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S. HRG. 110–441

PERSPECTIVES ON THE NEXT PHASE OF THE GLOBAL FIGHT AGAINST AIDS, TUBERCULOSIS, AND MALARIA

HEARING

BEFORE THE

COMMITTEE ON FOREIGN RELATIONS UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

DECEMBER 13, 2007

Printed for the use of the Committee on Foreign Relations

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

U.S. GOVERNMENT PRINTING OFFICE

43–704 PDF WASHINGTON : 2008

For sale by the Superintendent of Documents, U.S. Government Printing Office
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PERSPECTIVES ON THE NEXT PHASE OF THE GLOBAL FIGHT AGAINST AIDS, TUBERCULOSIS, AND MALARIA

THURSDAY, DECEMBER 13, 2007

U.S. SENATE,
COMMITTEE ON FOREIGN RELATIONS,
Washington, DC.

The committee met, pursuant to notice, at 2:37 p.m., in room SD–419, Dirksen Senate Office Building, Hon. Robert Menendez, presiding.

Present: Senators Menendez, Kerry, Feingold, Lugar, and Sununu.

OPENING STATEMENT OF HON. ROBERT MENENDEZ, U.S. SENATOR FROM NEW JERSEY

Senator MENENDEZ. This hearing will come to order.

The purpose of today's hearing is to discuss our efforts to combat HIV/AIDS, tuberculosis, and malaria. In 2003, Congress passed the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act to authorize funds for the President's Emergency Plan for AIDS Relief, known as PEPFAR, created the Office of the Global AIDS Coordinator, and authorized funds for the Global Fund to Fight AIDS, Tuberculosis, and Malaria.

We are here today to look at the progress and challenges to date as we look ahead toward next year's reauthorization of this important legislation.

I want to welcome our distinguished panel of experts, and we look forward to a productive discussion.

The issues that we are here to discuss remain as relevant and devastating as ever. Today, 6,800 people around the world will become infected with HIV, and 5,700 people will die of AIDS-related diseases. This year, more than 1 million people will die of malaria, most of whom will be children under 5, and tuberculosis will kill 1.6 million people, including 195,000 who are also infected with HIV/AIDS.

On May 30, President Bush requested that Congress authorize $30 billion to extend the Global HIV/AIDS Initiative an additional 5 years. In this call for reauthorization, the President emphasized the responsibility to continue to support those who have already been reached by PEPFAR, especially the continuation of antiretroviral treatment.

In reacting to the President's proposal, some advocates for the fight against AIDS, including a number of Members of Congress,

while praising progress to date, have called for $50 billion over 5 years to combat HIV/AIDS, TB, and malaria, rather than $30 billion. These resources would represent a significant increase over current funding levels.

The reauthorization of PEPFAR cuts across many of the most prominent challenges of foreign assistance. For example, regardless of the type of programs we are funding, many of the same local factors complicate the intervention. Culture, behavior, tradition, faith all play a role.

In terms of managing and implementing programs, many of the same structural challenges exist: Low government capacity, abject poverty, absence of government systems, lack of accountability, lack of data, and corruption.

And then, in terms of our strategy and design of programs, many of the same dichotomies are also at play. Centralized versus decentralized management, bilateral versus multilateral, country-driven versus donor-driven, targeted versus diffused, and Washington-driven versus field-driven.

Finally, how do we best monitor and evaluate programs, respect intellectual property rights, and incorporate the private sector and other partners?

None of these questions are easy. A few of the responses may not be fully satisfying, but we are here today to talk about PEPFAR and the Global Fund, and we hope to apply your insights to the wider universe also of foreign assistance.

As the chairman of the Subcommittee of Foreign Assistance, I'm interested in the overall management of the PEPFAR program in the context of our larger development goals and programs. Are we getting the most for our money? Are we doing the right mix of programs? How do we balance priorities in education, health, economic growth, social investment, and the environment? What oversight mechanisms are in place to ensure that the funds are being used for the purposes Congress intended? If increased resources are authorized, will those authorizations and resources—where would they come from, and, particularly, how well could they be used?

It's a unique opportunity today, because we have a chance to be both proactive and forward-thinking. While the devastation of these issues does not pause, certainly we need to be thoughtful and deliberate on how we approach them. Some of the best strategic and medical minds are working on these issues, so I'm confident we are on the path toward success, but this upcoming authorization will establish an important framework within which the next 5 years of work will take place.

There is good news and there is bad news. The good news is that the global health community has made great strides with HIV/AIDS. The bad news is that the questions are now even harder. While the U.S.-led effort has made substantial advances in providing access to treatment, the need still far outweighs the availability of services. The rate at which individuals become infected with HIV continues to outpace the rate at which they are treated. And, once begun, treatment is a lifelong obligation and expense.

Also, in looking at future costs of these programs, UNAIDS estimates that, to achieve universal access to antiretroviral medications, the global resource needs for 2010 would be approximately

$40 billion. This figure does not include costs for prevention or care. In the current zero-sum appropriations environment, no single intervention is funded in a vacuum; each one has an impact on all the others. In this case, I certainly reject the idea of a zero-sum budget environment, and I believe, as I have said before, that more resources need to be provided overall for foreign assistance, and this is a critical part of that effort.

So, the question is: How do we leverage additional resources within the government, from other countries, and from the private sector to help cover these costs?

And, last, even with the revised UNAIDS numbers, prevention is considered to be of particular importance in the next 5-year phase of PEPFAR and other programs. The only way that we are going to make inroads against HIV/AIDS is to improve prevention, and it cannot just be behavioral interventions that we have supported in the past, but we must find new medical ways of stopping the disease, whether that is medical male circumcision or microbicides or something that we don't yet understand. The important thing is that we keep our focus on the core issues.

I also believe that we cannot blind ourselves to the possibilities of a wave of new infections that may be coming. I believe that people lean toward talking about treatment because it's comfortable and measurable, but prevention needs to be a priority, moving forward. We can treat, forever; but until we learn how to slow the disease, we will not make a lasting difference.

So, we look forward to this incredibly important panel and what they have to say. We commend you for the work that you have all done, individually and collectively. You're making great contributions to lifesaving efforts around the world.

We are going to turn to our other colleagues here, starting with the ranking member of the full committee. We are, hopefully, not going to be challenged too early by votes on the floor, for which there will be several lined up. So, we will get through all of the witnesses' testimony, and then we'll see where our questioning session begins.

And, with that, I recognize the distinguished member of the full committee, Senator Lugar.

OPENING STATEMENT OF HON. RICHARD G. LUGAR, U.S. SENATOR FROM INDIANA

Senator LUGAR. Well, thank you very much, Mr. Chairman.

As you pointed out, the Foreign Relations Committee is meeting again to discuss the reauthorization of the Leadership Act Against HIV/AIDS, Tuberculosis, and Malaria. The Leadership Act, recognizing that the devastating AIDS crisis required an overwhelming response, created the $15 billion President's Emergency Plan for AIDS Relief—PEPFAR. This program has provided treatment to an estimated 1.1 million men, women, and children infected with HIV/AIDS in Africa and elsewhere.

Before the program began, only 50,000 people in all of sub-Saharan Africa were receiving lifesaving, but costly, antiretroviral drugs. Today, three times that many are being treated in Kenya alone. The Leadership Act also focuses on prevention programs, with the target of preventing 7 million new HIV/AIDS infections.

As Americans, we should take pride in our Nation's efforts to combat these diseases overseas. However, we must act with dispatch to build on these efforts, or lives will be lost needlessly.

On October 24, the committee heard testimony from the Department of State's Global AIDS Coordinator, Ambassador Mark Dybul. He noted that there is increasing concern about United States intent with regard to the AIDS programs. While there is little doubt that the Leadership Act will eventually be reauthorized, the uncertainty with regard to the timing and amount of American funding means that fewer new patients will receive lifesaving treatment. Partner governments and implementing organizations in the field have indicated that, without early reauthorization of the Leadership Act, they may not expand their programs in 2008 to meet PEPFAR goals.

At our last hearing, I cited a letter from the Ministers of Health of the 12 African focus countries receiving PEPFAR assistance. They wrote: "Without an early and clear signal of the continuity of PEPFAR support, we are concerned that partners might not move as quickly as possible to fill the resource gap that might be created; therefore, services will not reach all those who need them. The momentum will be much greater in 2008 if we know what to expect after 2008."

The committee also received support for early reauthorization from AIDS Action, which believes that our global partners need to be assured that the U.S. commitment and leadership will continue and grow.

We heard from the Foundation and Donors Interested in Catholic Activities, which argues that early reauthorization, "will encourage implementing partners to expand the number of patients receiving antiretrovirals at the 2008 target levels rather than holding back on the new services for fear the program's ending or being seriously curtailed. This means many more lives will be saved."

Part of the original motivation behind the PEPFAR program was to use American leadership to leverage other resources in the global community and the private sector. According to the United Nations, "every dollar invested by the United States leverages two dollars from Europe," in the battle against AIDS. The continuity of our effort to combat this disease, and the impact of our resources on the commitments of the rest of the world will be maximized if we act now.

The Leadership Act is due to expire in September 2008. This past August, I introduced Senate bill 1966, which reauthorizes the Leadership Act and doubles the funding to $30 billion. If the United States signals to the world that it is reaffirming its leadership on HIV/AIDS, that will guarantee critical continuity in the effort, and will save more lives.

After consulting extensively with American officials who are implementing PEPFAR, I included several modifications in my bill which I believe will enjoy broad congressional support. My bill clarifies the provision on prevention programs, to make more money available for mother-to-child transmission and blood-supply safety. It also proposes new benchmarks to strengthen accountability and transparency at the Global Fund to Fight AIDS, Tuberculosis, and Malaria, which has been a critically important partner.

I believe we should avoid changes that limit programs' flexibility, which has been at the heart of success.

I join the chairman in welcoming our distinguished panel of expert implementers who are engaged now in the fight against these diseases, and we look forward to their testimony.

I thank you, Mr. Chairman.

Senator MENENDEZ. Thank you, Senator Lugar.

Senator Sununu.

STATEMENT OF HON. JOHN E. SUNUNU, U.S. SENATOR FROM NEW HAMPSHIRE

Senator SUNUNU. Thank you very much, Mr. Chairman.

This is an extremely important hearing, and I think both Senator Lugar and Senator Menendez have done a great job of outlining the scope of the problem, and our—the panelists here probably have much deeper experience than any Member of Congress in understanding the scope of the crisis we face, its impact, not just on health, but on society, across the world, on governments, on security, on economic development. All of these are tied into the devastation that we've seen brought to people around the world as a result of the HIV/AIDS crisis.

Senator Lugar emphasized, and it is worth emphasizing, the importance of American leadership. Our leadership in addressing the problem, our leadership in providing funding, our leadership in making this a priority here in the United States and with all of the developed nations that we know, can provide significant assistance, as well. And I think it's important for Congress to bear in mind that that leadership will be demonstrated, and can be demonstrated in one very specific way, and that is by moving a strong and timely reauthorization bill for PEPFAR and related programs. Putting forward legislation early provides the clarity and the continuity that Senator Lugar emphasized. Sometimes in Congress we forget how that's received around the world, that other countries, whether they are Health Ministers, Foreign Ministers, Presidents, and Prime Ministers around the world, watch and see what kind of steps the United States is taking in an area as important as this.

So, moving aggressively with real leadership on PEPFAR reauthorization is critical. We have some important issues to discuss in that reauthorization, issues like the funding levels. The President has proposed a doubling of funds—$30 billion—but it's important that that's an issue that's addressed early so that our counterparts around the world know, in a sense, what is expected from them in the way of matching support. We need to talk about what obstacles are out there to delivering services, and, of course, what the priorities ought to be with respect to prevention and treatment, all the while keeping in mind that, without flexibility, we're going to make problems—we have the potential to make problems worse, and have the potential to limit the ability of individuals in countries around the world to respond to this crisis.

We have a real need—and I think, and I hope, our panelists will talk about the real need—for developing health care capacity in order to deliver prevention and treatment and information and support around the world. And "health care capacity" can mean in-

frastructure, it can mean workforce, it can mean communication, it can mean data collection. But we have a lot of work to do to develop systems that can adequately address the scope of the HIV/AIDS epidemic, you know, not over the next 1 or 2 years, but over the next two or three decades that we know it will still be with us.

This is something that has bipartisan support, and it—that makes it, in some ways, very enjoyable to work on. And it's something that we've seen experts around the world really focus upon and engage in. And the panelists we have here today are no exception. I want to welcome all those panelists.

I certainly want to particularly welcome Dr. Nils Daulaire. Dr. Daulaire and I had the opportunity to be together at an event that marked World AIDS Day, and talked about a lot of these issues. I've seen his presentation before, and I have no expectations that he's updated it in the last 10 days or so, but it was outstanding when he presented it at Dartmouth, and I'm sure it's still outstanding. I welcome him, as a fellow New Englander.

And I look forward to all of your testimony.

Thank you, Mr. Chairman.

Senator MENENDEZ. Thank you, Senator.

Again, we want to thank all of our distinguished witnesses for joining us today: Dr. Michel Kazatchkine, executive director of the Global Fund to Fight AIDS, TB, and Malaria; Dr. Helen Smits, the vice chair of the committee, of the Institute of Medicine; Dr. Nils Daulaire, the president and CEO of the Global Health Council; and Mr. Ken Hackett, the president of Catholic Relief Services.

We'll start with all of your opening statements. In the interest of time, so there can be a dialog here, we ask you to summarize your written statements to around 5 minutes or so. Of course, all of your written statements will be included fully in the record.

And, with that, we'll start with Dr. Kazatchkine.

STATEMENT OF DR. MICHEL KAZATCHKINE, EXECUTIVE DIRECTOR, GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS, AND MALARIA, GENEVA, SWITZERLAND

Dr. KAZATCHKINE. Thank you, Chairman Menendez.

Senator MENENDEZ. If you would push your button on.

Dr. KAZATCHKINE. Chairman Menendez, Ranking Member Lugar, Senator Sununu, I am honored to be here to present an overview on the progress that the Global Fund to Fight AIDS, TB, and Malaria has achieved so far, the challenges ahead of us, and issues that will be important to consider as you renew the PEPFAR program. Thank you for your leadership and commitment to the fight against the three diseases.

Through the creation of the Global Fund in 2002, and PEPFAR in 2003, as well as a number of other bilateral and multilateral programs, world leaders have engaged in health interventions in an unprecedented way.

To date, through the Global Fund, 1.4 million people living with HIV in developing countries have been reached with antiretroviral therapy. Together with PEPFAR, it is 2.8 million people receiving treatment. We are also starting to see results of large-scale HIV prevention efforts in a number of countries. And, in addition, through Global Fund support, 3.3 million people have been treated

with anti-TB drugs, and 46 million bed nets have been distributed to families at risk of contracting malaria.

The creation of the Global Fund was inspired by the vision to make a difference. In 5 years, the Fund has approved over 10 billion U.S. dollars for grants in 137 countries all across the globe, providing, currently, nearly a quarter of all international donor financing for AIDS and two-thirds of all international funding for TB and for malaria.

Since its initial founding pledge in 2001, the United States has played a critical role in the Fund's work, providing 2.5 billion U.S. dollars, nearly one-third of all Global Fund financing. Overall, G–8 countries continue to be the largest contributors to the Global Fund, providing 60 percent of all contributions. The Global Fund is extremely grateful to the Congress and the American people for its support and for their commitment to defeating AIDS, TB, and malaria. Be assured, your support to the Global Fund is bringing hope and saving lives.

As you know, the Global Fund approach is based on strong founding principles. The one principle underlying every aspect of Global Fund financing is country ownership. Within its national strategy, each country is responsible for determining its own needs and priorities based on consultation with a broad range of stakeholders, including government, but also civil society. The Global Fund is also committed to performance-based funding, meaning that only grant recipients that demonstrate measurable and effective results receive resources on an ongoing basis.

The Global Fund has a strong commitment to transparency and accountability. This includes working with recipient countries to identify key indicators to measure progress. We're presently in the process of consolidating a range of activities within a comprehensive risk-assessment and management framework that will include improving the overall quality of our local funding agents, the Global Fund's independent observers on the ground, and strengthening our data management systems in order to better capture information concerning grants and recipients.

As part of our commitment to transparency and accountability, the Global Fund recognizes the importance of having an independent and objective inspector general. The Global Fund board recently announced the appointment of a new IG and approved the policy to publicly disclose reports issued by that office. This policy requires that the inspector general post all final reports on the Global Fund's Web site not later than 3 working days after they are issued. While restrictions can be approved by the board, the presumption is that all the inspector general's reports will be made public, and that restrictions will be invoked rarely.

As you renew the PEPFAR program, I ask you to keep in mind some key issues. At the Global Fund, resource mobilization and sustainability of financing, which Senator Lugar mentioned in his remarks, are among our highest priorities. Earlier this year, the Global Fund board estimated that the Global Fund would have to commit $6 billion, and perhaps up to $8 billion annually, to meet country demand for the three disease areas by 2010.

In September 2007, the Global Fund completed its second replenishment cycle in which many donors made long-term pledges to the

Fund for the period 2008 to 2010. Through this process, the Global Fund received strong up-front pledges and other estimated contributions, totaling approximately $10 billion for the next 3 years. This level of funding will allow the Global Fund to renew existing programs and approve new funding rounds at existing levels over the next 3 years, but additional contributions from existing and new donors are absolutely needed if the Fund is to reach its funding targets for 2008–2010.

We will pursue strong resource mobilization efforts in the coming years, including attracting more contributions from the private sector and from key emerging economies and other innovative ways to generate resources. As the largest contributor to the Global Fund, U.S. leadership will be critical. As you renew PEPFAR, I hope that the United States will achieve its original commitment to provide one-third of all contributions to the Global Fund.

Another priority for me is strengthening the Global Fund as a partnership, which is essential, particularly at the country level. All constituencies involved in the Fund have crucial roles to play in governance, in generating demand, and implementing Global Fund-supported programs. The partnership includes recipient countries' own commitments, bilateral programs, multilateral agencies, such as World Bank, WHO, UNAIDS, but also NGOs, faith-based organizations, the private sector, and academic institutions. A strong partnership with PEPFAR is particularly important for the Global Fund, especially at the country level.

I would like to express, here, my thanks to Ambassador Mike Dybul for his dedication and leadership in building an excellent relationship between PEPFAR and the Global Fund, and I look forward to working even more closely with him in the future. In the next phase, we can do more to strengthen national strategies and planning processes, and ensure that our joint efforts are fully consistent with them.

AIDS has also highlighted the fragility of health systems in many developing countries. As you said, Senator Sununu, it has revealed that personnel, equipment, medicines, and infrastructures in many countries were never adequate to address the basic primary health care needs of the population, let alone a new epidemic. Implemented in strategic ways, investments to fight AIDS can be the fuel that keeps the entire health system's engine going.

Because of the many potential benefits of disease-specific programs, the Global Fund is engaging strongly with the broader health systems agenda. In November, the Global Fund board approved a new set of principles to guide Global Fund financing of health-system strengthening as part of approaches to the three diseases. The Global Fund is also the first major donor to give in-principle approval to accepting national strategies as financing instruments, which will be a major step in harmonizing the efforts of all donors as they come together to provide finance around a single national health plan, rather than multiple plans and strategies.

Finally, the Global Fund is currently working hard to make adjustments to the structures and operations of both its secretariat and grantmaking processes so that it is equipped to deal with the next phase of growth. In order to preserve our hard-won reputation as a lean, flexible, country-owned mechanism that provides financ-

ing rapidly, reliably, and in a sustainable manner, we're currently taking stock and working to streamline our processes so that interacting with the Global Fund is as simple as possible for countries.

During the past 5 years, PEPFAR and the Global Fund, together, have shown that significant impacts can be made against the major diseases of poverty. The world needs 5 more years of PEPFAR, and it needs the U.S. leadership and generosity in the field of global health. A well-funded Global Fund, along with PEPFAR, ensures that health benefits extend beyond the 15 PEPFAR focus countries, including communities affected by TB and malaria.

Mr. Chairman, distinguished Senators, AIDS, TB, and malaria continue to take a terrible toll on millions of people around the world. I ask for your ongoing concerted attention to fighting these diseases through the critical support of the U.S. Congress for PEPFAR and the Global Fund. Tackling these major diseases of poverty remains the most pressing public health challenge of our time.

Thank you very much.

[The prepared statement of Dr. Kazatchkine follows:]

PREPARED STATEMENT OF DR. MICHEL KAZATCHKINE, EXECUTIVE DIRECTOR, THE GLOBAL FUND TO FIGHT AIDS, TB AND MALARIA, GENEVA SWITZERLAND

Chairman Menendez and Ranking Member Lugar, and distinguished members of the Senate Foreign Relations Committee, I am honored to be here to present an overview on the progress the Global Fund has made so far, the challenges ahead of us and the issues that will be important to consider as you renew the PEPFAR program. As a physician who has treated people living with AIDS for over 20 years, I have seen first-hand the dramatic gains we have made in the fight against AIDS, TB, and malaria. Your work to reauthorize the AIDS program will undoubtedly help to leverage other donors to do more as well.

