.

There are people who will try to convince you that treatment somehow is prevention. They will tell you that prevention requires people to get tested, and that no one will get tested unless treatment is available. They will come up with complex mathematical models based on unrealistic assumptions to justify their assertions.

Don't be fooled. Prevention is prevention; treatment is treatment. Any overlap is mostly wishful thinking in the African context.

People promoting treatment as prevention in Africa ignore how HIV spreads in generalized epidemics. A large proportion of transmission takes place in early infection, when people's viral loads and infectiousness are highest, through networks of interlocking sexual partnerships, before people would even test positive, let alone enter treatment. How can treatment possibly stop that?

Today we have many well-meaning people who want desperately to believe that treatment will work for prevention, but they have very little real evidence to show that it does. Instead, they offer theoretical models about how maybe it might work, and pretend this is evidence.

The fact is that even in places like my hometown of San Francisco, where we have ideal conditions for so-called treatment as prevention, the evidence for whether it works is far weaker than people would have you believe. Yes, treatment can lower some people's viral load and make them less infectious, at least temporarily. But any benefit from this is probably overwhelmed by the negative effects of treatment on prevention. Once the general public knows that effective treatment is available, they worry less about AIDS and become riskier in their sexual behavior. We see this all over the world. My own research has shown this in places like Uganda and Brazil.

What does work for prevention? Look at Uganda, the African country where I have worked the most. In the late 1980s and early 1990s, Uganda was Africa's greatest prevention success story. This was before HIV testing was available, long before treatment was available, and even before many condoms were coming into the country.

But Uganda was able to cut its HIV infection rates by two thirds, simply by convincing people, on the average, to reduce their number of sexual partners. This was done with almost no donor funding.

Now fast-forward to 2010. What is happening in Uganda? Most Ugandans have forgotten about reducing their number of partners, and instead internalize the foreign-donor message that prevention is really about condoms and getting tested. Furthermore, Ugandans who believe that effective AIDS treatment is available are now the very ones most likely to have multiple sexual partners. And rates of HIV are going back up again.

I am not saying that treating people with AIDS is bad; I think it is great. If you can double funding for treatment in places like Uganda, I applaud you. But if you can't, PEPFAR needs to squarely face the reality of limits on how much treatment can be provided, and certainly not to raid the prevention budget to treat a few more people. Even if you double or triple funding, you will just have to face the same reality a year or 2 later.

Facing reality is not easy. It means telling people in governments that we cannot bankroll unlimited treatment. We need to say, in a clear, unapologetic way, because we have nothing to apologize for, how much we can contribute.

In Uganda and other African countries, treatment facilities are now turning away patients because the spots funded by PEPFAR and other donors are full. There was a recent cover story about this in the Wall Street Journal. It didn't help that Dr. Goosby was quoted as saying that PEPFAR will turn away no one who needs treatment. He may have been quoted out of context, but such statements will only breed resentment when it becomes impossible for us to make good on those words.

We are now faced with flat funding to deal with an overwhelming and growing backlog of need. When the supply of treatment no longer meets demand, we will need to be especially vigilant about how scarce lifesaving treatment is allocated. Remember that many PEPFAR priority countries have tremendous disparities between rich and poor, between men and women, between the capitol city and rural areas. Many have poorly functioning governments and serious problems with corruption.

We will need mechanisms to ensure that treatment funded by PEPFAR goes equitably to those who need it most, even in countries where nothing else is distributed equitably.

PEPFAR already pays a great deal of attention to transparent and corruption-free financial management. But this will be a whole other challenge that will require specific monitoring.

If any of my comments seem overly critical, I apologize. PEPFAR is a great program that has done great things in a short time, and about which all Americans should feel proud. But it now must grow

up and recognize that it is not really an emergency program at all, and that we are in this for the long haul.

We must be exceedingly wary of perceived open-ended promises that we cannot keep. We must base our efforts on reality, not wishful thinking. We must reject those who tell us that treatment is prevention, based on platitudes and unrealistic models. We must be clear and unapologetic about what we can and cannot do. And above all, we must not abandon the fight just because there are no easy solutions.

Thank you.

[The prepared statement of Dr. Hearst follows:]

Testimony of

Norman Hearst, MD MPH

Professor of Family and Community Medicine
And of Epidemiology and Biostatistics
University of California,
San Francisco

House Foreign Affairs Committee
Subcommittee on Africa and Global Health

March 11, 2010

Good morning. It's an honor to be here. As someone who has worked with AIDS epidemiology and prevention for 25 years, I greatly appreciate this opportunity to share my thoughts about the future of PEPFAR.

In my field at least, I know that congress can work together in a constructive and bipartisan way. PEPFAR has made a tremendous difference for many individuals and countries and has done great things for the reputation of the United States in large parts of the world. Thank you.

Nevertheless, PEPFAR today is at a crossroads and faces new and difficult challenges. Some of these are results of PEPFAR's success. Others are inevitable consequences of the mathematics of the AIDS epidemic.

The last time I testified here was before the full committee during the PEPFAR reauthorization hearings. The most contentious issue then was "earmarks" for prevention: whether to require that a proportion of prevention funds go toward reducing the behaviors that spread HIV as opposed to things like condoms and HIV testing. At that time, Tom Lantos, who had been my representative and for whom I voted many times, was chairing the committee. At that time, the main emphasis of my testimony was the solid scientific evidence behind the A and B of the ABC strategy for AIDS prevention (that is, Abstinence and Be faithful) and to make clear that it wasn't just some sort of plot by the religious right.

I'm happy to say that congress came up with a reasonable compromise on this issue. While ending rigid earmarks of spending for A and B, you required that PEPFAR programs in countries with a generalized AIDS epidemic provide a justification if they spend less than half of their prevention budget on A and B. Such justifications have now been submitted by some countries, and, for the most part, they appear reasonable. The system is working. I don't know if anyone is pressuring you to revisit this compromise. If they are, I don't know what the problem is that they're trying to fix.

But today, I'm concerned that PEPFAR's prevention efforts soon will be under an even greater threat than unfortunate ideological battles about how much to spend on promoting condoms vs. encouraging people to stick to a single partner. The threat now is that prevention money may be siphoned off for treatment. As I said the last time I testified, we cannot treat our way out of this epidemic.

What has happened since? PEPFAR is treating more people. But the number entering treatment is far less than the number of people getting infected: by somewhere between a 2:1 and 5:1 margin, depending whose numbers you believe. So despite rapidly scaling up treatment, we are falling farther and farther behind.

Funding for treatment cannot keep growing exponentially. And we now have many people on treatment whose virus is developing resistance to first-line drugs. This means they will require more and more expensive alternate drugs. Remember that we are not curing anyone. The people that PEPFAR treats have a lifetime entitlement to whatever

drugs they need, unless we want to cut them off and let them die. So it will become increasingly expensive just to maintain the people we have, let alone keep adding more.

This is ironic, because we have worked so hard to encourage people to get tested and come in for treatment. We have labored to create the demand for antiretroviral treatment, and now we will inevitably find ourselves unable to satisfy that demand. Instead of being good guys for keeping millions of people alive, we seem to have set things up so that we will now become bad guys for turning people away.

What we should be learning from the current situation is the importance of prevention. What I'm afraid will happen instead is tremendous pressure to divert the minority of PEPFAR funds going for prevention to treatment so as to briefly postpone the day of reckoning when we'll have to admit we can't treat everyone. This would be a terrible mistake.

There are people who will try to convince you that treatment somehow IS prevention. They will tell you that prevention requires people to get tested and that no one will get tested unless treatment is available. They will come up with complex mathematical models based on unrealistic assumptions to justify their assertions. Don't be fooled. Prevention is prevention. Treatment is treatment. Any overlap is mostly wishful thinking in the African context.

