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Final testimony as submitted

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Testimony by

Sandra Thurman
Director, Office of National AIDS Policy

Before the

House Of Representatives
Banking and Financial Services Committee

March 8, 2000

Mr. Chairman and other members of the Committee, I am delighted to be with you today to talk about the global AIDS pandemic – with a special focus on AIDS in Africa. Your interest in addressing this crisis is very much appreciated – and desperately needed.

I would like to use my time with you to lay out a vivid picture of the scope of this tragedy – particularly its impact on the stability of families, communities and nations. I would like to share with you some of my experiences with the faces behind these shocking facts. And I would like to outline for you some key components of our enhanced Administration response to this global pandemic.

By any and every measure – AIDS is a plague of Biblical proportion. And it is claiming more lives in Africa than in all of the wars waging on the continent combined. AIDS is now the leading cause of death among all people of all ages in Africa – and the progression of this pandemic has outpaced all of our projections. In 1991 the World Health Organization predicted that by 1999 there would be 9 million infected and nearly 5 million deaths in Africa due to AIDS. The resulting numbers are *two to three times* higher with nearly 24 million infected and 14 million deaths.

And yet this war rages on. Each and every day Africa buries 5,500 men, women, and children as a result of AIDS – and that count will more than double in the next few years. By 2005, it is now projected that more than 100 million people worldwide will have become HIV infected. And unlike other wars – it is women and children that are increasingly caught in the crossfire of this relentless pandemic.

In Africa, an entire generation of children is in jeopardy. Already, in several sub-Saharan African countries, between one-fifth and one-third of all children have already been orphaned by AIDS. And the worst is yet to come. Within the next decade, more than 40 million children will have lost one or both parents to AIDS. 40 million. That is about the same number as all children in the United States living east of the Mississippi River. Or taken another way, it is almost the same number as all children in public school in this country. Left unchecked, this tragedy will continue to escalate for at least another 30 years.

In just a few short years, AIDS has wiped out decades of hard work and steady progress in improving the lives and health of families throughout the developing world – infant mortality is doubling, child mortality is tripling, and life expectancy is plummeting by twenty years or more.

AIDS is not just a health issue, it is an economic issue, a fundamental development issue and a security and stability issue.

AIDS is having a dramatic effect on productivity, trade and investment – striking down workers in their prime, driving up the cost of doing business, impeding trade and investment, and reducing GNP. Professionals have been hit particularly hard in sub-Saharan Africa, including civil servants, engineers, teachers, miners, and military personnel. In Malawi and Zambia, more than 30% of teachers are HIV positive. Some

mining firms in South Africa are reporting that nearly half of their workers are infected. And many businesses are hiring at least two workers for every one skilled job, assuming that one will die from AIDS.

According to the *Economist* magazine, recent studies have found that AIDS is seriously eroding the economies of many of our partner nations. In Namibia, AIDS cost the country almost 8% of its GNP in 1996. By 2005, Kenya's GNP will be over 14% smaller than it would have been without AIDS.

Similarly, in Tanzania, The World Bank has predicted that its GNP will be 15 to 25% lower as a result of AIDS. The South African government has estimated that this epidemic costs the country 1% of its GNP each year, a situation that will only worsen without strong intervention.

AIDS is also affecting security and stability in the region. As Ambassador Holbrooke will discuss shortly, the UN Security Council recently held a daylong meeting on HIV/AIDS. This historic event highlighted the growing awareness that AIDS is a security threat that requires a global mobilization. It is hardly a coincidence that the National Intelligence Council recently released a report on the global infectious disease threat. The Report draws several very disturbing conclusions including the following:

- Development of an effective global surveillance and response system is at least a decade or more away.

- The economic costs of infectious diseases – especially HIV/AIDS – are already significant and could reduce GDP by as much as 20 percent or more in by 2010 in some sub-Saharan countries.
- Some of the hardest hit countries in sub-Saharan Africa – and possibly later in South and South East Asia – will face a demographic upheaval as HIV/AIDS and associated diseases reduce human life expectancy by as much as 30 years and kill as many as a quarter of their populations over a decade or less, producing a huge orphan cohort. Nearly 42 million children in 27 countries will lose one or both parents to AIDS by 2010; 19 of the hardest hit countries will be in sub-Saharan Africa.
- The relationship between disease and political instability is indirect but real.

The prevalence of HIV in the armed forces of many African countries is staggeringly high. The *Economist* has estimated the HIV prevalence in the Congo range at 50 to 80%. Other recent reports have projected that the South African military and police are also heavily impacted by HIV. Moreover, as these troops participate in an increasing number of regional interventions and peacekeeping operations, the epidemic is likely to spread.

Extremely high levels of HIV infection among senior officers could lead to rapid turnover in those positions. In countries where the military plays a central or strong role in

government, such rapid turnover could weaken the central government's authority. For those countries in political transition, this kind of instability could slow or even reverse the transition process. This is a dynamic that deserves serious attention not only in Africa, but also in the Newly Independent States of the Former Soviet Union, and in India where AIDS is intensifying its deadly grip.

The South African Institute for Security Studies has also linked the growing number of children orphaned by AIDS to future increases in crime and civil unrest. The assumption is that as the number of disaffected, troubled, and under-educated young people increases, many sub-Saharan African countries may face serious threats to their social stability. Without appropriate intervention, many of the 2 million children projected to be orphaned by AIDS in South Africa alone will raise themselves on the streets, often turning to crime, drugs, commercial sex, and gangs to survive. This seriously affects stability and promotes the spread of HIV among these highly vulnerable young people.

Yet my message to you today is not one of hopelessness and desolation. On the contrary, I hope to share with you a sense of optimism. For amidst all of this tragedy, there is hope. Amidst this terrible crisis, there is opportunity: the opportunity for us – working together – to empower women, to protect children, and to support families and communities throughout the world in our shared struggle against AIDS.

We know what works. With our partners in Africa we have developed useful knowledge and effective tools. Together, we have designed model programs and proven that they work. And today, we know how to stem the rising tide of new infections, how to provide basic care to those who are sick, and how to mobilize communities to support the growing number of children orphaned by AIDS. Uganda has demonstrated that with strong political commitment and sustained nationwide programs, HIV prevalence can be cut in half. And Senegal has shown that HIV can be stopped in its tracks and prevalence can be kept low. But there is more, much more that needs to be done if we are to bring these successes to scale.

The United States has been engaged in the fight against AIDS here at home since the early 1980s. But increasingly we have come to realize that when it comes to AIDS – both the crisis and the opportunity have no borders. We have much to learn from the experiences of other nations, countries, and the suffering of citizens in our global village touches and affects us all.

The United States has been the leader in the battle against AIDS. The Administration has taken an active role in sounding the alarm on the AIDS crisis in Africa, and in ensuring that the United States supports African efforts to combat this deadly disease.

Since 1986, this nation has contributed over $1 billion to the global fight against AIDS. More than 50% of those funds have been used to address the epidemic in sub-Saharan Africa. Overall, nearly half of all of the development assistance devoted to HIV care and

prevention in the developing world has come from the US. The United States has also been the leading supporter of the United Nation's Joint Program on AIDS – UNAIDS – contributing more than 25% of its budget.

It is a strong record of engagement and one of which we can be proud, but unfortunately it has not kept pace with this terrible pandemic. We have done much, but there remains much more that the United States and other developed nations can and must do.

During the past year and a half I have made four trips to eight African countries. Together with members and staff from both parties and chambers we went to witness firsthand both the tragedies and triumphs of AIDS in Africa. In response to the findings of these trips, the Administration requested and the Congress appropriated an additional $100 million in FY2000 for a cross agency initiative to enhance our global AIDS efforts.

This new Initiative, which includes USAID and CDC, provides for a series of steps to increase US leadership through support for some of the extraordinary community-based programs and to provide much needed technical assistance to developing nations struggling to respond to the needs of their people infected and affected by AIDS. This effort more than doubles our funding for programs of prevention and care in Africa, and challenges our G8 and other partners to increase their efforts, as well. This Initiative is a

significant increase in the US government's investment in the global battle against AIDS and it begins to reflect the magnitude of this rapidly escalating pandemic.

The Initiative focuses on four key areas:

- **Prevention**. Specifically, we hope to implement a variety of prevention and stigma reduction strategies, especially for women and youth, including: HIV education, engagement of political, religious, and civic leaders, voluntary counseling and testing, interventions to reduce mother-to-child transmission, and enhanced training and technical assistance programs.
- **Home and community-based care**. This will help create and enhance counseling and support systems, and help clinics and home health workers provide basic medical care (including treatment for related illnesses like STDs and TB).
- **Care of children orphaned by AIDS**. We hope to improve our ability to assist families and communities in caring for their orphaned children through nutritional assistance, education, training, health, and counseling support, in coordination with micro-enterprise programs.
- **Infrastructure**. These funds will help to increase the capacity for the effective delivery of essential services through governments, NGOs, and the private sector. We also need to enhance surveillance systems so that we can better track the epidemic and target HIV prevention efforts.