At the beginning of this decade a revolution was set in motion. The world used to think that health came as a consequence of development; but the AIDS crisis has shown us the reverse—that if you do not address health, other development efforts will falter. Within this new paradigm, it has become apparent that health needs to be looked at as a long-term investment that is essential to achieving development. Through the creation of the Global Fund in 2002 and the PEPFAR program in 2003, as well as a number of other bilateral and multilateral programs, world leaders have begun to engage in health in an unprecedented way by devoting attention and resources to fighting the diseases that take the greatest toll on the poor: AIDS, tuberculosis, and malaria.

As a result of this unprecedented effort, in just 6 years we are seeing dramatic change in the landscape of the countries where we work as more people have access to treatment and lives are being saved. In concert with what the PEPFAR program has achieved in its 1.5 focus countries, the Global Fund is translating the hope of access to prevention, treatment, and care into reality around the world. As we recently reported, results from Global Fund-supported programs show that millions of people are receiving essential health services and that coverage is at least doubling each year. To date, through the Global Fund, 1.4 million people living with HIV have been reached with life-saving antiretroviral (ARV) therapy and together with PEPFAR, 2.8 million people have received treatment. In addition to its focus on HIV/AIDS, the Global Fund has become the largest international financer for TB and malaria programs by far, providing two-thirds of all donor-funding for these two diseases. To date, 3.3 million people have been treated with anti-TB drugs and 46 million bed nets have been distributed to families at risk of contracting malaria.

These 2007 figures emphasize a strong and steady increase in the number of people treated for AIDS and TB, and a spectacular growth in coverage of malaria interventions. Those who have regained their health are able to care for their children, return to work and lead meaningful, productive lives. In Ethiopia, for example, as a result of comprehensive HIV prevention and treatment programs, HIV prevalence has declined from 8.6 percent to 5.6 percent among women who visit antenatal clinics. A multicountry malaria grant in Southern Africa has contributed to an 87–96 percent decline in malaria incidence. Eventually, societies most affected by declines

in human capital resulting from illness and death will be able to translate these gains into growth and opportunity. Building on what we have achieved, it is realistic to think that we can have an even more significant impact on AIDS, TB, and malaria in the future.

THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA

The creation of the Global Fund to Fight AIDS, Tuberculosis and Malaria was inspired by the vision to "make a difference." Simply put, the Global Fund is investing the world's money to save lives. This is a huge responsibility, and one that inspires me every day as the Global Fund's executive director. This vision has also allowed the Global Fund to come a long way in a very short period of time. Since 2002, the Global Fund has now approved over $10 billion for grants in 137 countries around the world, supplying nearly a quarter of donor financing for AIDS and providing two-thirds of donor funding for both TB and malaria.

Since its initial founding pledge in 2001, the U.S. has played a critical role in the Global Fund's dramatic scale-up, providing $2.5 billion in just 6 years, nearly one-third of all Global Fund financing. In total, G–8 countries continue to be the largest contributors to the Global Fund, providing 60 percent of all contributions. Other countries are doing their part. The Global Fund is grateful to Congress and the American people for its support and for their commitment to defeating AIDS, TB, and malaria.

With this massive amount of resources, the Global Fund has achieved significant impact. In mid-June, we estimated that 1.8 million lives had been saved through Global Fund supported programs, with an estimated 100,000 additional lives saved every month. In addition, the Global Fund is now disbursing more funds to more grants faster than ever before. More than half of the total amount disbursed (53 percent) has been to sub-Saharan Africa, with the remainder disbursed to East Asia and the Pacific, Latin America and the Caribbean and Eastern Europe and Central Asia, roughly equal at 10–14 percent. The Middle East/North Africa and South West Asia have received 5 percent and 6 percent respectively of the total amount disbursed.

The Global Fund supports integrated prevention and treatment strategies in the three disease areas. Although the portfolio has so far favored treatment, the proportion of spending for prevention is significant. For example, in 2006, one-third of the $926 million budgeted for HIV grants were allocated for prevention. Drugs and commodities account for nearly half of Global Fund spending, while broad health systems strengthening leveraged through disease programs, including human resources, management capacity-building, monitoring and evaluation and infrastructure/equipment represents between one-third and half of spending. This is consistent with the objectives of the Paris Declaration on aid effectiveness and highlights how AIDS, TB, and malaria funding can have a positive effect on health systems. The Global Fund has been among the first to transparently measure and report against the Paris indicators.

As well as supporting programs in 137 countries around the world, the Global Fund is also an integral partner with PEPFAR in its 15 focus countries. A strong partnership with PEPFAR is particularly important for the Global Fund, especially at the country level, where it provides additional leverage to PEPFAR resources, including addressing TB, which is a major cause of death for people living with HIV. The Global Fund provides a vehicle by which U.S. resources can be harmonized and leveraged with other major international donors, as well as civil society and private sector implementers, in the fight against AIDS, TB, and malaria.

Since I came on board as the Global Fund's Executive Director, I have been working closely with Ambassador Dybul to ensure that the U.S. bilateral program and the Global Fund are working effectively and efficiently together. We are seeing many examples of this coordination in the field. In Rwanda, Ethiopia, Côte d'Ivoire and Haiti, we are seeing increasingly strong collaboration and synergy, and I have made a number of joint country visits with Ambassador Dybul this year. In many other countries, coordination and information sharing are excellent. We are also working together on reporting results, to avoid duplication of efforts and "double counting."

GLOBAL FUND FOUNDING PRINCIPLES

Based on strong founding principles, the Global Fund has experienced dramatic growth in a short period of time. At its core, the Global Fund was created to provide a new channel for significant additional resources for the fight against AIDS, TB, and malaria by investing the world's money to make a difference and to save lives. The Fund has been, and remains, primarily a financing instrument. As a result, for

the Global Fund to continue its scale-up, multilateral and bilateral programs, including USAID, civil society, the private sector and others need to come together to assist in the development of country-driven funding proposals and to support the implementation of programs.

The guiding principle underlying every aspect of Global Fund financing is the concept of country ownership. Within its national strategy, each country is responsible for determining its own needs and priorities, based on consultation with a broad group of stakeholders that includes not only government, but other bilateral and multilateral organizations, civil society, faith-based organizations, the private sector and people living with or affected by the diseases. Global Fund grants are country-owned, but that does not mean they are always government-led. In fact, NGOs, faith-based organizations and the private sector are implementing about 40 percent of Global Fund grants. This multi-stakeholder approach is key to ensuring that resources reach programs for men, women and children who are suffering from and are at risk of AIDS, TB, and malaria.

The Global Fund is also committed to performance-based funding, meaning that only grant recipients who can demonstrate measurable and effective results will be able to receive additional resources. In other words, initial funding is awarded solely on the basis of technical quality of applications, but continued and renewed funding is dependent on proven results and achieved targets. In order to measure performance, the Global Fund has put in place a rigorous measurement and evaluation system that reviews program goals and objectives put in place by each of the recipient countries. This begins at the time the grant agreement is signed, when targets and indicators are agreed upon based on objectives outlined by the countries. Results are tracked at every point in the process, from disbursement requests to performance updates, and requests for continued funding at the 2-year point of the grant.

The Global Fund also has a strong commitment to transparency and accountability. This is illustrated by the broad range of information available on our Web site. All approved proposals, signed grant agreements and grant performance reports are available for review in unedited form, as are documents discussed at board meetings. The public is also able to track the progress of local programs by reviewing grantee reports. Additional efforts are underway to enhance available information concerning the performance and impact of grants.

As part of its commitment to transparency and accountability, the Global Fund recognizes the significant role and importance of an independent and objective Office of the Inspector General (OIG). The OIG reports directly to the Global Fund Board, not to the Secretariat, ensuring the integrity and effectiveness of Global Fund programs and operations. At its recent meeting in November the Global Fund Board announced the appointment of a new inspector general, and approved a policy for publicly disclosing reports issued by the OIG.

This new policy requires that the Inspector General post all final reports on the Global Fund's Web site no later than 3 working days after they are issued. In the case of some reports, the IG has the discretion to recommend, based on limited exceptions listed in the disclosure policy, that restrictions on publication be applied. Such exceptions are intended to allow for "exceptional circumstances where legal or practical constraints would limit the Global Fund's ability to achieve full transparency if it is to protect the interests of the Global Fund and its stakeholders or legitimate interests of those who deal with the Global Fund."[1] The restrictions would require the approval of the Global Fund's Board, following advice from the organization's legal counsel and review by its Finance and Audit Committee. It is important to emphasize that while restrictions can be approved by the board, the presumption is that reports would be made public and this restriction would be invoked rarely.

The Global Fund is also pioneering practical systems that balance the demand for accountability with the need for efficiency. This includes working with recipient countries to identify key indicators to measure progress, and ensuring that where possible, Global Fund reporting requirements rely on existing processes. The use of Local Fund Agents (LFA) is another accountability mechanism designed to provide appropriate oversight while respecting local implementation. LFAs are independent organizations that act as the Global Fund's eyes and ears on the ground, and play an important role in assessing the financial management systems and capacity of grant applicants, the performance of grants and the reporting of results.

The Global Fund is currently bringing together various risk management and oversight functions into a comprehensive risk assessment and management framework. It has also recently undertaken a process of retendering its LFA contracts to improve overall quality of these agents. The new LFA statement of work will con-

[1] Policy for Disclosure of Reports Issued by the Inspector General, GF/B16/8, Annex 3.

tain more explicit requirements on the monitoring of Principal Recipients and subrecipients.

Finally, the Global Fund is working on improving its data management systems in order to better capture information concerning grant subrecipients. Starting in January 2008, the Fund will begin implementation of the Enhanced Financial Reporting system which will entail requesting a minimum set of budget and expenditure information from Principal Recipients on a yearly basis, including cost category, program activity, and implementing entity. As part of an integrated information system, by January 2009, the Fund will have collected a full set of data on all grants and will be able to provide a very comprehensive analysis of the portfolio.

CHALLENGES AND PRIORITIES FOR THE FUTURE

Resource Mobilization and Sustainability

Resource mobilization and sustainability are among our highest priorities. Our commitment to treating millions of people with life-long ARV treatment means that long-term sustainability is a key issue for the future. We must not relent in building on our success. Slowing down would present an enormous risk in reversing the significant gains we have made in fighting AIDS, TB, and malaria.

Earlier this year, the Board estimated that the. Global Fund would have to commit $6 billion, and perhaps up to $8 billion annually, to help meet country demand by 2010 for prevention, treatment, and care in the three disease areas. At least tripling in size over the next 3 years will require significant effort on numerous fronts. The Global Fund is now receiving increasing support and trust from major donors, predominantly the G–8 countries, and solid progress has also been made in private sector engagement through Product (RED) and the development of new sources of funding, such as the Debt2Health initiative.

In September 2007 the Global Fund engaged in its Second Replenishment cycle which was a process to acquire long-term pledges for 2008–2010. At the Replenishment Meeting held in Berlin, the Global Fund received strong upfront pledges of $6.3 billion. Additional minimum contributions are anticipated at $3.4 billion, resulting in an approximate total of $10 billion for the next 3 years. These commitments ensure that we will have the resources we need to approve the continuation of all ongoing programs over the next 3 years—estimated at a total of $6.5 billion—and will also be in a position to support new programs valued at $3.2 billion. It is important to emphasize that this level of funding will essentially be more complex. In order to preserve our hard-won reputation as a lean, flexible, country-owned mechanism that provides financing rapidly, reliably and in a sustainable manner, we are currently taking stock and working to streamline our processes so that interacting with the Global Fund is as simple as possible for countries.

In order to focus on its mission to rapidly disburse resources, at its founding the Global Fund contracted with the World Health Organization to provide administrative services and human resources support. Having now matured as an organization, the Global Fund Board decided in November 2007 that the agreement with WHO will terminate at the end of 2008. As we evolve to become an independent foundation with its own systems and human resource policies, I am confident that the Global Fund Secretariat will become one of the most modern, dynamic and attractive workplaces in the field of global health.

CONCLUSION

During the past 5 years, PEPFAR and the Global Fund together have shown that significant impacts can be made against the major diseases of poverty. The world needs 5 more years of PEPFAR and it needs U.S. leadership and generosity in the field of global health.

The U.S. also needs a strong and well-funded Global Fund to compliment its work, ensuring that health benefits extend beyond the 15 PEPFAR focus countries, helping to harmonize U.S. support with that of other major donors and linking AIDS programs to those of the other major infectious diseases.

The progress that has been achieved to date in the field of global health is the result of both our efforts. PEPFAR and the Global Fund are showing that well-implemented bilateral and multilateral efforts can be mutually reinforcing, and that health and socio-economic development and stability are intertwined. They are showing that health programs can be a force—not only for development—but for international stability and security.

We recognize that AIDS, tuberculosis, and malaria continue to take a terrible toll on millions of people around the world. Continuing the fight against these diseases remains the most pressing public health challenge of our time.

Thank you again for the opportunity to testify. I look forward to answering your questions.

Senator MENENDEZ. Thank you.
Dr. Smits.

STATEMENT OF DR. HELEN SMITS, VICE CHAIR, COMMITTEE FOR THE EVALUATION OF PEPFAR IMPLEMENTATION, INSTITUTE OF MEDICINE, WASHINGTON, DC

Dr. SMITS. Good afternoon, Mr. Chairman and members of the committee. I'm Dr. Helen Smits, and I was honored to serve as the vice chair of the Institute of Medicine Committee that evaluated the early implementation of PEPFAR.

As you know, you mandated this study in the original Leadership Act. It was executed under contract with the Department of State and carried out by an interdisciplinary committee of experts from many nations who visited the PEPFAR focus countries to talk with people, funding and implementing programs.

I'd like to thank my fellow committee members and the IOM staff for all their hard work, as well as all the people in the focus countries and in OGAC who spent so much time with us.

The opportunity to visit focus countries in this context was very moving to me. I met an amazingly diverse group of people—individuals living with HIV, doctors, nurses, traditional healers, government ministers—and they gave one very consistent message; that was, "Thank you." It was very moving, at times. They sang for me, they danced, you know, they served me homemade cakes. At one point, I was given a gift of two live birds. They thanked me, as a representative of the American people, even though I was an evaluator, but I want to convey to you how heartfelt the appreciation is for the program you have funded—conceived and funded.

As my written statement, I've submitted a copy of the actual summary of the IOM report, and—with all of the committee's recommendations. I'll summarize them very briefly, and then focus a little bit more on the one recommendation applicable to Congress, which is that you remove all budget allocations.

We saw that the U.S. Global AIDS Initiative has made a very strong start, and our recommendations are intended to strengthen a good program, not to criticize the program.

The recommendations involve placing even greater emphasis on prevention. We're all agreed you can't treat your way out of this epidemic. We need to use a variety of strategies that are targeted to the local problem, and we need to be very careful to understand how well those strategies are working. We must continue to pay a great deal of attention to the vulnerability of women and girls, with emphasis on the legal, economic, social, and educational factors that make them so vulnerable. I'm sure you've all seen the charts that show that the disease rate of HIV infection rises very rapidly in young women in the late teen years in all of these countries, and it's very important to tackle that problem.

We have to strengthen and enhance our commitment to harmonization. The committee particularly suggested that an important step toward harmonization would be for us to work toward use of the WHO prequalification process as the single standard for approving generic medications. If there are problems with that proc-

ess, we should specify what they are, and we should use our expertise to help the WHO change them.

We also thought that all services—prevention, treatment, and care—can be better integrated, and that the resulting synergies will improve all of the programs.

As we continue to strengthen country capacity, we need to support the expansion of local human resources. It doesn't help to shift tasks from doctors to nurses if there aren't enough nurses. Expanding nursing schools and schools for clinical officers, appears very practical and something that we should be able to support.

And we need to know what works. We need to keep focusing on learning and reporting what have been the effective strategies so that the various participants in this program and the individuals implementing other programs, can learn from one another.

In order to support these improvements, we recommend that Congress eliminate all budget allocations, but shift to a focus on setting priorities and holding PEPFAR accountable. I want to make clear, we're not suggesting you decrease accountability; in fact, we think accountability for results will be better than simply accountability for how you spend the money.

We saw some very impressive staff out there in the field, working very hard. If Congress can specify the results it would like to see, we're sure that they can figure out how to get those results.

Let me just run very quickly through some specific reasons why we want allocations eliminated.

First of all, conditions vary greatly in the different countries. The challenge of reaching the rural poor in Mozambique and Tanzania across very bad roads is very different from the challenge of reaching urban patients in Nairobi. We didn't study the relative costs, but we assume that the cost of treatment where you have very serious travel problems, is going to be higher.

Second, the epidemic varies greatly in different countries. The strategy for Vietnam, where it's an injecting-drug-user epidemic, is very different from the strategy to be used in South Africa, where it's primarily an epidemic of heterosexual spread.

Interestingly enough, situations change very rapidly, and sometimes very much for the better, and the program needs to respond. Budget allocations can limit flexibility. We're in a new phase of prevention where male circumcision will become very important. It's a relatively expensive intervention, but it's a one-time intervention, where you have demand among adult men. If, at the same time, you begin circumcising newborn boys, eventually the need to provide that service will go—will greatly decrease.

Changes in drug prices, changes in the climate can make costs change. In Mozambique every few years, the north of the country is cut off from the south of the country, and you need to have the flexibility to have the money to help the country get its drugs out to the north so that people's treatment is not interrupted.

We saw the rigid separation among treatment, prevention, and care that results from the budget allocations as being very difficult. Predictions, for example—and I could give you many arguments about this—but the predictions are that many of the new cases in the next year, particularly in the countries with the greatest success to date in changing overall behavior, the new cases will come

from faithful, discordant couples, where one is positive and one is not. And, unfortunately, the fidelity message may mislead them into thinking they're safe. We need to focus on identifying them at the point of treatment or care, testing them and giving them very sophisticated message about how prevention applies to them.

In closing, I'd just like to say that in 2003 this Congress set the standard for international leadership in the fight against AIDS, and I'm certainly very proud, as an American, to see that you did that. You now have the opportunity to take the response to the next level and to leave a truly lasting legacy of American leadership. I hope you will seize this opportunity, and I hope, also, that you'll visit, for yourselves, and get some of those thank yous.

Thank you for the opportunity to testify. I'd be happy to address any questions you may have.

[The prepared statement of Dr. Smits follows:]

PREPARED STATEMENT OF HELEN L. SMITS, M.D., MACP, VICE CHAIR, COMMITTEE ON THE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF, (PEPFAR) IMPLEMENTATION EVALUATION, BOARD ON GLOBAL HEALTH, INSTITUTE OF MEDICINE, THE NATIONAL ACADEMIES, WASHINGTON, DC

Good morning, Mr. Chairman and members of the committee. I am Dr. Helen Smits, and it was my privilege to serve as the vice chair of the Institute of Medicine committee that evaluated the implementation of PEPFAR. As you know, this study was mandated by the Leadership Act and executed under a contract with the Department of State. It was carried out by an interdisciplinary committee of experts from many nations who visited the PEPFAR focus countries to talk with people funding and implementing programs. I would like to thank my fellow committee members and the IOM staff for their hard work as well as all of the people in the focus countries and at OGAC who spent so much time meeting with us.

The opportunity to visit focus countries was a very moving one. I met as diverse a group of people as you could imagine: Doctors and nurses, groups of people living with HIV, village councils and the orphans they cared for, missionaries and traditional healers, heads of government ministries, representatives of our partner countries, as well as the dedicated American staff members who make PEPFAR work. There was one consistent message: "Thank you." I was sung to; I attended special dance performances; I was served tea and homemade treats; I was even at one point given a gift of a pair of live birds. All of these people thanked me as a representative of the American people; I want to convey those thanks to you for conceiving and funding this program.

I have submitted as my written statement a copy of the Summary of the IOM committee's report with all of the committee's recommendations. I will summarize them briefly and spend a bit more time on the one recommendation that is directed to Congress—namely, to eliminate the budget allocations.

The U.S. Global AIDS Initiative has made a strong start and is progressing toward its 5-year targets. The challenge now is to maintain the urgency and intensity that have led to early success while placing greater emphasis on long-term strategic planning for an integrated program in which prevention, treatment, and care are much more closely linked, and on capacity-building for sustainability.

