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U.S. SENATOR BARBARA BOXER

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ABOUT BARBARA BOXER

BIOGRAPHY

ABOUT BARBARA BOXER
BIOGRAPHY
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AWARDS AND HONORS

Barbara Boxer became a United States Senator in January 1993. On November 3, 1998, she was elected to a second six-year term by the largest re-election margin for any California senator since 1980.

A strong California economy continues to be a top priority for Senator Boxer. She has worked to lower trade barriers, promote American products abroad, and protect property rights for California's high-tech and entertainment industries. As a member of the Budget Committee, she cast the tough votes that have led to six straight years of deficit reduction. She is committed to fiscal discipline and insists that any budget surplus be used to save Social Security first.

Education is of prime importance to Senator Boxer. She supports specific goals to ensure that every child can read at age 8, use a computer at 12, and attend college at 18. Her "Computers in Classrooms" law encourages the donation of computers and software to schools. Her After-School Education and Safety bill called for increased funds for after-school programs. In 1998, the Clinton Administration answered this call with $200 million for after-school programs across the nation.

Throughout her career, Senator Boxer has fought for a cleaner environment, introducing legislation to restore our nation's wetlands and remove the threat of offshore oil drilling along California's coast. She authored the Children's Environmental Protection Act, which would set environmental standards at levels that protect children; as a step toward this goal, she successfully amended the Safe Drinking Water Act to protect children, pregnant women, and seniors. She introduced the Clean Fuel Vehicles Act to encourage the use of fuel-efficient vehicles, and she has led the efforts to block unsafe nuclear waste dumps and preserve the Dolphin-Safe Tuna Labeling Act, which she authored. She was the Senate author of legislation that helped to preserve the Presidio of San Francisco as part of the national park system.

Senator Boxer fought for passage of the Family and Medical Leave Act and has worked to draw attention and resources to women's health issues, such as breast cancer research and stronger quality and safety standards for mammography. She supported expanding health coverage for children and is currently calling attention to the high incidence of prostate cancer and the need for more resources to fight it. A strong advocate of medical research, she is a leader in the drive to double funding for the National Institutes of Health. One of the first in Congress to recognize HMO abuses, she authored a Patient's Bill of Rights in 1997.

The Senate's leading advocate of a woman's right to

choose, Senator Boxer authored the Freedom of Choice Act and helped lead the floor fight for passage of the Freedom of Access to Clinic Entrances Act. She has authored the Family Planning and Choice Protection Act of 1999, which would protect women's reproductive health and strengthen family planning to reduce the incidence of abortion.

Long a champion of senior citizens, Senator Boxer has worked to preserve the safety net for older Americans. She has supported extending Medicare coverage and initiatives to strengthen Social Security. She introduced a series of bills to protect the pensions of working Americans, including the "401(k) Pension Protection Act of 1997," which was signed into law as part of the 1998 budget agreement.

Senator Boxer joined her colleagues to pass the landmark 1994 Crime Bill, which led to the lowest crime rate in 25 years and the lowest murder rate in 30 years. She voted for 100,000 new police on the beat, for anti-gang programs, and for the assault weapons ban. To curb gun violence, the #1 killer of California youth, Senator Boxer is working to get junk guns off our streets. Her legislation to stop the criminal use of personal information obtained through motor vehicle records was signed into law. She authored the Violence Against Women Act while she was in the House of Representatives and helped steer it successfully through the Senate. It too is now law.

Senator Boxer has worked for federal aid to ensure that California would be rebuilt after natural disasters. She also succeeded in passing legislation to allow federal funding to be used to strengthen the state's infrastructure before an earthquake strikes. Her seat on the Environment & Public Works Committee has enabled her to dramatically increase funding for California transportation and highways.

Senator Boxer helped establish a one-stop Defense Conversion Hotline to aid communities hit by defense cuts and base closures. She won many battles to retrain defense workers and retool defense technologies for civilian use, such as federal support for the "Stealth Bus," a fuel-efficient advanced technology bus made of stealth bomber materials. In the House, she was a leader in military procurement reform, revealing overcharges by Pentagon contractors (including the famous $7,600 coffeepot). She passed over a dozen procurement reforms, one of which, by itself, has saved taxpayers over $2.6 billion. In the Senate, she eliminated a Pentagon policy which allowed military felons convicted of heinous crimes to stay on the government payroll. Senator Boxer opposes a massive increase in defense budgets. Instead, she would eliminate unwanted and unnecessary weapons systems, using the savings to fund increased readiness and pay raises for military personnel.

Senator Boxer has been honored for her leadership in Congress by the Consumer Federation of America, the Coalition to Stop Government Waste, Planned Parenthood, the League of Conservation Voters, Public Citizen, the Sierra Club, the Center for Environmental Education, the Center for Defense Information, and the

American Association of University Women. She has been recognized as an Outstanding Mother by the National Mothers Day Committee and has been hailed as a champion of human rights by the Anti-Defamation League, the Human Rights Campaign Fund, and the Leadership Conference on Civil Rights.

Senator Boxer served in the House of Representatives for 10 years following six years on the Marin County Board of Supervisors, where she was elected the first female President of the Board.

Senator Boxer serves on the Senate committees on the Budget, Environment & Public Works, and Foreign Relations. She is a member of the Senate's Hispanic Caucus and its Smart Growth Task Force. She serves as the Western Regional Democratic Whip; Deputy Assistant Floor Leader; and Recruitment Chair, Democratic Senatorial Campaign Committee.

A former stockbroker and award-winning journalist, Barbara Boxer received her B.A. in Economics from Brooklyn College. She and her husband live in Greenbrae, California. They have two adult children, one son-in-law, and one grandchild.

BIOGRAPHY OF SENATOR RICHARD J. DURBIN

Biographical Milestones

- Name: Richard J. Durbin
- Born: November 21, 1944, in East St. Louis, IL
- Parents: William Durbin and Ann Durbin (nee Kutkin)
- Education: Assumption H.S., East St. Louis; Georgetown University, B.S., 1966 (Foreign Service, Economics); Georgetown University, J.D., 1969; Honorary Degree, Millikin University, 1994; Honorary Degree, Lincoln College, 1997
- Family: Married to Loretta Schaefer Durbin, three children and one grandchild
- Residence: Springfield, IL
- Occupation: Attorney/legislator
- First Elected: November 4, 1982, to represent 20th Congressional District
- Committees: Appropriations, Governmental Affairs, Budget and Select Committee on Ethics

Dick Durbin, a Democrat from Springfield, is the 47th U.S. Senator from the State of Illinois and the first Illinois senator to serve on the U.S. Senate Appropriations Committee in more than a quarter of a century.

Elected to the U.S. Senate on November 5, 1996, Durbin filled the seat left vacant by the retirement of his longtime friend and mentor, U.S. Senator Paul Simon. In addition to the Appropriations

Committee, Durbin is a member of the Senate Governmental Affairs, Budget and Ethics Committees in the 106th Congress.

U.S. Senate Democratic Leader Tom Daschle (D-SD) also has appointed Durbin to his leadership team, where Durbin serves as Assistant Floor Leader.

Durbin's assignment to the Senate Appropriations Committee marks his return to a congressional appropriations panel. Durbin spent 12 years of his 14 years in the U.S. House of Representatives as a member of the House Appropriations Committee, rising to the chairmanship of the Subcommittee on Agriculture and Rural Development.

During his chairmanship from 1993 through 1994, Durbin eliminated wasteful programs and trimmed more than a billion dollars from the federal budget while increasing funding for health and nutrition programs for mothers, infants and young children.

The House author of landmark legislation to ban smoking on commercial airline flights, Durbin has taken to the Senate his fight to protect children from the multi-billion-dollar tobacco industry's advertising tactics, to end federal tobacco subsidies and to hold the industry accountable for the harm caused by its products.

In addition to protecting children from tobacco industry marketing, Durbin has pursued legislation to keep guns out of the hands of kids. Following the horrific series of school shootings, he introduced bipartisan legislation to hold adults responsible for safely storing their firearms away from children.

During his service on the Senate Judiciary Committee in the 105th Congress, Durbin joined the Bureau of Alcohol, Tobacco and Firearms and local law enforcement agencies to launch an initiative to help make Illinois the first state to voluntarily trace every gun recovered from a crime scene.

Consumer protection also is high on Durbin's list of priorities. Inspired by meeting a Chicago mother whose six-year-old son died after

eating contaminated hamburger, Durbin has become a national leader in the effort to modernize the nation's food safety inspection system. His legislation to create a single, independent food safety agency out of the dozen agencies currently involved in the process has won the backing of major consumer and public health groups.

Public health groups also supported legislation Durbin introduced in the House to increase awareness of the need for organ donation. Durbin saw the results of his legislation during his first year in the Senate when more than 70 million organ donor cards were mailed out with 1997 federal income tax refunds — the largest solicitation ever for organ donors.

In the Senate, Durbin has taken on fraudulent telephone practices, including "slamming," the unauthorized switching of a person's long-distance service, and "cramming," the adding of unauthorized services on a consumer's phone bill. In other consumer protection efforts, he led the call for an investigation of skyrocketing electricity prices during the 1998 summer heat wave.

Durbin has worked to cut wasteful federal spending and protect taxpayers from unnecessary windfalls for special interests. In 1997, he led a bipartisan coalition of lawmakers in repealing a $50 billion tobacco industry giveaway that had been slipped into a tax relief bill. In 1998, he successfully fought a proposal to extend patents for certain drugs — a move that would have denied consumers less expensive generic drugs at a cost of millions of dollars.

Durbin supported the 1993 and 1997 deficit reduction packages which have resulted in the first balanced budget since 1969. He also has supported tax relief for working families, including a child tax credit, tax credits to help families pay for college and 100 percent tax deductibility for health insurance premiums for the self-employed.

The Illinois lawmaker also supports targeted tax incentives for business development, including the extension of the research and development tax credit. A longtime supporter of the reduced tax rate for ethanol-based fuels, Durbin has worked to help businesses and farmers create new agricultural products and identify new markets.

Durbin was first elected in 1982 to represent the 20th Congressional District in the U.S. House of Representatives. He and his wife Loretta have three children and one grandchild.

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Panel 2

DEPARTMENT OF HEALTH & HUMAN SERVICES

David Satcher, M.D.

U.S. Surgeon General and Assistant Secretary for Health

Dr. David Satcher, a physician, scholar and lifelong public health advocate, was sworn in on February 13, 1998 as the 16th Surgeon General of the United States and as Assistant Secretary for Health. Vice President Al Gore administered the oath of office to Dr. Satcher, 56, at a White House ceremony in the Oval Office with President Clinton.

Dr. Satcher served as Director of the Centers for Disease Control and Prevention (CDC) in Atlanta from November 15, 1993, until his swearing-in. As CDC Director, Dr. Satcher led the agency responsible for promoting health and preventing disease, injury, and premature death. CDC's eleven Centers, Institutes, and Offices work closely with local, state, and other federal agencies to protect the public health. During his tenure at CDC, Dr. Satcher spearheaded initiatives that increased childhood immunization rates to 78% in 1996 from 55% in 1992, upgraded the nation's capability to respond to emerging infectious diseases, and laid the groundwork for a new Early Warning System to detect and prevent food-borne illnesses.