Some of the other key components of this Initiative include an increase in our efforts to include the AIDS epidemic in our foreign policy dialogue, both to encourage and support political leadership in hardest hit countries and to promote an increased response by our developed nation partners. We are also taking steps to increase our coordination with the private sector and the many non-governmental organizations working in Africa, including religious organizations.

You will find a more complete description of this Initiative – both the problems and solutions – in the report released by the Administration last summer. I have submitted a copy to this Subcommittee and would like to request that it be included in the record as part of my remarks.

While this new Initiative greatly strengthens the foundation of a comprehensive response to the pandemic, UNAIDS has estimated that it will take $1 billion to establish an effective HIV prevention program in sub-Saharan Africa. Currently all donors combined are contributing less than $350 million to that end. In addition, UNAIDS estimates that it will take a minimum of $1 billion to begin to deliver even the most basic care and treatment to people with AIDS in the region. We have not even begun to scratch the surface when it comes to delivering treatment.

In the face of such tremendous need, the Administration has asked the Congress to appropriate another $100 million to enhance and expand our efforts to combat AIDS in Africa and around the world. These funds will enable us to increase our programs at

USAID and CDC and expand our comprehensive approach to include the Department of Labor and the Department of Defense.

Let me repeat, however, that the United States cannot and should not do this alone. Chairman Leach, you and the members of this Committee clearly recognize, as we do, that this crisis will require the active engagement of all segments of all societies working together. Every bilateral donor, every multilateral lending agency, the corporate community, the foundation community, the religious community and every African government must do its part to provide the leadership and resources necessary to turn this tide. It can and it must be done.

The bottom line is this: With no vaccine or cure available, we are at the beginning of an epidemic, not the end. What we see in Africa today, frankly, is just the tip of the iceberg. As goes Africa, so will go India and the Former Soviet Union. There must be a sense of urgency to work together with our partners in Africa to learn from the experiences there and to share the successes and avoid the failures in countries now standing on the threshold of the pandemic. Millions of lives... perhaps hundreds of millions of lives hang in the balance.

We look forward to working closely with each and every one you and are so grateful that this issue is receiving the broad-based bipartisan support it deserves. AIDS is not a democratic or republican issue – it is a devastating human tragedy that cries out to all of us for help.

We are one world – and in many ways – Africa's destiny is our destiny. There is hope on the horizon – but that hope will only be realized if we take constructive action together. Today, let us commit to seize this opportunity. And let me conclude by thanking this Subcommittee for its interest in this issue, and offer my continued assistance as you seek ways to respond to this terrible tragedy. As Archbishop Tutu said: "If we wage this holy war together – we will win."

Thank you.

Question:

What is the UN doing to combat the spread of HIV and AIDS?

Answer:

UNAIDS is the leading advocate for worldwide action against HIV/AIDS. Its mission is to lead, strengthen, and support an expanded response to the epidemic. With an annual budget of $60 million, UNAIDS is a modest-sized program with a substantial impact. The UNAIDS Secretariat operates as a catalyst and coordinator of action on AIDS, rather than as a direct funding or implementing agency.

Question:

In your testimony, you touch briefly on pending legislation concerning HIV/AIDS. Could you be more specific as to the Administration's views regarding the various bills that have been introduced?

Answer:

Question:

What is the UN policy regarding peacekeepers and the spread of AIDS? What efforts are underway to assure that they do not spread or contract this disease?

Answer:

Although the UN officially requires that prospective peacekeeping troops be "disease free," it is difficult to enforce this rule with such methods as HIV testing, given the paucity of available troops and the potential noncompliance of many contributing states.

Question:

There is grave concern about the high number of children who are drawn into national militia and guerrilla forces in regions such as the Congo. Many of these children have been orphaned due to AIDS. What is the United Nations position on the relationship between the participation of children in the military and the orphan crisis? Are there any strategies in place to curb this trend?

How can this strategy be tied to our efforts to address the AIDS crisis from the perspective of the orphan crisis, particularly as it related directly to the escalating number of child soldiers who have already or will contract HIV/AIDS?

Some ask why we are placing a priority on addressing the AIDS crisis in Africa and the developing world while infection rates in the US are rising, particularly in communities of color. How would you answer that question?

Is there support within the Administration to push for a creative and aggressive new AIDS program?

Answer:

To reduce the conscription rate of AIDS orphans, broad support mechanisms must be encouraged. These include strengthening the capacity of families to cope with HIV/AIDS, strengthening community-based responses, and ensuring that governments provide essential services including access to safe water, health services, and schooling.

The Interagency Working Group will examine all international HIV/AIDS issues, including the AIDS orphans issue and the child soldier issue.

The Administration's attention to the international HIV/AIDS crisis does not come at the expense of the domestic HIV/AIDS programs and policies. In addition to domestic HIV/AIDS concerns, HIV/AIDS must be made a priority in Africa because the enormous size of the epidemic in Africa threatens political and social institutions. We must intervene and assist now to mitigate the problems before they become more dangerous and more expensive.

Question:

How have multinational corporations responded to the AIDS crisis? What, if any, role do you think the private sector plays in this issue? Do you se a role or an opportunity for private-public partnerships? If so, describe how that would work? And who would best manage it?

Answer:

Multinational corporations play a vital and indispensable role in combating the HIV/AIDS epidemic. Many multinational companies have developed HIV/AIDS workplace intervention programs that focus on awareness and prevention. Other corporations have invested in health care infrastructure and donated drugs to PVOs and NGOs that engage in health care.

There are many opportunities for public/private partnerships. We could expand industry's active participation in AIDS education and prevention training programs in the workplace and increase the number of companies that participate in such AIDS programs. We could continue to coordinate with American Chambers of Commerce to gain ground level information on what activities the private sector is engaging in to further HIV/AIDS awareness in the work place. This expansion could utilize the resources of the Foreign Commercial Service and other Department of Commerce programs. An IWG chaired by DOC has several recommendations under review, which are geared to expanding public/private partnerships for HIV/AIDS; including looking for ways to increase access to essential drugs.

Question:

According to GAO report from 1992 and 1998, USAID's programs have not shown strong results. Why do you think that this has been the case? And how can we aggressively attack this problem in light of reports like these?

Answer:

The GAO report of July 1998 on HIV/AIDS (USAID and UN Response to the Epidemic in the Developing World) states that "USAID has made important contributions in the fight against HIV/AIDS by helping to support the development and implementation of interventions that have been proven effective in the global fight against the disease". It goes on to say that: "At the country level, USAID implemented projects that increased awareness of the disease, reduced risky behavior, increased access to STD treatment and condoms. These actions have helped slow the spread of the epidemic in target groups".

As the above report indicates USAID has been successful in establishing interventions that work in target populations. However, these target populations have been relatively small. While USAID ha been the largest bilateral donor for HIV/AIDS programs in sub-Saharan Africa ($50-70) million per year), we estimate that we reach less than 10% of vulnerable populations with this level of funding. USAID's budget for HIV/AIDS has remained essentially constant from 1993 to 1999, while HIV/AIDS prevalence rates have increased over 300%. It is useful to compare the funding for HIV prevention in Africa with that spent here in the U.S. Approximately $200 million is spent per year in sub-Saharan Africa from all donors, lending agencies, and host country governments to prevent over 4 million new annual infections of HIV. While over $800 million is spent per year in the United States to attempt to prevent 40,000 new infections.

The recent White House initiative called leadership in Investment for Fighting an Epidemic (LIFE) has added about $100 million to the HIV/AIDS budget of USG agencies. This amount will essentially double USAID resources in countries designated as priority countries under the LIFE initiative. USAID, the Department of State and UNAIDS is working to leverage other donor and host country resources. To attack the problem aggressively we have to strengthen this partnership, help mobilize additional resources through the private sector and foundations and generate country commitment.

Question:

Because of mixed results under the USAID programs; some may feel that this problem's solution is simply beyond our grasp. How would you respond to that? Can we have an impact? If so, how?

Answer:

USAID's support, both technical and financial has been crucial to the success of programs in Uganda and Senegal. Outside these countries USAID has largely supported small-scale efforts for demonstrating the effectiveness of key interventions and operational research. As a result of these investments, USAID and other stakeholders have a deeper knowledge of which interventions work. These include condom social marketing, intensive interpersonal behavior change strategies, voluntary HIV testing and counseling, reducing mother-to-child transmission, mobilizing the commitment of religious leaders and policy makers, and involvement of communities in the case of orphans and sick family members.