People promoting treatment as prevention in Africa ignore how HIV spreads in generalized epidemics. A large proportion of transmission takes place in early infection, when people's viral loads and infectiousness are highest, through networks of interlocking sexual partnerships, before people would even test positive, let alone enter treatment. How could treatment possibly stop this?

Today we have many well meaning people who want desperately to believe that treatment will work for prevention. But they have very little real evidence to show that it does. Instead, they offer theoretical models about how maybe it *might* work and pretend this is evidence. The fact is that even in places like my home town of San Francisco, where we have ideal conditions for so-called "treatment as prevention," the evidence for whether it works is far weaker than people would have you believe. Yes, treatment can lower some people's viral load and make them less infectious, at least temporarily. But any benefit from this is probably overwhelmed by the negative effects of treatment on prevention: once the general public knows that effective treatment is available they worry less about AIDS and become riskier in their sexual behavior. We see this all over the world. My own research has shown this in places including Uganda and Brazil.

What *does* work for prevention? Look at Uganda, the African country where I've worked the most. In the late 1980's and early 1990's, Uganda was Africa's greatest prevention success story. This was before HIV testing was available, long before treatment was available, and even before many condoms were coming into the country. But Uganda was able to cut its HIV infection rate by two thirds, simply by convincing

people, on the average, to reduce their numbers of sexual partners. This was done with almost no foreign funding.

Now fast-forward to 2010. What's happening in Uganda? Most Ugandans have forgotten about reducing their number of partners and instead internalized the foreign donor message that prevention is really about condoms and getting tested. Furthermore, Ugandans who believe that effective AIDS treatment is available are now the very ones most likely to have multiple sexual partners. And rates of HIV are going back up again.

I'm not saying that treating people with AIDS is bad. I think it's great. If you can double funding for treatment in places like Uganda, I applaud you. But if you can't, PEPFAR needs to squarely face the reality of limits on how much treatment can be provided and certainly not to raid the prevention budget to treat a few more people. Even if you double funding, you'll just have to face the same reality a year or two later.

Facing reality is not easy. It means telling people and governments that we cannot bankroll unlimited treatment. We need to say in a clear, unapologetic way (because we have nothing to apologize for!) how much we can contribute. In Uganda and other African countries, treatment facilities are now turning away patients because the spots funded by PEPFAR and other donors are full. There was a recent cover story about this in the *Wall Street Journal*. It didn't help that Dr. Goosby was quoted as saying that PEPFAR will turn away no one who needs treatment. He may have been quoted out of context, but such statements will only breed resentment when it becomes impossible for us to make good on those words.

We are now faced with flat funding to deal with an overwhelming and growing backlog of need. When the supply of treatment no longer meets demand, we will need to be especially vigilant about how scarce, life-saving treatment is allocated. Remember that many PEPFAR priority countries have tremendous disparities between rich and poor, between men and women, between the capital city and rural areas. Many have poorly functioning governments and serious problems with corruption. We will need mechanisms to ensure that treatment funded by PEPFAR goes equitably to those who need it most. This will prove a tremendous challenge in countries where nothing else is distributed equitably.

If any of my comments seem overly critical, I apologize. PEPFAR is a great program that has done great things in a short time and about which all Americans should feel proud. But it now must grow up and recognize that it is not really an "emergency" program and that we are in this for the long haul. We must be exceedingly wary of perceived open-ended promises that we cannot keep. We must base our efforts on reality, not wishful thinking. We must reject those who tell us that treatment is prevention based on platitudes and unrealistic models. We must be clear and unapologetic about what we can and cannot do. And, above all, we must not abandon the fight just because there are no easy solutions.

Mr. PAYNE. Thank you very much. Unfortunately, there is a vote that has been called, so I will divide the time between three of us here, maybe about 4 minutes each. And because there is a series of six votes, I certainly cannot ask the panel to remain for that long a period of time.

So let me begin by asking Dr. Mugenyi, how would you evaluate, overall, the situation in Uganda? As we have heard early on, Uganda was discussed because of the tremendous problem. Then we saw the fact that Uganda really stepped up and had really aggressive programs, and we saw the increase level off, and even start to decline. Now they say there is, once again, a gradual increase.

How would you characterize Uganda at the current time, maybe in a minute or two? And what you would suggest that we do to assist you, if we see things are in a negative mode?

Dr. MUGENYI. Thank you, Mr. Chairman. The situation in Uganda at the moment is quite worrying, for the simple reason that we are turning away patients. No provisions have been made, for example, for a pregnant woman. These pregnant women are turning up daily in various places. And the recent example is an HIV-positive pregnant woman who could not get treatment from several clinics because she is a new patient. We are not taking on new patients because the slots are few.

Now, the testing that people who came for testing, Mr. Chairman, when we first started, and offered treatment, was so great that our clinics were swamped with people who wanted to know the actual status and the understanding that treatment would be available to them.

Now, since the slots for treatment declined, our clinics can't go a day without anybody coming to offer testing. It is abundantly clear to us who are living on the ground in Uganda that treatment has been a great incentive for people to come for preventive services.

Mr. PAYNE. Thank you, thank you very much. What we might do is that we decided that we will ask questions, and then, although we will have to leave, we would like for the questions to be answered in the time that we will allow the staff to listen to the answers, so it becomes a part of the record. And that way we can accommodate everyone.

So I wonder, Ms. Messing, just a question. You became interested and involved in this area because of a person that you knew; and this issue, therefore, got your attention.

I think that we need many, all levels of people, all walks of life interested in trying to work on education. And I just wonder if you have any suggestions on how we can get other people of your stature. We find that when we have people that have a lot of notoriety taking on an issue, it helps. And so if you have any idea of how we can, you know, get more associates of yours to take an interest like you have—that would be interesting to hear.

And Dr. Carter, you know, in both the recent 5-year strategic plans for PEPFAR and the Global Health Initiative consultation documents, the U.S. Government states plans to better engage and leverage its relationship with multi-lateral partners, such as U.N. System and the Global Fund as a goal.

How would you specifically encourage the U.S. Government to enhance those relationships? And how could the U.S. Government better harmonize its efforts with its multi-lateral partners?

And just finally, Dr. Hearst, maybe you could give us a short synopsis of, once again, the priorities you would see, since you have indicated that we can't treat our way out. Too much is going for treatment and prevention efforts are lacking. Some ideas of how you would deal with that.

And I will yield now to the gentleman, Mr. Smith.

Mr. SMITH. Thank you, Mr. Chairman. I have a number of questions, but I will narrow it to four, and look forward to reading or hearing your answers upon our return.

I was at the U.N. Forum last year when Mr. Sarkozy and others made this real push for more mother-to-child transmission funding. And I wonder if all of you, or some of you, might want to comment on how inadequate or adequate our current funding level is in PEPFAR for mother-to-child transmission.

Secondly, and Dr. Carter, this might be more a focus for you; when the Global Fund was first launched, all of us thought this is an idea whose time has come. But it was bypassing faith-based organizations almost systematically. The CCMs that have been established very easily can sidestep a faith-based hospital infrastructure.

We know that in Africa, between 30 percent to 70 percent of the healthcare is under some religious auspices. It is a turnkey operation just waiting to be further utilized. I actually offered the Conscience Amendment, which passed only by one vote the first time in 2003, when we did the reauthorization when Tom Lantos was chairman. There was a broad consensus, and we had an excellent, solid conscience clause, so that certain faith-based groups that don't want to do certain kinds of prevention activities would not be precluded funding.

What is the faith-based focus—we have met with Dr. Christoph Benn on a number of occasions to try to raise this issue. Please give us an update on that.

