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U.S. Senator
JESSE HELMS
(R-NC)

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Welcome to my Homepage on the Intern

I genuinely appreciate your stopping by my homepage, a you will find the information helpful.

Please feel free to contact me via the internet -- and do le when I can be helpful to you.

Jesse Helms

jesse_helms@helms.senate.gov

Senator Helms protests that his resume is too long. However, since his has been a somewhat varied career, I feel that different aspects will be of interest to different people who make inquiry of us.

---- *Jimmy Broughton, Administrative Assistant*

Senator Helms was born in Monroe, North Carolina on October 18, 1921. He attended the Monroe public schools, Wingate (NC) Junior College and Wake Forest College. He holds honorary Doctor of Law degrees from Bob Jones University, Greenville, South Carolina and Grove City College, Grove City, Pennsylvania and he has received Honorary Degrees from Campbell University, Buies Creek, North Carolina, and Wingate University, Wingate, North Carolina.

He served in the U.S. Navy from 1942 through 1945. After WWII, he became the city editor of The Raleigh Times, and later, Director of News and Programs for the Tobacco Radio Network and Radio Station WRAL, in Raleigh.

He served as Administrative Assistant to United States Senator Willis Smith from 1951 to 1953 and United States Senator Alton Lennon in 1953.

In 1952, Mr. Helms directed the radio-television division of the presidential campaign of Senator Richard B. Russell of Georgia, who was seeking the Democratic Party nomination.

From 1953 through 1960, Mr. Helms was Executive Director of the North Carolina Bankers Association, and served as editor of the Tarheel Banker, which became the largest state banking publication in America under his stewardship.

He was Executive Vice President, Vice Chairman of the Board and assistant Chief Executive Officer of Capitol Broadcasting Company, Raleigh, North Carolina, from 1960 until his election to the Senate. From 1960 until he filed for the Senate in 1972, Mr. Helms wrote and presented daily editorials on WRAL-TV and the Tobacco Radio Network. His editorials were printed regularly in more than 200 newspapers throughout the United States. They were broadcast by more than 70 radio stations in North Carolina.

He served two two-year terms on the Raleigh City Council. During the four years, 1957 to 1961, he served as Chairman of the Council's Law and Finance Committee. He is past president of the Raleigh Rotary Club, and the Raleigh Executives Club. He is a 33rd degree Mason, Grand Lodge of Masons of North Carolina (Grand Orator, 1965, 1982, and 1991) and is a member of the Shrine.

He has served as the Director of the North Carolina Cerebral Palsy Hospital in Durham, the Director of the United Cerebral Palsy of North Carolina, and the Director of the Wake County Cerebral Palsy and Rehabilitation Center in Raleigh.

He is a Baptist, and prior to his election to the Senate served as a deacon and a Sunday School teacher at Hayes Barton Baptist Church in Raleigh.

He was one of the founders and serves as a director of Camp Willow Run, a Youth Camp for Christ at Littleton, North Carolina.

He has served on the Board of Trustees of Meredith College, John F. Kennedy College, Campbell University and Wingate College. In 1941, at age 20, he became the youngest reporter, up to that time, to win the annual North Carolina Press Association award for enterprising reporting.

In 1962, he received the annual Freedoms Foundation Award for the television editorial judged best in America. He was similarly honored by the Foundation in 1973 for a newspaper article.

He is the first Republican , as well as the first North Carolinian, to receive the Golden Gavel, an award given for presiding over the Senate more than 117 hours in 1973. He received a second Golden Gavel for presiding over the Senate more than 120 hours in 1974.

His name was placed in nomination for Vice President of the United States at the GOP convention in Kansas City in 1976. Although he asked the convention to withdraw his name, he nevertheless received 99 delegate votes.

He holds the Gold Medal of Merit from the Veterans of Foreign Wars, and the North Carolina American Legionaire Award.

In 1980, he was presented the Legislator of the Year Award by Christians for a Better America and proclaimed the National Man of the Year in Politics by Christian Voice, Inc. Also, in the same year, he received the North Carolina Public Service Award.

In 1980, 1981, and 1983, he was voted the Most Admired Conservative in Congress, by the readers of Conservative Digest.

Senator Helms was presented the American Security Council Award in 1982 and the Conservative Caucus 97th Congress Statesman Award in 1983.

He received the Golden Eagle Award in 1987 from the American Federation of Police and the "Spirit of Enterprise" Award in 1989 from the U.S. Chamber of Commerce.

He has received the Guardian of Small Business Award from the National Federation of Independent Business and the Watchdog of the Treasury Award form the National Associated Businessmen every year since his election in 1973. In addition, he has received the Taxpayers's Best Friend Award from the National Taxpayers' Union every year since 1981.

He is married to the former Dorothy Jane Coble of Raleigh. He is the father of three children: Jane (Mrs. Charles R. Knox), Nancy (Mrs. John Stuart) of Raleigh and Charles of Winston-Salem, and has seven grandchildren.

Senator Helms began his first term in the Senate in January 1973; was reelected to a second term on November 7, 1978; to a third term on November 6, 1984; a fourth term on November 6, 1990; and a fifth term on November 7, 1996. He is Chairman of the Committee on Foreign Relations, a member of the Committee on Agriculture, Nutrition and Forestry, and a member of the Rules Committee.

PHOTO GALLERY

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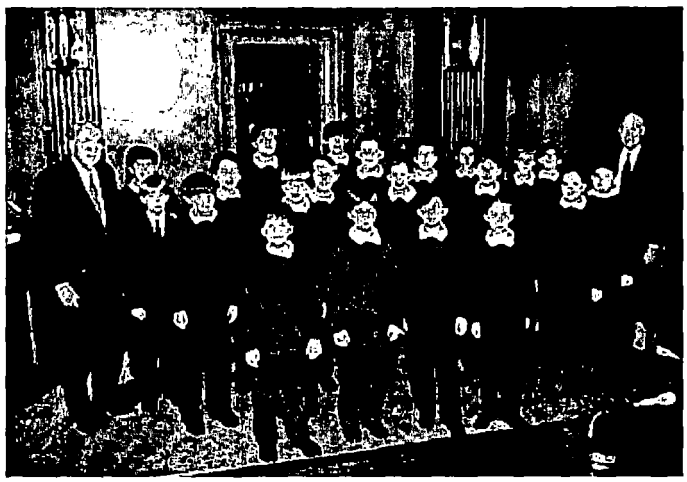
Senator Helms and his granddaughter. This photo was taken by former Senator Howard Baker Majority Leader of the Senate and later Chief of Staff to President

Senator Helms honors Mattie Hill Brown and Roger Schuh for receiving the North Carolina Jeffer by Brett Chambers, Community Affairs Director at WTVD, (far left) for her work feeding needy wife, Nancy(far right), was honored for constructing a playground in Winston-Salem for handicap image)

Senators Faircloth, Dole, Helms, and Thurmond show their enthusiasm for the Carolinas' new fo

Senator Helms meets with the Dalai Lama of Tibet. (click on photo for

Senator Helms holding 4 month old Rilee Hupart



Senator Helms with the Raleigh Boychoir during their annual Christmas visit to Washington. The
(click on photo for larger image)

Senator Helms meets with young students in his Washington o

Senator Helms with North Carolina's Girls Nations representa Julie Kerr of Hickory and Elizabeth Smith of Raleigh.