Under Dr. Satcher's direction, the CDC placed a greater emphasis on disease prevention. For example, the CDC's comprehensive breast and cervical cancer screening program increased from 18 to 50 states and the agency highlighted the importance of physical activity and good health by encouraging Americans to become more physically active in the landmark Surgeon General's Report on Physical Activity and Health.

On July 23, 1997, at a White House ceremony celebrating the fact that vaccine-preventable childhood illnesses had fallen to the lowest level in American history, HHS Secretary Donna E. Shalala called Dr. Satcher one of the CDC's "immunizations heroes," noting that "his own battle with childhood whooping cough inspired him to become a distinguished scientist, physician and public health leader." Dr. Satcher also served as Administrator of the Agency for Toxic Substances and Disease Registry (ATSDR), administering the HHS agency created by the Superfund law to prevent or mitigate adverse human health effects and diminished quality of life resulting from exposure to hazardous substances in the environment.

Dr. Satcher was President of Meharry Medical College from 1982 until he was named Director of CDC. Before joining Meharry, he served as professor and chairman of the Department of Community Medicine and Family Practice at the Morehouse School of Medicine in Atlanta.

Dr. Satcher is a former faculty member of the UCLA School of Medicine and the King/Drew Medical Center in Los Angeles. He developed and chaired King/Drew's Department of Family Medicine and, from 1977-1979, served as the interim dean of the Charles R. Drew Postgraduate Medical School. He also directed the King/Drew Sickle Cell Center for six years.

He has received wide recognition during his career. In 1986, he was elected to the Institute of Medicine of the National Academy of Sciences for his leadership skills. Also that year, he was appointed to the Council of Graduate Medical Education, which reports to Congress and to the Secretary of Health and Human Services. The Council, which Dr. Satcher chaired until his CDC appointment, presented three reports to Congress and the Secretary dealing with physician manpower and the financing of medical education.

In 1996, Dr. Satcher received the prestigious Dr. Nathan B. Davis Award in the category of Executive Branch Member Serving by Presidential Appointment for outstanding public service to advance the public health.

Other awards he has received include the Watts Grassroots Award for Community Service in 1979, the National Conference of Christians and Jews Human Relations Award in 1985, Ebony Magazine's American Black Achievement Award in Business and the Professions in 1994, and the Breslow Award for Excellence in Public Health in 1995.

Most recently, Dr. Satcher received the James D. Bruce Memorial Award for distinguished contributions in preventive medicine from the American College of Physicians, the John Steams Award for Lifetime Achievement in Medicine from The New York Academy of Medicine, and the Surgeon General's Medallion for significant and noteworthy contributions to the health of the nation.

A native of Alabama, Dr. Satcher graduated from Morehouse college in Atlanta in 1963 and was elected to Phi Beta Kappa. He received his M.D. and Ph.D. from Case Western University in 1970, with election to Alpha Omega Alpha Honor Medical Society.

He and his wife, Nola, have four children and currently live in Atlanta.

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Panel 3

Jeffrey D. Sachs

Biography

Jeffrey Sachs is the Director of the Harvard Institute for International Development and the Center for International Development, the Galen L. Stone Professor of International Trade at Harvard University, and a Research Associate of the National Bureau of Economic Research. Sachs serves as an economic advisor to several governments in Latin America, Eastern Europe, the Former Soviet Union, Africa and Asia. He was cited in The New York Times Magazine as "probably the most important economist in the world" and in a Time Magazine issue on 50 promising young leaders as "the world's best-known economist."

Sachs is the recipient of many awards and honors, including membership in the Harvard Society of Fellows, American Academy of Arts and Sciences, and the Fellows of the World Econometric Society. He received an Honorary Degree from St. Gallen University in Switzerland and Lingnan College in Hong Kong. In September 1991 he was honored with the Frank E. Seidman Award in Political Economy. He has delivered the prestigious Lionel Robbins Memorial Lectures at the London School of Economics, the John Hicks Lectures at Oxford University, the David Horowitz Lectures in Tel Aviv, and the Frank D. Graham Lectures at Princeton University.

Sachs was born in Detroit, Michigan, in 1954. He received his B.A., summa cum laude, from Harvard College in 1976, and his M.A. and Ph.D. from Harvard University in 1978 and 1980 respectively. He joined the Harvard faculty as an Assistant Professor in 1980, and was promoted to Associate Professor in 1982 and Full Professor in 1983.

February 17, 1999

Click here for a more biographical information about Professor Sachs.

International Federation of Pharmaceutical Manufacturers Associations
Fédération Internationale de l'Industrie du Médicament
Federación Internacional de la Industria del Medicamento

AIDS IN AFRICA

Testimony Before the United States Committee on Foreign Relations
Subcommittee on African Affairs

Dr. Harvey E. Bale, Jr.
Director-General
International Federation of
Pharmaceutical Manufacturers Associations (IFPMA)

Senate Dirksen Building, Room 419
February 24, 2000

Introduction

Mr. Chairman and other Members of the Subcommittee: I am the Director-General of the International Federation of Pharmaceutical Manufacturers Associations (IFPMA), based in Geneva, Switzerland, representing the research-based industry in over 55 countries. The Pharmaceutical Research and Manufacturers of America (PhRMA) is one of our important members. We represent our industry before the World Health Organization, the World Trade Organization, the World Bank, the World Intellectual Property Organization and other UN agencies, and the OECD. We are also full partners in the Global Alliance for Vaccines and Immunization (GAVI) and the Medicines for Malaria Venture (MMV).

Our mission is to seek to work with international agencies and national governments to find new ways to bring the therapeutic technologies and know-how of our industry together with efforts to reduce disease burdens. We also address the most important conditions necessary to strengthen the capability of our industry to continue to develop innovative therapies and vaccines: i.e., intellectual property rights, competition-based health care delivery systems, effective product regulatory systems and open information delivery policies for health care professionals and patients.

We are here today to focus on one of the most serious global threats to public health globally and the worst threat to Africans' well being and the economic development of the Sub-Saharan African region. The research-based pharmaceutical industry is strongly

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committed to helping people living with AIDS – who wait for better and less costly therapies and, hopefully in the not-too-distant future, a vaccine or vaccines to effectively prevent further HIV infections. I will seek to relate our perspective on this serious problem and to suggest what is needed.

The Seriousness of the HIV/AIDS Pandemic

HIV/AIDS is indeed *the* public health crisis in Africa. Over 34 million people in the world are currently infected with HIV/AIDS, with 95% of them living in developing countries. Most tragically, over 13 million children have lost one or both parents. Two-thirds of those infected live in sub-Saharan Africa, and more than 80 percent of the world's HIV/AIDS deaths have been in this region. HIV/AIDS is now the number one killer in Africa, taking more African lives each year than all the conflicts in the region combined, and HIV-related illnesses are an additional burden on already weakened public health services. According to WHO's 1999 World Health Report, HIV/AIDS has become the disease with the greatest impact on mortality in Africa. Indeed, life expectancy in Africa is declining because of AIDS, and in some places may fall back to 1960s levels, according to Dr Peter Piot, Executive Director of the Joint United Nations Program on HIV/AIDS (UNAIDS). This would mean a drop in expected life spans from 59 years in the early 1990s to just 45 years by 2010. As Dr. Piot recently noted, "AIDS in Africa has become a full-blown development crisis, and is on its way to becoming the single greatest threat to human security on the continent...Few sectors of African society remain untouched by AIDS. The epidemic is wiping out health, social and economic gains that Africa has worked towards for decades." Furthermore, AIDS is decimating the most productive elements of African society. UNDP Administrator Brown declared at the first meeting of the UN Security Council this year that "an extraordinary depletion of the region's human capital is underway. There are estimates that the number of active doctors and teachers in the most affected countries could be reduced by up to a third in the coming years."

Industry's Key Contribution: Searching for Cures

The pharmaceutical companies responsible for the discovery, development and supply of medical products for managing HIV/AIDS are acutely aware of the urgent need to tackle the epidemic in Africa and other parts of the developing world. We are devoted to finding hope for those affected by the tragedy unfolding before us, as literally millions of men, women and children are swept away to untimely deaths by the rising AIDS pandemic. We call upon all parties, national governments and international organizations to take coordinated strong action to fight AIDS. We in industry are prepared to participate in augmenting our contribution to the struggle against AIDS, based on our special expertise and scientific and technical resources.

Industry's primary role in combating HIV/AIDS worldwide is through its unique role in the discovery and development of new vaccines, medicines and treatments for diseases

and disorders. Indeed, it is important to recall that, twenty years ago, AIDS was not yet identified. At that time AIDS was considered untreatable as well as incurable, subjecting those infected with HIV to certain misery and untimely death. Today, there are about 15 antiretrovirals on the global market, with more in the industry's research pipeline. This tremendous advance in treatment is possible thanks to the billions of dollars that the industry has devoted to AIDS medicines and vaccine research, including research into treating opportunistic infections related to AIDS. Today, there are over 100 new AIDS medicines in our industry's R&D pipeline, including **35** new antivirals and **10** vaccines for HIV prevention. Such research will, we hope, one day yield: shorter-course treatments, such as nevirapine from Boehringer-Ingelheim for preventing mother-to-child transmission of HIV; more convenient and tolerable regimens, such as tests of "one-pill-a-day" regimens being tested by various researchers, including Bristol-Myers Squibb; as well as scientific breakthroughs which could open up whole new avenues to fight HIV, such as a recent announcement by Merck scientists that they have found two experimental compounds which were able to obstruct the activity of an enzyme called integrase that plays a critical role when the AIDS virus infects cells. New treatments developed by the pharmaceutical industry and introduced in the last several years – e.g., antiretrovirals (including the protease inhibitors and non-nucleoside reverse transcriptase inhibitors) as well as anti- infectives and antifungals to combat opportunistic infections – have begun to change the pattern of the AIDS epidemic.

Industry R&D can only continue when there is respect for and implementation of protection for intellectual property rights which promote and protect such research. The challenge now is to improve therapies and the search for cures, continue to extend access to these breakthrough medicines to all affected populations, and ultimately to develop an effective vaccine -- or several vaccines. Allowing market incentives to proceed without counterproductive interventions is vitally important in creating an environment favorable for developing new vaccines, treatments and possible cures for HIV and AIDS-related conditions. Drug research and development by the research-based pharmaceutical industry is financed by companies' own internal resources, and on average it takes hundreds of millions of dollars to research, develop and test a new medicine, including treatments for AIDS. It is vital that this research is not hindered by quick-fix solutions such as compulsory licensing, parallel trade and other measures which may sound attractive to some in the short term, but would fatally retard R&D into HIV/AIDS related medicines in the medium and long-term, disappointing the hopes of millions who look for a cure for AIDS. Today, we no longer speak of "incurable diseases" ----- only those diseases for which we have not *yet* developed a cure or vaccine. There are real concerns about access to AIDS medicines in Africa and elsewhere, but this access has little to do with patents, and weakening patents would not -- I repeat, not – significantly improve access for reasons discussed below.