Thirdly, very quick, Dr. Hearst, the Lancet had pointed out that the priority for adults should be B (be faithful), limiting one's partners; the priority for young people should be A (abstinence), or not starting sexual activity too soon. And that condoms, and you pointed out in some of your writings, and you had done a UNAIDS technical review, you said that when we look for evidence of public health impact for condoms in generalized epidemics, to our surprise, we couldn't find any. And you differentiated between generalized epidemics and a more focused one, a concentrated one.

And finally, the IG's report—Dr. Carter, you might want to speak to this—some 48 percent of its recommendations had been—I know we are running out of time—had been not fully implemented by the time of the OIG's review. Your view as to how the Office of Inspector General is working. Because, you know, from an accountability point of view, a dollar wasted means a lost life.

And we want, as we ramp up additional funding, we want the best impact possible, so good utilization of those dollars is important. Thank you.

Mr. PAYNE. Thank you. Mr. Miller.

Mr. MILLER. Thank you. Dr. Carter, I know that you are familiar with the slum legislation that I introduced. And at risk of sounding single-minded, I think all of you are familiar with the number of studies and pilot programs that have documented a connection between secure, adequate housing and health outcomes. Certainly communicable diseases in particular, including HIV/AIDS, but also other chronic non-communicable diseases.

But there doesn't seem to be much of a policy. And it appears not to just be a correlation that both inadequate and insecure, insecure housing occurs in very impoverished societies; but there seems to be a causal connection.

Do you see adequate housing programs as a health intervention for HIV/AIDS or other health conditions, for the prevention and treatment of HIV/AIDS? And do you think that there should be more of a policy focus on that as an approach to HIV/AIDS prevention and treatment?

Mr. PAYNE. Well, thank you very much. What I will do at this time, first of all, I would like to put into the record that Mrs. Dubula, who is the General Secretary of Treatment Act Campaign in South Africa, had originally planned to testify before the subcommittee today, but unexpectedly fell ill.

Therefore, I will ask unanimous consent that Mrs. Dubula's testimony be made part of the record. Hearing no objection, so ordered.

Also, before members will have 5 legislative days to revisit and extend, revise and extend their remarks. And with no objection, we will now ask the panelists if you would be kind enough to answer the questions that were asked to you, in the order.

And with that, we must leave to vote. Once again, let me thank all of you for coming, and we apologize, but we can't control what happens on the Floor. Thank you very much.

And just technically, for the record, this hearing will continue for the purpose of getting answers to questions asked by the members. It therefore makes you official. Thank you.

[Recess.]

Mr. PAYNE. Well, it has been indicated that we will be unable to hear your questions, according to a ruling here, and that we may ask you to give us your answers in writing—and that the meeting will—we are trying to see whether there is a non-voting Member of Congress. We do have Mr. Eni Faleomavaega, who is chair of the Asia, the Pacific and the Global Environment Subcommittee, who is a non-voting member on this particular subject. And if he is available, then he could sit.

Why don't we start responding? I guess Dr. Mugenyi, would you like to begin your answer?

Dr. MUGYENYI. Yes. Mr. Chairman, I was very concerned with Dr. Hearst's testimony, because the data that we are accruing in Uganda, and especially from my institution, which is closely involved with the HIV/AIDS since the early 1990s, clearly show that treatment is associated with strong incentives for prevention.

So my submission today is that data which we have shows that that is what we have, right from our clinic, and the data that we have recently published. We followed up, we followed up 3,400 severely infected patients with AIDS. And we found among those 340 babies were born. Not a single one among those was infected with

HIV. And secondly, not any of the babies have been infected through breastfeeding.

On maternal and child health, if we can provide PMTCT, we can prevent lots of pediatric infections. On the adults, we are finding that discordant couples, who are high-risk groups, perhaps the highest-risk groups, if you treat the infected partner, we are getting as high as a 90 percent reduction in infection. And then, very, very impressively, we find that if, in any clinic, you introduce treatment, people coming for testing just increase almost overnight. We have found opposite results in the clinics which do not have treatment. People just don't go for testing.

Our studies are indicating that it is people who don't know their status who have no incentives to come for testing, who are contributing significantly to the continuing spread of HIV in our countries.

I am not saying that prevention is not important. I am saying prevention and treatment, both of them are extremely important, and they need to be scaled up together. I would state quite categorically that without treatment, prevention is futile.

Mr. PAYNE. Thank you. Dr. Carter, maybe you can respond to one of the questions. And Mr. Faleomavaega is on his way down, and then we will hear each of you answer one of them, and see if there are any remaining questions to be answered. Thank you.

Ms. CARTER. Yes, thanks a lot. One question you asked was about the GHI's intent to work more with multi-lateral institutions. And maybe I will just say a few quick comments around the Global Fund. I mean, just to say that given that the Global Fund is providing about two thirds of the external donor funding for tuberculosis and malaria, it is actually a key back—and a quarter of AIDS funding—it is a key backbone for U.S. efforts.

And if you talk to the President's malaria initiative folks, but also as far as TB, and certainly a really important partner on HIV/AIDS. And again, I think really complimenting each other in a sense that PEPFAR has certainly been more focused, but the Global Funding and working in 144 countries has got that breadth of efforts that is kind of complimenting, but also filling in many of the gaps that PEPFAR is not reaching.

I think, as you are aware, PEPFAR is also providing important technical support and technical assistance to help in the implementation of Global Fund grants. And that is actually an important role.

And I would say there is a few lessons that are being gleaned from the Fund with regards to value for money. Like how do we reduce commodity costs, how do we actually benchmark the cost of quality interventions, like what does it cost to deliver AIDS treatment, what does it cost to deliver prevention in certain areas. And benchmarking some of those in a way that I think can benefit not just the Global Fund, but kind of all of our initiatives, and helping us find efficiencies on that.

So those are just I think some of the ways that PEPFAR can partner with, but also, I mean, in a very substantive way, but also in a kind of aid-effectiveness model with the Global Fund. And it is quite important.

Mr. PAYNE. Yes.

Ms. MESSING. Mr. Chairman, you asked how I could help bring attention to my peers in the Hollywood community, or other public people, so that they can help support this effort. I will commit to engage my peers in Hollywood.

What I would like to say is that I think what is an even more powerful strategy is to involve young people in the political process; to build leaders among our youth. I am so glad to see so many young people here today. I came a little bit late to the process.

And I would also like to say that it is, I believe that it is part of our DNA, as Americans, to help, regardless of where it is. That has been proven with our reaction to the Haiti crisis, and I think it is our moral imperative.

So I think that you can get people from—I am sorry.

[Pause.]

Ms. MESSING. I think that people in my community like to stand behind things that they know work. And the efforts that the U.S. Government has made, the investments that they have made in HIV prevention have been proven to work.

And it has been good works, so far. We just need to increase the funding for prevention, so that the good works can help more people.

Mr. FALCOMA [presiding]. I believe the question has been raised for all the members of the panel to respond to. And I want to thank Ms. Messing for her response.

And I believe Dr. Hearst may have a comment on this question, as well.

Dr. HEARST. Yes, thank you. They were kind of a series of questions thrown out, and I will try to kind of weave them together and address as many of them as I can.

I was asked what I would suggest the priorities would be, and what we should do. Even though I am someone who has worked in prevention mainly, and would love to see more resources going to prevention, I am not here making a pitch to increase the proportion of PEPFAR funding going to prevention. I think PEPFAR probably has the mix about right. And there is a tremendous need for treatment, and I am not arguing that that should be cut back.

All I am saying is let us not cut back prevention when we see this tremendous need in demand for treatment in front of us. And in the prevention area, my priorities would be to invest the money on what has worked; that is the ABC strategy. And now what is new in the last few years is the increasingly good evidence behind male circumcision, which you have just heard from Ms. Messing, as an effective, cost-effective intervention that actually there is a great deal of interest in. And we need to make sure that that is available to anyone who wants it, in an easy and affordable fashion.