Adoption of the interventions that work on a large scale is a challenge. It requires availability of adequate resources on a sustained basis and commitment of countries to embrace all possible measures with a sense of urgency. USAID can make an impact by focusing on priority countries, helping them mobilize resources for scaling up through private sector contributions, debt forgiveness, better donor coordination and management and making HIV/AIDS a top issue on the development agenda of African countries. Our Ambassador and USAID field offices have made HIV/AIDS a major priority and have undertaken actions ranging from advocacy to the mobilization of all development sectors in the fight against the disease. Ultimately, given sufficient time and money, these actions will make a difference.

Question:

What has worked in your experience in addressing HIV/AIDS in Africa and the developing world?

Answer:

The countries that have been identified as most successful in reducing the HIV/AIDS prevalence rates or containing them have been Uganda and Senegal in Africa, Thailand in Asia and Dominican Republic in Latin America. Additionally, there are now other countries in Africa that are showing similar signs of success. A recent national survey of HIV/AIDS in Zambia shows small but significant decline in prevalence rates among 15-19 year girls at a number of locations. Zambia may be poised to become the third country to make significant inroad in reducing the prevalence rates. Several districts in Tanzania have also reported declines in prevalence rates.

The most important element common to all the countries with successful programs is the commitment of the political leadership. This has facilitated open discussion of HIV/AIDS issues. Second, in Uganda and Senegal, religious leaders played an important role in conveying the right prevention messages to the young people. For instance, delaying sexual debut has contributed significantly to the decline in prevalence rates in Uganda. Third, a large part of the success in a number of countries is attributed to the availability of condoms and of facilities for voluntary HIV testing and counseling. Lastly, sustained contributions of donors and good coordination among them led to concerted efforts and better use of resources by these national programs.

telephones and vehicles.

We must be doing something right, because the President of Tanzania has invited us to replicate Nyumbani in Dar es Salaam and has proven their sincerity by giving us 20 acres of land to develop it. This is our next big move - God willing and assisting.

Father D'Ag's wish list:

American dollars/Kenyan prices.

The cost to bring merchandise into the country is high - at least 50 percent tax.

New tires for small pickup, van, and 4wd:

$1500 x 3 = $4500

Monthly electric bill : $500 x 12 = $6000

Child's wading pool:

$1500

New road surface: $20,000

Telephone exchange w/10 extensions: $5000

Build larger kitchen/add kitchen equipment:

$10,000

4wd Mobile clinic vehicle (right-hand drive, 4-door pickup):

$30,000

Total: $77,000

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Profile

FRANKLIN GRAHAM

William Franklin Graham, III, born July 14, 1952, is the fourth of five children born to evangelist Billy Graham and his wife, Ruth Bell Graham. Raised in a log home in the Appalachian Mountains outside Asheville, North Carolina, Franklin now lives in Boone, North Carolina.

At age 22, after a period of rebellion and traveling the world, Franklin committed his life to Jesus Christ while alone in a hotel room in Jerusalem. Soon after that, Dr. Bob Pierce, founder of Samaritan's Purse (and World Vision, the world's largest Christian relief and development organization), invited Franklin to join him on a six-week mission to Asia. It was during that time that Franklin felt a calling to work with hurting people in areas of the world affected by war, famine, disease, and natural disasters.

Franklin was elected to the Board of Samaritan's Purse in 1978, and one year later, following the death of Bob Pierce, he was elected president of the organization, a position he has held ever since. Today, with an annual budget of more than $85 million, Samaritan's Purse supports evangelical efforts and relief assistance throughout Africa, Asia, Eastern Europe, the Middle East, and North and South America. The organization is headquartered in Boone, North Carolina, with offices in Canada, the United Kingdom, Australia, and the Netherlands.

In 1989, Franklin conducted his first evangelistic crusade and committed to spend 10 percent of his time each year preaching. Each year he conducts up to 10 festivals around the world as an evangelist for the Billy Graham Evangelistic Association (BGEA). Since 1989, he has preached to more than 1.6 million people in cities from Johannesburg, South Africa, to Tupelo, Mississippi.

In 1995, Franklin was elected to serve as the first vice-chairman of the BGEA—a position with direct succession to become chairman and CEO of the organization. Franklin has served on the BGEA Board since 1979.

Franklin is the author of four books: *Living Beyond the Limits: A Life in Sync with God* (Thomas Nelson, 1998); *Kids Praying for Kids* (Thomas Nelson, 1998); his autobiography, *Rebel With A Cause: Finally Comfortable Being Graham* (Thomas Nelson, 1995); *Miracle in a Shoe Box* (Thomas Nelson, 1995), a children's book about Operation Christmas Child, a project of Samaritan's Purse; and *Bob Pierce: This One Thing I Do* (Word Books, 1983).

A graduate of Montreat College and Appalachian State University, Franklin has been honored with doctorate degrees from Toccoa Falls College, Lees McRae College, National University, and Liberty University. He and his wife, Jane, have

four children, William Franklin IV (Will), Roy, Edward, and Jane Austin (Cissie).

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SAMARITAN'S PURSE®

Newsletters

Statement of Faith

Our Financial Commitment

Career Opportunities at Samaritan's Purse

Information for Federal Employees

What's Unique About Us

Samaritan's Purse is a nonprofit Christian mission organization with a single-minded commitment to evangelism. We meet critical needs among hurting people for one ultimate purpose: so that men and women will come to faith in the Lord Jesus Christ. Our ministry is rooted in Scripture and based on the Biblical story of the Good Samaritan (Luke 10:25-37).

Many of those aided by Samaritan's Purse live in "hot spots" around the world—places like Bosnia, Romania, Sudan, India, and Lebanon that are torn by war, famine, disease, and natural disaster. Our assistance helps alleviate suffering and earn a hearing for the Gospel.

The needs we meet are as diverse as the people we encounter along life's road. Food, clothing, shelter, medical care . . . freshwater wells and agricultural equipment . . . Bibles, Christian literature, and transportation for national church workers—these and other essentials are given by Samaritan's Purse to further the work of world evangelization.

We specialize in responding quickly, efficiently, and without a lot of red tape or bureaucratic delays.

Founded in 1970 by the late Dr. Bob Pierce and now led by Franklin Graham, we are a link between concerned believers and needy people around the world, for the glory of Jesus Christ.

Hospice for HIV

[Ed. note: Father Angelo D'Agostino is a physician, psychiatrist and Jesuit priest with a heart as big as his credentials. We wanted to help spread the word about his work and asked him to write a little something for the newsletter]

Nyumbani

A hospice for HIV+ orphans in Kenya

While the number of new HIV infections has significantly decreased in the U.S. and Europe, thanks in part to public education and antiretroviral therapies, it is still a raging epidemic in sub-Saharan Africa. A conservative estimate is that over 1 million people are HIV+ in Kenya alone, which has a population of 25 million. Of those, at least 150,000 are perinatally infected. With parents dead and relatives too poor or too ignorant to care for them, these children are literally discarded.

As the only medical person on the Board of a large orphanage in Nairobi, I noticed that in 1991 some new admissions tested HIV+. Since the Board was unwilling to address the problem, I rented a little house and took in 3 orphans who tested positive. There was no facility in the entire country for them. Soon the house was crowded, so we moved to a larger facility and grew to 30. In 1995, we built our own little village of 10 family-style units with a house mother and six to eight children in each unit. We were fortunate in getting four very devoted religious sisters from southern India to live in as professional staff, two are registered nurses and two are experienced teachers.

While we cannot afford the $1000/month for antiretroviral medications, the good nutrition, careful medical monitoring (a pediatrician visits three times a week), and lots of loving care make the place a very joyful and alive place, so everyone who visits does comment. Of course, we do have a death every month or two, but the children are well prepared.

We asked the World Bank for help in 1992, but they refused us, yet they gave $60 million for the preservation of elephants. It seems that elephants are good for tourism. The USAID initially refused us, but I'm happy to say that recently they have relented and promised us help.

The Kenyan government has given us moral support at times, but the biggest donors have been the Japanese government and a Swiss foundation. A Board in the U.S. provides about half the annual budget of $150,000, and a Board in London and other private donors provide our solvency. The British Airways crew members have been extremely generous in providing clothes, shoes, and toys - as well as professional help.

We do need help with items and projects outside of the budget, like

TO: Sandy

FR: Alex

Urgent.

(A) 1st document is Holbrooke's "testimony".

(B) second, set of Q's + A's we received from State.

Alex.