First, many developing countries are not yet TRIPS-compliant and some such countries, such as India, already produce generic copies of patented AIDS drugs. If patents were indeed the problem, large populations within these countries should have easy access to

these copied, generic versions of AZT and other medications; but in India and parts of Africa this is demonstrably not the case.

Second, the cost of a pharmaceutical product is only a small part of the overall AIDS treatment costs, including training, patient diagnostics, treatment supervision and safe drug distribution – elements absolutely essential to ensure the effective use of complex AIDS treatment regimens.

Third, the ex-manufacturer price of drugs in developing countries is often only a small part of the final retail price for consumers due to high import tariffs, taxes and wholesale and retail distribution margins. In America, these mark-ups may add perhaps 40-60% to costs. In Africa, they often add 100-300 % to ex-manufacturer prices.

Fourth, parallel trade and systematic compulsory licensing regimes (which were abandoned by Canada and New Zealand 10 years ago), weaken patent protection, but are claimed as cost saving policy instruments by advocates. Actually, when one observes price differences across national boundaries one is seeing differences in retail prices – which are reflective of many factors including the margins mentioned previously and which do not form a basis for parallel trade. In any case, where parallel trade exists (e.g., within the European Union) evidence shows that the benefits of parallel trade to consumers are small because such trade mainly benefits the parallel traders, not consumers, because the former capture most of the "rents" arising from the differences in ex-manufacturer prices across countries. Some activists promote compulsory licensing as another "solution" to access to AIDS drugs. Such advocates present compulsory licensing as a way to create a more competitive market akin to post-patent generic competition in the United States and a few other industrialized countries. However, as compulsory licensing is a deliberate action by governments, it can lead to a limited number of licenses being issued, with recipients potentially being chosen due to political favors rather than objective criteria. Thus, price benefits may be minimal, while the quality of a copied version may not be equivalent to the original.

Finally, many of the millions of people of Africa earning less than a US dollar a day, and their governments, cannot afford good quality generic versions of AIDS drugs either. Patent-pirated versions appear in Africa, and their prices are often not significantly lower. And there are bottom limits to prices, set by costs; and at these levels the unit costs (especially when the rest of the full costs of a treatment are added in) are well beyond the capability of the poorest patients who need the most help.

Partnerships and New Incentives for R&D

We believe that the AIDS crisis requires a comprehensive, multisectoral response, led by committed governments and intergovernmental institutions – the World Health Organization and the World Bank. We must as a coalition of stakeholders (1) step up educational campaigns to change attitudes and behavior to curb the spread of HIV; (2)

enhance the capacity of health systems to deliver essential medical care to the people living with the disease; and (3) encourage further innovation into new therapies and vaccines while improving access to existing ones in regions such as Africa. We must also recognize that the problem of access to drugs for AIDS and related conditions is one aspect of the broader issue of access to adequate health care generally.

More generally, innovative approaches may be needed to attack disease patterns in the poorest countries. And more resources are required. Fortunately, novel approaches are being explored. For example, UNICEF, WHO, the World Bank and UNAIDS are looking at ways to guarantee a market for vaccines for diseases predominant in developing countries, picking up on an idea of creating a fund (to purchase vaccines) raised initially by Professor Jeffrey Sachs.

The Medicines for Malaria Venture (MMV) is another example of innovative public/private sector partnerships to address the need to develop new medicines for special categories of diseases -- in this case malaria. This public-private sector MMV, designed to develop new antimalarial drugs, is an excellent investment of resources to find new treatments for this widespread disease, which infects millions of people in developing countries, while researchers search for an effective antimalarial vaccine to protect future generations. We would urge the Congress and Administration to financially back the public/private MMV initiative, joining several other countries that have already done so. The financial requirements to contribute positively are relatively small compared to the very large potential benefits that will accrue to millions of malaria-threatened populations in Africa and elsewhere.

Other mechanisms should be explored as well. These include developing policy measures similar in concept to US orphan drug legislation, which includes tax credit and market exclusivity provisions. We note positively the proposal by the Administration to set up a market-based mechanism to support vaccine development for HIV, malaria and tuberculosis. New incentives should not be limited to vaccines, however. Breakthroughs in drug treatments may come more quickly than new vaccines and may provide cures, which would have an important impact on quality of life for those millions already living with these diseases. As with all innovative drugs, the investment in developing new antiretrovirals and researching an HIV vaccine is immense. The continually mutating nature of HIV adds additional complications to the search for more effective treatments as well as possible vaccines or even cures for AIDS. We must accept that, despite the progress being made, bringing an effective treatment, cure or vaccine to market will be a long and demanding process. Despite the large amount of research being conducted into HIV/AIDS, most estimates still reflect a view that a very effective vaccine may still be at least five or more years away.

Industry Partnerships in the Fight Against AIDS and Other Diseases Threatening Africa's Health and Development

Individual companies are working in partnership with the public sector and civil society to fight against AIDS worldwide, particularly in Africa. Such partnerships include the following:

- For over ten years, GlaxoWellcome's "Positive Action" and Merck's "Enhancing Care Initiative" have been offering support to communities for education, training, and social action projects to improve their capacity to deliver care to people in developing countries; GlaxoWellcome also partnered with UNICEF, providing sharply discounted antiretroviral products for projects in the Mother to Child Transmission (MTCT) Program as well as providing its products at substantially discounted prices through the UNAIDS HIV Treatment Access Initiative Pilot Program. GlaxoWellcome has also played a leading role in the Global Business Council on HIV/AIDS, bringing business leaders from many industry sectors together to develop, in cooperation with UNAIDS and NGOs, an effective corporate response to the epidemic.
- Bristol-Myers Squibb (BMS) has committed $100 million for HIV/AIDS Research and Community Outreach in five African Countries under their "Secure The Future™" Program, focusing on women & children in South Africa, Botswana, Namibia, Lesotho and Swaziland. An example of efforts supported by this initiative is a joint study of HIV-1C, a strain of HIV particularly prevalent in Africa, conducted by the Harvard AIDS Institute and the government of Botswana, supported by a US$18.2 million grant from BMS.
- Launched in November 1997, the UNAIDS HIV Drug Access Initiative is designed to develop innovative, effective models to improve access to needed drugs to treat HIV, its opportunistic infections, and sexually transmitted diseases in the developing world. The Initiative seeks to address the many challenges of developing-country drug access, such as lack of medical infrastructure, drug distribution channels, drug supply, professional training, and patient support through facilitating collaboration among pharmaceutical companies, health care providers, national governments, non-governmental organizations, and people living with HIV/AIDS. Pilot projects designed to increase access are underway in Uganda, Vietnam, Chile and the Ivory Coast. Pharmaceutical partners in the UNAIDS Initiative include: GlaxoWellcome, F. Hoffmann-LaRoche, Virco NV, Bristol-Myers-Squibb, Organon Teknika, Merck&Co., and DuPont Pharma.

There are also Industry initiatives in the eradication and prevention of other serious diseases impacting developing countries: AIDS is by no means the only serious threat to the well-being of the poorest developing countries. Often overlooked are the extensive activities of companies contributing their patented or off-patent medicines or technology for specific diseases of poorer countries. These programs were launched and are succeeding because as preconditions governments were required to fully commit to the success of the campaigns. This commitment is critical and offers lessons for the attack against AIDS in Africa and elsewhere. Examples of such company actions include:

- Merck has donated ivermectin free of charge for as long as it is needed to fight

onchocerciasis (river blindness). Key international partners involved with Merck have been the WHO, World Bank and the Carter Center.

- SmithKline Beecham and Merck are donating albendazole and ivermectin (two antiparasitic drugs for lymphatic filariasis, LF) free of charge for use in countries where LF in endemic. This also done with support of WHO and other agencies.
- GlaxoWellcome is donating an antimalarial combination drug (Malarone) free of charge to the public sector in malaria-endemic countries for treatment of cases which are resistant to standard first-line treatments.
- To help in WHO's global fight to eradicate polio, Aventis Pasteur has donated 50 million doses of oral polio vaccine to cover the vaccine needs for National Immunization Days scheduled in five conflict affected areas in Africa in 2000-2002. Countries to be covered are Angola, Liberia, Sierra Leone, Somalia and South Sudan.
- Pfizer is donating the oral antibiotic azithromycin to combat trachoma in 5 developing countries (Morocco, Ghana, Mali, Tanzania and Vietnam) in collaboration with the Edna McConnell Clark Foundation.
- Recently, Aventis Pharma donated the patent rights on life-saving eflornithine to WHO to treat African trypanosomiasis (sleeping sickness). This concluded a 15-year old public/private sector collaboration between Hoechst Marion Roussel and WHO, during which the development of the drug and its approval by drug authorities were finalized. The partnership in the effort to ensure efficient distribution of this drug includes WHO, Aventis Pharma and NGOs.
- Hoffmann-La Roche has conducted the "Sight & Life Program" dedicated to the prevention of xerophthalmia and other adverse effects of vitamin A deficiency that impairs the health of children in numerous developing countries. In this initiative, Hoffmann-La Roche donates vitamin A in many countries in Africa, Asia and Latin America, as well as educational materials.

There are other industry-wide efforts to improve health worldwide in partnership with the public sector including:

- The new Medicines for Malaria Venture (MMV), started in partnership between WHO, pharmaceutical industry and other parties has been established to stimulate the discovery and development of new treatments for this wide-spread disease. We are seeking to develop a new antimalarial therapy every 5 years beginning in this decade. We do not preclude, indeed we hope, that a new malaria vaccine might also come from the MMV or separately.
- The IFPMA and its vaccine company members are in full partnership in the Global Alliance for Vaccines and Immunization (GAVI). Through the Alliance, member partners will address ways to accelerate the development and introduction of new vaccines specifically needed by developing countries. The vaccine industry members of the IFPMA will, in cooperation with their GAVI partners, work to ensure accessibility to the vaccines and other related elements that are necessary for the immunization of all the world's children, with a particular focus on poor populations and countries.

- The WHO/CEO Roundtable process involves not only a yearly meeting between the Director-General of WHO and CEOs of IFPMA companies, but also WHO/industry working groups on issues relating to research&development, drug quality and access to drugs. For example, the WHO/CEO Roundtable process supports the "Malaria Pathfinder" initiative, which is a joint WHO/industry program examining ways to sustainably improve antimalarial access and rational use at the household level (in some cases, at the district level) as measured by improvements in rapid procurement and dispensing of appropriate treatments. A joint communiqué on the most recent meeting of the WHO/CEO Roundtable is available on the IFPMA and WHO web sites: (http://www.ifpma.org and http://www.who.int/medicines/).