Senator Helms greeting some North Carolinians who won a lunch in the Senate Dining Room. T

benefit the Greensboro Symphony.

Senator Helms meets with John Travolta

Senator Helms with five year old Cody Groce, National Ambassador for the March of Dimes Birt NC (He is the first March of Dimes Ambassador from North Car

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from Maryland

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BIOGRAPHY OF THE HONORABLE

PAUL SPYROS SARBANES

UNITED STATES SENATOR FROM MARYLAND

PUBLIC SERVICE

Elected on November 2, 1976 and re-elected in 1982, 1988 and 1994 to the United States Senate. Serves on the Joint Economic Committee; Senate Foreign Relations Committee; Senate Committee on the Budget, and as Ranking Member, Senate Committee on Banking, Housing and Urban Affairs, and Chairman of the Maryland Congressional Delegation.

Three-term member of the United States House of Representatives, first elected on November 3, 1970 to the 92nd Congress. Subsequently re-elected to the 93rd and 94th Congresses. Served in Congress as a member of the House Judiciary Committee, Merchant Marine and Fisheries Committee and the Select Committee on House Reorganization.

Served in the Maryland House of Delegates, 1966-1970. Member of the Judiciary Committee and the Ways and Means Committee. Vice Chairman of the Baltimore City Delegation for the 1968 session.

Executive Director of the Charter Revision Commission of Baltimore City, 1963-1964.

Administrative Assistant to Walter W. Heller, Chairman for President Kennedy's Council of Economic Advisers, 1962-1963. Legislative draftsman with the Maryland Department of Legislative Reference at the 1961 session of

the Maryland General Assembly.

LEGAL EXPERIENCE

Associate in the Baltimore law firm of Venable, Baetjer and Howard, 1965-1970.

Associate in the Baltimore law firm of Piper & Marbury, 1961-1962.

Law Clerk to Judge Morris A. Soper, United States Court of Appeals for the Fourth Circuit, 1960-1961.

HIGHER EDUCATION

Princeton University

Scholarship student, received A.B. degree in June, 1954. Majored in the Woodrow Wilson School for Public and International Affairs, graduating magna cum laude and Phi Beta Kappa.

Oxford University

Rhodes Scholar at Balliol College, 1954-1957. Received First Class B.A.

Honours degree in the School of Philosophy, Politics, and Economics.

Harvard Law School

Scholarship student, received LL.B. degree cum laude in June, 1960.

Served as Graduate Secretary of Phillips Brooks House, the Harvard-Radcliffe volunteer service organization.

PERSONAL

Born in Salisbury, Maryland on February 3, 1933, the son of Spyros (deceased 1957) and Matina Sarbanes, both of whom immigrated to the United States from Laconia, Greece. Attended the public schools in Salisbury, Maryland, graduating in June 1950 from Wicomico Senior High School. In June 1960, married Christine Dunbar of Brighton, England, a graduate of St. Hugh's College, Oxford University; Lecturer in Classics at Goucher College, 1960-1973; and teacher at Gilman School, 1978 to present.

Three children, two sons, John Peter, born May 1962 and Michael Anthony, born January 1965, a daughter, Janet Matina, born January 1968, and five grandchildren. Member of the Greek Orthodox Cathedral of the Annunciation in Baltimore.

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FY 2000 USAID and HHS Funding
Africa and International (non-Africa)

PREVENTION

USAID			
	Africa	$93.1 million	(70% of $133 m)
	International	$46.9 million	(70% of $67 m)
CDC	Africa	$10.25 million	

Subtotal: Africa: $103.35 million
Intl: $46.9 million

MTCT

USAID:			
	Africa	$6.65 million	(5% of $133 m)
	Int'l.	$3.85 million	(5% of $67 m)
CDC:	$2.75 million – Africa		

Subtotal: Africa: $9.4 million
Int'l: $3.85 million

CARE

USAID			
	Africa	$9.31 million	(7% of $133 m)
	International	$4.69 million	(7% of $67 m)
CDC	Africa	$9 million	

Subtotal: Africa: $18.31 m
Intl: $ 4.69 m

ORPHANS

USAID:	Africa	$10.64 million	(8% of $133 m)
	International:	5.36 million	(8% of $67 m)

CAPACITY BUILDING *

USAID			
	Africa	$13.3 million	(10% of $133 m)
	International	$6.7 million	(10% of $67 m)
CDC	Africa	$13 million	

Subtotal: Africa: $26.3 million
Int'l $6.7 million

Note: Africa Bureau is $94.6 m + 19.4 m from G Bureau for AFRICA = $133 m
Remainder is international ($67 m)

* Capacity Building includes surveillance

USAID Q & A
Senate Committee on Foreign Relations
Subcommittee on African Affairs

What is USAID's Role in the LIFE Initiative?

USAID is the lead USG agency responsible for ensuring a coordinated country level USG response. Given USAID's historic experience in designing, implementing and evaluating HIV/AIDS control programs, as well as its formal responsibility to negotiate with foreign governments, it is uniquely placed to coordinate the multiple USG agencies that may be involved. USAID is also the major implementor of HIV/AIDS prevention, care, and mitigation programs involving the health and non-health sectors. HHS technical assistance is designed to "wrap around" USAID's efforts (with the exception of surveillance which CDC is primarily responsible for).

What particular expertise is USAID providing in the implementation of the LIFE Initiative?