The committee recommendations to the Global Aids Coordinator, many of which are already in the process of implementation, are as follows:

- Even greater emphasis on prevention is needed. This must be based on a greater understanding of exactly where the latest cases have occurred.
- There should be increased attention to the vulnerability of women and girls with emphasis on the legal, economic, social, and educational factors that lead to spread of the disease.
- We must continue and strengthen our commitment to harmonization—with the host countries and with other donors. In particular, we should work with the World Health Organization to accept their prequalification process as the single standard for assuring the quality of generic medications.
- All services—prevention, treatment, and care—must be better integrated. The resulting synergies will improve programs in all areas.
- As we continue to strengthen country capacity to fight the local epidemic, we should support expansion of local human resources. Many of these countries

have too few nurses and clinical officers. Helping to train new ones will be more productive that only retraining the ones who exist.
- We need to know what works. A focus on learning from experience will only strengthen the program.

In order to support all of these improvements, we recommend that Congress shift from a budget allocation approach to one of setting priorities and holding PEPFAR accountable—from a focus on how the money should be spent to a focus on what the money is accomplishing. Allocations have unfortunately made spending money in a particular way an end in and of itself rather than a means to an end. They have reduced the program's ability to adapt to local conditions and to respond effectively to changes either in the epidemic or in our constantly growing knowledge of how to fight it.

In eliminating budget allocations, Congress should retain the results-oriented nature of the program. Let me be clear that the IOM committee is not suggesting the diminishment of accountability. Instead, we are recommending an approach that we believe will result in more meaningful targets and greater accountability. Congress should hold the Global AIDS Coordinator accountable for demonstrating that we are actually succeeding against the pandemic, not simply succeeding in spending money on it. If Congress can specify the results it would like to see, program staff can figure out how to get those results. The increase in flexibility that will result from the elimination of budget allocations will make us a better partner with the host countries and with other donors.

PEPFAR is not a single, uniform program the details of which can be specified by the Global AIDS Coordinator or Congress. In the focus countries PEPFAR is 15 distinct programs reflecting the unique circumstances and epidemics of each. I realize that this is nothing new for Congress—you contend with the uniqueness of 50 States everyday. But if you magnify many fold the variation that you see between Delaware, Indiana, Florida, and Alaska, you will begin to get a sense of the challenge of trying to apply a single approach across countries as different from one another as Guyana, South Africa, Mozambique, and Vietnam.

The specific reasons for eliminating allocations are as follows:
- Conditions vary greatly in the different countries. The challenge of treating the rural poor in Mozambique and Tanzania is very different from that of treating urban residents in the slums of Nairobi.
- The epidemic varies greatly in different countries. The strategies for reaching patients with treatment and for prevention are very different in Viet Nam, where the epidemic is driven by injecting drug users, from those in South Africa, where the spread is heterosexual.
- Situations change rapidly and the program needs to respond; budget allocations can limit crucial flexibility. We are in a new phase of prevention with adult male circumcision added to the armamentarium of effective strategies—and altering the cost of prevention. Changes in drug prices, availability of specific medications, approaches to testing, or even climate can have the same effect. Floods in Mozambique frequently cut the northern section of the country off from the south; means must be found to continue the regular delivery of medications when that happens.
- The rigid separation among treatment, prevention, and care that results from allocations should be ended. Predictions are that many of the new infections in affected countries over the next years will come from discordant couples where one partner is positive and one is not. Ensuring that treatment and care both carry a strong prevention message can make a real difference in our ability to reach the people we wish to target.

In closing, in 2003 Congress set the standard for international leadership in the fight against AIDS. You now have the opportunity to take the United States response to the global AIDS epidemic to the next level and leave a truly lasting legacy of American leadership.

I hope you will seize this opportunity. I also hope you will visit for yourselves to see the remarkable accomplishments of the program to date—and to receive in person the gratitude of those who benefit.

[EDITOR'S NOTE.—The Summary of the IOM committee's report and additional material mentioned above was too voluminous to include in this hearing. It will be maintained in the Foreign Relations Committee's permanent record. It can also be viewed at: http://www.nap.edu/catalog/11905.html.]

Senator MENENDEZ. Thank you. Thank you, Dr. Smits. What did you do with the two live birds?

Dr. SMITS. Oh——

[Laughter.]

Dr. SMITS [continuing]. I didn't think I'd do very well in Customs with them. We gave them——

[Laughter.]

Dr. SMITS [continuing]. To the nice young woman from the NGO who had taken us to visit the village.

Senator MENENDEZ. Dr. Daulaire.

STATEMENT OF DR. NILS DAULAIRE, PRESIDENT AND CEO, GLOBAL HEALTH COUNCIL, WASHINGTON, DC

Dr. DAULAIRE. Thank you, Mr. Chairman, for your approach to looking at PEPFAR in the broader context of U.S. foreign assistance; you, Ranking Member Lugar, for starting this process for reauthorization of PEPFAR; Senator Kerry, for your work as cochair of the CSIS Task Force on HIV/AIDS over the past several years; and my neighbor and colleague, Senator Sununu, with whom I had the pleasure of spending a snowy Sunday in his home State of New Hampshire just a couple of weeks ago.

I request that my written statement be entered into the record, and I will keep this short so that we will have time for some dialog.

But let me say, in summary of my written statement, the Leadership Act has been both historic and constructive. And the Global Health Council and our membership, both here in the United States and around the world, endorse its speedy and thoughtful reauthorization.

The Global Health Council is a worldwide membership alliance representing over 480 organizations around the world and over 5,000 health professionals. Our members are on the front lines of global health. They're the ones who are dealing with these issues, face to face. And, personally, I'm a physician and a public-health scientist, so I'm speaking to this issue from that standpoint.

Now, evidence is at the heart of everything that we try to do, and the evidence is this: PEPFAR and the Global Fund have begun to show substantial impact, in terms of reducing the toll of HIV/AIDS, reducing mortality, and we are beginning to show signs of reducing new incidents, as recent UNAIDS statistics have shown. So, in a sense, what we've had over the past 4 years, with the emergency plan is the public-health equivalent of an emergency room in full swing. But now it's time, under reauthorization, to start looking at this issue from the standpoint of managing the community health center. Someday we'd like to be able to close the emergency room and deal with this in the communities themselves, through prevention and early care, rather than having, as we've had to do, to mount an emergency campaign of this sort. But we must recognize that AIDS will be with us, no matter what the scenario, for a very, very long time; and so, we need to start thinking about AIDS like other chronic diseases.

The evidence in dealing with all chronic diseases, and the mounting evidence about HIV/AIDS globally at this point, is that thoughtful integration of treatment, care, and prevention can, and does, lead not only to better outcomes, but to fewer infections. And that certainly is an area that needs attention. As my colleague has just said, it's critical that PEPFAR–2, the next iteration, scale up

prevention using the growing body of information and evidence that we have about the varying characteristics of how HIV is spread. It's also very clear, as we just heard, that one size does not fit all, and that there has to be more flexibility built into the future authorization, whether that's a softening of earmarks or their elimination altogether.

Our members tell us that allowing decisions on prevention to be made by those who are actually dealing with it on a daily basis, dealing with the microaspects of this epidemic, has far better impact than having a one-size-fits-all determination coming out of Washington. And the facts on the ground do call for greater flexibility.

And, second, another provision in the existing law that has been deeply counterproductive, from the standpoint of our members who are on the front lines implementing, is the APP, the so-called "antiprostitution provision," which has made it more difficult, even though that was not its intent, for many of our members to engage constructively in dialog with prostitutes and commercial sex workers, and to really have an impact. That should be stricken from the new act.

We've been talking about AIDS this morning, but obviously it's an AIDS, TB, and malaria act, and the next point I'd like to make is the importance of integration across a wider range of issues.

First, it is critical to address TB and malaria, but, fundamentally, we must recognize the importance of strengthening health systems, especially human infrastructure, and to work much more closely with other health efforts. This is fundamentally important because if you've got a sick mother and an unhealthy child, whether they have HIV or not, they deserve attention. We have the same systems, the same health care workers, the same clinics that deal with them. And it's notable that, with the remarkable technical success of dealing with neonatal AIDS with the use of nevirapine, we've still had very little impact, because many women don't come to the HIV/AIDS clinics, because adequate maternal and child health services and family planning services aren't available there; their children don't come in because they don't have good basic child health care services. All of these services are critically important and need to be strengthened together.

Finally, it's important that PEPFAR move increasingly toward becoming a learning organization. Operations research, which is very different from the kind of clinical and scientific research carried out by the NIH, is vital to improving programs, to refining them; and sometimes it seems that there's been a little bit of a barrier between the operations research and the implementation side. Learning from operations research needs to be encouraged. We would not have eliminated smallpox around the world without on-the-ground operations research. And few of us would be using Apple computers and iPods and iPhones if Apple weren't doing that. So it's an important component.

Let me close by saying that many of us look forward to the day when not only AIDS and malaria, but the broad sweep of global health development and poverty alleviation is seen as critical to the U.S. engagement with the world. We strongly endorse continued and growing support of vital agencies, like the Global Fund, and

recognize that the United States must provide its fair share of funding for international and multilateral activities. We also hope someday to see a Department of International Development. It is as vital to America's interests in the world as our diplomatic and military engagements, but that's for another hearing. [Laughter.]

Dr. DAULAIRE. Thank you very much.

[The prepared statement of Dr. Daulaire follows:]

PREPARED STATEMENT OF NILS DAULAIRE, M.D., MPH, PRESIDENT & CEO, GLOBAL HEALTH COUNCIL, WASHINGTON, DC

Chairman Menendez and members of the committee, thank you for holding this important hearing today on the future of the United States response to global AIDS, tuberculosis, and malaria. I am Dr. Nils Daulaire, President and CEO of the Global Health Council, the world's largest membership alliance of over 5,000 health professionals and 480 service organizations working to save lives and improve health throughout the world.

Before I begin my remarks, let me applaud this committee for its commitment and dedication to global health issues, most notably HIV/AIDS. I congratulate the committee for its bipartisan work on the United States Leadership Act Against HIV/AIDS, Tuberculosis and Malaria, the law that authorized the President's Emergency Program for AIDS Relief—PEPFAR. This historic legislation set the stage for an unprecedented U.S. Government investment in the fight against a serious global health challenge. The importance of this massive investment cannot be overstated; it has literally transformed the concept of what is possible in the realm of global health. On behalf of the Council's members working in over 100 countries across the globe, and the millions whose lives are improved by U.S. Government-supported global health programs, we thank you.

The Global Health Council's members include nonprofit service organizations, faith-based organizations, schools of public health and medicine, research institutions, associations, foundations, private businesses and concerned global citizens whose work puts them on the front lines of global health—delivering programs, building capacity, developing new tools and technologies, and evaluating impact to improve health among the world's poorest citizens. Our members work on a wide array of issues, including, of course, HIV/AIDS, but also other infectious diseases, child and maternal health, family planning, water and sanitation, and health systems strengthening.

I am a physician and have been personally engaged for more than three decades in the global effort to improve the health of the poor. When AIDS was first recognized just 26 years ago, few anticipated that it would grow to become the worst pandemic of modern times, and the world's initial slow response gave the virus a chance to establish its death grip on the lives of millions. But the past decade has been heartening to those of us who have taken on the challenge of building health programs and services in the forgotten corners of the world. U.S. leaders, as well as leaders from other countries; the U.N.; the Global Fund to Fight AIDS, TB, and Malaria; and the Bill and Melinda Gates Foundation, have recognized both the severity and the moral call of HIV/AIDS, and the response has been unprecedented.

In fact, the response has begun to make a difference. As UNAIDS recently reported, new data show that the global HIV prevalence—the percentage of people living with HIV—has leveled off and that the number of new infections each year has fallen, in part as a result of the impact of HIV programs. However, in 2007 33.2 million [30.6–36.1 million] people were estimated to be living with HIV, 2.5 million [1.8–4.1 million] people became newly infected and 2.1 million [1.9–2.4 million] people died of AIDS.[1] When the reality is that every person with a new infection will need years of treatment and care, it remains clear that now is not the time to step back from U.S. leadership on this issue.

We need to continue the signal accomplishment of this new century—PEPFAR—the partnership between the Bush administration and a solid bipartisan majority of the U.S. Congress that made PEPFAR the cornerstone of the largest prevention, care and treatment effort the world has ever seen. It is clear that PEPFAR has had some enormous successes over the last 4 years. We are here today in order to build on them and to make them lasting.

The things that have worked well need to be reinforced, and those that haven't worked so well need to be fixed. The reauthorization process provides us with an opportunity to examine ways to make this program more effective for the long run. To help provide constructive and informed input into the PEPFAR reauthorization

process, the Global Health Council has for months now engaged a wide network of experts, implementers, and advocates through the Global AIDS Roundtable and the more programmatic HIV Implementers Group. We look forward to continuing our work with this committee to ensure that the next generation of this program continues its forward momentum.

This administration's commitment to the fight against the global spread of HIV/AIDS has resulted in extraordinary accomplishments. Similarly impressive efforts have begun for malaria under the President's Malaria Initiative (PMI). But one thing is clear to those of us who engage daily in delivering these services: While an emergency response focused on a single disease can have remarkable, short-term results, it will not succeed as a model for the long-term response that is necessary for reversing the HIV/AIDS pandemic.

Early in his tenure, the President's first Global AIDS Coordinator, Ambassador Randall Tobias, was asked about the inter-relationships between the HIV/AIDS response and other public health interventions such as maternal and child health, family planning, nutrition, clean water, and other diseases. His response was to acknowledge that these were important problems, but that his charter was to combat HIV/AIDS through the sharp lens of prevention, care and treatment. Congress had set very ambitious targets, he told us, and he had to stay completely focused on them.[2]

His point was understandable. But I believe that, with experience, that view was short-sighted, a mistake of first principles. Over the past few years, it has become very apparent that, in the long run, we cannot succeed in our efforts against HIV/AIDS without linking PEPFAR much more closely with these other interventions and with strengthening health systems more broadly.

Let me take as an example the issue of newborn infection with HIV, a preventable tragedy that occurs over half a million times a year.[3] PEPFAR addresses this through a program to test pregnant women and provide those who are HIV positive the drug nevirapine, a low-cost highly effective intervention. This has been a priority program under PEPFAR. Yet throughout the world, most women are never tested for HIV, a small proportion of those who could benefit receive nevirapine, only a small dent has been made in the numbers of infected children born in poor countries, and even less impact has been seen on overall child death rates.[3,5] Why is this?

First, because women generally come to the health care system in the first place not for HIV care but for routine family planning and maternal and child health care.[6] Most of them don't even know they are HIV positive. So unless the HIV services are deeply integrated with family planning and maternal and child health services, most who need them will never know they need them, much less get them.

These women need help not just with their HIV infections. Their first priority is for a safe pregnancy and delivery. They and their newborns need to sleep under malaria bed nets. They need access to nutritious food. They need to know how they can prevent or delay their next pregnancy.

And their babies, whether HIV infected or not, need basic newborn and childhood care. After all, most children who die, even most children dying as a consequence of HIV infection, die from diarrhea, pneumonia, malaria, and other common preventable or treatable childhood diseases.[7] Antiretroviral drugs alone can't save HIV-positive babies without the child health services that are currently not available because resources and manpower are being redirected toward HIV/AIDS.

The Global AIDS Coordinator, Ambassador Mark Dybul, acknowledges this reality, and has begun to explore programmatic linkages. I think he could use some help, and I believe that the Congress can provide that help by granting specific authority for, and even requiring, the Global AIDS Coordinator to link directly to the other U.S. agencies and programs that deliver these services and, when they are weak or inadequate, to support them directly with PEPFAR funds. Far from being a diversion of resources, this would assure that our HIV/AIDS dollars are spent most effectively.

Should PEPFAR then be the platform for all basic health services or bear the programmatic burden for the full array of health issues facing communities in the developing world? No. The appropriate U.S. policy approach must encompass, but not be based upon, responses to any single disease.

I will return to specific thoughts on PEPFAR reauthorization in a moment. But let me first offer you the bottom line here: While beyond the scope of this hearing alone, the U.S. Government ultimately needs a comprehensive strategy to guide its engagement in improving the health of the world's citizens and, in turn, protecting the health of its own. This is my fifth appearance before Congress this year. I have testified about maternal and child health, malaria, tuberculosis, and HIV/AIDS. I appreciate the opportunity to share perspective on each of these topics, but budget

line items and various agency authorities have dissected a single experience—health—into disparate funding, policies, and programmatic approaches that undermine our ultimate goal: Healthier individuals and families and therefore more stable and productive global communities. Investing in health is not just a humanitarian response. The returns on its investments are also seen in growing and stable political systems. With U.S. Government investments in global health on the order of $6 billion (with nearly $5 billion committed to AIDS alone), don't we want to make the most of our investment?[8] I have been at this for decades, and I can tell you with confidence that single-disease, single-intervention, or any other siloed approach simply will not succeed over the long run.

This hearing is about transitioning the U.S. response to the global AIDS crisis through PEPFAR from an emergency program to a sustainable one, because we recognize that the AIDS virus will be in our midst for generations to come. Our response to HIV/AIDS must now expand from a model designed to help get the emergency room up and running to one where the community clinic can successfully keep people out of the emergency room in the first place.

Of course, HIV-affected people must have access to antiretroviral drugs, but no one can survive on drugs alone. Just like everyone else, people who are living with HIV/AIDS—especially those who have gotten drugs to keep their infections in check—need good nutrition, clean water, vaccines, pre- and post-natal care for mothers and children and prevention, care and treatment for all the other major health threats that they face.

Let's face it, we are in a struggle to beat HIV/AIDS for the long haul—just like our battles to overcome cancer and heart disease at home. Now that HIV/AIDS is treatable, it has become a chronic disease, and chronic diseases require functioning health systems, working every day.[9,10] Clinics must be open, staffed, and supplied—and that can't be done just for HIV alone. Health providers must be trained, supervised, supported, and paid—and no one dreams that this could be an AIDS-specific cadre. Ministries of health and nongovernmental organizations alike must function smoothly and efficiently, with solid leadership and management skills—and these must be generalized skills because the systems they must support are necessary for each and every health intervention.

This is why beating HIV/AIDS demands more than HIV-specific prevention, care and treatment programs operating in isolation from other global health interventions. This is why the delivery of all essential health care services through strong and efficient health systems is necessary for the fight against AIDS. This is why greater integration and coordination of PEPFAR programs with other global health programs and services is the single-most important step the U.S. can take right now to maximize the program's effectiveness in the future. I call on Congress to make sure that this is supported and encouraged in your reauthorization bill.

PEPFAR can and should be better integrated on four different levels:

- Internally between its own prevention, treatment and care programs;
- Laterally across other U.S. global health programs addressing issues other than HIV;
- Nationally through the strengthening of health systems and support of expanded health manpower in countries with high burdens of disease; and
- Externally through enhanced coordination between PEPFAR and other HIV- and non-HIV specific programs managed by focus country governments and by other international donors.

INTERNAL INTEGRATION

To date, PEPFAR's programs have been separated into the categories of prevention, treatment or care, with the focus and lion's share of funding largely on treatment. This approach can work with certain targeted populations, but there is always the risk that this construction will prove too rigid to optimize the use of resources and most effectively save lives.

Those who are at high risk of contracting HIV need to know how to stay HIV free and what treatment options exist if they do become infected. Those who are HIV positive need to have access to the full range of prevention methods in order to improve their own health and to protect the health of those around them. It remains fundamentally true that treatment for people who are HIV positive still needs to be expanded, but as we find that for every individual treated there are six new infections, it is clear that we will never be able to treat our way out of this epidemic. Prevention activities must be significantly scaled up and built upon interventions that go beyond medical models to address the behavioral and social components of this disease.

I would be remiss if I did not flag two provisions within the current legislation that, if left unrevised, will undermine prevention, care and treatment activities. The first provision is the specific target that one-third of prevention funds be dedicated to abstinence-until-marriage activities. In communities where many young girls' first sexual encounter is by force or where being a young bride to an older man who has not limited his sexual encounters is the cultural norm, the current abstinence policy does not move us toward the desired outcomes—fewer HIV infections. Delayed sexual debut is ideal. However, a fundamental tenet of public health is that you tailor the intervention to local circumstances. A blanket abstinence target ignores this tenet and leaves too many young women without realistic recourse to protect their health.

The second provision is the antiprostitution pledge which all organizations receiving PEPFAR funds must sign. This provision must be repealed. Although not politically correct, the truth is that in many areas including India, Thailand, and the former Soviet Union the AIDS epidemic is driven in part by high-risk behaviors such as commercial sex work. Ideally, individuals would not engage in these activities. But, we cannot let the epidemic continue to spread because we take ideological issue with the behavior of a subset of men and women. Let us not tie the hands of organizations that are committed to providing the best interventions for people in their very real, complex, imperfect yet valuable lives. I strongly encourage the committee to consider the social and cultural complexities of the lives of people who experience this epidemic and to program accordingly.