Barriers to Access to Health Care

It must be recognized that only a committed effort by national governments can be effective in fighting AIDS, as the spread of AIDS is very much linked to poverty and underdevelopment which make people more vulnerable to becoming infected with HIV. Furthermore, there are several barriers to access to health care, barriers which industry can play only a limited role in overcoming. Indeed, the manufacturers' cost of pharmaceutical products is small in comparison to the overall distribution costs required to reach populations affected by AIDS or even to the retail price paid by the end consumer.

Understanding barriers to access is extremely important because they would make even free-of-charge antiretrovirals (ARVs) impossible for people living with AIDS in Africa to access regularly and effectively, making treatment useless and even possibly dangerous. Indeed, inappropriate use of these powerful drugs can and has resulted in strains of HIV developing which are resistant to all known treatments, making our search for a cure even more difficult. Also, due to the complexity of ARV regimens and the possible toxic side effects of these powerful drugs, appropriate medical support and careful monitoring is a vital part of using ARVs. According to UNAIDS and WHO, certain services and facilities must be in place before considering the use of antiretrovirals in any situation:

- Access to functioning and affordable health services and support networks into which ARV treatments can be integrated so that the treatments are provided effectively;
- Information and training on safe and effective use of ARVs for health professionals in a position to prescribe ARVs;
- Capacity to diagnose HIV infection and to diagnose and treat concomitant illnesses;
- Assurance of an adequate supply of **quality** drugs;
- Sufficient resources should be identified to pay for treatment on a long term basis; patients must be aware that treatment is "for life";
- Functioning laboratory services for monitoring, including routine hematological and biochemical tests to detect toxicities, must be available;

- Access to voluntary HIV counseling and testing (VCT) and follow-up counseling services should be assured, including counseling people living with HIV/AIDS on the necessity of adherence to treatment.

The barriers to access detailed below make it very difficult and even impossible to create the infrastructure described above which is so vital for the effective use of antiretrovirals and other medications for treating AIDS and related conditions. Therefore, examining access to AIDS health care from a broader perspective will help policy-makers focus their attention on reforms in the areas likely to have the greatest impact.

Military, Social and Political Issues

- Military spending priorities: The existence of international and civil wars in many developing countries increase peoples' vulnerability to HIV-infection and prevent people living with AIDS from being treated. Even in countries where there are no wars or external threats, governments give a higher priority to spending money on "defense" than on healthcare, including AIDS.
- Lack of priority due to political cynicism: Effective treatments are being offered by companies (often at substantial discounts) and cheaper therapies are becoming available. Yet, in some countries, groundless excuses for not increasing spending on AIDS treatments, such as an alleged excessive toxicity of antiretroviral AIDS drugs, have been made. These excuses mask the basic cynicism that some governments have concerning treating poor people living with AIDS or in preventing mother-to-child transmission of AIDS. A very recent article in the African press quoted a government official from the region as saying that trying to prevent mother-to-child transmission in impoverished areas would only shift the cause of mortality later on. In other words, the government that this official serves is making policy based on the cynical observation that poverty and malnutrition could lead to the same result as HIV in the motherless and impoverished child.
- Tolerance of corruption: In countries where official corruption is prevalent, health care access is impeded through the pilferage and diversion of products and services, with the poorest elements of society being harmed the most.
- Inefficiency and wastage: UNAIDS has found that, although the World Bank and other international agencies make money available for AIDS projects in Africa, much of it goes unspent because of bureaucratic complexities and other problems;
- Literacy and language barriers: If the patient is illiterate and/or does not understand the language used by the health care providers, then they will have difficulty in accessing care;
- Minority (including ethnic or gender) groups may experience discriminatory attitudes from health care providers. Illegal immigrants may fear discovery or be not entitled to full access to health care facilities, thus hindering their access to care;
- Stigma: the stigma attached to being HIV-positive in many cultures has led to ostracization, abandonment, violence and even murder of people living with HIV. In light of these dangers, people will refuse to be tested for their HIV status and, if they

do discover that they have HIV, they will be afraid to seek appropriate treatment due to the possible repercussions if others were to find out their status.

Financial Hurdles

- The shortage of financial resources in the poorer developing countries is the most important barrier to access to health care, including medicines, in these countries. International aid agencies, as well as industrialized countries, often play an important role in financing health care infrastructure in the poorest developing countries.
- In many countries in Africa and elsewhere, governments require patients to 'co-pay' for therapy costs (including diagnostics, training, health care infrastructure, etc.), ranging from $35 to hundreds of dollars per month. Clearly few can afford such payments; so that less than 1% of HIV infected patients receive such therapy. (In comparison, in Brazil a much higher percentage of infected persons receive therapy; but Brazil is aided by World Bank funds.)
- Many countries due to insufficient resources can provide not even rudimentary health care. For example, annual spending on health in some African countries is under US$4 per capita. This lack of spending can also result from governments not setting health care services, including care for people living with HIV/AIDS, as a high enough priority in determining the use of national resources.
- Inadequate purchasing power for medicines and a lack of an adequate number of medical professionals and hospital facilities to deliver health care result from this lack of adequate financial resources.

Physical Infrastructure Barriers

Lack of physical access to health care facilities or personnel is another major barrier to access in developing countries. There are several factors leading to such inadequate access:

- Adequate clean food and water is needed. Therapy for HIV/AIDS requires healthy food intake in some relation to the time of drug ingestion as well as access to clean water. Both are often missing in the developing world.
- Inadequate health care facilities to meet the needs of a growing population due to insufficient public and private resources.
- Insufficient transportation infrastructure to permit access to medical care providers for much of the population.
- Unequal distribution of health care facilities that may be concentrated in densely populated urban areas, leaving wider, rural areas without adequate coverage.

Bad Micro-Economic Policies

- Protectionism: Many governments protect their local insurance and pharmaceutical companies from foreign competition, making local insurance and pharmaceutical costs higher than they should be. Tariffs imposed on imported pharmaceuticals raise

drug cost margins to patients. In developing countries, the final price to a consumer is often 3-5 times the price received by the manufacturer, whereas in developed countries, the ratio is often less than twice the manufacturer's level.

- Non-competitive distribution networks: Protected wholesale and other distributors can artificially raise distribution margins, making drug costs in developing countries high – perhaps even higher than in some developed countries.
- Poor Intellectual Property Protection: The lack of adequate and effectively enforceable intellectual property rights hurts access to health care and pharmaceuticals by eliminating incentives for research and development of new products in at least two ways:

  (1) local firms in countries with good scientific infrastructure devote resources to copying (often without regard to Good Manufacturing Practices (GMP)) instead of focusing on research into diseases prevalent locally; and

  (2) countries which allow international patent exhaustion (i.e., parallel trade) discourage local pharmaceutical investment and the offer of companies to supply the local market on terms that local patients and governments would find more advantageous.
- Price Controls: Governments may look at price controls as one solution to access. However, price controls tend to damage incentives for research and development industry, they can also negatively affect the development of a GMP-based local generics industry. Furthermore, price controls destroy competition and usually evolve from being limits on price increases (or 'ceilings') to becoming fixed price 'floors' preventing consumers from enjoying benefits of market competition. One need only look at comparisons in changes in post-patent prices between Europe, where price controls exist, and the United States.

Informational Gaps

- People may fail to access health care due to a lack of information about the need to treat diseases such as tuberculosis, hepatitis, or hypertension.
- Patients may not know how or where to access health care (particularly in the cases of minorities or immigrants).
- Self-medication by poorly informed patients may lead to ineffective drug utilization.
- Poorly informed physicians in developing countries often treat illnesses such as diarrhea inappropriately with antibiotics or they may not always be aware of the most cost-effective therapy.
- There is often the lack of information about the quality of generic products. In most developing countries, providers and patients prefer brand name products because they are unsure of the origin, safety and reliability of generic products.
- Lack of adequate training for inspectors and regulators regarding pharmaceutical product quality issues hinders people's access to quality health care. Such insufficient training allows substandard and counterfeit drugs to enter national markets, which endangers the population's health, engenders uncertainty about the effectiveness of treatments, and often crowds quality out of the market.

- Gray-market or illegal workers not contributing to the national tax system may be excluded from the social and workers health insurance system of their country of residence.

Cost and Price Issues

How important are price and cost issues? We firmly believe that they are secondary or tertiary problems in Africa compared to those discussed above. Some have charged that patents for pharmaceutical products reduce access to these products. This focus on patents (and prices) ignores the complexity of the access to healthcare issue and prevents policy-makers from considering real solutions to this issue. This is recognized by patient groups and public-sector decision-makers alike. For example, the European Coalition of Positive People publicly stated with regard to HIV/AIDS drugs recently that focusing on patent protection and pricing is "simplistic and fails to take into account the serious practical problems that need to be addressed..." Drugs could be free and still not be appropriately used without adequate health care systems. In fact, they would rapidly become ineffective. The cost of drugs to patients in Africa is determined principally by distribution, infrastructure, training and other factors discussed above. The issues of patents and prices of AIDS drugs are not the key issues.

Approaching the access issue solely through debates over price is not only simplistic, as noted above, but also factually incorrect. Patents do not, in fact, have an influence on access to the drugs, which the population in developing countries actually consumes. These are primarily off-patent drugs; for example, almost all of the products on the WHO Essential Drug List are off-patent. Furthermore, many developing countries do not currently have TRIPS-compliant intellectual property legislation and the poorest of these countries will not be required to implement such legislation until 2005, perhaps even later if they apply for a longer transition period. Therefore, access to the drugs for which this population is looking is *not* inhibited by patent protection. Indeed, developing countries without effective patent protection have already started producing their own versions of patented AIDS products, including India and Brazil.

An additional indication that prices are not the major barrier to access to drugs is shown by the experiences of several companies when they instituted the programs (mentioned specifically above) to donate their products for free or at dramatically reduced prices. Drugs that had been offered at a zero price could not find their way to patients until the barriers and issues were addressed that constituted the real obstacles. The targeted populations could only receive the drugs they needed after national governments and international agencies undertook concrete actions to ameliorate these barriers to access.

One would expect that, if intellectual property protection were really a barrier to access that some claim that it is, there should be no problem for the population of these countries to obtain drugs at "affordable" prices. However, the evidence shows otherwise: Again, why is it that in India -- where patent protection is not required by TRIPS and where unprotected copies of AIDS drugs (patented in Europe and elsewhere) are available from

a number of local producers –that there is a drug access problem and the AIDS epidemic is reaching alarming proportions?

Accepting the alleged, but spurious, links between intellectual property rights, prices, and access to pharmaceuticals could lead political decision-makers to institute policies such as parallel trade and compulsory licensing, which destroy the basis upon which further scientific progress is based: intellectual property rights. By threatening to take away the fruits of innovative companies' labor, the advocates of compulsory licensing and other attacks on intellectual property rights are driving research-based companies away from working on diseases particularly affecting developing countries. If there are to be cures and vaccines for diseases and conditions that are currently incurable or untreatable, further research must be protected and encouraged. After all, before one can realistically talk about gaining access to drugs and vaccines, these substances first need to be discovered, developed, tested and registered, a costly process taking years to accomplish. Without protection, companies simply cannot devote the huge resources (literally hundreds of millions of dollars) necessary for bringing new products to market.