When I say I support the ABC approach, I support all three parts of it. But, as Mr. Smith was alluding to, in generalized epidemics it seems to be the B of the ABC that makes the most difference. You have got to get people to limit their number of partners, to stick to one partner, if not for a lifetime, at least one partner at a time.

It seems to be these networks of overlapping, ongoing relationships that, if one person in there gets infected, the whole thing

goes up in flames, so to speak. At least the research I have seen, Africans don't have any more—the number of sexual partners they have in their life isn't any higher than Americans or Europeans. But there seems to be, at least in some countries, more of these ongoing overlapping relationships, as opposed to the more serial monogamy we have in the U.S. I am not saying one is better than the other or worse than the other; it is just that the one facilitates the spread of HIV more. We need to break up these networks of multiple partnerships. That is what really makes the most difference.

And which really, when you get down to it, has nothing to do with testing. You will keep hearing, we have got to get testing, people have got to come in for testing to do prevention.

Testing is great. It has nothing to do with prevention. Being tested doesn't prevent a single infection. It only prevents infection if it then leads to changes in behavior.

So as Ms. Messing was describing, she comes in and tests negative; they tell her use condoms and stick to one partner. If she had tested positive, they would tell her use condoms and stick to one partner. The message is the same. You don't need testing to do prevention. You do need testing to do treatment.

I was asked, or we were all asked about mother-to-child transmission. Again, I think PEPFAR probably has the mix of funding about right. Mother-to-child transmission is a very appropriate target for our prevention efforts, because it is a moral imperative. We want to protect the most vulnerable, who certainly are infants. And it works. So it is a good place to invest our resources in that sense.

However, I have to qualify that a little bit, as an epidemiologist and looking at the public health perspective, to say that as important as it is, it doesn't really have much of any impact on the epidemic. Why? Because preventing transmission to babies is wonderful and an imperative and all that, but those babies wouldn't be transmitting the virus to anybody else, at least not until they grow up and survive into adolescence or adulthood. So they are sort of an epidemiological dead end. They are very important as human beings, but unfortunately less important, epidemiologically speaking, because they wouldn't transmit to others.

I was asked about, we were all asked about housing and poverty, and the relation to AIDS. And I think it is very important that we think of, that people need housing. I think it is a crime sometimes that the West will spend, and us, will spend thousands of dollars a year so that they don't die of AIDS, but who cares if they live in abject misery. And I think that is a real contradiction.

However, in the field of HIV/AIDS, unlike tuberculosis and many other diseases, there is no clear relation between income, poverty, and HIV/AIDS. In fact, in most African countries, HIV/AIDS rates are actually higher among those who are relatively better off.

So I think we need to do poverty alleviation because we need to do poverty alleviation, but really, we shouldn't fool ourselves into thinking that is AIDS prevention. Rich people do not have fewer sexual partners than poor people. In fact, particularly among men, they tend to have more partners. And that is what spreads the epidemic; it is having multiple partners, it is not being poor.

I think that touched on most of the questions that were asked. Thank you.

Mr. FALEOMAVAEGA. I don't know if a question was raised by members who were here previously, but just wondering, you know when HIV/AIDS first came about, the stigma attached to this illness was so negative, even when it touches on the gender.

And I wanted to ask the members of the panel if America has gone past that. If you are associated, or if you have HIV/AIDS, not only isolation, but they put you as something, almost classify you as someone who is immoral. And I was just wondering if members of the panel, what is your take on what seems to be the sentiments of members of our society, especially here in this country. I don't know how it compares to Africa. But I would be very curious.

Ms. Messing?

Ms. MESSING. Well, I can't speak to the specifics of the United States. But what I can tell you is what I saw and experienced in Zimbabwe, and at the New Start clinics that are part of the U.S. investment.

There is a focus on instilling hope, and empowerment to the people who have been diagnosed positive. I met with people who were positive, who were graduating from a long series of sessions, learning how to live positively. And I can tell you that whatever stigma there is—and there is a stigma there, as well—that the prevention efforts address that.

And if I may, I would just like to respond to Dr. Hearst, and say that in my travels in Zimbabwe, I saw firsthand the PSI programs at work. And they target reduction of concurrent sexual partnerships. That is a, one prong in a multi-pronged attack, which includes condoms, testing, counseling, male circumcision, delaying sexual debut.

I sat with a boy who was the first person to get circumcised in Zimbabwe, 18 years old. And he had never been sexually active prior to it. And he told me that through his counseling, he had determined that he was going to delay his onset of sexual activity.

And I sat with people who had gone through the HIV testing process, and I sat alongside people who were counseled. And they told me that the information that they had gotten from the New Start clinic had made them change their behavior regarding sexuality.

So to say that just condoms or just testing, it is so much more than that. It is, it is a comprehensive approach. And it is working.

Dr. MUGYENYI. Yes. Perhaps I could—

Mr. FALEOMAVAEGA. Dr. Mugenyi.

Dr. MUGYENYI. Yes. Perhaps I could take you inside Africa, and say that stigma was at its highest because people, among other things, feared death. You test positive, you are going to die.

Now, when treatment came, you test positive, you are not going to die; you are going to get treatment.

Stigma, particularly in a country like South Africa, has been declining. And the driver for the decline in the stigma has been availability of life-saving treatment.

There has also been a referral to testing. When you test, obviously you are not treating, you are testing. But people who come in such big numbers for testing, what do they get? They have come, they have presented themselves to a point of care. And when they present themselves to a point of care, it gives us great opportunity

to give them risk-reduction messages. This is where we tell them about male circumcision. This is where we tell them about condoms. This is where we tell them about being faithful, the B that is being mainly applauded by faith-based organizations. This is where we do all of those.

And it is through those kind of initiatives, where treatment is available, that we have been able to expand our operation. My organization has been able to expand 75 different places all over the countries, all over the country in Uganda. And everywhere we go, people are attracted. They know they are not going to test and be told the sad news today you are going to die. The clock has started ticking today. We give them the good news, if we find them positive, the good news that we will treat you, and what we require of you is to protect others against AIDS.

Lastly, Mr. Chairman, there was another point about prevention of mother-to-child. There is a moral imperative here. Prevention of mother-to-child works wonderfully. It has almost terminated childhood AIDS that is transmitted from mother to child in rich countries, including the United States.

In our countries, it is still a very big problem. So people support it because its effects are quite obvious.

But what do the moral imperative I am talking about, Mr. Chairman, is that currently we are giving prevention to the mother, treatment or prevention to the mother, so that the child can be born HIV-free. And then we let the mother die. She is a new patient; she can't get treatment. It is a moral imperative.

There has not been any provision that has been put in the PEPFAR, with flat-lined budget, that mothers will be treated. It is a particular imperative in Africa because the majority of the people who are living with AIDS, who are coming for testing, who are actually getting infected today, they are women. This is the moral imperative that we have.

Mr. Chairman, in 1990s the messages we were being told were that AIDS treatment was impossible in Africa. We are being told that prevention was the only thing that Africa needs. I am shocked to hear it this time, when it has been abundantly illustrated that treatment is possible in Africa, and data is coming out quite clearly, and it is showing that we can break the back of this epidemic by strengthened efforts on prevention, as well as strengthened efforts on treatment.

So Mr. Chairman, this is a critical time for us in Africa. And we hope these points are taken in account. And we do not get people who take us back to the dark ages of 1990s, when all of this was said to be impossible.

Mr. FALEOMAVAEGA. I would like to ask Dr. Carter, I have one or two questions. Did you want to comment on them?

Ms. CARTER. I wanted to just again, building on the point about prevention of maternal-to-child transmission, a couple of things.

I was talking about funding needs. The Global Fund has actually looked at what it is going to take. And by 2015, we could literally eliminate this vertical transmission from mother to child.