INTEGRATION AND COORDINATION ACROSS U.S. GLOBAL HEALTH PROGRAMS

Most people who are battling AIDS actually die from infections caused by other organisms that have found an open door due to HIV's suppression of the immune system; these are called Opportunistic Infections (OIs). Currently, tuberculosis (TB) kills about one-third of AIDS victims.[11] Pregnant women who contract malaria are at greater risk of HIV infection and those who are HIV-positive are at greater risk of malaria.[3,12] And as I have noted, most children dying with HIV die as a direct result of common childhood infections whether or not their immune systems are compromised.[13]

By only addressing the HIV/AIDS-specific aspects of the health of a person with coinfections and multiple susceptibilities, PEPFAR is, in some ways, saving lives only to leave them vulnerable to death or debilitating illness from other causes whose effects could have been minimized or eliminated with a more thoughtful and thorough programmatic response. A more comprehensive view of multiple disease risk and the appropriate response is needed. PEPFAR programs must have explicit linkages between their services and those other critical global health programs that focus on other diseases and health conditions.

A number of our member organizations do an excellent example of integrating HIV/AIDS programs with other health and development efforts. CARE has done some enormously creative and productive work toward that end. Family Health International (FHI) has also demonstrated the positive impact of an integrated response. A number of other Global Health Council members are engaged with RAPIDS—a PEPFAR-funded project that covers 53 districts in Zambia to provide home- and community-based care for people living with HIV/AIDS and support for orphans and vulnerable children through a coordinated response.[15] In this example of successful coordination across U.S. programs, USAID, CDC, DOD, Peace Corps, and the State Department have developed an intense, integrated, and coordinated response in which it funded various organizations to take on projects that cut across all sectors. The project funds agriculture, economic growth, health, education and democracy while at the same time aiming to scale up prevention, treatment and care. As a result, thousands of people living with HIV in Zambia are accessing basic health and development services, and not just antiretroviral therapy.

When PEPFAR was first announced, it was with assurances that this funding would be additive to funds already in place for global health and international development efforts. Sadly, we are seeing instances, such as in Ethiopia, in which PEPFAR and PMI funds have increased, while maternal and child health funds have been significantly cut.[16] Can the majority of that country's women and children who are dying despite being HIV-free, and whose deaths could readily be averted with effective, proven, low-cost interventions, consider this a victory?

STRENGTHENING HEALTH SYSTEMS AND BUILDING HEALTH MANPOWER

HIV/AIDS has taken weak health systems in the most highly afflicted countries, particularly those in sub-Saharan Africa, and stressed them to the point of collapse. A major contribution of PEPFAR was revealing the utterly desperate conditions of

the world's national health systems. Once money and resources began to flow, we quickly realized that we lacked the trained professionals to deliver life-saving interventions; we lacked the management systems to implement programs and handle large infusions of resources—nearly every link in the health system left something to be desired. Weak health infrastructure and lack of an adequate human resource supply in developing countries limit the ability to support the integration and coordination of HIV/AIDS services.

While there is much to be done, perhaps the most pressing issue is the supply, type and training of health workers, particularly in the areas of expanding prevention services and detecting opportunistic infections. As the Institute of Medicine (IOM) recommends, PEPFAR must contribute to strengthening health systems and adequately train and support critically needed new health workers.[17]

EXTERNAL COORDINATION BETWEEN PEPFAR AND NON-U.S. HIV AND NON-HIV PROGRAMS

Coordination is absolutely necessary within programs of the U.S. Government. It is also essential with the governments of focus countries if we are to continue to build upon PEPFAR's successes. According to the IOM's report, PEPFAR country teams "have been largely successful in aligning their plans" with a recipient country's national HIV/AIDS strategies.[18] Serious concerns remain, however, about ensuring that the siren call of available PEPFAR resources doesn't result in situations where national HIV/AIDS strategies become seriously misaligned in proportion to countries' specific disease burdens.

When lives are at stake every dollar has to count. The U.S. Government also must take care to chart whether other public or private donors are investing in the same kinds of programs and in the same places as PEPFAR so that duplication—or worse, destructive competition—is avoided.

Any discussion about vital coordination between PEPFAR and other HIV/AIDS efforts is incomplete without mention of the other cornerstone of the global response to this pandemic: The Global Fund to Fight AIDS, TB and Malaria. Early years saw aspects of unproductive competition between PEPFAR and the Global Fund. I applaud Ambassador Dybul for his efforts to assure closer coordination and cooperation with the Global Fund, and encourage efforts to assure that this continues and is expanded, since each of these mechanisms has its own particular strengths and advantages.[19]

Successful multidonor coordination on HIV/AIDS programs is not only possible, it makes for better programs. In Malawi, the U.K.'s Department for International Development, the Global Fund to Fight AIDS, TB and Malaria, and Malawi's Ministry of Health together designed the Emergency Human Resource Plan to build human resource capacity to address the severe HIV/AIDS crisis in the country. This joint planning and coordination helped Malawi to double its output of nurses in just 3 years and increase preservice training for doctors. The strategic coordination avoided duplicative efforts, allowing the program to address a wide range of problems related to health systems.[20]

LOOKING FORWARD

Even with its remarkable accomplishments over the past 4 years, PEPFAR faces an uphill battle against a virus that manages to stay ahead of the world's best efforts to defeat it. Just a few months ago, we heard about the failure of what had been considered our most promising vaccine candidate.[21] There is no doubt that more disappointments will follow. This will be a long struggle requiring persistence and patience.

As PEPFAR evolves with Congress's oversight, a number of issues must be addressed. First, the structure of U.S. global health assistance must be seriously reviewed and, I would recommend, redesigned. Each agency currently working as a part of the U.S. global AIDS response has a separate funding and procurement mechanism, different benchmarks for reporting, and different targeted communities. Under the current model, coordination and integration of HIV/AIDS is more difficult than it needs to be. Congress should take steps to correct this.

Congress must also assure that health systems and health manpower development are front and center in expanded efforts to address HIV/AIDS and other major causes of ill-health and death in highly affected countries.

Finally, the U.S., other donors, and national governments must take under serious consideration the financial implications of a sustainable response to global AIDS, specifically, and basic health more broadly. While U.S. funding for global AIDS grew from $125 million in 1997 to $5.4 billion in 2007, it still remains below the levels needed for fully scaling up prevention and treatment in the focus countries, much less the need for HIV/AIDS services in nonfocus countries where mil-

lions of people are infected or at-risk.[22] Treatment costs will rise with the need for second-line drugs and HIV-positive individuals living longer and requiring a wider array of health services.[4] Effective and widespread prevention services, although a wise long-term investment, will add significant costs.

This need for expanded funding will continue from a finite pool of resources. Still, the funding currently available for global AIDS programs dwarfs the U.S. investments currently made in other global health programs. For example, USAID's child and maternal health and reproductive health accounts have remained at around $360 million and $400 million a year respectively, and yet three times as many children and women die globally each year from non-HIV related causes than from AIDS.[23,24] Resource constraints as well as policy restrictions have impeded the successful "wrap around" of non-HIV services with HIV services.

Increased support for global AIDS programs must not come at the expense of other global health programs if we are to achieve both the goal of establishing an effective HIV/AIDS program and the goal of building comprehensive and efficient national approaches to all major global health threats.

CONCLUSION

The President's Emergency Plan for AIDS Relief may be relatively new, but the fight against the global spread of HIV/AIDS is not. We have reached a point where the emergency response is still necessary but no longer sufficient in our fight against HIV/AIDS. HIV/AIDS is inextricably linked with other diseases. To effectively combat this pandemic, we must expand our response, and a comprehensive approach to global health in developing countries is needed to do that successfully.

Today, I have proposed steps that could be taken in the near future to strengthen PEPFAR by better integrating PEPFAR services internally, across U.S. global health programs, with national health systems, and with external partners addressing HIV/AIDS in the developing world. We can improve upon the lessons learned through PEPFAR to improve our global AIDS response and reverse the HIV/AIDS pandemic.

In the long term, I urge Congress and the administration to also consider the role of PEPFAR in the context of developing a comprehensive U.S. strategy for addressing all critical global health issues. The Global Health Council and our members stand prepared to help address the realities in which a third of the world's people live—and in which a disproportionate number die.

Thank you again for the opportunity to testify before you today. I welcome your questions.

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Senator MENENDEZ. Thank you.
Mr. Hackett.

STATEMENT OF KEN HACKETT, PRESIDENT, CATHOLIC RELIEF SERVICES, BALTIMORE, MD

Mr. HACKETT. Thank you very much, Chairman Menendez and Ranking Member Lugar, Senator Sununu, and Senator Kerry. Thank you for allowing us to be here and share our perspectives on the next phase of PEPFAR and the global fight on AIDS.

I'm president of Catholic Relief Services, an organization which reaches out around the world to assist people in their state of poverty, and to try to give them the dignity and the help to rise above it.

We have been involved in addressing the HIV and AIDS questions and pandemic for more than 20 years. I must admit, we haven't done enough, or we haven't done it well enough. But, through PEPFAR, CRS, and our partners are providing antiretroviral therapy to 100,000 people and care right now to nearly a quarter of a million people living with HIV and AIDS in 12 out of the 15 focus countries. And we're also engaged in 40 other countries with our own private funds, nongovernmental funds, in reaching out and providing assistance to people living with AIDS.

Let me echo what my colleagues have said before. I believe that PEPFAR is an outstanding success for which the President, this Congress, and the American people can be most proud. The strong leadership and broad bipartisan support have resulted in an initiative that shows the best possible face of the American people.

PEPFAR has come through its gestation period. It was, at times, difficult, I'll tell you that. But now it is through it, and it's ready to take off. PEPFAR is, above all, a program of hope.

Just 2 weeks ago, during the World AIDS Day commemorations here in Washington, President Bush literally embraced a woman from Zambia by the name of Bridget Chisenga. Everybody who knows Bridget calls her "Auntie Bridget." She actually works for us in Zambia, promoting adherence to antiretroviral therapy and fighting stigma associated with AIDS. She gave President Bush a message that seemed to move him and caused him to embrace her. She said, "I've seen the Lazarus effect. I've seen people coming back to life." Auntie Bridget isn't just a PEPFAR implementer, she's also receiving antiretroviral therapy through the PEPFAR

program; and, without PEPFAR, she and many millions of others would not be alive. She herself was part of that Lazarus effect.

The HIV prevention efforts that are part of PEPFAR have also shown progress, particularly through the AB model of "abstinence and be faithful." Data about the effectiveness of abstinence and faithfulness have been largely ignored. However, there is a widespread consensus among many public health experts that partner reduction and the delay of sexual debut are critical and necessary components of any comprehensive approach to reduce the spread of AIDS.

Finally, I'd like to share some of what we consider to be the key issues for the next phase of PEPFAR.

First, I think we've learned how to control the disease. Now we must put adequate resources into initiatives that treat and prevent HIV. And we are now in a position to really pick up the momentum. "We," in that context, are that range of agencies that are out there on the front lines, in the villages beyond the end of the road, that are providing assistance.

Second, it's important to create linkages between PEPFAR and other U.S. assistance programs, particularly in the areas of nutrition, of livelihood, of income generating and education. And we'd like to emphasize that these complementary needs should be funded through other accounts, not through PEPFAR, but they should be coordinated at the country level.

Third, our model focuses on long-term sustainable development by building the capacity of local partners. That includes physicians and health care staff. But it will be a long time, in the poorest of countries, before they can really completely and independently take on the burden of addressing this pandemic. And, until then, providing these vital services through PEPFAR is the right thing to do.

Fourth, because we believe that PEPFAR, as implemented, has, so far, been widely successful, we urge you to preserve the basic programming model, but with several improvements. First, we feel that there must be a provision to maintain funding for abstinence and faithfulness programs. Without dedicated funding, these activities will be ignored. We've seen it before, we've been down that road before, and, until there was dedicated funding, we just couldn't access those programs.

Second, do not require PEPFAR implementers to offer family planning and reproductive services. Such a requirement runs counter to the moral values of some organizations, and may constrain or hinder some organizations from participating in the program. That will mean the program will not be offered to many millions of people.

Third, the therapeutic feeding program, called Food by Prescription, should be expanded to all PEPFAR countries providing antiretroviral therapy.

Fourth, increase the support in PEPFAR for children, including pediatric antiretroviral therapy and assistance for orphans and vulnerable children.

And, finally, maintain the centralized model for implementing antiretroviral therapy within PEPFAR.

In conclusion, I'd like to, once again, express my appreciation to you, Mr. Chairman and Ranking Member Lugar and all of the members of the committee, for calling this hearing to discuss the next phase of this—what we consider a most successful program, one of which our Nation can be proud. We urge timely authorization of this initiative so that the vital health of some of the world's poorest and most vulnerable people can be sustained and improved.

I'd be happy to take any questions, as well. Thank you.

[The prepared statement of Mr. Hackett follows:]

PREPARED STATEMENT OF KEN HACKETT, PRESIDENT, CATHOLIC RELIEF SERVICES, BALTIMORE, MD

Good afternoon Chairman Menendez, Ranking Member Lugar, and members of the committee. I commend you for calling this timely hearing and giving Catholic Relief Services the opportunity to share our experiences as an implementer of the President's Emergency Plan for AIDS Relief (PEPFAR) programs.

My name is Ken Hackett, President of Catholic Relief Services (CRS). For over 60 years and currently operating in more than 100 countries, CRS—the international relief and development agency of the United States Conference of Catholic Bishops—has been responding to the needs of people around the world in emergencies, humanitarian crises, and in development—especially for the poor, marginalized, and disenfranchised in the developing world. CRS has supported HIV and AIDS interventions for more than 20 years, almost since the beginning of the pandemic. Our 250 HIV and AIDS projects in 52 countries provide comprehensive and holistic services for orphans and other vulnerable children (OVC), home-based care, antiretroviral therapy (ART), other treatment support, education for religious leaders on HIV and AIDS and stigma reduction, and prevention education for sexually transmitted HIV—focusing on promotion of abstinence and behavior change.

SUCCESSES OF PEPFAR

First and foremost, let me say that PEPFAR is one of the most outstanding programs our government has ever created. Strong leadership and broad bipartisan support have shown the best possible face of the U.S. Government toward our world neighbors, and reflect the overwhelming compassion and generosity of the American people toward those affected by HIV and AIDS. And above all, PEPFAR is working. In a relatively short time, this massive new program was put in place and is literally saving lives everyday.

I remember returning to Kenya in 1992 after a 7-year absence, and hearing that so many of the Kenyans I had known had died. When I asked why, I was told it was tuberculosis or pneumonia. But when I probed a little deeper, I found they had died of AIDS. It was absolutely shocking. In those days, AIDS was a death sentence.

In contrast, just 2 weeks ago, during a World AIDS Day commemoration, President Bush embraced someone the Washington Post called "a regal-looking Zambian woman." Her name is Bridget Chisenga, but everybody who knows her calls her "Auntie Bridget." She works for CRS in Zambia promoting adherence to ART and fighting stigma associated with HIV. She gave President Bush a message that seemed to move him: "I've seen the Lazarus effect," she said. "I have seen hopes being raised. I have seen people coming back to life. And my message is, 'We are celebrating life to the fullest.'"

But Auntie Bridget is not just a crusader and implementer for PEPFAR—she is also receiving the same antiretroviral therapy as the people she counsels. Without PEPFAR, Auntie Bridget would not be alive. She is a beneficiary of the PEPFAR transformation.

Now PEPFAR is providing life-saving ART for nearly 1.5 million men, women, and children in 15 countries in Africa, Asia, and the Caribbean. It has supported outreach activities to more than 61.5 million people to prevent sexual transmission of HIV. It is providing care and support for more than 2.7 million orphans and vulnerable children, and more than 4 million people living with HIV and AIDS.[1] This is nothing short of astounding. This miracle is being repeated thousand of times as antiretroviral therapy provided through PEPFAR is bringing hope where there was

[1] From Statement of Ambassador Mark Dybul, U.S. Global AIDS Coordinator, Before the Committee on Foreign Relations, United States Senate, Washington, DC, October 24, 2007. http://www.senate.gov/~foreign/testimony/2007/DybulTestimony071024pp.pdf.

none. A complicated medical solution is now available to the poorest and most vulnerable people living in very remote areas.

And there are other benefits as well. This successful treatment offered through PEPFAR has actually become part of the prevention strategy. The fact that people are beginning to live with this disease, returning to their families and resuming their livelihoods, has reduced stigma in communities and has encouraged others to get tested for HIV.

CATHOLIC RELIEF SERVICES' EXPERIENCE WITH PEPFAR

Mr. Chairman, members of the committee, CRS has responded to the emergency of the HIV and AIDS pandemic as we do in all our emergency responses—with deliberate local capacity-building of existing partners and with an eye toward long-term sustainable development.

CRS' work is built on a vision rooted in the Church's teaching that values human life and promotes human dignity. The local Catholic Church is often our primary partner, and we work at the invitation of the local Catholic Bishops' conference in each country. However, we also work with partners of other faiths, as well as other nongovernmental and local community-based organizations to serve people based solely on need, regardless of their race, religion, or ethnicity.

CRS works through local church and religious partners because of their extensive network and reach. Every community in the world has a community of faith with credible leadership. Working with them and other local community-based organizations assures that programs are grounded in the local communities' reality. Equally important, this extensive network of contacts ensures the widespread delivery of comprehensive HIV treatment, prevention, and support programs.

HIV and AIDS programming is a major priority for Catholic Relief Services. Our FY 2008 HIV and AIDS budget of $171 million will account for nearly a third of the agency's annual programmatic expenses overseas.[2] With projects in 12 of the 15 PEPFAR focus countries, we are a major implementer of PEPFAR programs.[3]

Our largest PEPFAR award—AIDSRelief—is a $335 million CRS-led consortium that includes the Institute of Human Virology of the University of Maryland, Constella Futures, Catholic Medical Mission Board, and IMA World Health. AIDSRelief provides ART in nine PEPFAR focus countries by building the capacity of 164 local partners—the majority of them local faith-based health care providers. As of 31 October 2007, over 90,000 people are on ART and almost 146,000 are enrolled in care and support services. AIDSRelief has exceeded its overall targets each year of the grant to date.

Our model of care trains and mentors, local physicians, and health care staff to better manage high-quality treatment services to a growing number of patients. These locally trained community health workers and volunteer and paid treatment coaches and expert patients are expanding followup and support services for stabilized patients in the community. Many of the health care institutions we support now are exhibiting their growing capacity to access resources through the Global Fund locally and through other international donors. However, it will be a long time before the poorest countries of the world can completely and independently take on this burden. Until then, providing these vital services through PEPFAR is the right thing to do.

More than half of the AIDSRelief treatment sites are in rural areas where ART services would otherwise be unavailable. In war torn northern Uganda, where moving around safely is difficult, AIDSRelief is one of the few organizations supporting ART through local faith-based institutions. For the past 2 years, AIDSRelief has partnered with Dr. Ambrosoli Memorial Hospital in Kalongo where 302 patients are on ART and 1,246 receive care. And in Kassesse District, a remote mountainous area in western Uganda, AIDSRelief was the first to support the delivery of antiretroviral therapy in a health center run by the Banyatereza Sisters. Often walking long distances, the Sisters have developed an extensive community outreach program reaching 324 patients on ART and 725 in care. Without PEPFAR, these people would not have access to this life-saving treatment. In fact, without the ministry and care of this faith-based hospital and this religious community, the local population would probably not have access to health care at all.

Catholic Relief Services currently operates a $9 million, 5-year, PEPFAR-supported Orphans and Vulnerable Children Program that provides quality services to children in Botswana, Haiti, Kenya, Rwanda, Tanzania, and Zambia. As of 30

[2] 57 percent ($98 million) projected to come from PEPFAR.

[3] Ivory Coast, Namibia, and Mozambique are the only PEPFAR focal countries where CRS does not have PEPFAR programs—because we do not work in those countries at this time.

September 2007, this program is reaching 56,066 OVC, exceeding cumulative FY07 targets. The program provides education and vocational training, health care, psychosocial support, food and nutrition, protection services, shelter and care, and economic strengthening.

Our third PEPFAR central award addresses prevention of sexually transmitted HIV programming through age-appropriate abstinence and behavior change among youth in three focus countries—Rwanda, Ethiopia, and Uganda. Drawing upon extensive experience in HIV prevention in the target countries, as well as similar programs in more than 30 other CRS prevention programs worldwide, the "Avoiding Risk, Affirming Life" prevention program works with a broad range of faith- and community-based partners that share CRS' commitment to equip youth with the values, attitudes, skills, and support to either abstain from sex prior to marriage or recommit to abstinence before marriage, and then to remain faithful in marriage. As of 30 September 2007, the program has provided 346,768 youth and adults with information to help them make informed decisions about sexual behaviors and encourage health-seeking behaviors.

In addition to these PEPFAR central awards, we also have received numerous country-specific mission level grants to provide more or additional HIV services.