V. Conclusions and Recommendations

Industry, which has much experience -- not only in developing the drugs available today to patients everywhere and in developing the drugs and vaccines in the pipeline for tomorrow's use – but also in health care delivery systems experience which can be brought to the table if asked to do so – firmly insists that there are a number of key elements to resolving the AIDS crisis. They are:

1) Partnerships among public institutions and with the private sector is the only effective route. Recognize that no single solution will solve this problem. We in industry are working on more effective therapies and vaccines, but delivery will be a critical problem and this involves several key issues, including the following:

2) Political commitment and concrete actions by countries affected to prevent the spread of AIDS and to treat those affected. Raising AIDS awareness and as a priority is vital. Prevention through education must be a high priority. Regarding funding, as UNAIDS' Executive Director has noted, pumping money into a country where AIDS is a low priority will not end the epidemic. "If a country does not recognize that it has an AIDS problem, then it is not willing to take on the tough questions," Dr Piot said. "Outside support for something that can only be solved from the inside will not work." Figures in 1997 show that international aid paid for the bulk of the millions spent on AIDS prevention in Africa in 1997. Uganda accounted for much of the money that the African countries spent. National priorities in Africa need to be shifted away from arms and weapons towards healthcare, including AIDS care, if this epidemic is to be fought effectively.

3) International funding is needed to meet the crisis: Bridging the cost gap, in the case of drugs and future vaccines, between costs and prices of AIDS products and what people in poorer countries can afford will need new international financial support.

4) Infrastructure and distribution improvements: So much of current drug supplies are wasted. Why is it that the price paid by a patient for quality AIDS and other drugs in parts of Africa and other developing countries is three to five or more times the price received by the manufacturer – because of the level of taxes, tariffs, monopolistic distribution systems, etc. -- so that if you were to cut the manufacturers' price by, say, 50%, patients would not significantly benefit; and then if you counted in the cost of the health support services needed for AIDS treatments, a drug price reduction may not reduce overall costs of delivery at all.

5) Serious Partnerships: Our companies have been working with UNAIDS and countries on the pilot projects by supplying medicines and expertise in their use. Industry knows that it must contribute in this extraordinary crisis. But true partnership is required, not one-way partnership. For example, not all countries have responded positively to mother-to-child program offers of medicines, even at discounted prices. It seems that some countries prefer to use legalistic approaches to undermine patents instead of working together with industry. Partnership means we all must be committed. As a sign of the seriousness which the industry gives to partnership efforts, IFPMA and major pharmaceutical companies have represented the research-based pharmaceutical industry in deliberations of the International Partnership Against AIDS in Africa organized by UNAIDS, most recently in New York at a meeting convened by UN Secretary-General Kofi Annan. This partnership brings together stakeholders in this issue, including donor countries, NGOs, the private sector and the African countries themselves. It is our hope that this dialogue will create effective and practical ways for all of us to work together to fight the AIDS menace.

6) One of the most critical elements of a global strategy is fostering continued innovation through academic and industrial R&D. The industry has responded to the need for AIDS medicines and has spent billions of dollars to make current treatments available; but we are not there yet. We do not yet have a cure. We do not have a vaccine. We are working on them. Over 100 new medicines are in the industry's development pipeline, including second-generation protease inhibitors, new drugs for opportunistic infections and vaccines against HIV. But without a strong patent system we would not have these medicines today or in the future. Attacking patents on AIDS medicines would means causing industrial R&D to shift away from AIDS research to more research on heart disease, cancer, depression, etc. The only winner in a strategy to weaken patents is the industrial copier or parallel trader, and the loser is the AIDS patient worldwide who is waiting for help.

One caveat must be raised here. We cannot, in addressing the AIDS crisis, neglect the importance of addressing other serious threats to the health of Africa and other poor regions of the world. Malaria, TB, hepatitis, respiratory ailments and other diseases may become equal dangers in the future. I urge the Congress and Administration to support public-private initiatives such as the Medicines for Malaria Venture and the Global Alliance for Vaccines and Immunization. Let's also explore new vehicles for developing new vaccines and drugs taking the tax credit and market exclusivity aspects of the US Orphan Drug legislation as examples of possible approaches that may be needed in addition to traditional patent protection.

In closing, I want to convey the desire of the R&D pharmaceutical industry that IFPMA represents to work more with countries, WHO, UNAIDS and other parties on this most serious matter for Africa. With resolve and with positive partnerships, we believe that we all can make a real difference.

Peter Lurie

More About Public Citizen

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Founded by Ralph Nader in 1971, Public Citizen is the consumer's eyes and ears in Washington. With the support of more than 150,000 people like you, we fight for safer drugs and medical devices, cleaner and safer energy sources, a cleaner environment, fair trade, and a more open and democratic government.

We stand up for you against thousands of special interest lobbyists in Washington -- well-heeled agents for drug companies, the automakers, big energy interests, and the like. Our budget is small by comparison. But Public Citizen is respected and effective, precisely because we accept no government or corporate support. We speak only for you.

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CONGRESS WATCH champions consumer and citizen interests before the U.S. Congress. Among other issues, Congress Watch lobbies to strengthen protection of the public's health and safety and the environment; demands an end to corporate subsidies; fights to preserve citizen access to the courts to redress corporate wrongdoing; and seeks to ensure a strong democracy by exposing the harmful impact of money in politics and advocating for comprehensive campaign finance reform.

THE HEALTH RESEARCH GROUP fights for safe foods, drugs and medical devices; for greater consumer control over personal health decisions; and for universal access to quality health care. As the country's leading consumer watchdog group on health issues, HRG has exposed the tobacco industry's pervasive influence on Capitol Hill, the failure of state medical boards to discipline incompetent doctors, and the unnecessarily high rate of caesarean section deliveries.

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THE CRITICAL MASS ENERGY PROJECT is a powerful voice in the movement to decrease reliance on nuclear and fossil fuels and to promote safe, economical, and environmentally sound energy use through conservation and renewable sources. Critical Mass prepares and disseminates reports, lobbies Congress, and acts as a watchdog of key federal and state energy regulatory agencies.

GLOBAL TRADE WATCH leads the way in educating the American public about the enormous impact of international trade and economic globalization on our jobs, the environment, public health and safety and democratic accountabilty. Global Trade Watch works in defense of consumer health and safety, the environment, good jobs and democratic decision-making which are threatened by the so-called "free trade" agenda of the proponents of economic globalization.

BUYERS UP is a home heating-oil cooperative group buying program that acts as an information resource on home energy and environmental issues. Its reports have yielded important data on the over-promotion of high-octane gasoline by the oil companies, and the failure of many states to ensure the quality of gasoline sold to consumers.

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Senate Committee on Foreign Relations
Subcommittee on African Affairs

Hearing on AIDS in Africa

419 Dirksen Senate Office Building
2:30PM – 6:00PM

Panel 1: Senator J. Robert Kerrey (D-Nebraska)

Senator Gordon H. Smith (R-Oregon)

Senator Barbara Boxer (D-California)

Senator Richard J. Durbin (D-Illinois)

Panel 2: Surgeon General David Satcher, M.D.

Sandra Thurman
(You will both give opening remarks and then have Q and A. Dr. Satcher has to catch a plane.)

Panel 3: Jeffrey Sachs, Director, Harvard Institute for International Development

Harvey Bale, Director General, International Federation of Pharmaceutical Manufacturers Association

Peter Lurie, M.D., MPH, Public Citizen

Panel 4: Frank Graham, Samaritan's Purse (Faith-based NGO in Africa)

Father Angelo D'Agostino, Nyumbani Orphanage

BRIEFING FOR TESTIMONY BEFORE THE

SENATE COMMITTEE ON FOREIGN RELATIONS

SUBCOMMITTEE ON AFRICAN AFFAIRS

TOPIC: AIDS IN AFRICA

FEBRUARY 24, 2000 – 2:30PM

419 DIRKSEN SENATE OFFICE BUILDING

SANDRA L. THURMAN
DIRECTOR
OFFICE OF NATIONAL AIDS POLICY

Short

Testimony by

Sandra Thurman
Director, Office of National AIDS Policy

Before the

Senate Committee on Foreign Relations
Subcommittee on African Affairs

February 24, 2000

Mr. Chairman and other members of this Subcommittee and Full 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.

We have heard your colleagues and our Surgeon General lay out a vivid picture of the scope of this tragedy – particularly as it relates to the public health crisis. I would like to use my time with you to talk about 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. But unlike other wars – it is women and children that are increasingly caught in the crossfire of this relentless epidemic.

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 in Africa 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.

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, and driving down GNP. Dr. Sachs will address the economic impact of the epidemic in detail a little later.

AIDS is also effecting stability in the region. As you all know, the UN Security Council recently held a day-long meeting on HIV/AIDS. This historic event highlighted the growing awareness that AIDS is a security threat that requires a global mobilization. This reality was also addressed in a report recently released by the National Intelligence Council, which documents that the impact of this pandemic is far more serious a threat than we thought.

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.

It is important to remember that what we are talking about today is not numbers but names, not facts and figures but faces and families. Let me tell you the story of one inspirational grandmother I met in a small village outside of Masaka, Uganda.

Bernadette has lost 10 of her 11 adult children to AIDS. Today, at age 70, she is caring for her 35 grandchildren. With loans from a village banking system, she has begun growing sweet potatoes, beans, and maize, raising goats and pigs, and trading in sugar and cooking oil.

With the money she earns, she is now able to send 15 of her grandchildren to school, provide modest treatment for the 5 who are HIV+, and begin construction on a house big enough to sleep them all. In her spare time, she participates in an organization called "United Women's Effort to Save Orphans" – founded by the first lady of Uganda, Mrs. Museveni – linking in solidarity thousands of women allied in the same great struggle.

And these women are not alone. From the young people doing street theater in Lusaka to educate their peers about HIV to the support groups in Soweto providing home and community based care for people living with AIDS – communities are mobilizing and creating ripples of hope.

These are the faces of children and families living in a world with AIDS. And their spirit, their determination, and their resilience lead us on.

The good news is, 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 countries, and the suffering of citizens in our global village touches us all.

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 to enhance our global AIDS efforts.

This new initiative provides for a series of steps to increase US leadership through support for some of the extraordinary community-based programs currently being funded through USAID 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** – particularly stigma reduction strategies, especially for women and young people, including: HIV education, voluntary counseling and testing, and interventions to reduce mother-to-child transmission.
- **Home and community-based care** – This will help to create and enhance counseling and support systems, and to provide some basic medical care (including treatment for related illnesses like STDs and TB).

- **Care of children orphaned by AIDS** – 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.