USAID has responsibility for each of the four programmatic categories under the LIFE initiative: primary prevention, home and community based care and support, support for AIDS affected children, and capacity building. The LIFE initiative was developed in part to scale up those programs that USAID piloted. USAID has been a world leader in HIV/AIDS prevention and control since 1986 and has expertise in prevention, care, and mitigation. In addition, USAID as a development agency, is in a unique position to integrate HIV/AIDS prevention into the education, economic, agriculture, democracy and governance and other sectors.

USAID has been supporting community-based programs, NGO programs, as well as training for public health workers at all levels. USAID's expertise in prevention is well recognized (inclusive of interventions ranging from mass media communications to condom promotion to voluntary counseling and testing and mother to child transmission). USAID is also now leading the development of care interventions. USAID has been the principal architect of programs addressing AIDS affected children. Finally, USAID has been building African institutional and human capacity for over 30 years, including in the HIV/AIDS arena.

Please provide lessons learned from previous global public health initiatives that can be effectively utilized in the implementation of the LIFE Initiative.

The successful worldwide effort to eradicate smallpox demonstrated what a coordinated multi- and bilateral effort could accomplish. The involvement of all levels of government, multiple agencies, the availability of an effective vaccine, and community mobilization led to the conquering of an infectious disease—the same that we are striving for with HIV/AIDS.

The current effort to eradicate polio has demonstrated the value of what a public-private partnership can accomplish. The implementation of immunization programs has taught us the need to address health care system development broadly in order to ensure that our goals are achieved. It also demonstrated the need to be vigilant and to maintain a focus on maintaining high coverage rates, otherwise they decline. Finally, USAID's experience with population programs has illustrated the need for a sustainable commodity supply, as well as the need to address policy makers at all levels (particularly when they have been resistant).

If USAID is the lead agency on the ground, how is it effectively coordinating with other agencies.

USAID has a very long history of working with and coordinating other USG agencies. These include the State Department, multiple agencies of HHS (CDC, NIH, HRSA, FDA), DOD, and others.

As the designated LIFE initiative lead agency, USAID is responsible for developing and implementing country joint plans that include other USG agencies, the host country, and other non-governmental stakeholders. In all of the target LIFE countries, USAID is currently working on these plans and is including HHS/CDC. In addition, USAID has been working with the Departments of Labor, Commerce, and Defense to assist them in their HIV/AIDS activity planning. USAID is a key member of the Ambassador's country team in each country and coordinates with the embassy in this regard.

USAID also is the lead USG agency that coordinates with UNAIDS (as its largest funder), other UN agencies, and bilateral agencies, as well as with foundations, the private sector, and NGOs. USAID has been instrumental in the development of the UNAIDS International Partnership Against AIDS in Africa effort designed to improve donor coordination.

Why wasn't more money requested for the global AIDS pandemic during the first 6 years of the Administration?

[Sandy should craft a response to this]—here are my personal two cents worth:

We are very grateful to the Congress for its bipartisan support this year for the LIFE initiative. We as a government have been the largest donor by far (about half) for all international HIV prevention efforts in Africa during the past 7 years. Even given this level of resources (approximately $125 million/year for USAID worldwide + HHS research resources), we saw a need to significantly increase our own commitment, particularly as we provide leadership to other donors and the private sector to increase their commitment. And yet, we still need to do more.

What is USAID's relationship with UNAIDS and other multilaterals? What is USAID's relationship with other bilateral donors, and what is its approach to coordinate efforts with them.

USAID helped in the creation and launch of UNAIDS in 1996. We are the largest donor to UNAIDS, providing $15 million in 1999 of their $60 million budget. (25% of their budget) The U.S. serves on the UNAIDS Programme Coordinating Board and we work extremely closely with UNAIDS in key areas, including the International Partnership Against AIDS in Africa, surveillance of the pandemic, distilling "best practices" from our field programs, and monitoring the effectiveness of our interventions. We provide critical funding for specific UN cosponsors of UNAIDS (UNICEF, WHO, UNDP) through a special account that is administered by UNAIDS. We have good working relationships with other key bilateral donors, especially the UK, Japan, Sweden, Canada, Australia, Germany, Denmark, Norway and the Netherlands. We meet individually with these donors at a global level and within individual countries to collaborate on specific national plans. We have recently been meeting with the major OECD countries as part of the International Partnership Against AIDS in Africa. However, we still lack a reliable, consistent global forum for ongoing dialogue with donor countries and affected developing countries. There have been discussions about creating such a global mechanism (??PEACS???)

What have we learned from the success stories of Uganda and Senegal? What are the key components to an effective program?

First, that there is no <u>one</u> solution. There are many strategies that, together, make an effective response. Second, it takes time. Uganda's success was realized over a ten year period. Some of the key factors include:

- Consistent political dialogue at all levels, including the President.
- Active involvement of the religious/faith community in HIV/AIDS.
- Sustained funding (internal and external) over a long period of time.
- Establishment of a national climate that allows research to occur in the country.
- A free press that allows for open dialogue of the problem and criticism of the government if action is slow.
- The availability of broad voluntary counseling and testing programs, coupled with psycho-social and medical support services and referral networks.
- The active inclusion of NGOs in the fight against AIDS in the country.
- Sustainable supplies of condoms and other commodities.
- An operational surveillance system to track changes in the epidemic.

What are the greatest remaining obstacles to the progression of the Administration's goals:

- There continues to be a profound lack of political commitment at all levels of government in the most severely affected countries.
- The global pandemic has outstripped available resources. Currently, about $200 million is being expended on HIV/AIDS prevention programs in all of sub-Saharan Africa from all sources (donors,

lending agencies, and host country contributions.) We estimate that we would need at least $1 billion per year for sub-Saharan Africa, for prevention alone.

- This epidemic is still plagued by the immense problem of stigma. Until persons can talk openly about risk behaviors and whether they are infected or not, then we will continue to have weak behavior change and care and support programs.
- There is insufficient scale to our current programs. Due to all of the above problems, we probably reach only 10% of vulnerable populations around the world.
- We desperately need an effective vaccine and an effective topical microbicide. Our existing interventions do work, if implemented properly and to scale. But these two additional tools would make a huge difference in our fight against this pandemic.

How do we overcome the obstacles of unstable governments in host countries in as we seek to further progress on health issues like AIDS?

Conflict in countries has been a major determinant for the spread of AIDS as it contributes to the displacement of populations, large movements of people, as well as the movement of soldiers which are a very vulnerable group to HIV. Moreover, unstable governments are less likely to respond to the AIDS crisis in their midst. These issues point to the fact that AIDS is not a simple health issue, but that solutions depend on many other factors.