CHALLENGES AND RECOMMENDATIONS

PEPFAR programs in which CRS is involved have all been successful—often exceeding their targets. They have all faced numerous challenges—and overcome them. However, there are certain broader and more systemic challenges that need to be addressed by Congress as it prepares to reauthorize PEPFAR.

- *Prevention:* HIV infection in Africa is driven mostly by sexual transmission. The prevention of sexually transmitted HIV through promotion of abstinence (delay of sexual debut) and fidelity (partner reduction) is promoted by the Catholic Church and other religious health providers. Current PEPFAR legislation specifically allocates funds for abstinence and behavior change as part of wider ABC approach. As a result, CRS and other religious organizations have been able to expand their prevention programs. Prior to PEPFAR virtually no funding for abstinence and faithfulness was available.

  There is widespread consensus among public health experts that fidelity and abstinence are necessary components of any comprehensive approach to reduce the spread of AIDS. Evidence has shown that condoms alone are insufficient for a generalized epidemic.[4] According to the Centers for Disease Control and Prevention (CDC), the surest way to avoid transmission of HIV is to abstain from sexual intercourse, or to be in a long-term mutually monogamous relationship with a partner who is known to be uninfected. For persons whose sexual behaviors place them at risk for HIV, correct and consistent use of latex condoms can reduce the risk of HIV transmission. No protective method is 100 percent effective, however, and condom use cannot guarantee absolute protection against any STI, including HIV. In order to achieve the protective effect of condoms, they must be used correctly and consistently.

  Partner reduction is considered to have been the single greatest factor in reducing HIV prevalence in Uganda,[5] with an estimated 65 percent decline in the number of people reporting nonregular partners between 1989 and 1995.[6] Data show that the majority of Africans already practice A or B behaviors and that these behaviors are thus realistic for most people. In African countries for which Demographic and Health Surveys were available, an average of 77 percent of men and 97 percent of women ages 15 to 49 had 0 or 1 sexual partners in the past year; and 59 percent of unmarried young men and 68 percent of unmarried young women ages 15 to 24 were abstinent in the past year.[7]

  The promotion of abstinence-until-marriage and mutual fidelity within marriage has long been the cornerstone of CRS' HIV prevention programming. Abstinence and mutual fidelity reinforce the precise values and norms necessary for mobilizing people to avoid risk, and for reversing the epidemic.[8] In short, these approaches work and work well. Without designated funding these excellent programs will be under-resourced and the high quality faith-based health

[4] Halperin DT, Epstein H., "Concurrent Sexual Partnerships Help to Explain Africa's High HIV Prevalence: Implications for Prevention." The Lancet 2004; 363: 4–6.

[5] Green, E. 2003. Testimony at Harvard University before the African Subcommittee, U.S. Senate.

[6] Low-Beer, D. and R. Stoneburner. 2003. "Behavior and Communication Change in Reducing HIV: Is Uganda Unique?" African Journal of AIDS Research. 2: 9–12.

[7] Demographic and Health Surveys. Available at www.measuredhs.com.

[8] CRS. 2004. "AB Narrative Final for PEPFAR AB Grant." Baltimore.

structures and services in PEPFAR countries will be sidelined in the battle against HIV.

- *Certain Add-on Services:* We are similarly very concerned about efforts to define "comprehensive services" for HIV-positive women as necessarily including family planning and reproductive health services. CRS regrets these efforts and asks that such proposals be rejected. Moral tenets of religious organizations like Catholic Relief Services prevent them from offering these "comprehensive services." Our experience is that high quality care, treatment, and prevention can be provided without these additional services. If these services were mandated or given preferential treatment in awarding PEPFAR funds, then Catholic Relief Services and other religious implementers would be unable to participate in PEPFAR. Patients served through our networks, especially in the poorest, most remote areas of the globe, would face interrupted therapy or even cessation of life-saving therapy for lack of qualified providers.
- *Lack of Nutrition and Food Security:* Lack of food—or the money to buy it—is the No. 1 concern expressed by ART patients, OVC and their households. All aspects of food security are exacerbated by high rates of HIV and AIDS. The chronic and debilitating progression from HIV infection to full-blown AIDS, accompanied by loss of work and income while seeking treatment lead to poor nutrition, lack of food, hunger and food insecurity. Women and children are disproportionately affected.

  The low nutritional status of many ART patients compromises the effectiveness of their medications. To fully benefit from ARVs, many patients need therapeutic feeding for a limited period of time. PEPFAR provides funding through USAID for therapeutic feeding, through a pilot program called "Food by Prescription." The program has very clear biometric indicators for determining patient eligibility. However, this program is not available to all due to insufficient funding. Expansion of "Food by Prescription" to all PEPFAR countries providing ART, with commensurate increased funding, is desperately needed.

  The majority of CRS' 250 HIV and AIDS projects that target food-insecure people living with HIV as well OVC, include an integrated food element. Where possible, CRS partners with USAID Title II Food for Peace (FFP) and the World Food Program (WFP) to provide necessary food and nutrition. Where public resources are not available, CRS uses private resources to meet this need. In addition, CRS supports increased funding for nutrition support in ART programs. Congress needs to evaluate on a priority basis with the Office of the Global Aids Coordinator (OGAC) and USAID the requirements for additional food aid resources.
- *Health Care Workforce:* Care and treatment involves complex interventions that can either strengthen or weaken the health care systems in PEPFAR countries. The pandemic has greatly stretched the existing health care workforce, especially professionals—doctors, nurses, and pharmacists. Many AIDSRelief local partner treatment facilities will soon be unable to serve additional clients because of the lack of trained staff. PEPFAR needs to provide additional resources to increase the number of health care professionals, appropriately train for task shifting of care and treatment, as well as provide for training, supervision, and remuneration of other nonprofessional community and volunteer health care workers
- *Commitment to Meeting Pediatric ART Targets:* HIV is eroding gains made in child survival. Mortality and morbidity is high: 50 percent of HIV infected children below 2 years of age die without care and ART. In order to improve the outcome of pediatric HIV infection, programs that address prevention of maternal to child transmission (PMTCT) need to be strengthened and a definitive diagnosis of HIV-exposed infants needs to be made as soon after birth as possible. Moreover, health care professionals will require additional training in order to provide care and treatment for infected children and care; pediatric ARV formulations are not readily available, and affordable pediatric treatment programs need to be put into place.

  PEPFAR is results-driven and implementers of antiretroviral therapy (ART) projects are evaluated based on their ability to deliver ART to specific targets—10–15 percent for pediatric ART. Achieving this target is challenging for a number of reasons. Pediatric ART dosing according to complicated regimens based on changing age, weight, and height of growing children is very challenging. Also, pediatric formulations are more expensive than ART regimens for adults. Implementers are more likely to initiate adults on ART because it is easier and

cheaper and thus they are more likely to achieve their "number of people on ART" targets.

If PEPFAR implementers are to meet or exceed a 10-percent pediatric ART goal, as they should, they will need targeted funding.

- *High Numbers of Orphans and Vulnerable Children:* Older children in AIDS-affected households are often forced to quit school because of deteriorating family finances and/or because they need to care for their ailing parent. A most disturbing phenomenon is the reality of young girls forced into transgenerational sex to meet their own and their family's food needs. Younger children of school age often never even start school. Those lucky enough to attend school often don't have enough to eat. Linkages with WFP in Tanzania and USAID FFP in Kenya and Haiti enable us to provide critical nutritional support for these children. As Congress reconsiders PEPFAR reauthorization, there is an urgent need for increased funding for OVC support as well as a requirement to systematically link PEPFAR programming with food programming. Unfortunately, in other countries, rigid regulations, program requirements, or other bureaucratic problems have made it impossible to link PEPFAR OVC support with other funding for nutrition, education, or other critical needs.

  As Congress reconsiders PEPFAR reauthorization, there is an urgent need for increased funding for OVC support as well as a requirement to systematically link PEPFAR programming with food, education, and other programming.

- *Complicated PEPFAR Funding Mechanism:* The number of USG agencies involved in PEPFAR, the multiple levels of programming and budget consultation, decisionmaking, and grant management procedures (Central and Mission-level), and the number of countries involved, all contribute to increased costs and complicated/cumbersome reporting, cash disbursement, and decisionmaking. The CRS-led AIDSRelief ART project is a centrally awarded 5-year cooperative agreement through HRSA, but administered in the field by both CDC and USAID. Since year 2, a static portion of AIDSRelief funding continues to be obligated centrally through HRSA, while another increasingly larger portion is awarded each year through the Country Operating Plan (COP) at the local USG mission. The onerous COP process combined with late obligation of funds causes particular challenges for implementing partners in the field 10 months of the year.

  Furthermore, since we cannot predict out-year resources in the context of the current "annually renewable commitment" COP funding mechanism, long-term planning is extremely difficult. This affects the confidence of our partner sites to continue expanding their activities to meet their targets. As a result, many sites have taken a very conservative approach to scale-up due to fears that funding will be reduced or cut, and will result in the sites themselves needing to bear ongoing treatment costs—which most cannot afford.

  PEPFAR needs to institute multiyear funding for multiyear awards; strengthen the centralized funding mechanism; change the funding cycle to correspond to the fiscal year, and streamline/standardize the COP process.

- *The Global Fund:* Through Round 7, only 5–6 percent of the total funding channeled through the Prime Recipients (PR) of the Global Fund for AIDS, TB and Malaria (GF) were faith-based organizations. Even including subrecipients of Government or secular prime recipients, less than 15 percent of GF-support programs are faith-based organizations.[9] The nascent "dual track" financing mechanism hopes to put civil society on equal footing with national governments in the country coordinating mechanism (CCM)—Churches Health Association of Zambia is a poster-child for this innovation. However, the idea of pairing an NGO principal recipient with a government one is only a recommendation by GF to national CCMs. Religious health care providers account for 30–50 percent of health care services done in many developing countries—up to 70 percent in some countries.[10] Many religious health care providers report that they do not have access to the CCMs to help plan and achieve the national plan responding to AIDS, TB, and malaria. The huge potential of religious health care providers is not being adequately recognized and engaged in the fight. Since the U.S. Government is providing one-third of the resources for the Global Fund, Congress should take steps to make sure that local religious health care providers are

[9] "Distribution of Funding After 6 Rounds" on http://www.theglobalfund.org/en/funds__raised/distribution/.

[10] African Religious Health Assets Programme. 2006. "Appreciating Assets: The Contribution of Religion to Universal Access in Africa." Report for the World Health Organization. Cape Town: ARHAP, October 2006.

meaningfully engaged in their countries' CCM and adequately resourced to participate in achieving their countries' national plan. This will insure the most productive allocation of scarce resources to achieve the maximum impact possible in terms of lives saved and protected.

CONCLUSION

Finally, CRS strongly supports increased funding for PEPFAR—above $30 billion. The program, however, must maintain its focus on HIV, malaria, and TB and should not be expected to fund the many other related development needs that poor HIV-affected communities have. Similarly, an expanded PEPFAR must not come at the expense of urgently needed increases in other core poverty development accounts, including Child Survival, Title II Food for Peace, agriculture, and microfinance.

I would like to once again express my appreciation to Chairman Menendez, Ranking Member Lugar, and all the members of the committee for calling this hearing to discuss the next phase of this highly successful program. We urge timely reauthorization for this initiative that preserves the best and most effective elements of this program that is so vital for the health of some of the world's poorest and most vulnerable people. We and our partners stand ready to continue and expand the life-saving work that PEPFAR has enabled us to accomplish. I would be happy to respond to any questions the committee may have.

TABLE 1.—CRS-LED AIDSRELIEF ART PATIENT ENROLLMENT

[As of October 31, 2007] [1,2]

Country	Current # of LPTFs*	Current # of Patients on ART	Current # of Pediatric Patients (<15 years old) on ART (% of total)	% of total PEPFAR-funded ART patients who are enrolled through AIDSRelief**	Cumulative # of Patients in Care
Guyana	3	524	47 (9.0%)	22	1,462
Haiti	8	2,347	479 (20.4%)	18	7,471
Kenya	20	17,795	1,808 (10.2%)	11	38,499
Nigeria	22	11,706	492 (4.2%)	10	31,819
Rwanda	13	1,553	155 (10.0%)	5	3,174
Shared w/MAP	5	1,018	76 (7.5%)	—	3,126
South Africa	26	12,900	1,092 (8.5%)	6	30,523
Tanzania	31	13,825	993 (7.2%)	16	35,993
Uganda	16	13,788	1,037 (7.5%)	17	49,133
Zambia	14	15,407	990 (6.4%)	11	35,242
Total	153	90,638	7,169 (7.9%)	11	233,699

[1] "World AIDS Day 2007: The Power of Partnerships," Factsheet. PEPFAR, U.S. Government, December 1, 2007, available at: http://www.pepfar.gov/documents/organization/96070.pdf.
[2] "HRSA Monthly Report, October 2007."
* LPTF = Local Partner Treatment Facility.
** This column calculated based on September 30, 2007, PEPFAR and AIDSRelief data.
*** This is also the total percent of patients on ART in Kenya.

Senator MENENDEZ. Thank you, Mr. Hackett.

Thank you all for very insightful testimony.

We'll start with 5-minute rounds, and I think we'll have time before the first round of votes take place on the floor. The Chair will recognize himself.

Dr. Kazatchkine, the Global Fund and PEPFAR seem to appear most successful when they are able to coordinate their activities. What countries offer the best examples of that coordination? And what are those best practices being followed by others?

Dr. KAZATCHKINE. Thank you. Yes, indeed. Countries where both PEPFAR and Global Fund are strongly coordinating are making very rapid and impressive—particularly rapid and impressive progress.

Let me cite Ethiopia, where PEPFAR and Global Fund have been coordinating their efforts with regard to HIV/AIDS under the lead-

ership of the Minister of Health. We work together so that either first-line treatment—what we call first-line treatment; that is, the first treatment that is prescribed to patients—or second-line treatment, the treatment that is prescribed to patients who have become resistant to first-line treatment, are financed either by one or the other source, either PEPFAR or Global Fund, depending on what's more appropriate and easily available.

We have aligned, both of us, PEPFAR and Global Fund, on the national strategy, as established by the Ethiopian Government. The Ethiopian Government is in leadership. And that has led to spectacular increases in the number of people treated in Ethiopia.

This is—the same is happening in Kenya, in Côte d'Ivoire. I have been traveling to Côte d'Ivoire recently, together with Ambassador Dybul. We have also been to Rwanda, to Haiti. Wherever we go, our message is: We're working hand in hand, and——

Senator MENENDEZ. Are there a series of best practices that you——

Dr. KAZATCHKINE. Country best practices? Yes.

Senator MENENDEZ [continuing]. Are trying to promote with others?

Dr. KAZATCHKINE. Yes, indeed; particularly with regard to antiretroviral therapy, modalities of prescribing and distributing antiretroviral therapy. And, in fact, I think that it now, basically, in the 15 focus countries of PEPFAR, these practices—best practices are being implemented.

Senator MENENDEZ. Let me ask both Dr. Smits and any others who want to address this, I read the recent report by the Global HIV Prevention Working Group, which, in its report entitled "Bringing HIV Prevention to Scale, an Urgent Global Priority," opened up with, "We should be winning in HIV prevention. There are effective means to prevent every mode of transmission. Political commitment has never been stronger. Financing for HIV programs in low- or middle-income countries increased sixfold between 2001 and 2006. However, while attention to the epidemic, particularly for treatment access, has increased in recent years, the effort to reduce HIV incidence is faltering." And I know some of you touched upon this.

I'd like to know what we and the rest of the world should be doing more aggressively on the question of prevention and what are we doing well, and what are we not doing that we should be doing in this regard? There are promising technologies, such as male—medical male circumcision. I'd like to hear what we should be doing on the prevention side that we are not.

I'll start with you, Dr. Smits, and any others who want to address it.

Dr. SMITS. First, I wouldn't be—personally, and I think the committee—would not be as negative as that statement appears to be. Certainly, the new U.N. numbers suggest very strongly that, in some countries, we're really moving ahead on prevention. But we need to do a great deal more in terms of very precise evaluation of what's happening. We ought to be—we're—in a sense, we're waiting, now, to see the epidemic change in order to figure out whether the behavior changes we're teaching are really making a

difference. I think we can look more carefully at behavior changes with targeted surveys.

I was privileged to go to the implementers meeting last June, and I heard several very good talks, particularly one by David Apuli, who is the head of the program in Uganda, who says that the way to fight AIDS is to know where your last thousand cases came from, and to target your prevention efforts there so that you don't keep doing what you were doing very successfully 2 years ago. I think there's a risk of that. He particularly emphasized the discordant couples and the need to develop different messages for them, not just condom distribution, but a lot more counseling in the treatment and care settings with someone known to be HIV positive, about what the implication is for their partner.

I think that message—What were the last thousand cases, and how can we best attack them?—is really the most useful.

So, I don't think we can tell people in these countries how to do their programs. I think that they know a great deal about it. We need to give them the flexibility, and we need to give them the scientific support to look at the results of what they're trying to do.

Senator MENENDEZ. Dr. Daulaire.

Dr. DAULAIRE. Thank you, Mr. Chairman.

I would concur. I think there is starting to be good evidence that the tide is beginning to be turned. Certainly, in some places like Thailand and Uganda, there has been substantial impact from prevention activities. And what's striking there is how very different the prevention activities that those two countries undertook were. In Uganda, as my friend Ken Hackett has pointed out, the issues of partner reduction, faithfulness, abstinence have been very important components. In Thailand, the issue of condoms was much more important, and that was because the dynamics of the epidemic were very different in the two places.

Clearly, in order to turn—really turn the tide, in terms of prevention, recognizing that AIDS is, fundamentally, an asymmetric kind of disease, it doesn't spread the same way everywhere, it really depends on different populations, different routes of transmission. What is most important is making prevention, the reduction of new infections of HIV, a priority—a stated priority, that has to be measured, that has to be tracked and followed. And those new infections, particularly, should be focused on those most likely to continue the chain of transmission, because, when you're looking at the numbers over time, that's where successful interventions can have the biggest impact.

So, I don't believe that a prescription is called for here, in terms of the new legislation, in terms of "do this or that at these percentages," but I do believe that prevention should be clearly prioritized. I think the first Leadership Act rightfully focused on treatment, because there was virtually no treatment in the world. And I think there is good justification for its focus on abstinence, because that was a neglected part of the equation. I think the world, and the world of implementation, has changed a great deal since that time.

Senator MENENDEZ. Thank you.

I'd love to hear from all of you, but I need to get to Senator Lugar, so maybe in the next round I can hear some of your further answers on this.

Senator Lugar.

Senator LUGAR. Thank you very much, Mr. Chairman.

Dr. Kazatchkine, I appreciated your thoughts about transparency and accountability. These are virtues that are shared by the Congress, and our oversight, really, is dedicated to this. I just want to, more specifically, inquire about the Global Fund's ability to attract the most effective, efficient contracts for medicines and services at the lowest possible prices. What are your largest contracts, and how do you go about bringing about transparency, accountability, and auditing of those contracts?

Dr. KAZATCHKINE. Yes; we have a number of mechanisms in place in order to ensure transparency and accountability.

First, we do have portfolio managers in the secretariat at the Global Fund that track every single grant throughout the grant cycle, from grant signing to implementation, and follow, from our Geneva office, everything that happens during the grant cycle.

On the ground in countries, the—what we call the country coordinating mechanism, which is a collective group of stakeholders, government, civil society, multilaterals, bilaterals—the U.S. Embassy or USAID is usually represented in most of our CCMs—are—have, also in their functions, to provide oversight on the country program.

And then, at the country level, we have an independent observer with whom we subcontract, which we call the local funding agent, and that local funding agent reports to us every 3 months, or sometimes, when necessary, more often, on both the financial aspects of the grant, the disbursements, but also on the programmatic results and how those match.

Whenever something appears going wrong, we call the—we trigger—this triggers what we call an early alert response system, and, if necessary, we call on an outside investigation or we call on an audit by the inspector general from the Global Fund. That inspector general this year, as you know, has been the inspector general of WHO, as an interim inspector general, from January this next year, a new inspector general has now been appointed, John Parsons, who, until now, has been the inspector general of UNESCO.

Senator LUGAR. Why, thank you very much for that testimony.

I have a second question with regard to China and its participation. I understand that China is a member of the board. It makes a contribution to the Global Fund. But, at least our information is, it receives from the Global Fund a very large multiple of that amount of money for various reasons. Do you follow that? With the insight of what China may be able to do for itself in due course; that is, replace those particular services and funds now that are received from the Fund, as there may be others who are in much more difficult financial condition, given the practicalities of world growth, Chinese growth, and so forth. Can you make a comment about the Chinese situation?

Dr. KAZATCHKINE. Yes. Thank you.

I see two aspects to your question. One is the specific issue of China, the other is funding, by Global Fund, of grants in-country with, let's say, rapidly emerging economies, and that, in addition to China, is also India and Russia.