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, and to engage the private sector, including business, labor, foundations, the religious community and other non-governmental 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 requested, in the President's 2001 Budget submission, an additional $100 million increase to enhance and expand our efforts to combat AIDS in Africa and around the world. These funds will enable us to bolster our efforts already underway at USAID and CDC, and to expand our approach to include the Departments of Labor and Defense for efforts to address HIV/AIDS transmission in the workplace and in the military.

Let me repeat, however, that the United States cannot and should not do this alone. This crisis will require engagement from all segments of all societies working together. Every bi-lateral donor, every international 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 the tide. It can be done.

The bottom line is this: We have no vaccine or cure in sight, and we are at the beginning of a global pandemic, 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 Newly Independent States of the Former Soviet Union. There must be a sense of urgency to work together with our partners in Africa and around the world to learn from the experiences there and to share the successes and avoid the failures in countries now standing on the brink of disaster. Millions of lives – perhaps hundreds of millions of lives – hang in the balance.

We look forward to working closely with each and every one of 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.

OFFICE OF NATIONAL AIDS POLICY
EXECUTIVE OFFICE OF THE PRESIDENT
THE WHITE HOUSE

FOR IMMEDIATE RELEASE
February 8, 2000

Contact: (202) 456-2437

AIDS Czar Praises FY 2001 Budget Request for AIDS Care, Prevention, and Research

WASHINGTON, DC – Saying that it is clear that this Administration remains committed to addressing HIV and AIDS in the U.S. and abroad, Sandra Thurman, Director of the White House Office of National AIDS Policy, stated: "The Clinton/Gore Administration continues to meet the challenge both here and abroad head on. We must all remember that we are at the beginning and not the end of a relentless pandemic. The Administration's Fiscal Year 2001 budget moves forward on several fronts including prevention, care and treatment (for both new treatments and an effective vaccine), and housing, as well as in our global battle against HIV/AIDS."

Citing an 8 percent increase in Ryan White CARE funding, Ms. Thurman said, "this increase continues the progress we have made in bringing community-based care and treatment to individuals and families living with HIV/AIDS. Working to ensure that those who cannot afford health care are able to receive it helps us meet our obligation to those in need. The Ryan White CARE Act is our nation's premier AIDS program and a model for the world. This Administration remains committed not only to its increased funding but also to its swift reauthorization. This program has always received broad-based bipartisan support in Washington, and in States, cities and communities across the country – and I trust that cooperation and partnership will continue."

Additional funding for AIDS-related research at the National Institutes of Health will "help continue our efforts to find effective treatments, search for a vaccine, and study behaviors which place people at risk for infection with HIV." "Our commitment to research continues," said Ms. Thurman.

Other highlights of the FY 2001 budget request as it relates to HIV/AIDS include:

- ✓ Funding for the Ryan White CARE Act, which helps cities and states care for those living with HIV and AIDS, is increased $125 million to $1,719.8 million (8% over last year and 472$ since 1993.
- ✓ HIV prevention funding to the Centers for Disease Control and Prevention is increased by $65 million to $795 million (9% over last year and 59% since FY 1993).
- ✓ AIDS research funding to the National Institutes of Health will go up by approximately $87 million to $2,111 million (4% over last year and 98% since FY 1993).
- ✓ Funding for substance abuse services targeting those at highest risk of HIV infection, through the Substance Abuse and Mental Health Services Administration (SAMHSA) is increased by $6 million to $128 million (5% over last year and 132% since FY 1993)
- ✓ The Housing Opportunities for People With AIDS (HOPWA) Program at the Department of Housing and Urban Development request is $260 million, a $28.0 million increase (12% over last year and 132% since FY 1993).
- ✓ In support of Vice-President Al Gore's historic presentation the United Nation's Security Council in which he presented HIV/AIDS as a international security concern, an increase of $100 million is being requested to enhance the Administration's efforts on global AIDS, including funding efforts through the Centers for Disease Control and Prevention, Department of Defense, Department of Labor and the U.S. Agency for International Development.

Ms. Thurman said she is eager to continue to work with Congress, and applauded the bipartisan support that HIV/AIDS funding has received in the past. Ms. Thurman said, "AIDS continues to be a very real, very human tragedy. Now, more than ever, we must enhance our efforts. With 40,000 Americans being infected every year – and almost half of them under the age of 25 and more than one-half from communities of color, we must do more. And because we are a global community and because the global battle against AIDS is a shared responsibility, we must do more. We owe it to ourselves, our children and our future.

See attached chart for specific information on AIDS program increases.

##30##

Selected AIDS Programs *(in millions)*	FY93	FY00*	FY01 *	Change Since FY00		Change Since FY93		Minority Initiative*	Minority Initiative Change
Food and Drug Administration	**$ 73.0**	**$ 70.0**	**$ 70**	**$ 0**	**-4%**	**0**	**-4%**		
Health Resources and Services Administration									
Ryan White	**$ 364.4**	**$ 1,594.6**	**$ 1719.6**	**$ 125**	**8%**	**$ 1,355.2**	**472%**	$ 74.1	**$0**
Title I - Metropolitan Areas		$ 546.5	$ 586.5	40	7.3%				
Title II - AIDS Drug Assistance Program		$ 528.0	$ 554	26	4.9%				
Title II - non-ADAP		$ 296.0	$ 310	14	4.&%				
Title III - Early Intervention Clinics		$ 9138.4	$ 171.4	33	17%				
Title IV - Pediatric and Youth		$ 51.0	$ 60	9	17.6%				
Title V - Dental		$8.0	$ 85	.5	6.25%				
AIDS Education and Training Centers		$ 26.7	$ 29.15	2.45	9.2				
Other			**$ 5,219.7**						
HHS Office of the Secretary			$ 50					**$ 50**	**0**
Office of Minority Health			$ 9.7					**$ 9.7**	**0**
Centers for Disease Control and Prevention	**$ 498.0**	**$ 730.0**	**$ ***795.0**	**65.0**	**8.9%**	**297**	**59.6%**		
Global AIDS Initiative		$ 35.0	$ **26						
Community Planning		$ 277.6	***						
Minority AIDS Initiative		$ 60.6	***70.6					$ 70.6	10
Other Prevention		$ 357.6	***						
National Institutes of Health - AIDS Research	**$ 1,071.0**	**$ **2,170.0**	**$ 2111.1**	**87.1**	**4.0%**	**1040.1**	**98%**	**$ 7.2**	**$ -1.5**
Substance Abuse and Mental Health Services Admin.	**$ 55.0**	**$ 122.0**	**$ 128.0**	**$ 6.0**	**5%**	**$73.0**	**132%**	**$ 62.7**	**$ 15**
Housing and Urban Development - HOPWA	**$ 100.0**	**$ 232.0**	**$ 260.0**	**$ 28.0**	**12%**	**$160.00**	**160%**		
Total	**$ 2,161.4**	**$ 4,781.6**	**$ 5219.7**	**$ 438.0**	**7.6%**	**$2,984.2**	**138%**	**$ 274.3**	**$ 23.5 (+9.4%)**

*Includes $274 in funding for the Minority AIDS Initiative which is detailed in the last two columns.
**Does not include $10 million in funding allocated each to the Departments of Labor and Defense, nor $54 million allocated to US Agency for International Development.
**Estimates based on overall increase in funding – specific allocations have not yet been finalized.

Reps/murguia/2001budgetchart

Testimony by

Sandra Thurman
Director, Office of National AIDS Policy

Before the

Senate Committee on Foreign Relations
Subcommittee on African Affairs

February 24, 2000

Mr. Chairman and other members of this Subcommittee and Full 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.

We have heard your colleagues and our Surgeon General lay out a vivid picture of the scope of this tragedy – particularly as it relates to the public health crisis. I would like to use my time with you to talk about 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. But unlike other wars – it is women and children that are increasingly caught in the crossfire of this relentless epidemic.

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 in Africa 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, and driving down 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 already 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 effecting stability in the region. As you all know, the UN Security Council recently held a day-long meeting on HIV/AIDS. This historic event highlighted the growing awareness that AIDS is a security threat that requires a global mobilization. This reality was also addressed in a report recently released by the National Intelligence Council. The Report draws several very disturbing conclusions including the following:

- The epidemic is far worse than predicted.
- 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% or more 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 already 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.

It is important to remember that what we are talking about today is not numbers but names, not facts and figures but faces and families. Let me tell you the story of one inspirational grandmother I met in a small village outside of Masaka, Uganda.

Bernadette has lost 10 of her 11 adult children to AIDS. Today, at age 70, she is caring for her 35 grandchildren. With loans from a village banking system, she has begun growing sweet potatoes, beans, and maize, raising goats and pigs, and trading in sugar and cooking oil.

With the money she earns, she is now able to send 15 of her grandchildren to school, provide modest treatment for the 5 who are HIV+, and begin construction on a house

big enough to sleep them all. In her spare time, she participates in an organization called "United Women's Effort to Save Orphans" – founded by the first lady of Uganda, Mrs. Museveni – linking in solidarity thousands of women allied in the same great struggle.

And these women are not alone. From the young people doing street theater in Lusaka to educate their peers about HIV to the support groups in Soweto providing home and community based care for people living with AIDS – communities are mobilizing and creating ripples of hope.

These are the faces of children and families living in a world with AIDS. And their spirit, their determination, and their resilience lead us on.

The good news is, 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 Joint United Nations Programme on HIV/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 to enhance our global AIDS efforts.

This new initiative provides for a series of steps to increase US leadership through support for some of the extraordinary community-based programs currently being funded through USAID 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 requested, in the President's 2001 Budget submission, an additional $100 million increase to enhance and expand our efforts to combat AIDS in Africa and around the world. These funds will enable us to bolster our efforts already underway at USAID and CDC, and to expand our approach to include the Departments of Labor and Defense for efforts to address HIV/AIDS transmission in the workplace and in the military.

Let me repeat, however, that the United States cannot and should not do this alone. This crisis will require engagement from all segments of all societies working together. Every bi-lateral donor, every international lending agency, the corporate community, the foundation community, the religious community and every African government must do their part to provide the leadership and resources necessary to turn the tide. It can be done.

The bottom line is this: We have no vaccine or cure in sight, and we are at the beginning of a global pandemic, 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 Newly Independent States of the Former Soviet Union. There must be a sense of urgency to work together with our partners in Africa and around the world to learn from the experiences there and

to share the successes and avoid the failures in countries now standing on the brink of disaster. Millions of lives – perhaps hundreds of millions of lives – hang in the balance.

We look forward to working closely with each and every one of 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.

testimony to deliver

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Director, Office of National AIDS Policy

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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 in Africa 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.

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, and driving down GNP. Dr. Sachs will address the economic impact of the epidemic in detail a little later.

AIDS is also effecting stability in the region. As you all know, the UN Security Council recently held a day-long meeting on HIV/AIDS. This historic event highlighted the growing awareness that AIDS is a security threat that requires a global mobilization. This reality was also addressed in a report recently released by the National Intelligence Council, which documents that the impact of this pandemic is far more serious a threat than we thought.