Supporting community-based responses that rely less on central governments is one approach to ensuring that communities have the resources and information to act to prevent HIV/AIDS. Engaging our own Department of Defense to discuss HIV/AIDS with other militaries and UN Peacekeeping forces, and to implement HIV intervention programs is critical. Involving African leaders to discuss HIV/AIDS with their peers is one approach that requires further nurturing. Mobilizing religious leaders is another important strategy that can assist in such situations. In the end, preventing social upheaval is vital to preventing HIV/AIDS. As such, the recent UN Security Council meeting on HIV/AIDS represents a watershed in the world communities recognition of the interplay between AIDS and security issues.

[Set 2]

You have mentioned the US Government's leadership in this area. What are our other partners doing in other countries and in the private sector?

The U.S. Government has been a world leader in the fight against HIV/AIDS. We are not alone however. USAID, our lead implementing agency, has excellent working relationships with other bilateral and multilateral donors. The U.S. is the largest donor to UNAIDS (25%). USAID has been instrumental in helping UNAIDS develop its International Partnership Against AIDS in Africa (IPAA). At the country level, numerous other donors are active, as well as NGOs, foundations, universities and so on. Our programs are always designed in a way that maximizes coordination with these other donors and stakeholders. We are also very involved with the private sector and labor unions. For example, in South Africa, USAID and HHS have provides technical assistance to the Ford Motor Company to develop workplace based policies and community programs. USAID has worked extensively with COSATU via the Solidarity Center to help COSATU craft their HIV/AIDS policy. We are working with pharmaceutical companies, businesses, labor, NGOs, and many other partners to expand the response to the AIDS pandemic.

We have heard much about the pharmaceutical industry issues and the access to antiretroviral drugs in Africa? What is your view on this and how should we best respond as a government?

I believe that we must address a much wider access issue. For example, in Africa and in many other developing countries, even the most basic antibacterial, antifungal, and pain medications are not available. With better access to these common, and generally inexpensive, drugs we could significantly prolong the lives of people infected with HIV/AIDS. We must also address training for health care workers. We are developing a process to explore possible solutions to the access to drugs issue. As you know this is a complicated issue. However, in the meantime, USAID, along with HHS, are supporting programs to expand the availability of medical, palliative, and psychosocial care for persons affected with AIDS. Their work in this field is leading other donors and countries to increase their responses as well Finally, we are reminded that in Africa in many countries, 60-70% of hospital and clinic beds are currently occupied by persons with AIDS-related conditions. This has tremendous implications for the health care system requiring a large scale systemic response.

If we to double or even triple the USG budget for HIV/AIDS in Africa, what could we achieve?

The entire world community and nations in Africa contribute $350 million a year for HIV prevention and care. Compared to the $3 billion annual estimated need (source: UNAIDS), we clearly have a long way to go. As we developed the LIFE initiative, USAID identified a set of global targets that the international community agreed to. These are included in my LIFE initiative report. With increased resources, we wold be in a position to scale up our prevention and care efforts. Interventions such as voluntary counseling and testing need to be expanded. USAID, with new resources, is now leading the development of care and support interventions. Much more needs to be done in this arena. We have made a significant beginning to address the AIDS affected children issue—the prospect of 40 million

African orphans calls for more resources and novel solutions. USAID, along with other federal agencies and NGOs, will need to step up their capacity building efforts. Finally, USAID has been leading the development of multisectoral responses to HIV/AIDS. Expanding these will require additional resources.

I congratulate you on providing the leadership to move this issue to the forefront of the Administrations agenda. Why has there been such a lack of political will and leadership in Africa to deal with HIV/AIDS? What are you doing to reverse that? Involvement with religious leaders?

There are three major obstacles that we must overcome to make headway in the fight against HIV.AIDS in Africa. The first is the chronic lack of political will in African nations to address this issue. There are some notable exceptions such as in Uganda and Senegal—two countries that have had major successes in reversing or controlling the epidemic. Thankfully, we are seeing more leaders discuss the issue. For example, after my visits to Zambia, President Chiluba began discussing HIV/AIDS publicly. Just the nature of a high level White House official, or a Cabinet Secretary can make a difference. Leaders in other countries such as Tanzania, Ghana, Malawi, Mozambique, South Africa, and even Zimbabwe are discussing the issue with more frequency. USAID has been supporting a number of key efforts to inform decision makers about the issue and the need to take urgent action.

The second factor, very much influencing the first, is the high level of stigma and denial in countries. This has been difficult to change, but we are mobilizing to help countries develop strategies to encourage people to discuss their status openly. In the U.S., you may recall, it was not until celebrities such as Rock Hudson, Magic Johnson, and children such as Ryan White publicly discussed their status that our own public's opinions began to change about HIV. In this regard, religious leaders in Africa play an extremely important role to help change social norms and attitudes.

The third factor is resources.

You have articulately noted the impact that 40 million orphans in Africa will have, as well as the toll on economic and political security. This seems such a daunting challenge. What can we realistically do?

This is a very frightening prospect. Thus far, our efforts have targeted the development of community based models to support children affected by AIDS. This includes children who are infected by HIV as well as those who are the primary caregivers, who end up as orphans, who head households at a very early age, and who are most vulnerable. USAID has led the development of models to respond to this need. They serve many, but so much more is needed. Services such as health care, school fees, vocational training, microenterprise, and more are needed. Other groups such as UNICEF, religious organizations throughout the continent, and others are also very much involved in this effort. We are urging countries to do more to prevent HIV transmission, if only to prevent more orphans which may pose significant economic and security threats. My office is considering the formation of an interagency group that will develop additional possible solutions that can be scaled up.

[See Grigsby Q&A]

We have heard the exciting news of nevirapine to prevent mother to child transmission. How fast can we scale up mother to child transmission?

Preventing the transmission of HIV from mother to child, or MTCT as it is known, is a key priority for us. But, this is a complex area. The news about a new drug, nevirapine, is exciting. However, there are still some key unanswered questions about its safety and long term efficacy. USAID, HHS, UNICEF, and others are looking into the development of larger scale MTCT programs. These include the availability of voluntary counseling and testing, the provision of the drug, as well as providing health care services for the mother over a longer period of time. Currently, USAID and UNICEF are supporting 11 pilot sites in Africa and in Asia for MTCT. They are currently looking at scaling these up. In addition, USAID and HHS are increasing their support for VCT services and general care and support. We must also keep in mind the stigma issue that prevents women from steeping forward. For example, in Botswana where the government was providing MTCT services and prevention, of all women offered the service, only 17% came forward due to the associated possible stigma.