1. Both Reps. Leach and Lee introduced legislation to garner a broad base of interntional support, including other G-7 nations and the private sector, for AIDS prevention, treatment, and other services. Does the United Nations have any existing programs that call for similar contributions? Can you describe some of the challenges the UN has faced in implementing these initiatives, particularly with member countries and in negotiations with the private sector?

- UNAIDS recently launched the International Partnerships Against AIDS in Africa (IPAA). This initiative seeks to improve political commitment, increase resources, and expand the number of public and private partners who can mount effective responses.

- UNAIDS estimates that it would require at least $1 billion dollars per year to implement adequate prevention activities in sub-Saharan Africa. Currently, the entire expenditure is less than $200 million, mostly coming from donor countries.

- At least another $1 billion per year is needed to provide a very basic package of care and support for those persons already infected with HIV in Africa.

- The U.S. (through USAID) and UNAIDS have worked closely on the creation of the IPAA, together with other major donor countries, including the UK, Sweden, Denmark, Norway, Canada, and the Netherlands. Each of these countries is attempting to identify increased resources for HIV/AIDS, often in the context of diminishing overall foreign assistance budgets.

- Mobilizing increased resources from the impacted countries has proved far more challenging. With the exception of a handful of African countries (e.g., South Africa) few can provide better funding, especially in light of the overwhelming burden of caring for HIV infected persons in public hospitals and clinics. Uganda, for instance, now expends close to 80% of its health budget caring for persons with AIDS.

2. There is increasing support to invest more money for Global AIDS. And there are seven bills in the House and Senate to authorize more funding for AIDS. With the increase in funding, there is concern about the possible misuse of funds by the African governments. What policies has the UN adopted that the US might model its efforts under to ensure that there is transparency in any funding to national governments, especially given the level of corruption in some countries?

- Both the U.S. and UN agencies have responded to the potential of misuse of funds. A very small part of USAID's funding goes directly to African governments. Over 70% goes to community based NGO's to develop and implement prevention and care programs.

- These NGO's are monitored by both USAID and U.S. based PVO's, who are contracted to manage and monitor specific projects, including regular financial audits.

- Funding for activities that can only be implemented through African governments is generally handled by utilizing intermediate organizations that actually receive and expend the funds. For example, USAID supports development of school based life skills curriculum by directly funding private organizations to work with the Ministry of Education.

- UN agencies face similar challenges, and often implement projects directly or through NGO's, instead of directly funding governments to undertake projects.

3. What is the UN's position on parallel imports, or compulsory licensing, for pharmaceutical companies and the TRIPS agreement?

- WHO and UNAIDS advocate access to reasonably priced drugs, especially for AIDS patients, in a way that assures the safety and efficacy of the drugs, preserves IPR, and promotes development of new drugs. Parallel trade and compulsory licensing schemes should not be over-emphasized in the effort to increase access to drugs. Compulsory licensing, a provision of the new TRIPS Agreement, involves governments obliging patent holders to license their product to others.

- WHO Director-General Brundtland is pursuing a dialogue with the private sector and has developed a roundtable with pharmaceutical companies to discuss issues such as drug development, affordable pricing, and strengthening of reliable distribution systems.

4. Also, in the past year, you have lobbied hard for UN Arrears payments. Therefore, you probably are awar of how decision-makers in Congress are positioned on this issue. Would you say that there is enough support in Congress to have a bill on the President's desk by the end of this session? If not, what are the obstacles?

- The Administration is pleased that arrears legislation was passed last year.

5. What is the history of UNAIDS? How does UNAIDS operate? What is the relationship between the UNAIDS programs and the UN's other programs?

- The Joint United Nations Program on HIV/AIDS (UNAIDS) is responsible for leading the international response to the HIV/AIDS epidemic. UNAIDS acts as a catalyst and coordinator of action on HIV/AIDS, rather than as a direct funding agency of programs in developing countries.

- The USG was instrumental in the creation of UNAIDS, which was launched in 1996. UNAIDS consists of a secretariat, and seven UN cosponsors: UNICEF, UNESCO, UNDP, UNDCP, UNFPA, WHO, and the World Bank. The program recognizes AIDS not simply as a health problem but a multisectoral issue that requires attention across sectors - education, health, finance, development - and not only within national governments, but within the UN system.

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USUN:RPEddy/JDey

Question:

What is the UN doing to combat the spread of HIV and AIDS?

Answer:

UNAIDS is the leading advocate for worldwide action against HIV/AIDS. Its mission is to lead, strengthen, and support an expanded response to the epidemic. With an annual budget of $60 million, UNAIDS is a modest-sized program with a substantial impact. The UNAIDS Secretariat operates as a catalyst and coordinator of action on AIDS, rather than as a direct funding or implementing agency.

Question:

In your testimony, you touch briefly on pending legislation concerning HIV/AIDS. Could you be more specific as to the Administration's views regarding the various bills that have been introduced?

Answer:

Question:

What is the UN policy regarding peacekeepers and the spread of AIDS? What efforts are underway to assure that they do not spread or contract this disease?

Answer:

Although the UN officially requires that prospective peacekeeping troops be "disease free," it is difficult to enforce this rule with such methods as HIV testing, given the paucity of available troops and the potential noncompliance of many contributing states.

Question:

There is grave concern about the high number of children who are drawn into national militia and guerrilla forces in regions such as the Congo. Many of these children have been orphaned due to AIDS. What is the United Nations position on the relationship between the participation of children in the military and the orphan crisis? Are there any strategies in place to curb this trend?

How can this strategy be tied to our efforts to address the AIDS crisis from the perspective of the orphan crisis, particularly as it related directly to the escalating number of child soldiers who have already or will contract HIV/AIDS?

Some ask why we are placing a priority on addressing the AIDS crisis in Africa and the developing world while infection rates in the US are rising, particularly in communities of color. How would you answer that question?

Is there support within the Administration to push for a creative and aggressive new AIDS program?

Answer:

To reduce the conscription rate of AIDS orphans, broad support mechanisms must be encouraged. These include strengthening the capacity of families to cope with HIV/AIDS, strengthening community-based responses, and ensuring that governments provide essential services including access to safe water, health services, and schooling.

The Interagency Working Group will examine all international HIV/AIDS issues, including the AIDS orphans issue and the child soldier issue.

The Administration's attention to the international HIV/AIDS crisis does not come at the expense of the domestic HIV/AIDS programs and policies. In addition to domestic HIV/AIDS concerns, HIV/AIDS must be made a priority in Africa because the enormous size of the epidemic in Africa threatens political and social institutions. We must intervene and assist now to mitigate the problems before they become more dangerous and more expensive.

Question:

How have multinational corporations responded to the AIDS crisis? What, if any, role do you think the private sector plays in this issue? Do you se a role or an opportunity for private-public partnerships? If so, describe how that would work? And who would best manage it?

Answer:

Multinational corporations play a vital and indispensable role in combating the HIV/AIDS epidemic. Many multinational companies have developed HIV/AIDS workplace intervention programs that focus on awareness and prevention. Other corporations have invested in health care infrastructure and donated drugs to PVOs and NGOs that engage in health care.

There are many opportunities for public/private partnerships. We could expand industry's active participation in AIDS education and prevention training programs in the workplace and increase the number of companies that participate in such AIDS programs. We could continue to coordinate with American Chambers of Commerce to gain ground level information on what activities the private sector is engaging in to further HIV/AIDS awareness in the work place. This expansion could utilize the resources of the Foreign Commercial Service and other Department of Commerce programs. An IWG chaired by DOC has several recommendations under review, which are geared to expanding public/private partnerships for HIV/AIDS; including looking for ways to increase access to essential drugs.

Question:

According to GAO report from 1992 and 1998, USAID's programs have not shown strong results. Why do you think that this has been the case? And how can we aggressively attack this problem in light of reports like these?

Answer:

The GAO report of July 1998 on HIV/AIDS (USAID and UN Response to the Epidemic in the Developing World) states that "USAID has made important contributions in the fight against HIV/AIDS by helping to support the development and implementation of interventions that have been proven effective in the global fight against the disease". It goes on to say that: "At the country level, USAID implemented projects that increased awareness of the disease, reduced risky behavior, increased access to STD treatment and condoms. These actions have helped slow the spread of the epidemic in target groups".

As the above report indicates USAID has been successful in establishing interventions that work in target populations. However, these target populations have been relatively small. While USAID ha been the largest bilateral donor for HIV/AIDS programs in sub-Saharan Africa ($50-70) million per year), we estimate that we reach less than 10% of vulnerable populations with this level of funding. USAID's budget for HIV/AIDS has remained essentially constant from 1993 to 1999, while HIV/AIDS prevalence rates have increased over 300%. It is useful to compare the funding for HIV prevention in Africa with that spent here in the U.S. Approximately $200 million is spent per year in sub-Saharan Africa from all donors, lending agencies, and host country governments to prevent over 4 million new annual infections of HIV. While over $800 million is spent per year in the United States to attempt to prevent 40,000 new infections.