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 –

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The good news is, 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.

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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 to enhance our global AIDS efforts.

This new initiative provides for a series of steps to increase US leadership through support for some of the extraordinary community-based programs currently being funded through USAID 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** – particularly stigma reduction strategies, especially for women and young people, including: HIV education, voluntary counseling and testing, and interventions to reduce mother-to-child transmission.
- **Home and community-based care** – This will help to create and enhance counseling and support systems, and to provide some basic medical care (including treatment for related illnesses like STDs and TB).

- **Care of children orphaned by AIDS** – 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.

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, and to engage the private sector, including business, labor, foundations, the religious community and other non-governmental 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 requested, in the President's 2001 Budget submission, an additional $100 million increase to enhance and expand our efforts to combat AIDS in Africa and around the world. These funds will enable us to bolster our efforts already underway at USAID and CDC, and to expand our approach to include the Departments of Labor and Defense for efforts to address HIV/AIDS transmission in the workplace and in the military.

Let me repeat, however, that the United States cannot and should not do this alone. This crisis will require engagement from all segments of all societies working together. Every bi-lateral donor, every international 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 the tide. It can be done.

The bottom line is this: We have no vaccine or cure in sight, and we are at the beginning of a global pandemic, 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 Newly Independent States of the Former Soviet Union. There must be a sense of urgency to work together with our partners in Africa and around the world to learn from the experiences there and to share the successes and avoid the failures in countries now standing on the brink of disaster. Millions of lives – perhaps hundreds of millions of lives – hang in the balance.

We look forward to working closely with each and every one of 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.

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Thank you.

bios of members

Subcommittee on African Affairs

1. Senator Joseph R. Biden (D-Delaware)
2. Senator Sam Brownback (R-Kansas)
3. Senator Russell D. Feingold (D-Wisconsin)
4. Senator Bill Frist, M.D., Chair (R-Tennessee)
5. Senator Rod Grams (R-Minnesota)
6. Senator Jesse Helms (R-North Carolina)
7. Senator Sarbanes (D-Maryland)

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3. Senator Senator Bill Frist, M.D., Chair (R-Tennessee)
4. Senator Rod Grams (R-Minnesota)
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Subcommittees of the Senate Committee on Foreign Relations

- Subcommittee on African Affairs
- Subcommittee on East Asian and Pacific Affairs
- Subcommittee on European Affairs
- Subcommittee on International Economic Policy, Export and Trade Promotion
- Subcommittee on International Operations
- Subcommittee on Near Eastern and South Asian Affairs
- Subcommittee on Subcommittee on Western Hemisphere, Peace Corps, Narcotics and Terrorism

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*The Chairman and Ranking Minority Member of the full committee are ex officio members of each subcommittee on which they do not serve as members.

Subcommittee on African Affairs

Bill Frist, Chair
Rod Grams
Sam Brownback

Russell D. Feingold, Ranking
Paul S. Sarbanes

The subcommittee has geographic responsibilities corresponding to those of the Bureau of African Affairs in the Department of State. The subcommittee considers all matters and problems relating to Africa, with the exception of countries bordering on the Mediterranean Sea from Egypt to Morocco, which are under the purview of the Subcommittee on Near Eastern Affairs.

This subcommittee's responsibilities include all matters, problems and policies involving promotion of U.S. trade and export; terrorism, crime and the flow of illegal drugs; and oversight over U.S. foreign assistance programs that fall within this subcommittee's regional jurisdiction.

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Subcommittee on East Asian and Pacific Affairs

Craig Thomas, Chair
Jesse Helms
Chuck Hagel
Gordon H. Smith
Lincoln D. Chafee

John F. Kerry, Ranking
Russell D. Feingold
Paul D. Wellstone
Robert G. Torricelli

The geographic scope of the subcommittee extends from China and Mongolia to Burma, inclusive of the mainland of Asia, Japan, Taiwan, Hong Kong, the Philippines, Malaysia, Indonesia, Australia and New Zealand, Oceania, and the South Pacific Islands.

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1

Divider Title: _____

Joseph R. Biden

UNITED STATES SENATOR-DELAWARE

Biography

Joseph R. Biden, Jr., has served in the United States Senate since January, 1973. Now the senior Democrat on the Foreign Relations Committee and a member of the Judiciary Committee, he has earned national and international recognition as a policy innovator, effective legislator and party spokesman on issues ranging from international relations and arms control to crime prevention and drug control.

In the Senate, Biden served as Chairman of the Judiciary Committee from 1987 to 1995, and ranking member from 1995 to 1997. He is now the ranking Democrat on the Subcommittee on Youth Violence and co-chairs the Senate Caucus on International Narcotics Control.

Biden is a leader on anti-crime and drug policy. He has authored every major piece of crime legislation this decade, including the Violent Crime Control and Law Enforcement Act, which was signed into law in 1994. The Act includes his Violence Against Women Act, the first comprehensive law to address gender-based crimes. Biden also wrote the law creating the nation's "drug czar," which mandates a national drug control policy. He continues to work to control new drugs such as Ketamine and Rohypnol.

In January, 1997, Biden became the ranking Democrat on the Senate Foreign Relations Committee. A member of the committee since 1975, he served as Chairman and is now the ranking Democrat on the European Affairs Subcommittee. Biden is the Co-Chairman of the Senate NATO Observer Group, Vice Chairman of the Senate Delegation to the North Atlantic Assembly, and Co-Chairman of the Senate National Security Working Group.

Biden is widely recognized as one of the Senate's leading foreign policy experts, and he has published numerous editorials and articles, nationally and internationally, on international relations. Biden was among the first to predict the collapse of communism and to call for a comprehensive redefinition of American foreign policy to fit the post-Cold War world. In the spring of 1993, Senator Biden called for active American and Western leadership to contain the war and to support the Bosnian government with air power and military supplies.

In 1997, Senator Biden led the successful effort in the Senate to approve ratification of the Chemical Weapons Convention and in 1998 led the effort to expand NATO. He also has been a forceful advocate for arms control agreements and has authored legislation to curb the proliferation of weapons of mass destruction.

In 1998, *Congressional Quarterly* named Biden one of "Twelve Who Made A Difference" for playing a lead role in several foreign policy matters including NATO enlargement and the successful passage of bills to streamline our foreign affairs agencies and punish religious persecution overseas.

In May, 1999, Biden became the youngest Senator ever to cast 10,000 votes in the Senate. At that time, Senate Minority Leader Tom Daschle said: "His steel will, dedication and compassion, reinforcing a powerful intellect and impressive communication skills, have made Senator Biden an exceptional Senator."

Senator Biden grew up in New Castle County, Delaware, and graduated from the University of Delaware in 1965, and from the Syracuse University College of Law in 1968. Prior to his election to the Senate, Biden practiced law in Wilmington, Delaware, and served on the New Castle County Council from 1970 to 1972. Since 1991, Biden has been an adjunct professor at the Widener University School of Law, where he teaches a seminar in constitutional law.

Senator Biden lives in Wilmington, Delaware, and commutes to Washington when the Senate is in session. He is married to the former Jill Jacobs, and has three children: Beau, Hunter, and Ashley; and two granddaughters: Naomi and Finnegan.

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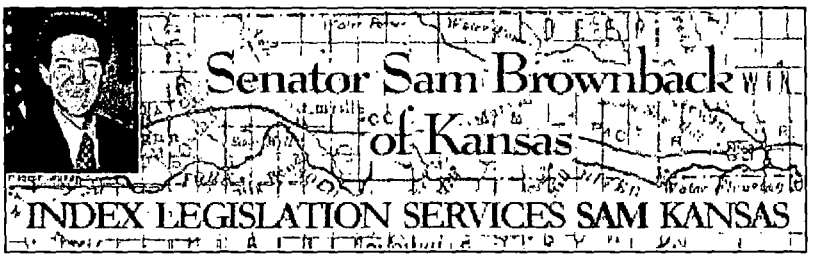

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Biography

See Also: The Brownback Family

Kansans re-elected U.S. Senator Sam Brownback, champion of working families and government reform, to a full six-year term in November 1998. Brownback was elected by a margin of 33 points in the general election, capturing 65% of the vote. First elected to the Senate in 1996 to fill the remainder of Senator Bob Dole's term, Brownback became Kansas' 32nd U.S. Senator as well as the senior senator from Kansas on January 7, 1997.

In the 106th Congress, Brownback serves on four key committees: the Committee on Health, Education, Labor and Pensions; the Committee on Commerce, Science and Transportation; the Committee on Foreign Relations; and the Joint Economic Committee.

Brownback is a leading advocate of several Congressional measures vital to Kansans and all Americans. Saving and reforming Social Security for current and future generations is a top priority for Brownback. Providing tax relief to working families through ending the marriage penalty tax and providing marginal tax rate reductions are main goals. Brownback remains committed to government reform, including paying off the national debt and changing the way the Congress produces a budget and spends our hard-earned tax dollars.

As Chairman of the Foreign Relations Subcommittee on Near Eastern and South Asian Affairs, Brownback has taken an active role in developing U.S. foreign policy in that region of the world. Brownback also forcefully advocates for trade policy supporting U.S. agriculture exports in the international marketplace.

Prior to his election to the Senate, Brownback served one term as a U.S. Congressman representing the Second District of Kansas. As a member of the House of Representatives, Brownback took a lead role among the freshman class of 1994 in pursuit of his philosophy to reduce the size and intrusiveness of the federal government, and to reform the Congress. Brownback led the New Federalists, a group of freshmen members who called for free-market reforms and legislation to reduce the regulatory and tax burdens imposed by the federal government.

Sam Brownback was born September 12, 1956, and grew up on the family farm near Parker, Kansas, where he still owns farmland and enjoys helping out with the chores. Brownback received a Bachelor of Science degree with honors in Agricultural Economics from Kansas State University, and a law degree from the University of Kansas. While at K-State, he was elected student body president and served as state president and as a national officer of the Future Farmers of America.

Through his career, Brownback has worked as an administrator, broadcaster, attorney, teacher, and author. As secretary of agriculture for the state of Kansas, Brownback developed innovative programs which significantly reduced public expenditures and expanded markets for Kansas products.

Brownback is the co-author of two books and numerous articles. He is a frequent lecturer on trade, agriculture, leadership, and motivation. He and his wife Mary have four children, Abby, Andy, Liz, and Mark, and they live in Topeka.

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Russ Feingold

U.S. SENATOR FROM WISCONSIN

Welcome to my home page! I hope you find this to be a useful resource to learn more about my efforts to represent the State of Wisconsin in the United States Senate.

I hope you will check out my Issues section, where you can learn more about my work on reducing the deficit and cutting wasteful spending, protecting social security and fighting for Wisconsin families, just to name a few.

Thanks for visiting. I hope you leave feeling you know more about me and the work I do representing the people of Wisconsin. To find out how to contact me or my staff, please click here.

Please feel free to email me with any questions or comments.