GARRETT GRIGSBY, SFRC

QUESTION:

How much is USAID funding programs supporting HIV/AIDS-affected children?

ANSWER:

USAID is deeply committed to providing assistance to children affected by HIV/AIDS. These include the millions of orphans who have lost one or both parents due to HIV/AIDS. It also includes children who are taking care of parents with HIV/AIDS. Some of these children are HIV positive themselves. As the parent(s) die, the children are either cared for by the extended family and community members, increasingly become heads of households themselves, or end up on the streets.

Children affected by AIDS face a variety of short and long-term problems that are unique from those faced by other orphans. Two options are generally recognized for the provision of appropriate care and protection for these children. These options include both orphanages and community-based approaches. While some orphanages provide excellent care for surviving children, these institutions are rare, usually very expensive and can serve only an almost insignificant proportion of the tens of millions of AIDS affected children in need. The history of orphanages in developing countries demonstrates that the vast majority of child-care institutions do not provide an acceptable level of care or protection. USAID's ten years of experience in thousands of communities in many AIDS-affected countries suggests that the special needs of children affected by AIDS are best addressed in communities, where there is communal recognition and support for the children. In these settings, children are in family-living situations including care provided by extended families, traditional variations of foster care or adoption and community group homes.

Since 1988, USAID's Displaced Children and Orphans Fund (DCOF), has spent over $17 million in Africa supporting AIDS orphans programs. DCOF currently supports community-based programs in Malawi, Zambia, and Burkina Faso and will expand to other countries in Africa. This assistance includes many innovative programs.

In FY 1999 Congress appropriated $10 million in supplemental funds for USAID to support activities focusing on children affected by HIV/AIDS. $7 million of these funds have been allocated for activities in African countries, including programs in Cote D'Ivoire, Kenya, Malawi, Nigeria, Rwanda, South Africa, Uganda, and Zimbabwe. The remainder went to Cambodia, India, Nepal, as well as to USAID/Global Bureau to support a program in Haiti as well as monitoring and evaluation efforts and operations research. In FY 1999, USAID provided $250,000 in direct assistance to the Nyumbani Orphanage in Kenya. In addition, USAID provided $87,500 to Catholic Relief Services in Kenya to provide management and technical assistance to Nyumbani. With this

support, Nyumbani is developing a community-based effort to support HIV/AIDS-infected children living in the community.

In FY 2000, with additional increases in HIV/AIDS funding from Congress, USAID is planning to spend $20 million for children affected by HIV/AIDS. This reflects a continuation of the FY 1999 funding level commitment, as well as an additional $10 million in Title II food aid targeted at children affected by AIDS. The Title II program is new and will build on the existing food aid programs. The LIFE initiative includes AIDS orphans and affected children as one of the four critical programmatic areas (along with primary prevention, care and support, and capacity building).

Finally, USAID remains a leader in the effort to prevent the transmission of HIV/AIDS worldwide. It is through primary prevention that children of the future will be protected from the trauma of living with a parent who is ill or experiencing the death of a parent as a result of AIDS

SUPPLEMENTAL AND DCOF FUNDING
FOR CHILDREN AFFECTED BY HIV
COUNTRY TOTALS
FY 1999

COUNTRY	SF	DCOF
ANGOLA		$500,000
BURKINA FASO		$625,000
COTE D'IVOIRE	$200,000	
KENYA	$1,150,000	
MALAWI	$85,000	$372,000
NIGERIA	$815,000	
RWANDA	$1,000,000	$1,385,156
SOUTH AFRICA	$1,450,000	
UGANDA	$1,000,000	$1,000,000
ZAMBIA	$1,000,000	$1,208,875
ZIMBABWE	$300,000	
SUB-TOTAL	$7,000,000	$4,091,031
GLOBAL	$800,000	
HAITI	$200,000	
INDIA	$600,000	
CAMBODIA	$1,000,000	
NEPAL	$200,000	
BUREAU FOR HUMANITARIAN RELIEF	$200,000	
GRAND TOTAL	$10,000,000	$7,650,000

Are you aware of any successful World Bank Trust Funds?

Yes. The Onchocerchiasis Control Program Trust Fund (River Blindness) has been a very successful program. This trust fund has combined financial management by the World Bank and implementation by an African based program. Donors contribute a total of approximately $40 million to the trust fund annually; USAID provides $3.5 million. The private sector does not contribute to the fund, but do make free contributions separately of the key medication, ivermectin (Merck). Whereas the Bank provides overall management of the funds, the implementing agency is the WHO Onchocerchiasis program based in Burkina Faso. They manage the training, distribution of the medication, and monitoring interventions. Three years ago, donors established the African Program for Onchocerchiasis Control (APOC), also based at WHO Burkina, that now increases granting to NGOs, as well as to expand operations in 27 additional countries. Results have been dramatic with very large decreases in the incidence of river blindness.

In the case of OCP, donors have used the trust fund as their primary mechanism and the intervention is a relatively effective and straightforward one. With respect to HIV/AIDS, there are numerous donor and private sector mechanisms, and interventions to control HIV/AIDS are much more complex than that for OCP.

Do you believe that there is a need for a Trust Fund to encourage the World Bank and other donors, public and private, to contribute funds?

There are numerous mechanisms by which donors can contribute funds to the international fight against AIDS. These include bilateral programs, UNAIDS and their unified budget that distributes funds to other UN agency cosponsors, and direct contributions to UN agencies. The private sector has contributed funds in a number of ways. The World Bank is actively trying to step up its own HIV/AIDS program lending. It is not clear to us whether a World Bank trust fund is the answer or some other arrangement of an independent foundation could be of greater utility to meet the needs of multiple stakeholders. We are exploring various options at this time.

Would the US Government contribute to a World Bank Trust Fund?

To date, the primary US Government assistance for HIV/AIDS internationally has been delivered through bilateral arrangements. USAID's missions have been very effective in working collaboratively with countries to develop, implement and monitor HIV/AIDS prevention and care interventions that are tailored to the individual country needs. What has distinguished the U.S.' leadership in this field has been its strong field presence. The same holds true for HHS and other USG agencies active in this area. USAID works very closely with UN agencies such as UNICEF, UNDP, and WHO that are active in countries, as well as the World Bank. The USG contributes $15 million per year to UNAIDS, via USAID, to assist with international coordination. We do not expect a change in how USG assistance is channeled to implementing country based HIV/AIDS programs.