Now, the Global Fund has played a key role in triggering access to prevention and to treatment of HIV in China. We are, indeed—have a very large portfolio of grants there, over 400 million U.S. dollars. If there had not been the Global Fund, we wouldn't have seen prevention among IV-drug users that are one of the drivers of the epidemic, particularly in southern China, we wouldn't have seen developed the efforts of prevention among truck drivers and among some of the vulnerable populations that are reached by our funding through civil society.

I do agree with you that, following that first phase, it is time for China, progressively, as it is for emerging countries, not to only be a recipient, but also become a larger donor to the Global fund.

Now, Russia has just given an example. Russia, that has received $270 million from the Global Fund, and where the Global Fund has also been a key trigger of access to services for vulnerable populations, has decided, last year, to reimburse, actually, every single donor dollar that it has received from the Global Fund by 2010, and they came to our recent replenishment conference with signing a first check of 70 million U.S. dollars.

I do hope that China and India will progressively follow that example. And my advocacy with these countries—I'll be in India next week—is to ask them to provide a percent of their annual increase in wealth for global health.

Senator LUGAR. Very good news.

Thank you very much, sir.

Senator MENENDEZ. Thank you.

Senator Kerry.

Senator KERRY. Mr. Chairman, thank you. And thank you very much for having this important hearing.

Obviously, dealing with this issue is not a partisan issue, as the record of this committee well displays. As we know, over 90 percent of all the children infected with HIV live in Africa, so that's 2 million out of the 2.3 million kids that we know are affected. And 1,800 more become infected every single day. And more individuals are becoming infected than are being treated, which is the challenge, obviously.

I just came back from South Africa and Botswana, and got an up-close-and-personal reminder of how devastating it is, and the threat that it poses to an entire continent's stability. I had the privilege of visiting the Umgeni primary school and talking with people in Kwankalosi and Kwazulu-Natal, near Durban, and I saw very inspiring, but, at the same time, heartbreaking situations. I remember one woman in a mud hut, tiny mud hut, cooking some—with a caregiver, a caregiver who was trying to help her, comes once a week. She has three kids. They are in school. Her sister has already died of the disease. And it just—you know, you can just extrapolate that, you know, thousands upon thousands of times. I was inspired by the work of the Valley Trust caregivers, but I also met orphans who, at a young age, have become the caretakers of their whole family, assuming adult responsibilities. And, again and again, I heard, from those on the front lines of this pandemic, that their greatest challenges is the public-relations battle to educate their communities.

I was struck, also, in a session that I had with some of those folks responsible for educating and caregiving, as I tried to elicit from them the figures. Because there was some press around, and some other public people, they just were very clammed up. They wouldn't want to talk about it. They were fearful of retribution for telling the truth about what's going on. And, privately, they pulled me aside later and, sort of, told me why they were fearful and couldn't tell me, sort of, the real numbers of kids in the school. I asked, How many kids here? In fact, they're—how many kids are orphans—and so forth.

We have to work incredibly hard. And we all know the problem that existed with President Mbeke and the government itself in South Africa in getting this truth out. But it reaffirmed for me the fact that, while AIDS has done the killing, the disease's best allies have been denial, indifference, and ignorance. And that's what we have to, sort of, fight here, partly, in whatever we structure here as the follow-on.

Let me also nitpick for a tiny moment, if I may, on a personal level. As I was walking out of one of those locations, I saw this poster up on the wall, and it said, "The President's Emergency Program." And it, sort of, hit me, to be honest with you. I said, "What do you mean, the President's? First of all, which President?" But, second, that legislation was written right here in this committee by Bill Frist and myself, and Jesse Helms joined into writing that. Remember, Senator Lugar? And Senator Lugar and others put that together. And it's not the President's, it's the American people's, it's the United States, and it would do us a lot more good, frankly, if more people knew what the United States of America is doing, and what the American people are doing, with respect to this. And so, Mr. Chairman and Mr. Ranking Member, I hope when we redo this, we're going to clarify that. I think that's important as a matter of policy.

Equally importantly, if I may say, that—you know, we did that in 2002, and we proposed the futures of $15 billion; and so—but we're delighted the President came and picked it up, and we're delighted, without his leadership and involvement—obviously we wouldn't, probably, have gotten the money, in the end. But I think we ought to, sort of, see this for what it is, in its reality.

But what I want to focus on with the panel that's here right now as we think about this is, sort of—we're all aware of the 2-7-10 goal for 2008. My fear is that, unless we can break through more effectively on this education—my daughter, incidentally, went over for a summer as a medical student; she's now an intern. But she went to Ghana, and she went to Rwanda, and she worked in AIDS for the entire summer. And she wrote her paper—her graduate paper on the truck routes and how that is. You were speaking, Dr. Smits, about knowing where the last thousand cases is. Well, that's where the last—how many—tens of thousands of cases have come through, is the truck routes, and obviously there are other causes. But it seems to me that there has to be a much more intensive focus on coordinating the prevention, slash, education breakdown and mythology, and engagement of the governments themselves. I mean, the leaders have got to go out there and have these tests, not just guests. And they've got to do it regularly. And they've got

to really prove the importance of this. And, otherwise, these dollars are just, kind of, going to go incessantly at this increasing population of people that we're not treating. And, you know, I don't think we want to make this like Sisyphus pushing the rock up the hill, if we don't have to. And I don't think we have to. So, my hope is that we could do that.

One of the things I heard at the University at Witzwatersrand, where we met with public health folks, was their concern about PEPFAR being a separate track, completely, and not integrated enough into the rest of the health care delivery system. Now, to some degree, when you started up, that may have been necessary. But, at this point in time, it strikes me, we may want to try to create a greater integration. So, I wonder if you'd just take a moment—I've exceeded my time in questioning—just ask the one question: What do each of you see, in terms of that potential of integration, and how do we frame this better to deal with this ad infinitum added population and break down the mythology and get greater accountability in these countries?

Dr. Kazatchkine, do you want to start? And then we'll go right down the line.

Dr. KAZATCHKINE. Yes; I'll—very briefly. And then, Mr. Chairman, I regret, but I'll ask the committee's permission that I leave; I have to fly back to Geneva right this afternoon.

Thank you for your question, Senator Kerry. Right before you came in, I had a question from Senator Menendez on integration between PEPFAR and the Global Fund. Actually, in countries where PEPFAR and Global Fund are both present—that is, in fact, in the 15 focus countries—there is a very strong integration of both programs around the national priorities. The Global Fund itself that is in the other countries—and we're currently funding grants in 137 countries around the world—is, as I discussed in my remarks, a country-owned mechanism. We're funding what the countries request us to fund. So, in fact, we do align, by definition, on the national program. So, there is full integration of Global Fund grants with national programs. And we're currently moving into, as I also very briefly discussed in my remarks, going to fund national strategies, rather than pieces of national strategies, in the future.

Senator KERRY. Dr. Smits.

Dr. SMITS. I only did—the committee visited in small groups, so I only visited——

Senator MENENDEZ. Before you continue, Dr. Smits—

Doctor, we're going to excuse you. We were told that you had a flight. We appreciate your testimony. There may be questions submitted for the record, that we'd ask you to respond to, subsequently. And have a safe journey.

Dr. KAZATCHKINE. I will be pleased to. Thank you very much.

Senator MENENDEZ. Thank you.

Dr. KAZATCHKINE. I'm sorry.

Senator MENENDEZ. Dr. Smits.

Dr. SMITS. I only visited three countries on a formal basis, but I would say that the degree of coordination that I saw in all of those was really quite good, and the response of PEPFAR to government priorities was very good. For example, in one, the ministry responsible for orphans said, "It's so wonderful to have you here.

We've had all these plans for these programs, and PEPFAR's commitment to orphans will make a huge difference. And I want you to promise to come back in 2 years and see how much we've accomplished, because I'm just starting now."

In another country, we visited with the Ministry of Defense, which is doing some very exciting things. As you know, African countries with a strong military earn money by sending their soldiers into other countries on peacekeeping missions, and must send them out HIV negative, and protect them when they're away. And they've done a marvelous job. That ministry told us that they believed that PEPFAR was the result of divine intervention. I thought maybe the Congress would have something to do with it. But that sense that we had come——

Senator KERRY. We are very divine these days. [Laughter.]

Dr. SMITS. We had come and brought resources to something they wanted to do, and they had planned, that was important to them on a national basis. So—and we certainly saw a number of examples, the other team members did, in many of the countries, very close coordination with the Global Fund. It's a bit variable, country by country. A lot has to do with how strong the country leadership is. But I think you can't dictate it. You can say it's very important, but you can't say how to do it. But I think it really is happening.

Senator MENENDEZ. Thank you.

Senator Feingold.

Senator FEINGOLD. When I was in Uganda recently, I met with key representatives from the HIV/AIDS community, and we discussed the importance of building national capacity so that these countries will be increasingly able to meet the health needs of their own citizens. But some of the health experts have argued that international HIV/AIDS programs might worsen overall health in developing countries because of the phenomenon of local health workers being attracted to the United States and multilateral initiatives that provide higher compensation and benefits than those offered by public health centers. This migration of HIV/AIDS programs could also leave fewer health workers available to treat people suffering from other health complications. Do you think this is a valid criticism and concern?

Dr. DAULAIRE. Let me start, Senator Feingold. It is a valid concern. We are seeing, all over sub-Saharan Africa, the migration of health care workers; in some cases, from Africa to more affluent countries—brain drain—because of better salaries; in some cases, moving from low-paid government jobs in clinics doing maternal and child health services into HIV/AIDS programs. This is not to argue that we shouldn't be doing these things, and that we shouldn't be funding them, but it certainly is a clear argument that health workforce development and support, as part of a broader approach to health systems strengthening and development, is critical.

Ultimately, at the end of the line, the person who administers the antiretroviral therapy, who does the health education for prevention, is the same person who takes care of the mother during her pregnancy, who takes care of the child when the child gets ill with pneumonia or diarrhea, the HIV-negative child. And unless

we work to strengthen the integration of the HIV programs into the broader primary health care system, we're going to be at risk of turning this into a two-track system which could have negative consequences for health.

Senator FEINGOLD. Sure.

Mr. HACKETT. If I could just add to that with a specific example, because I agree with Nils.

Recently—well, 3 months ago, in Kenya, the Catholic bishops made an appeal to the President; a personal appeal. They were losing most of their good staff from the Catholic hospitals, which represent a sizable portion of health care in Kenya, and they were losing them to those government programs that got a recent grant, both from the Global Fund and UNAIDS. I think we would all agree, here, that there has to be a better coordination of all kinds of approaches, both programs, in a national sense, and also local programs.

For instance, we, the U.S. Government, directly and through the World Food Program and through agencies like mine, provide food assistance, sometimes, in the country, or money for agricultural activity. It is not generally coordinated with the AIDS program, so that those people that you met in South Africa, those young orphaned kids, one of their worries is where they're going to get a meal. And we could do a much better job in integrating services. What about the woman who has gone through the antiretroviral therapy, comes out of the hospital. She's sold everything—pots, pan, tin roof. She's got nothing. What she needs is a way to start her life again.

Senator FEINGOLD. Well, how do we make sure that another aspect of the United States or the NGOs that we contract with do not actually hire away these scarce professionals who do the AIDS work? How do we deal with that?

Dr. DAULAIRE. I think a question, Senator, is you're dealing with a finite resource, and if we focus on putting a cap on that relatively small bottle of trained health care providers, I don't think that's going to resolve the problem, because the bottom line is, there is a huge deficit of health care workers in these countries to begin with. We have to be intimately involved, along with our partners, along with the host countries, in supporting the development and training of a much larger cadre of health care providers, not primarily doctors, I would say, because they are the most fluid of all—they migrate like crazy—but nurses, paramedics, people who are actively involved in community health in their own communities, and who can be trained to do 95 percent of what needs to be done, in terms of HIV care and the other aspects of primary health care. So, training, deployment, management, and support are critical here.

Senator FEINGOLD. Thank you, Mr. Chairman.

Senator MENENDEZ. Senator Lugar.

Senator LUGAR. Thank you, Mr. Chairman.

I just wanted to ask Mr. Hackett, as someone in the field to respond to this. We have premised this hearing, the one we had before, and early introduction of legislation, on this basis that other countries and other contributors need to have assurance that we are going to have continuity of our support. As all of us have wit-

nessed our appropriation process this year, we're coming into the final days of calendar year with 11 of our 13 bills not passed, and this is noted by other countries. They understand that we're going to be there for them in due course, but have been raising questions, in terms of the continuity of support, and therefore, what they are likely to contribute in the process. Now, they can go ahead without us. But, as we are a leader and a large contributor, we think, at least, that this is very important.

I would just like a confirmation statement from you, or other members of the panel, as to the importance of the timeliness of action, as opposed to the fact that, evenutally, it will happen but maybe after many lives have been lost if there is a break in service.

Mr. HACKETT. Senator, I couldn't emphasize more that the message you are sending is heard. And if there is a swift and robust action to authorize the second PEPFAR at a level that we're talking about, either at the higher level, or even at the $30 billion level, that will be heard, and it will send, to the richer nations, a clear message that they must step up to the plate. And I think—it was said earlier, those people, our partners that we work with, want to know that there is a future. They've started people on antiretroviral treatment. Those people are alive. They want to keep them alive. So, they want to be sure about this. And there are many millions of people affected.

Senator LUGAR. Thank you very much.

Dr. DAULAIRE. Senator, if I may, it is critical to get this done over the next several months. Particularly concerning antiretroviral treatment, if we get a break in the chain of treatment of people who are already under care, we are at risk of building a cataclysm, in terms of drug-resistant HIV, so we're no longer dealing with infections that are susceptible to the first line of treatment. It is vital that this program be reauthorized and refunded quickly.

Senator LUGAR. Yes.

Dr. SMITS. Can I just add? First of all, to second that, one of the accomplishments of PEPFAR is that we have not yet experienced any major disruption in drug availability, and we need to keep up that record. But many of the people doing the implementation of all aspects of the programs are employees of NGOs in these countries; and if the program is not reauthorized in a timely manner, those NGOs may have legal obligations to begin issuing layoff notices. So, it's really critical, in terms of moving forward, to have early reauthorization—I know you know that, but I—at least I can say it for the record.

Senator LUGAR. Well, this is important testimony. I know that the chairman has been working with Senator Kennedy, who is very instrumental, at the HELP committee. We all have at stake, and we're attempting to do our part.

I am encouraged by Dr. Kazatchkine's comments about the Russian contribution and this whole premise that many countries now, surprisingly, have economies that are growing, and growing rapidly. There is substantial new wealth and ability to step up to the plate, in terms of world responsibility, as opposed to being, necessarily, recipients. It could very well be the timeliness of our action that would be helpful as he works with members of his board, who may now be able to turn large recipients to substantial

contributors. This is, I think, a facet that's arisen from this hearing. This knowledge, at least for me, about how others may be taking a look at it, may mean a lot in the future in terms of their own contributions.

Thank you, Mr. Chairman.

Senator MENENDEZ. Thank you. Thank you, Senator.

Two last questions before we'll break. And we thank you all for the time you've spent with the committee.

Dr. Smits, one of the central recommendations of the IOM report is to the U.S. Global AIDS Initiative to maintain its urgency and its intensity, but to shift to a more sustainable approach. As we talk about reauthorization, especially—the timeliness of it and, the importance of it—the question is, presumably, that same recommendation could be extended to the Global Fund, as well. How do you believe, for example, that PEPFAR and other programs can begin this transition to sustainability?

Dr. SMITS. There are many details in the report that move that way—longer term planning cycles, total coordination with the country coordinating mechanism—and we saw some very good examples of that—so that the country is doing the planning, and we are supporting it, not us doing the planning and then just, sort of, showing them the papers. Then there is the support of training programs. I worked in Mozambique several years, I know the details of nurse training and clinical officer training in Mozambique. It would not be expensive to expand those programs. You just need the money to keep the schools open. The teachers are paid on a module basis; pay the teachers for more modules. You could expand workforce quite reasonably. And my understanding is, many other of these countries have similar arrangements. Expanding medical schools, there, as here, is probably slower and more expensive, but that can be done, as well. We need to be a participant in that. Many other donors already are. But—so, long-term planning, more workforce, and the most efficient use of our dollars, particularly by eliminating the separation across prevention, treatment, and care.

Senator MENENDEZ. One last question. A leading killer of people with HIV/AIDS is tuberculosis. It is inextricably linked to the epidemic. And, given the high rates of TB/HIV co-infection in the 12 PEPFAR focus countries in Africa, TB programs present an opportunity to identify additional HIV-positive individuals who are eligible for treatment. Similarly, the HIV clinics provide an opportunity to screen for TB. PEPFAR has been in the process of expanding efforts to combat tuberculosis in HIV patients, but we could be doing far more in this area. Should addressing TB/HIV by increasing integration and coordination among programs be a greater focus in PEPFAR reauthorization?

Dr. DAULAIRE. Yes.

Senator MENENDEZ. That's about as clear as it gets around here, you know. [Laughter.]

Dr. DAULAIRE. The——

Senator MENENDEZ. It's a refreshing answer, but I know you want to embellish a little bit on it.

Dr. DAULAIRE. Very short. [Laughter.]

Dr. DAULAIRE. The reality is that, currently, one-half of one percent of people receiving HIV/AIDS care and treatment are tested for TB. You've got to look for it before you can start doing anything.

Senator MENENDEZ. Dr. Smits.

Dr. SMITS. I'll also say yes. One of the impressive things PEPFAR does is hold the implementers conference every year. People working in the field have a lot of very good things to say about that conference. The discussion about the TB integration made it clear there, that that is an area that has lagged. But people are very concerned, and there are some best practices being put in place. Yes; I agree it's an important aspect.

Senator MENENDEZ. Well, seeing no other members before the committee, I want to thank all of you for your testimony today. It's been incredibly important as we move to what will hopefully be a timely reauthorization.

The record will remain open for 2 days so that committee members may submit additional questions to the witnesses. We would ask the witnesses respond expeditiously to these questions.

Senator MENENDEZ. And, if no one has any additional comments, the hearing is adjourned.

[Whereupon, at 4:05 p.m., the hearing was adjourned.]

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF DR. PAUL ZEITZ, EXECUTIVE DIRECTOR, GLOBAL AIDS ALLIANCE, WASHINGTON, DC

GLOBAL AIDS ALLIANCE,
Washington, DC, December 13, 2007.

Hon. JOSEPH R. BIDEN,
Chairman, U.S. Senate Committee on Foreign Relations, Dirksen Senate Office Building, Washington, DC.

DEAR SENATOR BIDEN: On behalf of the Global AIDS Alliance and the Health Gap coalition, I would like to formally request that the attached document be submitted as part of the record of the Senate Foreign Relations Committee hearing held on December 13, 2007.

The document details recommendations for the next phase of the U.S. global AIDS initiative developed by African civil society organizations and people living with HIV/AIDS working on the front lines of the AIDS pandemic.

The Global AIDS Alliance is dedicated to mobilizing compassionate and comprehensive response to the global AIDS crisis, and we believe that the voices of African civil-society stakeholders—and the communities they represent are essential to ensuring that U.S. global AIDS policies and programs effectively meet the needs and priorities of the people they are meant to serve.

Sincerely yours,

Dr. PAUL S. ZEITZ,
Executive Director.

Attachment.

AFRICAN CIVIL-SOCIETY RECOMMENDATIONS ON THE NEXT PHASE OF U.S. GLOBAL AIDS ASSISTANCE—DECEMBER 11, 2007

On December 10–11, 2007, representatives of 21 civil-society organizations, including representatives of PLHA organizations as well as large PEPFAR AIDS treatment providers, met in Nairobi to provide feedback and recommendations on the future of U.S. global AIDS policy. The meeting was hosted by the Kenyan AIDS Treatment Access Movement, Global AIDS Alliance, and Health GAP. In light of the upcoming debates on PEPFAR reauthorization, we respectfully submit the following recommendations from people living with HIV/AIDS and working on the front lines of the AIDS pandemic. The following summarizes our prioritized recommendations, and a full report will be made available shortly.

1. *Numbers on treatment versus measuring healthy patients:* PEPFAR is doing a historic and important job of getting people on ARV treatment. However, counting a person who is receiving AIDS drugs is not the same as supporting health for people with HIV. The urgent and important work of attempting to meet treatment targets is not integrated with more comprehensive support for actual patient health. When patients are only provided one part of what we need to survive, however important, the end result is poor health outcomes, questionable accounting practices, and unacceptable loss to follow up.

- The second five years of U.S. global AIDS initiatives should measure longer term patient health outcomes in addition to simple numbers of people on ARV treatment. This should be backed up by independent patient satisfaction surveys and spot audits of PEPFAR-supported medical facilities.