If the Global Fund was fully funded at the highest-end scenario, it could actually cover some 75 percent of that need. If you then add what the Global Health Initiative could do, we could actually

cover 100 percent, and we could achieve essentially ending vertical transmission.

I would just also say to build on Dr. Mugenyi's point, is that it is both a moral imperative, but it is also, you know, these children are born, when they are born without HIV. So what are the most important markers for their survival?

One is to be born without HIV, the second to have a mother who survives. So the importance of both of those things is absolutely key.

And then just a couple of other, maybe I will comment on one other question, and then I will come back. I want to come back to Congressman Smith's questions about the Global Fund.

But just on the question around the issue of slums, I would only say obviously links between housing and issues like tuberculosis, and housing and issues like stress. But I think there is also the issue of the degree to which economic situations create vulnerabilities for people which then put them at risk, both physically, but also socially and economically, for these diseases.

So I think a hugely important issue about just the economic situation, that families, in particular women, find themselves in. And that certainly includes housing, but the overall situation that they are surviving in.

Mr. FALEOMAVAEGA. You caught me on that. I was going to ask you to give us an update on the Global Fund, including faith-based organizations; and also your opinion of whether or not the Inspector General's recommendations are taken seriously by the Global Fund Secretariat. Can you respond to that?

Ms. CARTER. Yes, I can, and I very much want to. I think, first on the issue of faith-based organizations, the data that, the best data that we have that is compiled shows that nearly 80 percent of the country-coordinating mechanisms that are requirements for the Global Fund for countries to be able to put forward grants, have at least one representative of the faith-based community.

And we know that it is, the data is probably better than that, and I will come back to that, because they are compiling new data. But that is the data we have as of a couple of years ago.

Also, what we will note is that the percentage of funding going to faith-based organizations as the principal recipients of Global Fund money and as sub-recipients is highest where they play the biggest role in health-care delivery. So just for example, in Western Central Africa, faith-based organizations—again, and this data is a bit outdated. It is better now, but I can give you this.

In Western Central Africa, about 12 percent of funding; in Latin America, in the Caribbean, about 11 percent of the funding. And just to note that there have been new and major grants to faith-based organizations, including its principal recipients in Round 8, to a broader range of them, and some large grants to faith-based organizations in DRC, in South Africa. And the Global Fund is updating a study, and we will have that by the end of this year, which will include data from Round 8 of grants and Round 9, on faith-based organizations.

And I would say just having been involved in a number of gatherings of civil society organizations, there has been a big focus on how do we actually increase overall the role of civil society, includ-

ing through dual-track financing. Which, I do not know if you are familiar with, but since Round 8 the Global Fund has actually been really pushing to have two principal recipients of grants, for grants, one governmental, one non-governmental. And also really a productive push at looking at the role of faith-based organizations, especially again where they are a big proportion of service delivery.

On the Inspector General for the Global Fund, just a couple, again a couple of broad points, and then a more specific answer to your question.

So the Inspector General operates independently of the Secretariat. It reports directly to the Board. The Inspector General's reports are required to be posted on the Web within 3 days of providing them to the Board.

There is an enormous amount of transparency on the part of the Global Fund around these things. In some ways I think the Global Fund can sometimes suffer just by the level of transparency, which I think, you know, is not met by most other aid agencies. But it is some important things.

The Inspector General's budget has doubled between 2008 and 2009. The office is now a 12-person team with a wide network of experts that they can contract, if needed. And this has really allowed for robust investigative capacity.

And in addition to providing an anonymous hotline for complaints, the IG is now also proactively identifying high-risk countries based on transparency, international indices, so they can be more closely monitored.

I know the Board is really very engaged in this. I think if there is a slight lag time sometimes in implementing all of the IG's recommendations, I think there is transparency about that, too. But the Board takes this very seriously. The Fund takes it seriously, the Secretariat does.

It is clear that the Board, by doubling the funding for the Inspector General's Office, is wanting to actually strengthen and increase this function. So, and the Global Fund has a very strong Inspector General. So I feel actually very positive about the direction that this is going.

Mr. FALEOMAVAEGA. Not taking anything away from Africa, but I wondered if any of you would comment about the two most populous nations of the world; mainly, China and India, and Asia for that matter. Because I am positive that HIV/AIDS is just as serious, in terms of what is happening in that region of the world.

Does anybody care to comment on that?

Dr. MUGYENYI. Yes, Mr. Chairman, if I may just make a brief comment.

Mr. FALEOMAVAEGA. Please.

Dr. MUGYENYI. Because AIDS is an insidious disease if it is being ignored. And if there is complacency, that is what happens. We have huge populations in Asia, especially China and India, and a very small percentage increase means huge numbers in those countries.

And there is a bit of complacency which was there. And AIDS was spreading insidiously. It is the same situation that we are seeing and we are worried about. AIDS was allowed to spread in Africa.

For example, in South Africa, which is the highest incidence country, with over 5 million people living with AIDS, at the time when Uganda had the highest peak, South Africa had very low. In some of the areas, it was as low as only 1.5 percent. But no action reactivated this disease.

And so the fear is that if the AIDS in Asia, those huge populous countries, is not taken seriously, small percentages means lots of people. And AIDS is unforgiving if action is not taken. And it needs continuous awareness, as we need, even at this stage where we are in Africa. We can't afford to ignore it. It is not going to stop; it is going to keep growing. And things will not become any easier; they will become more complicated.

And in Africa, we are now trying to prevent catastrophes of need for second-line drugs. And need for second-line drugs, if stop the sharing out drugs, those who are using them, and stop people not taking proper dosages. Because if resistance happens in Africa, if we don't take action now to make sure that access to treatment is available, people are going to misuse drugs.

Because you can't hide the fact that drugs are available. They are already aware. So all they can do, if we don't give them support, is misuse them, with the consequence of resistance happening at public sector level; and also making the HIV complicated, HIV epidemic much more complicated, and much more expensive to manage in the future.

In Asia and in Africa, we need not to relax, but to continue all of the efforts. It needs more funding, unfortunately, even when there is a recession. AIDS unfortunately does not go in a recession.

Mr. FALEOMAVAEGA. If I may, the members of the panel, if you have any concluding statements that you would like to make, as I am sure members of the committee may want to submit further questions to each of you. It will be made part of the record if you would like to do that.

So I would like to give you parting shots, or the best that you could relate to our hearing this morning. Dr. Hearst.

Dr. HEARST. I don't know if this is really a parting shot, but I wanted to address your question about Asia. And I think the point was made that even if prevalences are low, that populations are so large it can add up to a lot of people.

I think we have to remember always in our thinking about AIDS and how to respond to it, this key difference between countries with concentrated epidemics and with generalized epidemics.

The generalized epidemics have only occurred in a few countries, mostly in sub-Saharan Africa, for reasons that we don't completely understand, but are now understanding better, when the conditions are right to have spontaneous transmission and a growing epidemic within the general heterosexual population.

I like to tell students to think of it as if you are in a grassland, and somebody is throwing matches out there. If the grass happens to get just dry enough, the whole thing will go up in flames. Otherwise you will get a little smoldering there, and that will be it.

And that is sort of the same thing, with the transmission dynamics, in a generalized, as opposed to a non-generalized, epidemic.

Fortunately, there are no generalized epidemics in Asia, except maybe Papua New Guinea, and there never will be. AIDS has been

around long enough that anywhere that there is going to be a generalized epidemic, it would have already happened.

That doesn't mean there is not a serious problem. In China there is a serious problem mainly related to injecting-drug use.

Mr. FALEOMAVAEGA. Dr. Hearst, when you say generalized epidemic, what do you mean by that?

Dr. HEARST. I mean an epidemic that is self-sustained in the general population of people who do not belong to any particular high-risk group.