U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON BANKING AND FINANCIAL SERVICES
ONE HUNDRED SIXTH CONGRESS
2129 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6050

February 18, 2000

Ms. Sandra L. Thurman
Director
White House Office of National AIDS Policy
736 Jackson Place
Washington, DC 20503

Dear Director Thurman:

The Committee on Banking and Financial Services invites you to testify at hearing to be held on Wednesday, March 8, 2000, at 10:00 a.m., on the global AIDS crisis and on legislation (H.R. 3519) to create a new World Bank AIDS Prevention Trust Fund. The hearing will be held in Room 2128 of the Rayburn House Office Building.

The Committee would welcome your assessment of the impact of the global AIDS crisis on developing countries, especially in Sub-Saharan Africa, as well as the implications of the spread of AIDS for U.S. national interests. In particular, the Committee would be interested in your views on the unique role that the World Bank can play, in coordination with the United Nations and other relevant agencies, in combating the effects and spread of this devastating disease. In this context, the Committee would welcome ONAP's views and comments on H.R. 3519, the World Bank AIDS Prevention Trust Fund Act. A copy of the bill is enclosed.

Banking Committee rules require that written testimony be made available to Members of the Committee 24 hours in advance of a hearing. Accordingly, it would be appreciated if 200 copies of your testimony could be delivered to Room 2129 of the Rayburn House Office Building by 10:00 a.m. on Tuesday, March 7, 2000. In addition, the Committee would appreciate receiving a copy of the statement on a 3.5 inch computer disk which will be placed on the Committee's Internet home page in compliance with House Rule XI 2(e)(4).

If you have any questions regarding this invitation, please do not hesitate to contact Jamie McCormick at (202) 226-0473 or Cindy Fogleman (202) 226-3280. We look forward to your participation.

Sincerely,

James A. Leach
Chairman

Enclosures

cc: The Honorable John J. LaFalce

Agenda

Panel I

- John F. Kerry, United States Senator
- Amo Houghton, United States Representative

Panel II

- Richard C. Holbrooke, the U.S. Ambassador to the United Nations
- Sandra L. Thurman, Director, White House Office of National AIDS policy
- Timothy F. Geithner, Undersecretary (International Affairs)
  U. S. Department of Treasury

Panel III

- Mary Fisher, Founder and Chair, Family AIDS Network
- Mpule Kwelagobe, Miss Universe 1999
- Mary M. Kanya, Ambassador, Kingdom of Swaziland

Panel IV

- James M. Sherry, M.D., Ph.D., Director of Program Development and Coordination, UNAIDS
- Gary Slutkin, MD, Professor of Epidemiology and International Health, University of Illinois School of Public Health, formerly Chief of Prevention, WHO Global Program on AIDS
- Catherine Wilfert, M.D., Scientific Director, Elizabeth Glaser Pediatric AIDS Foundation
- Thomas Welty, MD, Medical Epidemiologist, Cameroon Baptist Convention Health Board

Panel V

- Ronald Dellums, President Healthcare International Management Company, and Chairman, Constituency for Africa

AMB
testimony

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- UNAIDS has five major roles: (1) to track the epidemic through global surveillance, (2) to advocate for improved political commitment and for increased resources from public and private sources, (3) to create a collection of international "best practices" to guide the implementation and monitoring of country programs, (4) to coordinate the UN cosponsors both at global and country levels, and, finally, (5) to assist country programs in the development of their national AIDS strategy.

- The seven UN cosponsors of UNAIDS are responsible for supporting regional and country programs, based on their respective expertise. For example, WHO focuses on surveillance systems and care and support for HIV-infected persons. UNICEF focuses on children affected by AIDS, reducing mother-to-child HIV transmission and increasingly through support to AIDS orphans. The UNAIDS Secretariat provides coordination and technical guidance at the global level, and the country level using the "Theme Group" mechanism to harmonize activities of UN partners, and work with national ministers of health, education, finance, development, etc.

- UNAIDS and the cosponsoring agencies are making progress against the odds. UNAIDS urges a dramatic and rapid expansion in current national AIDS activities, especially in Africa, and there are some recent examples that give cause for hope.

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UNAIDS\Holbrooke testimony 3-00.doc

Cleared: IO/T:LLambert
IO/S:DWynes
OES/EID:NCarter-Foster
AF:TNiblock
G:Jchow/DGraham
USAID:PDelay
EB/TPP/MTA/IPC:JRoberts
USUN:RPEddy/JDey

Q+A

FY 2000 USAID and HHS Funding
Africa and International (non-Africa)

PREVENTION

USAID			
	Africa	$93.1 million	(70% of $133 m)
	International	$46.9 million	(70% of $67 m)
CDC	Africa	$10.25 million	

Subtotal: Africa: $103.35 million
Intl: $46.9 million

MTCT

USAID:			
	Africa	$6.65 million	(5% of $133 m)
	Int'l.	$3.85 million	(5% of $67 m)
CDC:	$2.75 million – Africa		

Subtotal: Africa: $9.4 million
Int'l: $3.85 million

CARE

USAID			
	Africa	$9.31 million	(7% of $133 m)
	International	$4.69 million	(7% of $67 m)
CDC	Africa	$9 million	

Subtotal: Africa: $18.31 m
Intl: $ 4.69 m

ORPHANS

USAID:	Africa	$10.64 million	(8% of $133 m)
	International:	5.36 million	(8% of $67 m)

CAPACITY BUILDING *

USAID			
	Africa	$13.3 million	(10% of $133 m)
	International	$6.7 million	(10% of $67 m)
CDC	Africa	$13 million	

Subtotal: Africa: $26.3 million
Int'l $6.7 million

Note: Africa Bureau is $94.6 m + 19.4 m from G Bureau for AFRICA = $133 m
Remainder is international ($67 m)

* Capacity Building includes surveillance

USAID Q & A
Senate Committee on Foreign Relations
Subcommittee on African Affairs

What is USAID's Role in the LIFE Initiative?

USAID is the lead USG agency responsible for ensuring a coordinated country level USG response. Given USAID's historic experience in designing, implementing and evaluating HIV/AIDS control programs, as well as its formal responsibility to negotiate with foreign governments, it is uniquely placed to coordinate the multiple USG agencies that may be involved. USAID is also the major implementor of HIV/AIDS prevention, care, and mitigation programs involving the health and non-health sectors. HHS technical assistance is designed to "wrap around" USAID's efforts (with the exception of surveillance which CDC is primarily responsible for).