2. *Opportunistic infection drugs are not available:* Many programs provide free ARVs, which are urgently required and profoundly appreciated. However, efforts to scale up access to AIDS treatment is taking place without an eye toward actually increasing patient survival. While anti-AIDS medicines are almost always free, medicines to treat the opportunistic infections that accelerate our death are often unavailable from clinics and too costly for patients to purchase from pharmacies. Stock-outs at medical facilities and dispensaries are also common and very harmful to patient health.

- PEPFAR should provide free and accessible OI treatment and services at all health facilities.

3. *Unequal standards of care:* Powerful new antiretroviral drugs are transforming the lives of people with HIV in the United States, producing much more durable viral suppression, greatly reduced toxicity and side effects, and improved prospects for long-term adherence. With few exceptions, these new drugs are not available through PEPFAR-supported ART sites or other treatment support programs. We recognize that drug regimen decisions are largely made at the country level, but guidance from PEPFAR strongly influences treatment formularies.

- Support provision of quality regimens that are less toxic and more accessible, affordable, and manageable for people living with HIV/AIDS.
- The U.S. should work with countries, generic drug manufacturers, and PEPFAR recipient programs to ensure that there are equitable standards of medical care between the North and South.

4. *Services for young adults:* HIV prevalence is mostly impacting children and young people between the ages of 9 and 24.

- Funding and programs should specifically target children and young people, and meet the needs of the increasing number of orphans and other vulnerable children. The age bracket receiving support from the OVC earmark should be increased to include young adults, and the percentage of funding for orphans, vulnerable children, and youth should be increased.

5. *Efforts to reach marginalized populations should be expanded:* Programs should be designed and implemented with respect for the human rights of marginalized groups, such as people living with HIV/AIDS, orphans and other vulnerable children, women, prisoners, commercial sex workers, men who have sex with men, people with disabilities, migrants, people living in conflict or post-conflict situations, pastoralists, rural populations, ethnic minorities and the elderly. PTMCT services are the privilege of a few, and many poor mothers cannot afford recommended services, such as alternatives to breast milk. There is a new wave of stigma due to existing PEPFAR prevention policies, and current programs are insensitive to age, culture, and gender-specific needs. The abstinence-only earmark is a distraction from meaningful work to reduce rates of new infections in our countries.

- Services should be tailored to meet the needs of vulnerable populations and be accessible, affordable, and within reach.
- Prevention programs should invest in evidence-based preventive strategies that strengthen community-based and peer-led awareness creation and behavior change programs, placing vulnerable populations at the center of prevention responses, and addressing the social, economic, and cultural issues that drive new infections.
- Prevention program should be context-specific, include prevention services for people living with HIV/AIDS, and step up efforts to address AIDS-related stigma and gender-based violence.
- New efforts should be launched to support active outreach to underserved, high-risk groups such as prisoners and people in post-conflict areas.

- PMTCT services should be scaled up to provide nutritional support, alternative infant nutrition, and affordable Cesarean sections for pregnant HIV-positive women.
- PMTCT programs should be linked to AIDS treatment and sexual and reproductive health programs, including family planning, pre-, post-, and antenatal services, and socioeconomic support for mothers.

6. *Lack of medical equipment:* Many health facilities—especially in rural areas—are poorly equipped in terms of equipment and supplies. In particular, countries urgently need CD4 machines and reagents as well as x-ray machines. People with HIV are required to show CD4 results or x-rays in order to medically qualify for AIDS or tuberculosis treatment and to monitor therapies. Too often, the machines are not available in any accessible medical facility, or the tests are prohibitively expensive.

- Procure and maintain medical equipment needed to provide AIDS care, including x-ray and CD4 machines and necessary reagents.

7. *Shortages of trained health workers and facilities:* There is a shortage of health care providers in our countries, and provision of primary health care suffers when PEPFAR-supported programs hire away scarce health professionals from public sector primary care facilities. Training of existing health professionals has not kept pace with the scale-up of AIDS programs at the country level, and improved quality assurance measures are necessary. Women and people with HIV serving as community health workers and home-based care providers bear the brunt of providing care and services to people living with HIV/AIDS, but are not recognized, supported, or paid. Additionally, access to functioning care facilities can be very difficult outside of urban centers, and too many rural clinics are understaffed, inadequately equipped, and inconsistently supplied.

- U.S. AIDS initiatives should invest to substantially increase the supply of health professionals, support pre- and ongoing in-service training of all cadres of new and existing health workers, and work with countries and professional associations to develop HIV care provider accreditation standards and monitoring.
- Much more should be done to retain existing health workers, including increased remuneration and improved working conditions.
- Community health workers should be trained, certified, equipped, and supported by a functioning referral systems and increased number of health professionals. Community health workers should be paid a wage sufficient to support a family and be integrated into the mainstream health system.
- More health facilities are needed in rural areas, as well as transportation support for patients.

8. *PEPFAR country plans are not aligned with national plans or accountable to civil society:* U.S. programs are too often operated as parallel systems—duplicating, undermining, or even weakening country-level capacity to respond effectively to health issues. While civil-society organizations have been at the forefront of the fight against AIDS, we are not consulted or meaningfully able to contribute to U.S. efforts, policies, plans, and priorities.

- Broader and transparent consultation is needed to ensure that PEPFAR programs are more responsive to country contexts, complement country plans and priorities, and strengthen the country ownership necessary to ensure sustainability.
- PEPFAR should prioritize integrating services into existing programs, especially in public-sector health facilities, rather than running parallel services. Parallel efforts such as the Supply Chain Management System (SCMS) should be required to work with in-country partners to transfer operations over time.
- PEPFAR programs should be developed in consultation with civil-society organizations, including networks of people living with HIV/AIDS and other vulnerable groups, to ensure community ownership, leadership, and sustainability. Future U.S. AIDS initiatives should adopt a bottom-up approach to empower communities to take leadership in policy design and implementation.

The following organizations developed these recommendations, and thank you for considering their inclusion as the U.S. global AIDS initiative is reauthorized, reformed, and renewed:

Alex Margery, Tanzanian Network of People Living with HIV/AIDS (TANEPHA)
Alice Tusiime, National Coalition of Women with AIDS in Uganda (NACOA)
Ambrose Agweyu, Health Workforce Action Initiative, and Kenya Health Rights Advocacy Forum (HERAF)
Ann Wanjiru, GROOTS Kenya
Beatrice Were, Global AIDS Alliance (Africa)

Carol Bunga Idembe, Uganda Women's Network (UWONET)
Caroline A. Sande, UNAIDS Consultant
Elizabeth Akinyi, International Community of Women Living with HIV/AIDS (ICW)
Everlyne Nairesicie, GROOTS Kenya
Flavia Kyomukama, National Forum of PLWHAs Networks in Uganda (NAFOPHANU)
James Kamau, Kenyan AIDS Treatment Access Movement (KETAM)
Joan Chamungu, TNW+ and Tanzanian National Council of People Living with HIV/AIDS (NACOPHA)
Linda Aduda, Kenyan AIDS Treatment Access Movement (KETAM)
Paddy Masembe, Uganda Network of Young People Living with HIV/AIDS (UNYPA Positive)
Maureen Ochillo, ICW
Micheal Onyango, Men Against AIDS in Kenya
Nick Were, East Africa AIDS Treatment Access Movement (EATAM)
Prisca Mashengyero, Positive Women Leaders, Uganda
Rose Kaberia, EATAM

Plus two additional individuals representing large AIDS treatment programs supported largely by PEPFAR, who wish to remain anonymous to protect their ability to offer candid assessments.

Sponsors:

James Kamau, Kenyan AIDS Treatment Access Movement (KETAM)
Alia Khan, Global AIDS Alliance (DC)
Paul Davis, Health GAP (Global Access Project)

RESPONSES OF DR. MICHEL KAZATCHKINE TO QUESTIONS SUBMITTED FOR THE RECORD BY SENATOR BIDEN

Question. The Center for Global Development issued a report entitled, "Following the Funding for HIV/AIDS," which analyzed PEPFAR, Global Fund, and World Bank funding practices. In its recommendations to the Global Fund, the Center advised the Fund to keep its focus on funding gaps or underresourced priorities and to reexamine strategies to build local capacity. Could you explain your strategy to address each of these two important issues over the next 5 years?

Answer. One of the principal challenges to scaling-up efforts to mitigate the impact of HIV/AIDS, tuberculosis and malaria has been a country's capacity to effectively deliver services in a given setting. These capacity limitations exist within the governmental as well as nongovernmental sector and at the national as well as subnational level. Despite an increase in overall international resources to enhance the response, limitations in financial management, human resource management, M&E, training, remuneration for staff, communication/information technology and strategic planning may be preventing countries from effectively implementing programs and reaching their targets.

In recognition of the comparative advantage of the different sectors involved in mitigating the three diseases, and areas where added capacity may not be harnessed, the Global Fund Board passed a key Decision Point in April 2007 entitled "Strengthening the Role of Civil Society and the Private Sector in the work of the Global Fund." The Decision Point calls upon the Global Fund to strengthen key areas of its architecture in order to improve upon the effectiveness of the role of nongovernmental stakeholders in Global Fund processes, such as increasing the participation of key affected populations on Country Coordinating Mechanisms (CCMs), providing further guidance on the representation of civil society and private sector representatives to be members of CCMs, simplified access to CCM funding, and of particular relevance, the utilization of dual-track financing (DTF)[1] and the funding of community systems strengthening (CSS) to address gaps and constraints to national scale-up.

Both dual-track financing and community systems strengthening are designed to increase the role and effectiveness of both the governmental and nongovernmental sectors in implementation and service delivery, as well as to develop a longer term strategy for institutional development of the weaker sectors, to take on a greater role in service provision in the future.

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[1] DTF refers to the recommendation that CCMs routinely select both government and nongovernment sector Principal Recipients to lead program implementation in proposals submitted the the Global Fund.

Dual Track Financing: Starting in Round 8, countries submitting applications to the Global Fund will be encouraged to nominate both a governmental and non-governmental PR and will be required to provide a detailed explanation in the case that the proposal does not nominate, at a minimum, one Principal Recipient (PR) from each sector. The governmental sector has often demonstrated its comparative advantage in the provision of health infrastructure, the procurement of essential medicines, the training of national, district and local-level health professionals, as well as implementing larger scale programs at the national level.

Civil society organizations, similarly, are becoming increasingly recognized for their role in scaling up access to treatment, through the targeting of communities to increase uptake in more formal health settings and treatment literacy; as well as their acknowledged role in reaching vulnerable and marginalized populations which the governmental sector may have more difficulty accessing. Through working together at a national level, these sectors would be able to provide a more holistic and comprehensive response to the three diseases as well as to develop sustainable partnerships for service delivery for the long term.

Community Systems Strengthening: Proposals submitted may already include activities that strengthen the community-level response to the three diseases. However it is recognized that weaknesses at the community level affect the performance of existing grants, as well as overall demand for and access to services. The proposal form and guidelines for Round 8 therefore provide greater encouragement to applicants to include provision for strengthening and/or further development of community systems and institutional capacity to ensure improved outcomes for the three diseases. This encouragement takes the form of increased information on potential indicators, and also commentary on anticipated improvement in community systems. In this context, the Global Fund describes CSS as funding to build the capacity of community-based organizations, including NGOs, to improve and expand service delivery (for example, home-based care, outreach, prevention, orphan care, etc.).

Funding for CSS may go to:

- Subrecipients (SRs), and as relevant, sub-subrecipients (SSRs) of existing Global Fund grants in anticipation of building sufficient capacity for a PR nomination in a future round;
- Other already existing local and subnational CBOs who do not already have established relationships within the Global Fund framework, but have the potential to be key partners in the delivery of services; and
- Young or emerging CBOs (initiated within approximately the last 5 years) and/or organizations little or no track record in attracting or managing outside finances.

CCMs will be required to demonstrate and identify in future proposals all gaps to enhanced service delivery, and in this particular case, gaps which prevent it from utilizing the capacity of both sectors at the PR-level to implement dual track financing and gaps and constraints in the ability of governmental and nongovernmental organizations at the subnational level to scaling up effective responses to the three diseases. From Round 8, applications which seek to implement the DTF model or demonstrate the need for CSS funding at the subnational level, in particular among CBOs, would therefore be eligible for funding throughout the life of the grant.

Question. U.S. law requires a "snapshot" of international contributions that have been made to the Global Fund as of July 31 of each year. How does the timing of this snapshot affect the funding process? As Congress considers reauthorization of global HIV/AIDS, tuberculosis, and malaria programs, are there alternatives to current practice that would provide a window into—and perhaps help spur—international contributions but that might remedy reported difficulties stemming from the July 31 deadline?

Answer. The July 31 deadline poses problems because almost all other major donors have different financial years. For example, most European donors follow their own calendars and pay their contributions at the end of the year. Therefore, the July deadline is problematic to these donors, essentially forcing them to transfer their money earlier. To date, other donors have obliged, but to improve our relationships with donors, it would be helpful to have this deadline shifted or removed.

Question. The Global Fund does not have a particular grant category to address the needs of women and girls, but all involved recognize that women are physically, economically, and socially more vulnerable to HIV/AIDS. Could you tell us how the Global Fund is helping to address these gender issues within its grants?

Answer. The Global Fund fully recognizes the particular vulnerability of women and girls to HIV/AIDS and is already funding a number of programmes supporting activities that benefit this population directly.

There is evidence that many of the Global Fund programmes are reaching women. Of the 1.1 million people on antiretroviral therapy by mid-2007, 57 percent were women who represent 48 percent of infections. Other activities currently underway range from care and treatment programs for sexually exploited underage girls in Costa Rica, to supporting grandmothers who care for orphans in Swaziland and financing a network of HIV-positive women in Kenya working on antidiscrimination and the social integration of women living with HIV and AIDS.

Despite the many interventions that can be catalogued, the Global Fund is acutely aware of the disproportionate burden placed on women by AIDS and of their unique vulnerability. Therefore, the Global Fund is emphasizing the need to develop and expand programs targeted at women and girls in future proposal rounds. In addition, in November 2007 the Global Fund Board made a key decision regarding the importance of gender and the particular importance of women and girls:

SCALING UP A GENDER-SENSITIVE RESPONSE TO HIV/AIDS, TUBERCULOSIS, AND MALARIA BY THE GLOBAL FUND

Decision Point GF/B16/DP26:

The Board recognizes the importance of addressing gender issues, with a particular focus on the vulnerabilities of women and girls and sexual minorities, in the fight against the three diseases, more substantially into the Global Fund's policies and operations.

The Board authorizes the Secretariat as a matter of priority to immediately appoint senior level "Champions for Gender Equality," with appropriate support, who will:

a. Work with technical partners and relevant constituencies to develop a gender strategy.

b. As an immediate priority, provide guidance to the Portfolio Committee on revisions to the Guidelines for Proposals for Round 8 to encourage applicants to submit proposals that address gender issues, with a particular reference to the vulnerability of women and girls and sexual minorities.

The Board requests the Policy and Strategy Committee to review the Gender Strategy and present it to the Board for approval at the 17th Board meeting.

The Global Fund Secretariat has recruited a consultant to ensure that work on this initiative starts immediately. In addition, an intense consultation process was undertaken to ensure the Round 8 Guidelines for Proposal are appropriately adjusted to reflect this priority and encourage countries to ensure their programming takes into account gender as a factor of the epidemics and that they plan accordingly.

The recruitment of the gender champions will begin as soon as the role has been properly defined in the context of a strategic framework. The Global Fund is working with partners to ensure that appropriate technical assistance is available to ensure evidence-based and technically sound proposals on this area are prepared for submission for Round 8.

RESPONSES OF DR. HELEN SMITS TO QUESTIONS SUBMITTED FOR THE RECORD BY SENATOR BIDEN

Question. PEPFAR has made real strides in addressing issues of gender and the special needs of women and girls, but we have not been able to keep pace with the spread of the pandemic or the fact that women are increasingly among its victims. Women and girls are physically more vulnerable to HIV/AIDS, but economic, political, and legal disparities make them more so. In many countries, such as South Africa, young women are four times more likely to be HIV-infected than young men.

- Specifically, how can efforts to address the special vulnerabilities and needs of women and girls be expanded and improved in the next phase of our HIV/AIDS efforts?

Answer. The IOM report recommends that the U.S. Global AIDS Initiative continue to increase its focus on the factors that put women at greater risk of HIV/AIDS and to support improvements in the legal, economic, educational, and social status of women and girls. The IOM committee believes such improvements are necessary to create conditions that will facilitate the access of women and girls to HIV/AIDS services; support them in changing behaviors that put them at risk for HIV transmission; allow them to better care for themselves, their families, and their communities; and enhance their ability to lead and be part of their country's response to its HIV/AIDS epidemic.

Specifically, the IOM committee was encouraged by OGAC's formation of the Technical Working Group on Gender and the focus that it could bring on the needs of women and girls and approaches to meet them. The IOM committee also urges the Global AIDS Coordinator to keep his commitment to implement expeditiously the recommendations developed as a result of the June 2006 "Gender Consultation" hosted by PEPFAR.

Although the IOM study was not designed to judge the effectiveness of individual programs, I would like to add my personal impression, from the country visits, of the very exciting and relatively low-cost programs underway. Many of the ones I saw are based in local NGOs with a strong sense of what local women can do to achieve economic independence. In the legal sense, these include programs to counsel women when traditional practices (such as the personal dwelling reverting to the husband's family at his death) are in conflict with national law. I met a number of women who had been able to retain their control over their home and its contents—a huge step in surviving widowhood. I also saw programs which provided women with both training and modest capital in order to become independent entrepreneurs; these programs included raising chickens and selling them in the market, selling soft drinks, and creating crafts with a "western" look that has enabled the groups of women to sell to major international distributors.

I am sure with the experience already gained, the Technical Working Group on Gender will be able to advise all PEPFAR countries in the development of strong programs in this important area.

Question. Are current targets and indicators on gender sufficient?

Answer. The IOM committee did not find any "targets" per se for women and girls, and is in principle supportive of meaningful targets for desired program outcomes. PEPFAR reports on the number of programs and services it supports that are directed at reducing the risks faced by women and girls in the following categories: (1) Increasing gender equity, (2) addressing male norms, (3) reducing violence and sexual coercion, (4) increasing income generation for both women and girls, and (5) ensuring legal protection and property rights. However, no information of the kind the IOM committee would like to see was yet available—that is, information with which to determine either the individual or collective impact of these activities on the status of, and risks to, women and girls.

Consistent with its call for better data about focus country epidemics, support for country monitoring and evaluation systems, and evaluation of the impact of PEPFAR-supported programs, the IOM committee would want the U.S. Global AIDS Initiative to develop and be accountable for harmonized indicators of the health and other status of women and girls. The kinds of indicators that are under discussion include the length of schooling for girls, evidence of implementation of property right laws, and numbers of women engaged in productive work that generates an income sufficient for family survival.

RESPONSES OF DR. NILS DAULAIRE TO QUESTIONS SUBMITTED FOR THE RECORD BY SENATOR BIDEN

Question. PEPFAR has made real strides in addressing issues of gender and the special needs of women and girls, but we have not been able to keep pace with the spread of the pandemic or the fact that women are increasingly among its victims. Women and girls are physically more vulnerable to HIV/AIDS, but economic, political, and legal disparities make them more so. In many countries, such as South Africa, young women are four times more likely to be HIV-infected than young men.

- Specifically, how can efforts to address the special vulnerabilities and needs of women and girls be expanded and improved in the next phase of our HIV/AIDS efforts?
- Are current targets and indicators on gender sufficient?

Answer. One of the first ways to address the special vulnerabilities and needs of women and girls is linking PEPFAR with an overall health and development strategy. To date, PEPFAR has been implemented in a vertical, medical model which does not allow for addressing nonmedical concerns such as access to basic services. This lack of access exacerbates the vulnerability of women and girls. U.S. investments in HIV/AIDS must be coupled with adequate and increased assistance to core health and development programs.

Better wraparound programs are needed to adequately address the needs of women and girls including better referral services to non-HIV health services such as maternal health, reproductive health, etc. Prevention and treatment programs

need to be integrated into maternal and child health clinics in order to better reach women. Women also need increased access to basic health services.

The means of evaluating PEPFAR programs success need to be revised across the board. Currently, OGAC is primarily focused on output indicators. Output indicators do not really help in determining how to improve a program. They help generate quantifiable results. Our implementing agencies are calling for more outcome indicators including those used for gender assessments.

PEPFAR also needs to strengthen programs that address gender-based violence by working with countries to establish better social, medical, and legal referral systems for victims of sexual violence, integrating gender-based violence screening into HIV programs and providing post-exposure prophylaxis and emergency contraception.

Overall, GHC implementing agencies feel that OGAC is on the right track for addressing gender needs. It is a question of how to scale up projects and integrate PEPFAR services with other health services. Implementing agencies are also calling for increased focus on stigma as this affects women and girls more. We need to know more about OGAC's work around stigma and discrimination to better help address the vulnerabilities of women and girls.