The recent White House initiative called leadership in Investment for Fighting an Epidemic (LIFE) has added about $100 million to the HIV/AIDS budget of USG agencies. This amount will essentially double USAID resources in countries designated as priority countries under the LIFE initiative. USAID, the Department of State and UNAIDS is working to leverage other donor and host country resources. To attack the problem aggressively we have to strengthen this partnership, help mobilize additional resources through the private sector and foundations and generate country commitment.

Question:

Because of mixed results under the USAID programs; some may feel that this problem's solution is simply beyond our grasp. How would you respond to that? Can we have an impact? If so, how?

Answer:

USAID's support, both technical and financial has been crucial to the success of programs in Uganda and Senegal. Outside these countries USAID has largely supported small-scale efforts for demonstrating the effectiveness of key interventions and operational research. As a result of these investments, USAID and other stakeholders have a deeper knowledge of which interventions work. These include condom social marketing, intensive interpersonal behavior change strategies, voluntary HIV testing and counseling, reducing mother-to-child transmission, mobilizing the commitment of religious leaders and policy makers, and involvement of communities in the case of orphans and sick family members.

Adoption of the interventions that work on a large scale is a challenge. It requires availability of adequate resources on a sustained basis and commitment of countries to embrace all possible measures with a sense of urgency. USAID can make an impact by focusing on priority countries, helping them mobilize resources for scaling up through private sector contributions, debt forgiveness, better donor coordination and management and making HIV/AIDS a top issue on the development agenda of African countries. Our Ambassador and USAID field offices have made HIV/AIDS a major priority and have undertaken actions ranging from advocacy to the mobilization of all development sectors in the fight against the disease. Ultimately, given sufficient time and money, these actions will make a difference.

Question:

What has worked in your experience in addressing HIV/AIDS in Africa and the developing world?

Answer:

The countries that have been identified as most successful in reducing the HIV/AIDS prevalence rates or containing them have been Uganda and Senegal in Africa, Thailand in Asia and Dominican Republic in Latin America. Additionally, there are now other countries in Africa that are showing similar signs of success. A recent national survey of HIV/AIDS in Zambia shows small but significant decline in prevalence rates among 15-19 year girls at a number of locations. Zambia may be poised to become the third country to make significant inroad in reducing the prevalence rates. Several districts in Tanzania have also reported declines in prevalence rates.

The most important element common to all the countries with successful programs is the commitment of the political leadership. This has facilitated open discussion of HIV/AIDS issues. Second, in Uganda and Senegal, religious leaders played an important role in conveying the right prevention messages to the young people. For instance, delaying sexual debut has contributed significantly to the decline in prevalence rates in Uganda. Third, a large part of the success in a number of countries is attributed to the availability of condoms and of facilities for voluntary HIV testing and counseling. Lastly, sustained contributions of donors and good coordination among them led to concerted efforts and better use of resources by these national programs.

1. Both Reps. Leach and Lee introduced legislation to garner a broad base of interntional support, including other G-7 nations and the private sector, for AIDS prevention, treatment, and other services. Does the United Nations have any existing programs that call for similar contributions? Can you describe some of the challenges the UN has faced in implementing these initiatives, particularly with member countries and in negotiations with the private sector?

- UNAIDS recently launched the International Partnerships Against AIDS in Africa (IPAA). This initiative seeks to improve political commitment, increase resources, and expand the number of public and private partners who can mount effective responses.

- UNAIDS estimates that it would require at least $1 billion dollars per year to implement adequate prevention activities in sub-Saharan Africa. Currently, the entire expenditure is less than $200 million, mostly coming from donor countries.

- At least another $1 billion per year is needed to provide a very basic package of care and support for those persons already infected with HIV in Africa.

- The U.S. (through USAID) and UNAIDS have worked closely on the creation of the IPAA, together with other major donor countries, including the UK, Sweden, Denmark, Norway, Canada, and the Netherlands. Each of these countries is attempting to identify increased resources for HIV/AIDS, often in the context of diminishing overall foreign assistance budgets.

- Mobilizing increased resources from the impacted countries has proved far more challenging. With the exception of a handful of African countries (e.g., South Africa) few can provide better funding, especially in light of the overwhelming burden of caring for HIV infected persons in public hospitals and clinics. Uganda, for instance, now expends close to 80% of its health budget caring for persons with AIDS.

2. There is increasing support to invest more money for Global AIDS. And there are seven bills in the House and Senate to authorize more funding for AIDS. With the increase in funding, there is concern about the possible misuse of funds by the African governments. What policies has the UN adopted that the US might model its efforts under to ensure that there is transparency in any funding to national governments, especially given the level of corruption in some countries?

- Both the U.S. and UN agencies have responded to the potential of misuse of funds. A very small part of USAID's funding goes directly to African governments. Over 70% goes to community based NGO's to develop and implement prevention and care programs.

- These NGO's are monitored by both USAID and U.S. based PVO's, who are contracted to manage and monitor specific projects, including regular financial audits.

- Funding for activities that can only be implemented through African governments is generally handled by utilizing intermediate organizations that actually receive and expend the funds. For example, USAID supports development of school based life skills curriculum by directly funding private organizations to work with the Ministry of Education.

- UN agencies face similar challenges, and often implement projects directly or through NGO's, instead of directly funding governments to undertake projects.

3. What is the UN's position on parallel imports, or compulsory licensing, for pharmaceutical companies and the TRIPS agreement?

- WHO and UNAIDS advocate access to reasonably priced drugs, especially for AIDS patients, in a way that assures the safety and efficacy of the drugs, preserves IPR, and promotes development of new drugs. Parallel trade and compulsory licensing schemes should not be over-emphasized in the effort to increase access to drugs. Compulsory licensing, a provision of the new TRIPS Agreement, involves governments obliging patent holders to license their product to others.

- WHO Director-General Brundtland is pursuing a dialogue with the private sector and has developed a roundtable with pharmaceutical companies to discuss issues such as drug development, affordable pricing, and strengthening of reliable distribution systems.

4. Also, in the past year, you have lobbied hard for UN Arrears payments. Therefore, you probably are awar of how decision-makers in Congress are positioned on this issue. Would you say that there is enough support in Congress to have a bill on the President's desk by the end of this session? If not, what are the obstacles?

- The Administration is pleased that arrears legislation was passed last year.

5. What is the history of UNAIDS? How does UNAIDS operate? What is the relationship between the UNAIDS programs and the UN's other programs?

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Final testimony as submitted

Testimony by

Sandra Thurman
Director, Office of National AIDS Policy

Before the

House Of Representatives
Banking and Financial Services Committee

March 8, 2000

Mr. Chairman and other members of the Committee, I am delighted to be with you today to talk about the global AIDS pandemic – with a special focus on AIDS in Africa. Your interest in addressing this crisis is very much appreciated – and desperately needed.

I would like to use my time with you to lay out a vivid picture of the scope of this tragedy – particularly its impact on the stability of families, communities and nations. I would like to share with you some of my experiences with the faces behind these shocking facts. And I would like to outline for you some key components of our enhanced Administration response to this global pandemic.

By any and every measure – AIDS is a plague of Biblical proportion. And it is claiming more lives in Africa than in all of the wars waging on the continent combined. AIDS is now the leading cause of death among all people of all ages in Africa – and the progression of this pandemic has outpaced all of our projections. In 1991 the World Health Organization predicted that by 1999 there would be 9 million infected and nearly 5 million deaths in Africa due to AIDS. The resulting numbers are *two to three times* higher with nearly 24 million infected and 14 million deaths.

And yet this war rages on. Each and every day Africa buries 5,500 men, women, and children as a result of AIDS – and that count will more than double in the next few years. By 2005, it is now projected that more than 100 million people worldwide will have become HIV infected. And unlike other wars – it is women and children that are increasingly caught in the crossfire of this relentless pandemic.

In Africa, an entire generation of children is in jeopardy. Already, in several sub-Saharan African countries, between one-fifth and one-third of all children have already been orphaned by AIDS. And the worst is yet to come. Within the next decade, more than 40 million children will have lost one or both parents to AIDS. 40 million. That is about the same number as all children in the United States living east of the Mississippi River. Or taken another way, it is almost the same number as all children in public school in this country. Left unchecked, this tragedy will continue to escalate for at least another 30 years.