What particular expertise is USAID providing in the implementation of the LIFE Initiative?

USAID has responsibility for each of the four programmatic categories under the LIFE initiative: primary prevention, home and community based care and support, support for AIDS affected children, and capacity building. The LIFE initiative was developed in part to scale up those programs that USAID piloted. USAID has been a world leader in HIV/AIDS prevention and control since 1986 and has expertise in prevention, care, and mitigation. In addition, USAID as a development agency, is in a unique position to integrate HIV/AIDS prevention into the education, economic, agriculture, democracy and governance and other sectors.

USAID has been supporting community-based programs, NGO programs, as well as training for public health workers at all levels. USAID's expertise in prevention is well recognized (inclusive of interventions ranging from mass media communications to condom promotion to voluntary counseling and testing and mother to child transmission). USAID is also now leading the development of care interventions. USAID has been the principal architect of programs addressing AIDS affected children. Finally, USAID has been building African institutional and human capacity for over 30 years, including in the HIV/AIDS arena.

Please provide lessons learned from previous global public health initiatives that can be effectively utilized in the implementation of the LIFE Initiative.

The successful worldwide effort to eradicate smallpox demonstrated what a coordinated multi- and bilateral effort could accomplish. The involvement of all levels of government, multiple agencies, the availability of an effective vaccine, and community mobilization led to the conquering of an infectious disease—the same that we are striving for with HIV/AIDS.

The current effort to eradicate polio has demonstrated the value of what a public-private partnership can accomplish. The implementation of immunization programs has taught us the need to address health care system development broadly in order to ensure that our goals are achieved. It also demonstrated the need to be vigilant and to maintain a focus on maintaining high coverage rates, otherwise they decline. Finally, USAID's experience with population programs has illustrated the need for a sustainable commodity supply, as well as the need to address policy makers at all levels (particularly when they have been resistant).

If USAID is the lead agency on the ground, how is it effectively coordinating with other agencies.

USAID has a very long history of working with and coordinating other USG agencies. These include the State Department, multiple agencies of HHS (CDC, NIH, HRSA, FDA), DOD, and others.

As the designated LIFE initiative lead agency, USAID is responsible for developing and implementing country joint plans that include other USG agencies, the host country, and other non-governmental stakeholders. In all of the target LIFE countries, USAID is currently working on these plans and is including HHS/CDC. In addition, USAID has been working with the Departments of Labor, Commerce, and Defense to assist them in their HIV/AIDS activity planning. USAID is a key member of the Ambassador's country team in each country and coordinates with the embassy in this regard.

USAID also is the lead USG agency that coordinates with UNAIDS (as its largest funder), other UN agencies, and bilateral agencies, as well as with foundations, the private sector, and NGOs. USAID has been instrumental in the development of the UNAIDS International Partnership Against AIDS in Africa effort designed to improve donor coordination.

Why wasn't more money requested for the global AIDS pandemic during the first 6 years of the Administration?

[Sandy should craft a response to this]—here are my personal two cents worth:

We are very grateful to the Congress for its bipartisan support this year for the LIFE initiative. We as a government have been the largest donor by far (about half) for all international HIV prevention efforts in Africa during the past 7 years. Even given this level of resources (approximately $125 million/year for USAID worldwide + HHS research resources), we saw a need to significantly increase our own commitment, particularly as we provide leadership to other donors and the private sector to increase their commitment. And yet, we still need to do more.

What is USAID's relationship with UNAIDS and other multilaterals? What is USAID's relationship with other bilateral donors, and what is its approach to coordinate efforts with them.

USAID helped in the creation and launch of UNAIDS in 1996. We are the largest donor to UNAIDS, providing $15 million in 1999 of their $60 million budget. (25% of their budget) The U.S. serves on the UNAIDS Programme Coordinating Board and we work extremely closely with UNAIDS in key areas, including the International Partnership Against AIDS in Africa, surveillance of the pandemic, distilling "best practices" from our field programs, and monitoring the effectiveness of our interventions. We provide critical funding for specific UN cosponsors of UNAIDS (UNICEF, WHO, UNDP) through a special account that is administered by UNAIDS. We have good working relationships with other key bilateral donors, especially the UK, Japan, Sweden, Canada, Australia, Germany, Denmark, Norway and the Netherlands. We meet individually with these donors at a global level and within individual countries to collaborate on specific national plans. We have recently been meeting with the major OECD countries as part of the International Partnership Against AIDS in Africa. However, we still lack a reliable, consistent global forum for ongoing dialogue with donor countries and affected developing countries. There have been discussions about creating such a global mechanism (??PEACS???)

What have we learned from the success stories of Uganda and Senegal? What are the key components to an effective program?

First, that there is no <u>one</u> solution. There are many strategies that, together, make an effective response. Second, it takes time. Uganda's success was realized over a ten year period. Some of the key factors include:

- Consistent political dialogue at all levels, including the President.
- Active involvement of the religious/faith community in HIV/AIDS.
- Sustained funding (internal and external) over a long period of time.
- Establishment of a national climate that allows research to occur in the country.
- A free press that allows for open dialogue of the problem and criticism of the government if action is slow.
- The availability of broad voluntary counseling and testing programs, coupled with psycho-social and medical support services and referral networks.
- The active inclusion of NGOs in the fight against AIDS in the country.
- Sustainable supplies of condoms and other commodities.
- An operational surveillance system to track changes in the epidemic.

What are the greatest remaining obstacles to the progression of the Administration's goals:

- There continues to be a profound lack of political commitment at all levels of government in the most severely affected countries.
- The global pandemic has outstripped available resources. Currently, about $200 million is being expended on HIV/AIDS prevention programs in all of sub-Saharan Africa from all sources (donors,

lending agencies, and host country contributions.) We estimate that we would need at least $1 billion per year for sub-Saharan Africa, for prevention alone.

- This epidemic is still plagued by the immense problem of stigma. Until persons can talk openly about risk behaviors and whether they are infected or not, then we will continue to have weak behavior change and care and support programs.
- There is insufficient scale to our current programs. Due to all of the above problems, we probably reach only 10% of vulnerable populations around the world.
- We desperately need an effective vaccine and an effective topical microbicide. Our existing interventions do work, if implemented properly and to scale. But these two additional tools would make a huge difference in our fight against this pandemic.