Unlike the epidemics in the U.S., in every rich country in the world, and in fact in all but about a dozen countries of the world, although those dozen are very important because they account for more than half of all AIDS cases in the world, you don't have these conditions for generalized spread. So though you get infection transmitted in certain high-risk groups—men who have sex with men, injecting-drug users, in Asia commercial sex, very important, the sex industry, the clients.

And then there are a few unlucky people, victims or whatever you want to call them, who get infected by someone who is in one of these groups. But the point is they don't, on the average, you have to have each person on the average infecting more than one other person for it to become self-sustaining.

So it stays in these concentrated groups. A few others get infected, then they infect fewer, it smolders out. That doesn't mean that there aren't millions of people infected in India, but it is not a generalized epidemic. And if it was going to be, it would have been already.

Mr. FALEOMAVAEGA. So what makes Papua New Guinea in that classification as a generalized epidemic?

Dr. HEARST. I have never been there or worked there. But from what little I know about it, it probably has to do with patterns of sexual behavior more than anything else.

Mr. FALEOMAVAEGA. Papua New Guinea has about 7 million people, and about three to four hundred tribes. And each of those tribes speak different languages. So I was just curious when you mentioned that. I have a little familiarity with that part of the world. I was just curious.

Dr. HEARST. Well, you are more familiar than I am, so I shouldn't really speculate on that.

Mr. FALEOMAVAEGA. Besides Papua New Guinea, are there other countries in the same category?

Dr. HEARST. Not in Asia, there are not other countries with generalized epidemics. And that, in a way, has made it easier to respond.

For example, in Thailand, it was mainly related to sex work; also to injecting-drug use. So they can, you can get very high rates of condom use in the brothels. Cambodia, too. And you can bring down the infection rates very successfully, like they have done.

Mr. FALEOMAVAEGA. Ms. Messing.

Ms. MESSING. Thank you, Mr. Chairman. I just want to thank you for having me here today. It is an honor to be able to speak as a part of this hearing.

And I just want to reiterate that the U.S. Government's funding for HIV prevention is working. I saw it firsthand in Zimbabwe. It

is a success story. And I just encourage the United States Government to continue their robust support of PEPFAR and the Global Fund, so that the success can be built on, and we can bring a halt to the spread of HIV. Thank you.

Mr. FALEOMAVAEGA. Well, as our Good Will Ambassador, I think we could not have selected a better person than you, Ms. Messing, for doing this. I deeply appreciate your service and your commitment in helping resolve this very serious problem in the world. Thank you.

And thank you. We are honored by your presence of being here this morning. Thank you very much.

Dr. Carter.

Ms. CARTER. Thanks very much. I am going to just quickly reiterate a couple of the points I made at the beginning. I mean, just to say again among the opportunities we have, aggressively addressing TB, HIV, and supporting TB programs, the low-hanging fruit for saving lives in terms of people with HIV.

Second, that the Global Fund is an enormously important mechanism for AIDS, but also for TB and malaria, and for broader impact in maternal and child health; and it leverages other donor resources, and lots of lessons to learn from how it works, so I think really important.

And I guess the last thing I would say in terms of what sort of ended up on this panel as I think a bit of a debate around prevention and treatment, I want to say I think part of where that is coming is this feeling that the challenge of fighting over what looks like a pie, unlimited pie that can't be expanded.

And I want to say this committee and the work that has been done here changed the reality of what was possible around HIV/AIDS, and really created a new reality and how we are seeing this.

I think we all support, absolutely support, the aggressive, the need for aggressive prevention. We have talked about PMTCT, we have talked about other really critical prevention. My own organization supports access to education for children, especially girls in Africa, because of its prevention effects, among other things. So I think we all support that.

I think what we are also saying is that treatment can have important impacts on prevention. You know, and that the good news is if we can aggressively scale up treatment, there are models that do suggest that we could actually bend the curve. But it will take aggressive treatment and aggressive prevention to do that.

And so, you know, I guess my message is this is working, you guys have led on this, the U.S. and the U.S. Congress has led on this. And we can't give up now. We actually have to increase the resources so that we can do both, and basically bend the curve down. Thank you.

Mr. FALEOMAVAEGA. Thank you, Dr. Carter. Dr. Mugenyi.

Dr. MUGYENYI. Thank you, Mr. Chairman. Like Dr. Carter, I want to conclude on that note. We need continued support so that we can build on the clear successes of PEPFAR, which it has achieved.

And if we build on those successes that are quite clear, that are commented by virtually everybody who has access to the program,

we can treat our way out of the epidemic. Not only with the treatment by itself. We can clearly treat our way out of this epidemic if we accompany it with the robust new preventive initiatives. Actually, there is not any other way with such a vicious epidemic, other than to scale up treatment and support robust preventive initiatives.

Thank you, Mr. Chairman.

Mr. FALEOMAVAEGA. Well, I certainly want to say that on behalf of my colleagues and the committee, to thank all of you for taking the time from your busy schedules, and coming here to testify, sharing with us your expertise and understanding of this important issue.

Again, thank you so much for coming. The committee stands adjourned.

[Whereupon, at 12:23 p.m., the subcommittee was adjourned.]

A P P E N D I X



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SUBCOMMITTEE HEARING NOTICE
COMMITTEE ON FOREIGN AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, D.C. 20515

SUBCOMMITTEE ON AFRICA AND GLOBAL HEALTH
Donald M. Payne (D-NJ), Chairman

TO: MEMBERS OF THE COMMITTEE ON FOREIGN AFFAIRS

You are respectfully requested to attend the following OPEN hearing of the Subcommittee on Africa and Global Health to be held in **2172 of the Rayburn House Office Building.**

DATE: Thursday, March 11, 2010

TIME: 10:00 a.m.

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

WITNESSES: Peter Mugenyi, M.D.
Director and Founder
Joint Clinical Research Center

Joanne Carter, D.V.M.
Executive Director
Educational Fund
RESULTS
(Also Board Member of The Global Fund to Fight AIDS, TB and Malaria)

Ms. Vuyiseka Dubula
General Secretary
Treatment Action Campaign

Ms. Debra Messing
Global AIDS Ambassador
Population Services International

Norman Hearst, M.D.
Professor of Family and Community Medicine
and of Epidemiology and Biostatistics
Department of Family and Community Medicine
University of California, San Francisco

By Direction of the Chairman

The Committee on Foreign Affairs seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202/225-5021 at least four business days in advance of the event, whenever practicable. Questions with regard to special accommodations in general (including availability of Committee materials in alternative formats and assistive listening devices) may be directed to the Committee as noted above.

**Subcommittee on Africa and Global Health Hearing
U.S. Investments in HIV/AIDS: Opportunities and Challenges Ahead
March 11, 2010**

Statement by Rep. Christopher H. Smith

Thank you, Mr. Chairman, for calling this important and timely hearing to explore the future of the President's Emergency Plan for AIDS Relief.

As you know, the Leadership Act, originally passed by Chairman Henry Hyde and Tom Lantos and signed into law by President George Bush, initiated this historic health initiative in 2003 with strong bipartisan support. It has been extraordinarily successful in countering the devastating toll that the HIV/AIDS pandemic was taking on women, men and children throughout the world, most particularly in Africa. The United State's bilateral funding has provided life-saving antiretroviral treatments for over 2.4 million individuals – over half of the nearly four million persons receiving treatment in low- and middle- income countries. It has directly supported care for almost 11 million people affected by HIV/AIDS, including 3.6 million orphans and vulnerable children. Almost 340,000 babies have been born without HIV, even though their mothers were HIV-positive, thanks to PEPFAR's mother-to-child transmission prevention programs. And an incredible 29 million people have received PEPFAR-supported HIV counseling and testing.