In just a few short years, AIDS has wiped out decades of hard work and steady progress in improving the lives and health of families throughout the developing world – infant mortality is doubling, child mortality is tripling, and life expectancy is plummeting by twenty years or more.

AIDS is not just a health issue, it is an economic issue, a fundamental development issue and a security and stability issue.

AIDS is having a dramatic effect on productivity, trade and investment – striking down workers in their prime, driving up the cost of doing business, impeding trade and investment, and reducing GNP. Professionals have been hit particularly hard in sub-Saharan Africa, including civil servants, engineers, teachers, miners, and military personnel. In Malawi and Zambia, more than 30% of teachers are HIV positive. Some

mining firms in South Africa are reporting that nearly half of their workers are infected. And many businesses are hiring at least two workers for every one skilled job, assuming that one will die from AIDS.

According to the *Economist* magazine, recent studies have found that AIDS is seriously eroding the economies of many of our partner nations. In Namibia, AIDS cost the country almost 8% of its GNP in 1996. By 2005, Kenya's GNP will be over 14% smaller than it would have been without AIDS.

Similarly, in Tanzania, The World Bank has predicted that its GNP will be 15 to 25% lower as a result of AIDS. The South African government has estimated that this epidemic costs the country 1% of its GNP each year, a situation that will only worsen without strong intervention.

AIDS is also affecting security and stability in the region. As Ambassador Holbrooke will discuss shortly, the UN Security Council recently held a daylong meeting on HIV/AIDS. This historic event highlighted the growing awareness that AIDS is a security threat that requires a global mobilization. It is hardly a coincidence that the National Intelligence Council recently released a report on the global infectious disease threat. The Report draws several very disturbing conclusions including the following:

- Development of an effective global surveillance and response system is at least a decade or more away.

- The economic costs of infectious diseases – especially HIV/AIDS – are already significant and could reduce GDP by as much as 20 percent or more in by 2010 in some sub-Saharan countries.
- Some of the hardest hit countries in sub-Saharan Africa – and possibly later in South and South East Asia – will face a demographic upheaval as HIV/AIDS and associated diseases reduce human life expectancy by as much as 30 years and kill as many as a quarter of their populations over a decade or less, producing a huge orphan cohort. Nearly 42 million children in 27 countries will lose one or both parents to AIDS by 2010; 19 of the hardest hit countries will be in sub-Saharan Africa.
- The relationship between disease and political instability is indirect but real.

The prevalence of HIV in the armed forces of many African countries is staggeringly high. The *Economist* has estimated the HIV prevalence in the Congo range at 50 to 80%. Other recent reports have projected that the South African military and police are also heavily impacted by HIV. Moreover, as these troops participate in an increasing number of regional interventions and peacekeeping operations, the epidemic is likely to spread.

Extremely high levels of HIV infection among senior officers could lead to rapid turnover in those positions. In countries where the military plays a central or strong role in

government, such rapid turnover could weaken the central government's authority. For those countries in political transition, this kind of instability could slow or even reverse the transition process. This is a dynamic that deserves serious attention not only in Africa, but also in the Newly Independent States of the Former Soviet Union, and in India where AIDS is intensifying its deadly grip.

The South African Institute for Security Studies has also linked the growing number of children orphaned by AIDS to future increases in crime and civil unrest. The assumption is that as the number of disaffected, troubled, and under-educated young people increases, many sub-Saharan African countries may face serious threats to their social stability. Without appropriate intervention, many of the 2 million children projected to be orphaned by AIDS in South Africa alone will raise themselves on the streets, often turning to crime, drugs, commercial sex, and gangs to survive. This seriously affects stability and promotes the spread of HIV among these highly vulnerable young people.

Yet my message to you today is not one of hopelessness and desolation. On the contrary, I hope to share with you a sense of optimism. For amidst all of this tragedy, there is hope. Amidst this terrible crisis, there is opportunity: the opportunity for us – working together – to empower women, to protect children, and to support families and communities throughout the world in our shared struggle against AIDS.

We know what works. With our partners in Africa we have developed useful knowledge and effective tools. Together, we have designed model programs and proven that they work. And today, we know how to stem the rising tide of new infections, how to provide basic care to those who are sick, and how to mobilize communities to support the growing number of children orphaned by AIDS. Uganda has demonstrated that with strong political commitment and sustained nationwide programs, HIV prevalence can be cut in half. And Senegal has shown that HIV can be stopped in its tracks and prevalence can be kept low. But there is more, much more that needs to be done if we are to bring these successes to scale.

The United States has been engaged in the fight against AIDS here at home since the early 1980s. But increasingly we have come to realize that when it comes to AIDS – both the crisis and the opportunity have no borders. We have much to learn from the experiences of other nations, countries, and the suffering of citizens in our global village touches and affects us all.

The United States has been the leader in the battle against AIDS. The Administration has taken an active role in sounding the alarm on the AIDS crisis in Africa, and in ensuring that the United States supports African efforts to combat this deadly disease.

Since 1986, this nation has contributed over $1 billion to the global fight against AIDS. More than 50% of those funds have been used to address the epidemic in sub-Saharan Africa. Overall, nearly half of all of the development assistance devoted to HIV care and

prevention in the developing world has come from the US. The United States has also been the leading supporter of the United Nation's Joint Program on AIDS – UNAIDS – contributing more than 25% of its budget.

It is a strong record of engagement and one of which we can be proud, but unfortunately it has not kept pace with this terrible pandemic. We have done much, but there remains much more that the United States and other developed nations can and must do.

During the past year and a half I have made four trips to eight African countries. Together with members and staff from both parties and chambers we went to witness firsthand both the tragedies and triumphs of AIDS in Africa. In response to the findings of these trips, the Administration requested and the Congress appropriated an additional $100 million in FY2000 for a cross agency initiative to enhance our global AIDS efforts.

This new Initiative, which includes USAID and CDC, provides for a series of steps to increase US leadership through support for some of the extraordinary community-based programs and to provide much needed technical assistance to developing nations struggling to respond to the needs of their people infected and affected by AIDS. This effort more than doubles our funding for programs of prevention and care in Africa, and challenges our G8 and other partners to increase their efforts, as well. This Initiative is a

significant increase in the US government's investment in the global battle against AIDS and it begins to reflect the magnitude of this rapidly escalating pandemic.

The Initiative focuses on four key areas:

- **Prevention**. Specifically, we hope to implement a variety of prevention and stigma reduction strategies, especially for women and youth, including: HIV education, engagement of political, religious, and civic leaders, voluntary counseling and testing, interventions to reduce mother-to-child transmission, and enhanced training and technical assistance programs.
- **Home and community-based care**. This will help create and enhance counseling and support systems, and help clinics and home health workers provide basic medical care (including treatment for related illnesses like STDs and TB).
- **Care of children orphaned by AIDS**. We hope to improve our ability to assist families and communities in caring for their orphaned children through nutritional assistance, education, training, health, and counseling support, in coordination with micro-enterprise programs.
- **Infrastructure**. These funds will help to increase the capacity for the effective delivery of essential services through governments, NGOs, and the private sector. We also need to enhance surveillance systems so that we can better track the epidemic and target HIV prevention efforts.

Some of the other key components of this Initiative include an increase in our efforts to include the AIDS epidemic in our foreign policy dialogue, both to encourage and support political leadership in hardest hit countries and to promote an increased response by our developed nation partners. We are also taking steps to increase our coordination with the private sector and the many non-governmental organizations working in Africa, including religious organizations.

You will find a more complete description of this Initiative – both the problems and solutions – in the report released by the Administration last summer. I have submitted a copy to this Subcommittee and would like to request that it be included in the record as part of my remarks.

While this new Initiative greatly strengthens the foundation of a comprehensive response to the pandemic, UNAIDS has estimated that it will take $1 billion to establish an effective HIV prevention program in sub-Saharan Africa. Currently all donors combined are contributing less than $350 million to that end. In addition, UNAIDS estimates that it will take a minimum of $1 billion to begin to deliver even the most basic care and treatment to people with AIDS in the region. We have not even begun to scratch the surface when it comes to delivering treatment.

In the face of such tremendous need, the Administration has asked the Congress to appropriate another $100 million to enhance and expand our efforts to combat AIDS in Africa and around the world. These funds will enable us to increase our programs at

USAID and CDC and expand our comprehensive approach to include the Department of Labor and the Department of Defense.

Let me repeat, however, that the United States cannot and should not do this alone. Chairman Leach, you and the members of this Committee clearly recognize, as we do, that this crisis will require the active engagement of all segments of all societies working together. Every bilateral donor, every multilateral lending agency, the corporate community, the foundation community, the religious community and every African government must do its part to provide the leadership and resources necessary to turn this tide. It can and it must be done.