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Russ Feingold

U.S. SENATOR FROM WISCONSIN

BIOGRAPHY

Personal:

Born:	March 2, 1953, Janesville, Wisconsin
Spouse:	Mary Feingold
Children:	Russ's Children: Jessica Feingold, born 3/29/80; Ellen Feingold, born 3/8/83 Mary's Children: Sam Speerschneider, born 12/1/80; Ted Speerschneider, born 3/8/83
Residence:	Middleton, Wisconsin
Parents:	Leon Feingold: Attorney, Janesville (1912-1980) Sylvia Feingold: ret. (former abstractor), Janesville
	The Feingold family has lived in South-Central Wisconsin since 1917

Employment:

Jan. 1993 to present:	United States Senator Member, Committee on the Judiciary Member, Committee on Foreign Relations Member, Committee on Budget Member, Special Committee on Aging Member, Democratic Policy Committee
Jan. 1983 to Jan. 1993	State Senator for Wisconsin's 27th Senate District Chairman of Senate Committee on Aging, Banking, Communications and Taxation Vice Chairman of Senate Committee on Judiciary and Consumer Affairs Member of Senate Committee on Agriculture, Corrections, Health and Human Services
Aug. 1985 to Jan. 1993	Visiting professor at Beloit College on "The Law and Politics of Censorship"
June 1979 to Jan. 1985	Practicing attorney (litigation) with Foley & Lardner, and with LaFollette & Sinykin both in Madison, Wisconsin

Education:

Graduated June 1979	Harvard University Law School, Cambridge, MA, Juris Doctor with honors
Graduated July 1977	Oxford University, Magdalen College, Oxford, England. Rhodes Scholar, first-class honors in Final Honours, School of Jurisprudence
Graduated May 1975	University of Wisconsin-Madison, Bachelor of Arts with honors in history and political science
Graduated June 1971	Janesville Craig High School

Awards From:

ABATE of Wisconsin, Inc's Award, 1994, 1995, 1996

Coalition of Wisconsin Aging Groups, *Community Building Award*, 1988, 1992

Concerned Consumers League, *Sheridan McCabe Memorial Award*, 1990

Concord Coalition, *Deficit Hawk Award*, 1994, 1997; *Deficit Reduction Honor Roll*, 1993 and 1998

Disabled American Veterans Wisconsin Veterans Department Award, 1989

Friend of the Family Farm, *Family Farm Award*, 1985, 1995

Home Care Leadership Award, 1999

Long Term Care Campaign, *Claude Pepper Legislative Leadership Award*, 1997

Lutheran Social Services, *Leadership Award*, 1996

Milwaukee Minority Business and Development Center Award, 1992

National Association of Police Organizations, *Senator of the Year Award*, 1997

National Association for Home Care, *"Champion of Home Health"*, April/May 1998

National Fair Housing Alliance, *Award for Excellence*, 1996

National Farmers Union, *Voting Achievement Appreciation Award*, 1994, 1995, 1996

Taxpayers for Common Sense Action, *Taxpayer Hero*, 1997, 1998

Vietnam Veterans of America, *Government Affairs Special Recognition Award*, 1998

Wisconsin Alzheimer's Information and Training Center, *Advisory Council's Legislative Advocacy Award*, 1989

Wisconsin Department of Public Instruction, *Friend of Education Award*, 1992

Wisconsin Environmental Decade, *Clean Sixteen Award*, 1987-88, 1989-90 and 1991-92

Wisconsin State Council of Vietnam Veterans of America, *Distinguished Achievement Award*, 1993; *Legislator of the Year*, 1997

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UNITED STATES SENATE

Bill Frist, M.D.

United States Senator, Tennessee

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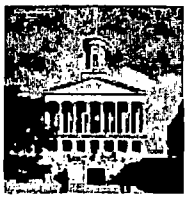

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Frist Applauds Erosion Control Work of Shiloh National Military Park

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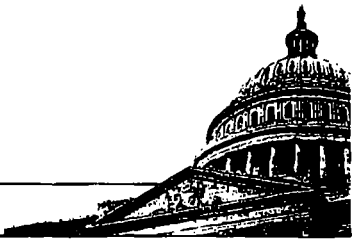
Bill Frist

UNITED STATES SENATOR • TENNESSEE



U.S. SENATOR BILL FRIST, M.D.
BIOGRAPHY

On November 8, 1994, Bill Frist was elected to the United States Senate. The only challenger to defeat a full-term incumbent Senator in the 1994 elections, he became the first practicing physician to join the Senate since 1928. A fourth generation Tennessean, Frist was born February 22, 1952, and raised in Nashville. He and his wife Karyn have three sons, Harrison, Jonathan and Bryan. They are Presbyterians.

Graduating from Princeton University in 1974, Frist specialized in health care policy at the Woodrow Wilson School of Public and International Affairs. He received his medical degree with honors from Harvard Medical School in 1978, after which he spent seven years in surgical training at Massachusetts General Hospital and Stanford University Medical Center. He is board-certified in both general and heart surgery.

In 1986, Bill Frist joined the teaching faculty at Vanderbilt University Medical Center in Nashville. He founded and served as Director of the multi-disciplinary Vanderbilt Transplant Center, which under his leadership became an internationally renowned center of multi-organ transplantation. In addition, as Director of the Heart and Lung Transplantation program, Frist performed hundreds of heart and lung transplant procedures. He has written over 100 articles, chapters and reports on medical research, and authored the book *Transplant* which examines the social and ethical issues of transplantation and organ donation.

With the same dedication he showed his patients, Frist serves the people of Tennessee. To hear their views, he visits all 95 counties on a regular basis. In the Senate, Frist has made education, health care and science his top priorities. In 1999, Frist was named as a Deputy Whip in the Senate leadership.

Education—Frist is committed to improving educational opportunities for all children in America. After examining the waste and duplication in federal education programs, Frist wrote and enacted "Ed-Flex" legislation. The law cuts through Washington red tape, exchanging greater local control in the use of federal funds for greater accountability in student achievement. He has held education forums statewide and introduced legislation to enhance teacher training and recruitment. He is a long-time supporter of Character Counts, which seeks to teach the importance of character to students.

Health Care—Since coming to Congress, Frist has put his medical expertise to work on a variety of critical health care issues. He was instrumental in passing the Health Insurance Reform Act, which allows people changing jobs or suffering from a pre-existing illness to maintain coverage. He wrote a bill to guarantee insurance coverage for women who require medical care for up to 48 hours after giving birth and introduced legislation to establish Medical Savings Accounts. Frist also succeeded in reforming the Food and Drug Administration to make information about lifesaving drugs more readily available. He passed bills to improve research and treatment for women's health and include organ donor cards in income tax returns. Frist's practical approach to Medicare reform resulted in a law to curb the growing costs of health care for seniors while maintaining quality by allowing doctors and hospitals to form Medicare provider groups. He also served on the National Bipartisan Commission on the Future of Medicare.

Science—Frist brings a scientific approach to government which he has applied to modernizing the government through streamlining and technology. He passed legislation to create the "Next Generation Internet," which could work up to 1000 times faster than today's Internet. Recognizing that scientific research is key to our continued economic success, he introduced legislation to double our nation's commitment to basic research and increase funding for biomedical research.

Other priorities include reducing the deficit for future generations. On the Budget Committee, he worked to pass the first balanced budget in nearly 30 years and deliver tax cuts for hardworking Americans. He continues to work to free Americans from excessive government regulations, urging additional tax relief and expanded economic opportunities for Tennessee. Fighting for his constituents, Frist authored a proposal to refinance TVA's debt and ensure that it will carry out its responsibilities without unfairly burdening ratepayers.

Frist serves on four key committees: Budget; Commerce, Science and Transportation; Health, Education, Labor and Pensions; and Foreign Relations. In addition, he is Chairman of the Subcommittees on Public Health; Science, Technology and Space; and African Affairs.

Bill Frist is a legislator whose goal is to provide effective leadership for Tennessee by bringing strong values and basic common-sense to the United States Congress.

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United States Senator

Rod Grams

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NEW **Senator Grams' November Cable TV Show - Social Security**

NEW **Senator Grams' Agricultural Action Plan**

Senator Rod Grams
257 Dirksen Senate Office Building
Washington, D.C. 20510
(202) 224-3244
(202) 228-0956 (FAX)
(202) 224-9522 (TTD/TTY)

2013 2nd Avenue North
Anoka, Minnesota 55303
(612) 427-5921
(612) 427-8872 (FAX)
(612) 427-5902 (TTD/TTY)

e-mail: mail_grams@grams.senate.gov

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Biography of Senator Grams

Senator Rod Grams (R-Minnesota) was sworn in as a member of the U.S. Senate on January 4, 1995. A champion of taxpayers and the middle class, Grams' priorities focus on downsizing government and making it more effective, cutting taxes, and providing a safer environment for our children.

Through his appointment to four key Senate committees, Grams has a direct impact on issues of Minnesota, national, and global importance. In the 105th Congress, Grams serves as Chairman of the Subcommittee on International Operations of the Senate Foreign Relations Committee and as Chairman of the Subcommittee on Securities of the Senate Committee on Banking, Housing, and Urban Affairs. Grams also serves on the Senate Committee on the Budget, and the Joint Economic Committee. In addition, Grams chairs the Senate Medical Device and Technology Caucus and was appointed by the Majority Leader to the Senate's Task Forces on the Workplace and Judicial Nominations.

Grams has twice been appointed by President Clinton and confirmed by the U.S. Senate to serve as a Congressional Delegate to the U.N. General Assembly, in 1996 and 1998.

Prior to his election to the U.S. Senate, Grams was elected in 1992 to represent Minnesota's Sixth District in Congress. In an impressive first term, Grams earned a reputation as a leader on budget and tax issues. It was Grams' "Families First" plan and its $500 per-child tax credit centerpiece which House and Senate Republicans chose as the framework for the 1994 Republican budget alternative. Grams was also elected by his freshman Republican colleagues to serve as freshman Republican Whip for the 103rd Congress.

Grams spent 23 years in the field of television and radio broadcasting before his entrance into political service. For 18 of those years, he worked as a producer and anchorman for several television stations. From 1982 to 1991 he was the senior news anchor at KMSP-TV in Minneapolis/St. Paul. Prior to that, he worked as a news anchor/producer for KFBB-TV-TV in Great Falls, Montana; WSAU-TV in Wausau, Wisconsin; and WIFR-TV in Rockford, Illinois. Prior to his broadcasting career, he worked seven years for an engineering consulting firm.

In 1985, Grams formed Sun Ridge Builders, a Twin Cities construction and residential development company, serving as its President and CEO. In addition to running the company, he was involved in architectural design and has been particularly interested in the use of solar energy in residential homes.

Grams was born February 4, 1948, in Princeton, Minnesota, and was raised on a dairy farm about 50 miles north of the Twin Cities. He attended St. Francis High School in Anoka County, Anoka-Ramsey Junior College, Brown Institute in Minneapolis, and Carroll College in Helena, Montana.

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