To achieve these results, as well as to make annual contributions to the Global Fund to Fight AIDS, TB and Malaria and related programs to treat tuberculosis, the

United States has dedicated over \$32 billion since FY2004. The African people who have been the prime beneficiaries are well aware of the American taxpayers' generosity. During my travels to Africa, I have been repeatedly overwhelmed with gratitude from people of all ages and walks of life who credit President George W. Bush and the American people with saving their lives, their families and their communities.

However, Mr. Chairman, it is critical that we take this opportunity to step back and examine the best way to move ahead. As the title of this hearing indicates, there are significant challenges as well as opportunities. One challenge is with respect to how treatment will be provided to new patients over the coming years. Estimates of the rate of new HIV infections compared to those obtaining treatment range from between 2:1 and 5:1. While Congress authorized \$39 billion in the 2008 reauthorization for HIV/AIDS programming for FY 2009 – 2013, even this amount cannot fully cover the growing need. It is apparent that our country alone cannot continue to carry this increasing burden. I look forward to hearing our distinguished witnesses' proposals for resolving this dilemma.

An issue with respect to PEPFAR that I find particularly disturbing is the administration's proposed implementation of the so-called "prostitution pledge." The purpose of this pledge, created to ensure compliance with a PEPFAR mandate, is to prevent PEPFAR funding from being misdirected to those who refuse to oppose prostitution and sex trafficking as a matter of policy. Prostitution and sex trafficking exploit and degrade women and children and exacerbate the HIV/AIDS pandemic.

Yet despite a clear statutory mandate based on an equally-clear United States Government policy opposing prostitution and sex trafficking, the Department of Health and Human Services has issued a proposed rule that would substantially undermine that law and policy. It would create loopholes to allow not only affiliation but shared facilities, staff, legal status and bank accounts as determined on a case-by-case basis between PEPFAR-funded entities and entities that support prostitution and sex trafficking. It also would significantly reduce the assurance that USAID is supposed to

have that a PEPFAR-funded organization is in compliance with the relevant provision of the PEPFAR legislation.

Unfortunately, HHS has not yet posted on the official regulations website the comment that I submitted strenuously opposing this proposed rule. My office is attempting to correct this omission, and I invite those concerned about the negative impact of prostitution and sex trafficking in general, and with respect to HIV prevention in particular, to read it. The HHS proposed rule is unacceptable, and should be rejected. If the proposed rule is promulgated, I will leave no stone unturned in fighting it.

I must also express my grave reservations with respect to certain aspects of the President's Global Health Initiative. When the reauthorization of PEPFAR was being debated in 2008, references to integrating and providing explicit funding authorization for "reproductive health" in relation to HIV/AIDS programming in initial drafts were rejected. The term does not appear in the final legislation.

However, the new GHI emphasizes the "integration" of HIV/AIDS programming with family planning, as well as various health programs. This is being undertaken in the context of a family planning program which – due to President Obama's rescission of the Mexico City Policy – now includes foreign non-governmental organizations that provide and support abortion. When one considers that this involves over \$715 million in family planning funding under the FY2011 proposed budget, the ability for abortion groups to leverage this funding in relation to U.S. HIV/AIDS funding under the GHI is deeply disturbing. This integration priority is wrong – we are trying to prevent HIV/AIDS, not children! It's time to recognize that abortion is child mortality – aborting methods dismember, poison, and starve to death a baby and wound their mothers.

"Safe abortion" is the ultimate oxymoron. Child dismemberment, forced premature expulsion from the safety of the womb, chemical poisoning or deliberate starvation—one of the chemicals in RU486 actually denies nourishment to an unborn child—can never, ever be construed to be benign, compassionate or safe.

Goal #4 of the Millennium Development Goals (MDGs) calls on each country to reduce child mortality while at the same time pro-abortion activists lobby for an increase in access to abortion. It is bewildering to me how anyone can fail to understand that abortion is, by definition, infant mortality. Abortion destroys children!

At least 102 studies also show significant psychological harm, major depression and elevated suicide risk in women who abort. At least 28 studies—including three in 2009—show that abortion increases the risk of breast cancer by some 30-40% or more yet the abortion industry has largely succeeded in suppressing these facts.¹ So-called safe abortion inflicts other deleterious consequences on women as well including hemorrhage, infection, perforation of the uterus, sterility and death. Just last month, a woman from my home state of New Jersey died from a legal abortion, leaving behind four children.²

At least 113 studies show a significant association between abortion and subsequent premature births. For example a study by researchers Shah and Zoe showed a 36% increased risk for preterm birth after one abortion and a staggering 93% increased risk after two.³ Similarly, the risk of subsequent children being born with low birth weight increases by 35% after one and 72% after two or more abortions.⁴ Another study shows the risk increases 9 times after a woman has had three abortions.⁵

¹ Dolle J., Daling J., White E., Brinton L., Doody D., et al. Risk factors for triple-negative breast cancer in women under the age of 45 years, *Cancer Epidemiology Biomarkers Prevention* 2009; 18:4, 1157-1166; Ozman V., Ozcinar B., Karanlik H., Cabioglu N., Tukenmez M., et al. Breast cancer risk factors in Turkish women—a University Hospital based nested case control study. *World Journal of Surgical Oncology* 2009; 7:37; Xing P., Li J., Jin F., A case-control study of reproductive factors associated with subtypes of breast cancer in Northeast China. Humana Press, e-publication online September 2009.

² Michael Feeny, Barry Paddock, Jonathan Lemire, “Queens clinic A1 Medicine probed after Alexandra Nunez is fatally injured while undergoing abortion,” NY Daily Online, January 27, 2010 (http://www.nydailynews.com/news/2010/01/27/2010-01-27_queens_clinic_probed_after_abortion_death.html).

³ Shah P., Zao J. on behalf of Knowledge Synthesis Group of Determinants of Preterm/LBW Births. Induced termination of pregnancy and low birthweight and preterm birth: A systematic review and meta-analysis. *International Journal of Obstetrics and Gynaecology (BJOG)* 2009; 116:1425-1442.

⁴ Ibid.

⁵ Brown J., Adera T., Masho S., Previous abortion and the risk of low birth weight and preterm birth, *Journal of Epidemiology and Community Health* 2008 (Jan.); 16:1, 16-22. Laura Blue, *Study Links Abortion and Preemies*, TIME Magazine, Dec. 18, 2007 (<http://www.time.com/time/health/article/0,8599,1695927,00.html>).

What does this mean for her children? Preterm birth is the leading cause of infant mortality in the industrialized world after congenital anomalies. Preterm infants have a greater risk of suffering from chronic lung disease, sensory deficits, cerebral palsy, cognitive impairments and behavior problems.⁶ Low birth weight is similarly associated with neonatal mortality and morbidity.⁷

So, Mr. Chairman, the future of PEPFAR, particularly in the context of the GHI, is indeed fraught with challenges. I look forward to exploring them with you and our distinguished witnesses.

Thank you.

⁶See Kessinich, M., Developmental outcomes for premature, low birth weight and medically fragile infants, *Medscape* 2003 (<http://www.medscape.com/viewarticle/461571>).

⁷*Ibid.* See also National Center for Health Statistics, *More Babies Born at Very Low Birthweight*, January 24, 2005 (<http://www.cdc.gov/nchs/PRESSROOM/05news/lowbirthwt.htm>) and MacDorman, M., Martin, J., et. al., Explaining the 2001-2002 Infant Mortality Increase: Data from the Linked Birth/Data Set, *National Vital Statistics Reports* 2005, Center for Disease Control; 53:12 (http://www.cdc.gov/nchs/data/nvsr/nvsr53/nvsr53_12.pdf).

Testimony for the USA Committee on Foreign Affairs, sub Committee on Africa and Global Health

“Investments in HIV/AIDS: opportunities and challenges ahead”

By Vuyiseka Dubula, General Secretary of the Treatment Action Campaign (TAC),
South Africa

I am honoured to be given this opportunity to share and testify before the sub committee on Africa and global health. I testify before you on behalf of many people living with HIV in my country and on the African continent.