The bottom line is this: With no vaccine or cure available, we are at the beginning of an epidemic, not the end. What we see in Africa today, frankly, is just the tip of the iceberg. As goes Africa, so will go India and the Former Soviet Union. There must be a sense of urgency to work together with our partners in Africa to learn from the experiences there and to share the successes and avoid the failures in countries now standing on the threshold of the pandemic. Millions of lives... perhaps hundreds of millions of lives hang in the balance.

We look forward to working closely with each and every one you and are so grateful that this issue is receiving the broad-based bipartisan support it deserves. AIDS is not a democratic or republican issue – it is a devastating human tragedy that cries out to all of us for help.

We are one world – and in many ways – Africa's destiny is our destiny. There is hope on the horizon – but that hope will only be realized if we take constructive action together. Today, let us commit to seize this opportunity. And let me conclude by thanking this Subcommittee for its interest in this issue, and offer my continued assistance as you seek ways to respond to this terrible tragedy. As Archbishop Tutu said: "If we wage this holy war together – we will win."

Thank you.

Final testimony as submitted

Testimony by

Sandra Thurman
Director, Office of National AIDS Policy

Before the

House Of Representatives
Banking and Financial Services Committee

March 8, 2000

Mr. Chairman and other members of the Committee, I am delighted to be with you today to talk about the global AIDS pandemic – with a special focus on AIDS in Africa. Your interest in addressing this crisis is very much appreciated – and desperately needed.

I would like to use my time with you to lay out a vivid picture of the scope of this tragedy – particularly its impact on the stability of families, communities and nations. I would like to share with you some of my experiences with the faces behind these shocking facts. And I would like to outline for you some key components of our enhanced Administration response to this global pandemic.

By any and every measure – AIDS is a plague of Biblical proportion. And it is claiming more lives in Africa than in all of the wars waging on the continent combined. AIDS is now the leading cause of death among all people of all ages in Africa – and the progression of this pandemic has outpaced all of our projections. In 1991 the World Health Organization predicted that by 1999 there would be 9 million infected and nearly 5 million deaths in Africa due to AIDS. The resulting numbers are *two to three times* higher with nearly 24 million infected and 14 million deaths.

And yet this war rages on. Each and every day Africa buries 5,500 men, women, and children as a result of AIDS – and that count will more than double in the next few years. By 2005, it is now projected that more than 100 million people worldwide will have become HIV infected. And unlike other wars – it is women and children that are increasingly caught in the crossfire of this relentless pandemic.

In Africa, an entire generation of children is in jeopardy. Already, in several sub-Saharan African countries, between one-fifth and one-third of all children have already been orphaned by AIDS. And the worst is yet to come. Within the next decade, more than 40 million children will have lost one or both parents to AIDS. 40 million. That is about the same number as all children in the United States living east of the Mississippi River. Or taken another way, it is almost the same number as all children in public school in this country. Left unchecked, this tragedy will continue to escalate for at least another 30 years.

In just a few short years, AIDS has wiped out decades of hard work and steady progress in improving the lives and health of families throughout the developing world – infant mortality is doubling, child mortality is tripling, and life expectancy is plummeting by twenty years or more.

AIDS is not just a health issue, it is an economic issue, a fundamental development issue and a security and stability issue.

AIDS is having a dramatic effect on productivity, trade and investment – striking down workers in their prime, driving up the cost of doing business, impeding trade and investment, and reducing GNP. Professionals have been hit particularly hard in sub-Saharan Africa, including civil servants, engineers, teachers, miners, and military personnel. In Malawi and Zambia, more than 30% of teachers are HIV positive. Some

mining firms in South Africa are reporting that nearly half of their workers are infected. And many businesses are hiring at least two workers for every one skilled job, assuming that one will die from AIDS.

According to the *Economist* magazine, recent studies have found that AIDS is seriously eroding the economies of many of our partner nations. In Namibia, AIDS cost the country almost 8% of its GNP in 1996. By 2005, Kenya's GNP will be over 14% smaller than it would have been without AIDS.

Similarly, in Tanzania, The World Bank has predicted that its GNP will be 15 to 25% lower as a result of AIDS. The South African government has estimated that this epidemic costs the country 1% of its GNP each year, a situation that will only worsen without strong intervention.

AIDS is also affecting security and stability in the region. As Ambassador Holbrooke will discuss shortly, the UN Security Council recently held a daylong meeting on HIV/AIDS. This historic event highlighted the growing awareness that AIDS is a security threat that requires a global mobilization. It is hardly a coincidence that the National Intelligence Council recently released a report on the global infectious disease threat. The Report draws several very disturbing conclusions including the following:

- Development of an effective global surveillance and response system is at least a decade or more away.

- The economic costs of infectious diseases – especially HIV/AIDS – are already significant and could reduce GDP by as much as 20 percent or more in by 2010 in some sub-Saharan countries.
- Some of the hardest hit countries in sub-Saharan Africa – and possibly later in South and South East Asia – will face a demographic upheaval as HIV/AIDS and associated diseases reduce human life expectancy by as much as 30 years and kill as many as a quarter of their populations over a decade or less, producing a huge orphan cohort. Nearly 42 million children in 27 countries will lose one or both parents to AIDS by 2010; 19 of the hardest hit countries will be in sub-Saharan Africa.
- The relationship between disease and political instability is indirect but real.

The prevalence of HIV in the armed forces of many African countries is staggeringly high. The *Economist* has estimated the HIV prevalence in the Congo range at 50 to 80%. Other recent reports have projected that the South African military and police are also heavily impacted by HIV. Moreover, as these troops participate in an increasing number of regional interventions and peacekeeping operations, the epidemic is likely to spread.

Extremely high levels of HIV infection among senior officers could lead to rapid turnover in those positions. In countries where the military plays a central or strong role in

government, such rapid turnover could weaken the central government's authority. For those countries in political transition, this kind of instability could slow or even reverse the transition process. This is a dynamic that deserves serious attention not only in Africa, but also in the Newly Independent States of the Former Soviet Union, and in India where AIDS is intensifying its deadly grip.

The South African Institute for Security Studies has also linked the growing number of children orphaned by AIDS to future increases in crime and civil unrest. The assumption is that as the number of disaffected, troubled, and under-educated young people increases, many sub-Saharan African countries may face serious threats to their social stability. Without appropriate intervention, many of the 2 million children projected to be orphaned by AIDS in South Africa alone will raise themselves on the streets, often turning to crime, drugs, commercial sex, and gangs to survive. This seriously affects stability and promotes the spread of HIV among these highly vulnerable young people.

Yet my message to you today is not one of hopelessness and desolation. On the contrary, I hope to share with you a sense of optimism. For amidst all of this tragedy, there is hope. Amidst this terrible crisis, there is opportunity: the opportunity for us – working together – to empower women, to protect children, and to support families and communities throughout the world in our shared struggle against AIDS.

We know what works. With our partners in Africa we have developed useful knowledge and effective tools. Together, we have designed model programs and proven that they work. And today, we know how to stem the rising tide of new infections, how to provide basic care to those who are sick, and how to mobilize communities to support the growing number of children orphaned by AIDS. Uganda has demonstrated that with strong political commitment and sustained nationwide programs, HIV prevalence can be cut in half. And Senegal has shown that HIV can be stopped in its tracks and prevalence can be kept low. But there is more, much more that needs to be done if we are to bring these successes to scale.

The United States has been engaged in the fight against AIDS here at home since the early 1980s. But increasingly we have come to realize that when it comes to AIDS – both the crisis and the opportunity have no borders. We have much to learn from the experiences of other nations, countries, and the suffering of citizens in our global village touches and affects us all.

The United States has been the leader in the battle against AIDS. The Administration has taken an active role in sounding the alarm on the AIDS crisis in Africa, and in ensuring that the United States supports African efforts to combat this deadly disease.

Since 1986, this nation has contributed over $1 billion to the global fight against AIDS. More than 50% of those funds have been used to address the epidemic in sub-Saharan Africa. Overall, nearly half of all of the development assistance devoted to HIV care and

prevention in the developing world has come from the US. The United States has also been the leading supporter of the United Nation's Joint Program on AIDS – UNAIDS – contributing more than 25% of its budget.

It is a strong record of engagement and one of which we can be proud, but unfortunately it has not kept pace with this terrible pandemic. We have done much, but there remains much more that the United States and other developed nations can and must do.

During the past year and a half I have made four trips to eight African countries. Together with members and staff from both parties and chambers we went to witness firsthand both the tragedies and triumphs of AIDS in Africa. In response to the findings of these trips, the Administration requested and the Congress appropriated an additional $100 million in FY2000 for a cross agency initiative to enhance our global AIDS efforts.