Modification of policy restrictions such as the antiprostitution pledge and abstinence until marriage earmarks would also help increase outreach to women.

Question. How do shortages of health care workers and shortcomings in health systems affect your organization's (or your member organizations') efforts to combat HIV/AIDS, TB, malaria, and other health challenges? What are the most important steps to take in the next phase of our HIV/AIDS, TB, and malaria programs to try to address these challenges?

Answer. Global Health Council member organizations implementing HIV/AIDS programs have cited lack of human resource capacity as a critical issue. According to our agencies, achieving PEPFAR targets in a sustained way is going to be practically impossible without an appropriate strategy for addressing the human resource issue. Currently, according to our member partners, not enough PEPFAR resources are available for training new health care workers or for building health infrastructure. As such, organizations often have to rely on using their own health personnel or have to pull health personnel away from non-HIV primary health care services. This results in scaling back in other non-HIV programs and services.

Furthermore, there currently is no support to assist countries in conducting national human resource forecasting to help determine capacity required to implement a project. Organizations have called for scaling up of community-based workers but these workers must be integrated into a primary health care system. While the task shifting approach can have positive impacts by allowing nurses to manage ART patients, this approach must be carefully implemented so as not to further siphon away health personnel from non-HIV health services.

Another challenge is the type of training. Most PEPFAR health care worker training is limited to administering ARV drugs. However, there remains a significant lack of trained health care workers in pediatrics and palliative care. According to our members, many patients on ART are dying of opportunistic infections in part due to lack of trained health care workers to diagnose and treat opportunistic infections.

Our member organizations are also concerned about not having enough trained professionals in the area of pediatric HIV/AIDS. A number of children and infants are not being reached through treatment, care or prevention programs and even if they are, services are limited due to a shortage of trained health professionals.

Training also needs to be increased in the areas of counseling and testing, prevention education and other activities, and in other types of counseling such as nutritional counseling. Ideally trained health professionals working in HIV/AIDS also need to be able to detect other global health needs such as childhood malnutrition, preventable diseases such as pneumonia.

Lack of health infrastructure is even a bigger challenge than trained health care workers. PEPFAR must start building primary health care infrastructure instead of HIV-only infrastructures. Only recently has OGAC begun to use the primary health care model for delivering HIV programs and services.

- Many have called for greater linkage between food and nutrition assistance and efforts to combat HIV/AIDS.
  - How does food insecurity affect efforts to combat HIV/AIDS?
  - What are the barriers to greater integration?
  - What are the dangers of providing food assistance only to those who are AIDS-affected when food insecurity in an area is widespread and help for those who are not HIV positive may not be available? Should we have an indi-

vidual-centered approach, a family-centered approach, or a community-centered approach?

According to many experts, World Health Organization, UNAIDS, and our own implementing agencies, high malnutrition rates are present in a number of HIV-affected communities, particularly in sub-Saharan Africa. Food is often identified as most immediately needed by people living with HIV/AIDS. Our implementing organizations are concerned about scaling up care and antiretroviral therapy without planning for appropriate nutrition. They have found that adherence to ARV is low when an individual with HIV/AIDS lacks proper nutrition.

However, Global Health Council implementing agencies have found it difficult to integration nutrition and HIV. Barriers to integrating food and nutrition assistance with HIV/AIDS programs and services are the same for any "wrap around" activity. There are two challenges: 1. Coordination; 2. Funding.

The first problem is that there appears to be a lack of coordination amongst agencies. Currently, to our knowledge, there is not a joint assessment among agencies on the needs of an HIV-affected community (not just for HIV programs and services but what else is needed: Food, water, doctors, etc). Individual implementing organizations have to tie the various pieces together themselves. For example, if an organization is working in an HIV-affected community that also lacks access to food or water, the organization itself must coordinate with other agencies like World Food Programme or USAID's Public Law 480 rather than OGAC coordinating ahead of time with the World Food Programme. Organizations must then rely on availability of funding through other sources and must also address different procurement mechanisms and a different funding cycle which adds to the reporting burdens.

Furthermore, PEPFAR programs and food programs are often in different locations which makes coordinating even more difficult.

Finally, funding is an issue. Core programs, including food aid, have not grown at the same rate as PEPFAR. Additional funding to support non-HIV services in PEPFAR programs has not been available. If it is available, it is coming at the expense of services accessed by nonheavily affected HIV communities.

As far as providing assistance is concerned, a number of our implementing agencies have long called for a community-centered approach. Several implementing agencies, particularly partners working with orphans and vulnerable children have experienced problems as they are seen as favoring HIV-positive families in communities where those who are HIV negative are still coping with significant health issues.

GLOBAL HEALTH COUNCIL RECOMMENDATIONS FOR PEPFAR REAUTHORIZATION

We would also request that attached recommendations be inserted into the record.

In addition to the attached recommendations, we also call on Congress to remove the antiprostitution pledge (APP). There is no evidence that the APP has improved HIV prevention. It has alienated some U.S. Government partners and created uncertainty for others. It is a disincentive for innovative programming with sex workers as program implementers fear inadvertently breaching the pledge requirement. The "pledge" further stigmatizes the vulnerable people we are trying to reach and serve, making prevention efforts more difficult. It has also raised constitutional issues and has been struck down by two Federal district courts, though the appeals process is still under way. We see no point in the Congress prolonging a legal battle with the government's partners in the fight against AIDS over a provision that does not improve public health outcomes.

Finally, the Global Health Council, recommends that the U.S. Congress and the U.S. President work together to develop a more comprehensive response to global health needs, which would include developing a longer term global health strategy that guides all U.S global health programs, including PEPFAR. A comprehensive approach to global health would be informed by analyses of the causes of the greatest burden of disease in the world's poorest countries and a commitment to supporting long-term development needs in partner countries as well as taking advantage of public diplomacy opportunities to strengthen America's reputation abroad. With the support of the U.S. Congress, this administration has achieved extraordinary results in global health through PEPFAR and increasingly through the President's Malaria Initiative. However, as an alliance of public health experts, we know that health is not achieved by fighting specific diseases in isolation. In order to combat HIV/AIDS successfully, U.S. programs on global HIV/AIDS must evolve from an emergency response to a long-term investment in global health that is connected to achieving our other goals in areas, such as reducing maternal and child mortality, combating other infectious diseases and access to basic development services such as water and sanitation.

[Attachment follows:]

SUMMARY OF THE GLOBAL HEALTH COUNCIL MEMBER RECOMMENDATIONS FOR STRENGTHENING PEPFAR

The President's Emergency Plan for AIDS Relief (PEPFAR), is a 5-year, $15 billion, comprehensive approach for combating HIV/AIDS in 15 focus countries. The program, and the legislation that supported it, will expire in 2008. To assure the continuation of PEPFAR and strengthen the U.S. Government response to the pandemic, the Global Health Council convenes a group of its members with expertise in implementing HIV programs. Under the Council's leadership, representatives of its member organizations developed the following recommendations.

RECOMMENDATIONS FOR IMPROVING THE IMPLEMENTATION OF PEPFAR PROGRAMS AND SERVICES:

1. HIV/AIDS Prevention Efforts Must Be Scaled Up

Council members endorse the administration's proposal to increase the number of people reached by HIV/AIDS prevention programs from 7 million to 12 million. Members support developing prevention strategies tailored to the needs of specific types of epidemics and populations that are designed at the country level and based on evidence of what interventions are effective. In order to provide prevention programs to significantly more people, members recommend eliminating the prostitution pledge and modifying guidance on harm reduction, which currently only allows for prevention interventions among HIV-positive injecting drug users.

2. More Flexibility Is Needed in PEPFAR's Budgetary Allocations

Members support modifying budgetary allocations to allow for country-specific and epidemic-specific programming.

3. Increase Ability To Use PEPFAR Resources Between Program Areas and Between HIV and non-HIV Health Services

Create the policy and budgetary environment to support more wraparound services or linkages between HIV and non-HIV services. This includes allowing the flexibility in use of funds for integrated programming such as child immunizations in a PEPFAR pediatric treatment site.

4. Expand Treatment and Care Programs and Improve Quality of Treatment Programs

Members support expanding access to antiretroviral therapy through public-private partnerships; expanding technical support and resources to increase access to palliative care; increasing acccess for infants and children for diagnosis and care and treatment services; improving patient followup practices; and recognizing the World Health Organization (WHO) prequalification process for availability of drugs.

5. Train Additional Health Care Workers and Strengthen Health Systems

Members support using PEPFAR resources to increase the number of health care workers in HIV-affected communities to contribute to, not draw down from, the total number of health care workers. Members recommend training more workers particularly in providing palliative care, pediatric treatment and diagnosis, and in the ability to provide other sets of services for HIV patients. Members support using PEPFAR resources to strengthen the health system in HIV-affected communities

6. Improve and Expand Operations Research

PEPFAR is a learning organization and as such it should modify and improve its current monitoring and evaluation process and devote more resources to operations research. Members recommend that PEPFAR communicate more with implementing agencies to share best practices and lessons learned to help inform policy and budgetary decisions in the future.

RESPONSES OF KEN HACKETT TO QUESTIONS SUBMITTED FOR THE RECORD BY SENATOR BIDEN

Question. PEPFAR has made real strides in addressing issues of gender and the special needs of women and girls, but we have not been able to keep pace with the spread of the pandemic or the fact that women are increasingly among its victims. Women and girls are physically more vulnerable to HIV/AIDS, but economic, political, and legal disparities make them more so. In many countries, such as South Africa, young women are four times more likely to be HIV-infected than young men.

- Specifically, how can efforts to address the special vulnerabilities and needs of women and girls be expanded and improved in the next phase of our HIV/AIDS efforts?

Answer. It is true that PEPFAR has made real strides in addressing issues of gender and the special needs of women and girls during the first 4 years of its implementation. However, it has not done enough to prevent HIV transmission among women, which is now the largest growing population of PLHIV. Catholic Relief Services, a major implementing partner of PEPFAR, is managing the AIDSRelief project under which nearly a quarter of a million PLHIV are in care; consistent with other PEPFAR ART providers, close to 70 percent of PEPFAR-supported ART patients are women. Moreover, of the 153 CRS AIDSRelief local partner treatment facilities which provide care on a daily basis to the patients, more than 30 offer Prevention to Mother to Child Transmission services.

To improve our capacity to address gender issues in our HIV response, CRS will carry out a study in 2008 to determine how best to improve gender mainstreaming across the agency, including an assessment of current strengths and gaps in gender programming and an industrywide review of State of the Art gender programming.

CRS believes that PEPFAR can address the special vulnerabilities and needs of women and girls by recognizing that simply by being female is to be at high risk of HIV and AIDS. PEPFAR can implement a global HIV prevention strategy that emphasizes the root causes of these vulnerabilities and the factors that affect their rate of HIV infection. Some of the activities which should be included in this HIV prevention strategy are:

GIRLS EDUCATION AND LIFE SKILLS

- Supporting expanded and safe educational opportunities for women and others at risk, including curricular and infrastructural reforms to address social nouns and reduce risk of school dropout of girl children.
- Supporting age-appropriate life skills education for young girls so that they are informed how best to protect themselves, from HIV infection, through delay of sexual debut (abstinence until marriage) and partner reduction (faithfulness in marriage).

WOMEN'S ECONOMIC EMPOWERMENT AND STRENGTHENING THEIR LIVELIHOODS

- Supporting the development of livelihood initiatives, access to markets, job training and literacy and numeracy programs, and other such efforts to assist women and girls in developing and retaining independent economic means.
- Supporting the development and expansion of local and community groups focused on the needs and rights of women and girls; and involving these organizations at the community level in program planning and implementation.

REDUCING STIGMA AND DISCRIMINATION

- Preventing violence against women, including intimate partner and family violence, sexual assault, rape and domestic and community violence against women and girls.
- Encouraging the participation and involvement of local and community groups representing different aspects of women's lives in drafting, coordinating, and implementing the national HIV/AIDS strategic plans of their countries.
- Promoting changes in social norms attitudes and behavior that currently condone violence against women, especially among men and boys, and that promote respect for the rights and health of women and girls, reduce violence, and support and foster gender equality.

LEGAL SUPPORT FOR WOMEN AFFECTED BY HIV/AIDS

- Protecting the property and inheritance rights of women through direct services as well as legal reforms and enforcement.

Question. Are current targets and indicators on gender sufficient?

Answer. No; current targets and indicators are not sufficient.

PEPFAR should invest in the disaggregation of data by age as well as sex to better understand HIV infection trends among different age groups; expand operations research and evaluations of gender-responsive interventions in order to identify and replicate effective models; develop gender indicators to measure both outcomes and impacts of interventions, especially interventions designed to reduce gender inequalities; develop and encourage the utilization of gender analysis tools at the country level, and disseminate lessons learned among different countries.

PEPFAR must not only disaggregate its data, but also must develop indicators to measure the effectiveness of gender programming, and the extent to which gender is being mainstreamed into PEPFAR. PEPFAR must be able to report which programs are working to address the needs of women PLHIV, such as expanding PMTCT, but also which programs are working to reverse discrimination and stigma, such as sensitivity training for men. Moreover PEPFAR must report which programs are working to increase women's education and economic empowerment, as well as increase young women's life skills. PEPFAR should not only state how many projects or programs support these strategies, but also measure the impact of these programs through evidence-based reporting.

Question. How do shortages of health care workers and shortcomings in health systems affect your organization's (or your member organizations') efforts to combat HIV/AIDS, TB, malaria, and other health challenges? What are the most important steps to take in the next phase of our HIV/AIDS, TB, and malaria programs to try to address these challenges?

Answer. Catholic Relief Services leads a consortium which implements a PEPFAR-funded antiretroviral therapy project AIDSRelief—that provides life-saving antiretroviral medications for 90,000 patients and provides care for another 146,000 HIV-positive people through 153 local partners in nine countries. Some AIDSRelief partners are approaching a "ceiling" in the number of people that they can treat and care for, not because of lack of drugs, but because of lack of trained health care personnel.

Most countries lack sufficient trained medical professionals and other trained health personnel to support and supervise care and treatment as they scale-up beyond the large numbers of people in need of ART. It is estimated that the African Continent has a shortage of 2 million trained health professionals. Brain-drain, emigration, and poaching of trained health professionals to meet the health professional shortages in the developed world (principally North America and Europe), as well as attrition by death due to AIDS, are all contributing factors to this shortage.

As a result, CRS-led AIDSRelief has been working with alternative nurse-led models of care and task shifting from physicians to nurses, and nurses to community health workers (CHWs) and volunteers. Our partners train and supervise many CHWs and volunteer treatment "buddies" (or treatment coaches)—many of whom are PLHIV on ART themselves.

Because of task shifting and the resultant mobilization of large numbers of CHWs and volunteers among CRS-led AIDSRelief partners, we are experiencing 85–95 percent retention rates of our patients in the program. Those who remain in the program are 80–95 percent adherent to their antiretroviral medication regimen. This results in successful viral suppression and the ability to keep most patients on less-expensive first-line drugs.

What can be done to ensure sufficient health care workforce and thus the ability to maintain current patients on successful therapy and also to scale-up? More funding in PEPFAR for training, supervision, continuing education, upward mobility in the health care workforce, and some kind of compensation package (salaries for full-time CHWs and stipends/incentives for volunteer treatment buddies/coaches) would help ensure the ability of CRS-led AIDSRelief partners to continue and expand services.

In addition, in several developing countries, there is an intermediary level of trained professional between that of physicians and nurses called a "clinical officer," a level that does not exist in North America and Europe. As a result, clinical officers are not "exportable" to other health systems outside of their home country and are therefore more likely to provide long-term HIV diagnosis, care, and treatment services in their home country. Training more "clinical officers" would thus provide one avenue for a more stable workforce.

Question. Many have called for greater linkage between food and nutrition assistance and efforts to combat HIV/AIDS.

- How does food insecurity affect efforts to combat HIV/AIDS?

Answer. The No. 1 issue that we hear from people living with HIV and AIDS and their families in the 52 countries where we have HIV programming, is lack of food and the money to purchase it. All aspects of food insecurity availability, access and use of food—are exacerbated by high rates of HIV and AIDS. The chronic and debilitating progression from HIV infection to full-blown AIDS (if untreated or treated late) accompanied by the loss of work and income while seeking treatment leads to hunger, poor nutrition, and food insecurity.

HIV significantly undermines a household's ability to provide for basic needs because HIV-infected adults may be unable to work, reducing food production and/or

earnings. Healthy family members, particularly women, are often forced to stop working to care for sick relatives, further reducing income for food and other basic needs. Households may have trouble paying costs associated with heath care and nutritional support. They may also be severely restricted in participating in community activities. Children may be withdrawn from school because families can no longer afford school fees and/or because children are needed to care for ill parents. This affects opportunities for future generations. Furthermore, as a result of this HIV-to-poverty or poverty-to-HIV cycle, the quantity and quality of diet diminishes for the entire PLHIV household.

The interaction between nutrition and ART is well documented. Inadequate nutrition causes malabsorption of some ARVs. Some medications have to be taken on an empty stomach, while others with a fatty meal. Preliminary evidence from the 153 CRS AIDSRelief ART sites suggests that patients initiating ART with access to food respond to treatment better than those lacking adequate nutrition. Continued data collection is important for a more comprehensive picture.

Question. What are the barriers to greater integration?

Answer. Short-term food/nutrition supplements and household basket rations, while necessary, do not address underlying food insecurity.

Food and nutrition and HIV activities are not well-integrated across various USG agencies and programs. Title II food programs are targeted to geographical regions with the greatest food insecurity, which does not always allow us to reach food insecure PEPFAR-supported OVC and PLHIV living in other regions of the same country. In addition, interagency coordination and integration of services is not always consistent across countries.

CRS' AIDSRelief ART Project uses PEPFAR funding to provide "Food by Prescription" to ART patients meeting certain stringent physical biometric criteria in Kenya and Uganda where other food/nutrition resources are not available. This creative and needed approach is not currently available in other PEPFAR focus countries.

Cutbacks in Title II funding have exacerbated the challenge. Successful projects like I-LIFE, RAPIDS, SUCCESS, and Return to Life in the southern Africa region have led to better integration of HIV and nutrition programs with sustainability by targeting the causes of food insecurity. All have not received continued or expanded funding because of Title II cutbacks. A recent SUCCESS (Scaling Up Community Care to Enhance Social Safety-nets) evaluation report shows the overwhelmingly positive impact of nutritional supplements on HIV-positive home-based care clients not taking ARVs that also met household food insecurity criteria for targeted nutritional supplementation.

In addition, shortages of health care workers, including nutritionists, limit the time and ability of existing staff to provide food/nutrition counseling.

Question. What are the dangers of providing food assistance only to those who are AIDS-affected when food insecurity in an area is widespread and help for those who are not HIV positive may not be available?

Answer. From our almost 50 years of food aid experience with Title II, when food is given only to the patient, we have observed that individual food rations are usually shared with the rest of the household—diminishing the intended benefit to the individual. As a result, CRS strives to use other resources—from Title II, WFP, and our private funds—to distribute basket rations to families and households affected by HIV. The key to avoiding unintended jealousy or conflict in the community is to involve the community in targeting these basket rations to those most in need.

While the following is not from a PEPFAR-supported program, it illustrates the value of basket rationing to households—the preferred model of nutritional support for HIV-affected families. Through the Public Law 480 Title II-supported I–LIFE program in Malawi, CRS and its partners provide food assistance to the chronically ill (most of whom are PLHIV) and their households. This helps entire households maintain a healthy nutritional status, provides for increased calorie and protein needs of those infected, eases the time and resource constraints of caregivers, and allows other members living in vulnerable households to pursue productive livelihoods. I–LIFE also provides community education programs that incorporate information about HIV prevention, health and nutrition, and challenge the stigma associated with the disease. Through these interventions CRS and its partners reduced food insecurity and eased the effects of the HIV and AIDS epidemic in the region. Unfortunately, many beneficial Title II-supported programs like I–LIFE have either ended or are in their last year because of Title II funding cuts.

Question. Should we have an individual-centered approach, a family-centered approach, or a community-centered approach?

Answer. The approach has to be flexible to respond to the varying needs in any given HIV-affected population. However, family and household basket food rations will be most appropriate in cases where affected individuals live in families that have used all available resources and coping mechanisms to meet the needs of the HIV-infected individual and have nothing left to meet the nutritional needs of either the patient or the household. Providing food to the HIV-infected individual in a food insecure household will lead the infected recipient of an individual ration to share the ration with all members in the household; this then fails to meet the urgent nutritional need of the targeted HIV-infected recipient and is also insufficient to meet the food security needs of the other members of the household. Done correctly, community involvement is key to successful identification of individuals and households in need of nutrition and food assistance without causing jealousy among the rest of the community.