South Africa has only 0.7% of the global population, but 17% of the HIV burden and 28% of the global population living with both HIV and tuberculosis. Over the past decade we have faced a reduction in our life expectancy from over 60 to under 50 years.

HIV remains an emergency and international humanitarian crisis in South Africa and the region, yet we are seeing worrying signals that governments and funders may soon backtrack on their commitments to universal access.

PEPFAR has been South Africa’s biggest donor and has been critical to increasing access to antiretroviral therapy. With support from PEPFAR and other international donors, South Africa now has the biggest antiretroviral programme in the world. According to our government 900 000 people are receiving treatment in the public sector yet this is less than half of people in need of treatment now.

In the financial year 2008, South Africa received nearly \$590.9 million (R4.43 billion) from PEPFAR. Further, following President Zuma’s World AIDS Day announcement, PEPFAR committed an additional \$120 million (approximately R900 million) to cover the funding gap for ART treatment. South Africa has also received support from the Global Fund on AIDS TB and Malaria, which receives contributions from the United States.

After a decade of AIDS denialism, South Africa is now facing a new era in terms of its AIDS response. The new government has demonstrated political will and commitment to combat the epidemic. This has been seen in terms of revised guidelines to implement evidence-based improvements to our HIV treatment, prevention and care programs as well as increasing the financial resources for health. Further, after years of civil society activism, South Africa now has a strong, comprehensive national policy for the treatment and prevention of HIV which aims to provide treatment to 80% and to reduce new infections by 50% by 2011.

The South African government has continued to scale up funding for HIV programs and has budgeted to increase government spending on HIV to R6.5 billion (\$866 million) in financial year 2010/11.

Now is the opportunity for South Africa, the epicenter of the epidemic, to turn the tide of HIV. PEPFAR should take this opportunity to strengthen its programs and

partnerships in South Africa. Yet TAC is worried about signals that PEPFAR and the United States is turning away from commitments to expanding access to funding for HIV treatment and prevention. We call on you to clarify whether this is indeed your intention.

It would be a major missed opportunity and lead to much avoidable suffering if shifting donor priorities were to undermine country efforts and the PEPFAR supported antiretroviral rollout.

The move away from funding HIV is being promoted by arguments that HIV funding has been at the expense of other diseases, other millennium development goals and health system strengthening. In a high prevalence country like South Africa this argument is flawed due to the nature of HIV and the argument's failure to account for the social and economic impact of HIV.

Poor health systems and health outcomes in South Africa (and indeed in all other developing countries) are not a consequence of HIV funding but instead of years of chronic underfunding of health more generally. Flat-lining or reducing funding for HIV will weaken health systems and reduce our ability to meet other millennium development goals and improve health outcomes.

If new patients are unable to access treatment and patients already on treatment face stock-outs and shortages, this will increase the burden on doctors and nurses facing increasing deaths and opportunistic infections and AIDS related diseases. As well as increasing workloads, AIDS deaths have reduced the number of healthcare workers in the country before treatment was available.

The nature of HIV/AIDS treatment also makes it possible to successfully treat a range of other diseases, including TB. One argument is that HIV is responsible for poor health outcomes in other areas such as diarrhoea which is not the case – as seen in Rwanda. Prior to the introduction of a public ART programme in Rwanda, 94% of patients treated for chronic diarrhoea had HIV, and 72% had clinical AIDS.¹

As well as destabilizing health systems and worsening health outcomes, a move away from funding HIV would be devastating for economies and societies in the region. As a killer of young adults – the backbone of any economy – untreated HIV will destabilize the growth of our economy. Further, young women are disproportionately affected by HIV, which has reinforced their unequal position in society. Providing treatment to women and children reduces the burden of care that we face, making it possible for us to concentrate on improving our own lives. Being sick and dying incapacitates and demoralizes us.

¹ Clerinx J., Bogacrts J., Taclman H., Habyarimana J.B., Nyirabaraja A., Ngendahayo P. and Van de Perre P. Chronic Diarrhea among Adults in Kigali, Rwanda: Association with Bacterial Enteropathogens, Rectocolonic Inflammation, and Human Immunodeficiency Virus Infection. *Clinical Infectious Diseases* 1995 21: 1282-4

A focus area of PEPFAR support in South Africa has been maternal and infant health and the prevention of mother to child transmission (PMTCT) programs. Support for PMTCT and ART for mothers and infants is necessary to improving infant and maternal health in South Africa and the region. In South Africa, nearly half of maternal deaths and more than half of deaths of children under five are due to HIV.

There is a double standard of care between the global North and global South in terms of maternal care. In the North, mother to child transmission of HIV has been virtually eliminated, whereas in the South mother to child transmission remains far too prevalent. Closing this gap is the responsibility of governments in the global South as well as the international community.

South Africa is facing an antenatal HIV prevalence of 30%. Yet still many mothers do not know their status and are never offered treatment. Recently our government has taken a number of steps to close this gap. This includes the implementation of provider initiated HIV testing, extending PMTCT regimens and providing triple regimen antiretroviral therapy at higher CD4 counts. Also, HIV positive infants will receive ART immediately which has been shown to reduce mortality by 75%.²

A move away from funding HIV by international donors will threaten the implementation of these changes. Furthermore, in other countries in the region, the loss of international funding will completely destabilize treatment programs.

Access to ART is also necessary to reducing opportunistic infections and AIDS related diseases that are prevalent in young woman. In South Africa, the high rates of HIV has led to increasing rates of cervical cancer in young women. Cervical cancer, which is the most common cause of cancer amongst African women, kills about 1 500 women in South Africa each year.

Health is underfunded in Africa, yet funding for HIV is not the cause of this. Further reducing funding for HIV will worsen ALL health outcomes, destabilize health systems and impede our ability to meet millennium development goals. Increasing funding for newly identified donor priorities should not be done at the expense of people living with HIV. Rather, health system strengthening must be funded in partnership with HIV treatment, prevention and care. The benefits of HIV treatment, prevention and care extend beyond the individual receiving care. When I began treatment in 2004, not only was my life saved but treatment was also beneficial to my family. Because I have access to treatment and prevention services, I have an HIV negative baby and husband. Also, as I am healthy, I am able to work and study, give back to my community and support HIV treatment, prevention and care in my country.

In addition to all of the above, we are also seeing more and more evidence that HIV treatment is not only a life saving medicine, but also an effective method of

² Violari, A. et al. 'Early antiretroviral therapy and mortality among HIV-infected infants.' *N Engl J Med.* 2008 November 20. 359, 2233-44. <http://www.ncbi.nlm.nih.gov/pubmed/19020325>

prevention that must be available as part of a comprehensive package of prevention services.

Since the establishment of PEPFAR and the Global Fund, in 2003 and 2002 respectively, the United States has supported the expansion of access to HIV treatment, prevention and care. There have been many challenges during this time including AIDS-denialism from the previous government. However today, with the support of PEPFAR and the Global Fund, South Africa has the biggest public antiretroviral programme in the world and is taking steps to expand access to and strengthen its HIV programs and health systems. Now is the time for South Africa, with the assistance of the international community, to turn the tide of the epidemic.

I urge you not to become complacent about HIV as it remains an emergency and international humanitarian crisis, particularly throughout the Southern African region. The right to good health and life of the poorest people and countries in the world is a responsibility first and foremost of our governments. But it is also a duty of the international community and developed countries that is as important as other global challenges such as stemming climate change and combating terrorism.

A move away from HIV funding will destabilize health systems and economies throughout the region. This will have far reaching effects not only on our lives, but eventually on the world as a whole.

We call on you to urge Congress to avoid this catastrophic path of diminished funding and, instead, to continue and increase the contributions of recent years.

ENDS