This new Initiative, which includes USAID and CDC, provides for a series of steps to increase US leadership through support for some of the extraordinary community-based programs and to provide much needed technical assistance to developing nations struggling to respond to the needs of their people infected and affected by AIDS. This effort more than doubles our funding for programs of prevention and care in Africa, and challenges our G8 and other partners to increase their efforts, as well. This Initiative is a

significant increase in the US government's investment in the global battle against AIDS and it begins to reflect the magnitude of this rapidly escalating pandemic.

The Initiative focuses on four key areas:

- **Prevention**. Specifically, we hope to implement a variety of prevention and stigma reduction strategies, especially for women and youth, including: HIV education, engagement of political, religious, and civic leaders, voluntary counseling and testing, interventions to reduce mother-to-child transmission, and enhanced training and technical assistance programs.
- **Home and community-based care**. This will help create and enhance counseling and support systems, and help clinics and home health workers provide basic medical care (including treatment for related illnesses like STDs and TB).
- **Care of children orphaned by AIDS**. We hope to improve our ability to assist families and communities in caring for their orphaned children through nutritional assistance, education, training, health, and counseling support, in coordination with micro-enterprise programs.
- **Infrastructure**. These funds will help to increase the capacity for the effective delivery of essential services through governments, NGOs, and the private sector. We also need to enhance surveillance systems so that we can better track the epidemic and target HIV prevention efforts.

Some of the other key components of this Initiative include an increase in our efforts to include the AIDS epidemic in our foreign policy dialogue, both to encourage and support political leadership in hardest hit countries and to promote an increased response by our developed nation partners. We are also taking steps to increase our coordination with the private sector and the many non-governmental organizations working in Africa, including religious organizations.

You will find a more complete description of this Initiative – both the problems and solutions – in the report released by the Administration last summer. I have submitted a copy to this Subcommittee and would like to request that it be included in the record as part of my remarks.

While this new Initiative greatly strengthens the foundation of a comprehensive response to the pandemic, UNAIDS has estimated that it will take $1 billion to establish an effective HIV prevention program in sub-Saharan Africa. Currently all donors combined are contributing less than $350 million to that end. In addition, UNAIDS estimates that it will take a minimum of $1 billion to begin to deliver even the most basic care and treatment to people with AIDS in the region. We have not even begun to scratch the surface when it comes to delivering treatment.

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Thank you.

J. ROBERT KERREY OF NEBRASKA

Courage is a rare commodity in politics. However, since arriving on Capitol Hill in 1989, Bob Kerrey, Nebraska's senior Senator, has never been afraid to speak the truth. He has impressed political observers with his independence, his candor and his willingness to speak specifically on issues important to the nation and to his constituents.

After only two terms of office, Kerrey has become a recognized advocate of fiscal responsibility, a strong national defense, educational technology, health care and entitlement reform and a strong farm economy.

For 16 years as both Governor and U.S. Senator, Kerrey has been a staunch advocate for improving education opportunities for Nebraska's youth. He has fought to increase and improve our investment in Title I funds, particularly in the areas of math and science. He has also been a consistent supporter of Head Start and early childhood education programs. He has led the efforts to increase awareness of the importance of youth and family mentoring. Additionally, Kerrey has tirelessly promoted vocational education to ensure Nebraska students obtain the skills they need to succeed in their chosen careers.

In 1996, Kerrey launched the CLASS (Communications Learning and Assessment in and Student centered System) Project, designed to develop a fully accredited, interactive high school curriculum on the Internet. The CLASS project enables schools to access classes they would be unable to afford through traditional means of delivery.

Often lauded for his persistent leadership in reforming the Medicare program, Kerrey served on the National Bipartisan Commission on the Future of Medicare. He has proposed bold new ideas for the country's health care system, and he retains his commitment to universal health care eligibility for all Americans.

Appointed as the Chair of the Bipartisan Commission on Entitlement and Tax Reform by the President, Kerrey catapulted the issue of entitlement reform to the forefront of the nation's agenda. The commission's report is cited by economic experts and national leaders as the definitive analysis of the entitlement system. The experience prompted him to propose an $800 billion cut in the payroll tax so that families may build wealth to ensure security for their retirement.

His work as Co-Chairman of the National Commission on Restructuring the IRS led to his authorship of comprehensive reform legislation that changes the way the IRS operates.

Kerrey has long been recognized as a leading advocate for farmers in Nebraska and throughout the nation. He is a zealous proponent for family farmers and believes the growth of a handful of large companies is having a major impact on agriculture, causing significant financial hardship for most of Nebraska's producers.

Kerrey is also a member of the Senate Finance Committee and the Senate Agriculture Committee and recently finished serving as Vice Chairman of the Senate Select Committee on Intelligence. He served on the Senate Appropriations Committee from 1989 through 1996.

Born in Lincoln, Nebraska on August 27, 1943, Kerrey attended Lincoln Public Schools and graduated from the University of Nebraska at Lincoln in 1966. He then earned a spot in the elite Navy SEALs and saw combat in Vietnam. He earned the Congressional Medal of Honor, America's highest military

honor, and is currently the only member of Congress who has received this honor.

Returning from the war and starting from scratch in 1972, Kerrey built a chain of highly successful restaurants and health clubs that now employ more than 900 people.

Upon taking office as Governor in 1982, Kerrey inherited a three percent deficit and was faced with severe federal cutbacks during the greatest economic depression since the 1930's. Kerrey made tough budget cuts and brought the deficit under control. Kerrey not only balanced the state's budget in each of his four years in office, he also turned the deficit into a seven percent surplus upon leaving office in 1987. Kerrey initiated programs for welfare reform, education, job training and environmental protection that have become models for the nation.

Kerrey won election to the Senate in 1988 by an overwhelming margin over an incumbent senator and was reelected in 1994.

Kerrey makes his home in Omaha, Nebraska. He has two children, Benjamin and Lindsey.

Gordon H. Smith

Biography

U.S. SENATOR FOR OREGON

Gordon Harold Smith of Pendleton, Oregon, was sworn-in to the United States Senate on January 7, 1997, becoming the 23rd Oregonian to serve in the seat held by distinguished leaders such as Mark O. Hatfield, Richard L. Neuberger, Charles L. McNary and Edward Baker. He defeated Tom Bruggere in the general election by a margin of 50%-46%. Gordon also becomes the first U.S. Senator from eastern Oregon since 1938.

Gordon Smith made history in 1996, becoming the first candidate ever to run for a state's two U.S. Senate seats in one calendar year. Although Gordon lost a close special election in January, 1996, to fill the seat vacated by Sen. Bob Packwood, he bounced back to run for Oregon's other Senate seat left open by the retirement of Sen. Hatfield.

In his campaigns for the Senate, Gordon emphasized the need for a balanced budget, improved access to education and a more balanced approach to our natural resource laws.

Gordon has membership on important Senate committees. He serves on the Budget, Energy and Natural Resources, and Foreign Relations Committees. On Energy and Natural Resources, Gordon is the vice-chair of the Subcommittee on Water and Power, and also sits on the Subcommittee on Forests and Public Land Management and the Subcommittee on Energy Research, Development, Production and Regulation. On Foreign Relations, he chairs the Subcommittee on European Affairs and also serves on the Subcommittee on Near Eastern and South Asian Affairs and the Subcommittee on International Operations. The Budget Committee has no standing subcommittees.

Gordon was born on May 25, 1952, in Pendleton, OR, to his father, Milan Dale Smith and mother, Jessica Udall Smith. Gordon's father left the family food processing business to accept an appointment to the Eisenhower Administration as executive assistant to the Secretary of Agriculture, and the Smiths relocated their family to Bethesda, MD. After high school, Gordon served a two year church mission in New Zealand, and earned a degree in history from Brigham Young University. It was at BYU where Gordon met his wife, the former

Sharon Lankford.

After graduating from BYU in 1976, Gordon and Sharon moved to Los Angeles, where Gordon earned a law degree from Southwestern University in 1979. He served as a law clerk to Justice H. Vern Payne of the New Mexico Supreme Court and practiced law in Arizona. Gordon then purchased a frozen vegetable processing company in eastern Oregon. Through hard work and determination, Gordon guided the business out of debt and back to profitability. Smith Frozen Foods is now one of the largest private label packers of frozen vegetables in the United States.

In 1992, Gordon campaigned for and won a seat in the Oregon state Senate. In 1995, Gordon's colleagues elected him Senate president, a position he held until he began his service in the United States Senate.

Gordon and Sharon have three children, Brittany, Garrett and Morgan.

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