How do we overcome the obstacles of unstable governments in host countries in as we seek to further progress on health issues like AIDS?

Conflict in countries has been a major determinant for the spread of AIDS as it contributes to the displacement of populations, large movements of people, as well as the movement of soldiers which are a very vulnerable group to HIV. Moreover, unstable governments are less likely to respond to the AIDS crisis in their midst. These issues point to the fact that AIDS is not a simple health issue, but that solutions depend on many other factors.

Supporting community-based responses that rely less on central governments is one approach to ensuring that communities have the resources and information to act to prevent HIV/AIDS. Engaging our own Department of Defense to discuss HIV/AIDS with other militaries and UN Peacekeeping forces, and to implement HIV intervention programs is critical. Involving African leaders to discuss HIV/AIDS with their peers is one approach that requires further nurturing. Mobilizing religious leaders is another important strategy that can assist in such situations. In the end, preventing social upheaval is vital to preventing HIV/AIDS. As such, the recent UN Security Council meeting on HIV/AIDS represents a watershed in the world communities recognition of the interplay between AIDS and security issues.

[Set 2]

You have mentioned the US Government's leadership in this area. What are our other partners doing in other countries and in the private sector?

The U.S. Government has been a world leader in the fight against HIV/AIDS. We are not alone however. USAID, our lead implementing agency, has excellent working relationships with other bilateral and multilateral donors. The U.S. is the largest donor to UNAIDS (25%). USAID has been instrumental in helping UNAIDS develop its International Partnership Against AIDS in Africa (IPAA). At the country level, numerous other donors are active, as well as NGOs, foundations, universities and so on. Our programs are always designed in a way that maximizes coordination with these other donors and stakeholders. We are also very involved with the private sector and labor unions. For example, in South Africa, USAID and HHS have provides technical assistance to the Ford Motor Company to develop workplace based policies and community programs. USAID has worked extensively with COSATU via the Solidarity Center to help COSATU craft their HIV/AIDS policy. We are working with pharmaceutical companies, businesses, labor, NGOs, and many other partners to expand the response to the AIDS pandemic.

We have heard much about the pharmaceutical industry issues and the access to antiretroviral drugs in Africa? What is your view on this and how should we best respond as a government?

I believe that we must address a much wider access issue. For example, in Africa and in many other developing countries, even the most basic antibacterial, antifungal, and pain medications are not available. With better access to these common, and generally inexpensive, drugs we could significantly prolong the lives of people infected with HIV/AIDS. We must also address training for health care workers. We are developing a process to explore possible solutions to the access to drugs issue. As you know this is a complicated issue. However, in the meantime, USAID, along with HHS, are supporting programs to expand the availability of medical, palliative, and psychosocial care for persons affected with AIDS. Their work in this field is leading other donors and countries to increase their responses as well Finally, we are reminded that in Africa in many countries, 60-70% of hospital and clinic beds are currently occupied by persons with AIDS-related conditions. This has tremendous implications for the health care system requiring a large scale systemic response.

If we to double or even triple the USG budget for HIV/AIDS in Africa, what could we achieve?

The entire world community and nations in Africa contribute $350 million a year for HIV prevention and care. Compared to the $3 billion annual estimated need (source: UNAIDS), we clearly have a long way to go. As we developed the LIFE initiative, USAID identified a set of global targets that the international community agreed to. These are included in my LIFE initiative report. With increased resources, we wold be in a position to scale up our prevention and care efforts. Interventions such as voluntary counseling and testing need to be expanded. USAID, with new resources, is now leading the development of care and support interventions. Much more needs to be done in this arena. We have made a significant beginning to address the AIDS affected children issue—the prospect of 40 million

African orphans calls for more resources and novel solutions. USAID, along with other federal agencies and NGOs, will need to step up their capacity building efforts. Finally, USAID has been leading the development of multisectoral responses to HIV/AIDS. Expanding these will require additional resources.

I congratulate you on providing the leadership to move this issue to the forefront of the Administrations agenda. Why has there been such a lack of political will and leadership in Africa to deal with HIV/AIDS? What are you doing to reverse that? Involvement with religious leaders?

There are three major obstacles that we must overcome to make headway in the fight against HIV.AIDS in Africa. The first is the chronic lack of political will in African nations to address this issue. There are some notable exceptions such as in Uganda and Senegal—two countries that have had major successes in reversing or controlling the epidemic. Thankfully, we are seeing more leaders discuss the issue. For example, after my visits to Zambia, President Chiluba began discussing HIV/AIDS publicly. Just the nature of a high level White House official, or a Cabinet Secretary can make a difference. Leaders in other countries such as Tanzania, Ghana, Malawi, Mozambique, South Africa, and even Zimbabwe are discussing the issue with more frequency. USAID has been supporting a number of key efforts to inform decision makers about the issue and the need to take urgent action.

The second factor, very much influencing the first, is the high level of stigma and denial in countries. This has been difficult to change, but we are mobilizing to help countries develop strategies to encourage people to discuss their status openly. In the U.S., you may recall, it was not until celebrities such as Rock Hudson, Magic Johnson, and children such as Ryan White publicly discussed their status that our own public's opinions began to change about HIV. In this regard, religious leaders in Africa play an extremely important role to help change social norms and attitudes.

The third factor is resources.

You have articulately noted the impact that 40 million orphans in Africa will have, as well as the toll on economic and political security. This seems such a daunting challenge. What can we realistically do?

This is a very frightening prospect. Thus far, our efforts have targeted the development of community based models to support children affected by AIDS. This includes children who are infected by HIV as well as those who are the primary caregivers, who end up as orphans, who head households at a very early age, and who are most vulnerable. USAID has led the development of models to respond to this need. They serve many, but so much more is needed. Services such as health care, school fees, vocational training, microenterprise, and more are needed. Other groups such as UNICEF, religious organizations throughout the continent, and others are also very much involved in this effort. We are urging countries to do more to prevent HIV transmission, if only to prevent more orphans which may pose significant economic and security threats. My office is considering the formation of an interagency group that will develop additional possible solutions that can be scaled up.

[See Grigsby Q&A]

We have heard the exciting news of nevirapine to prevent mother to child transmission. How fast can we scale up mother to child transmission?

Preventing the transmission of HIV from mother to child, or MTCT as it is known, is a key priority for us. But, this is a complex area. The news about a new drug, nevirapine, is exciting. However, there are still some key unanswered questions about its safety and long term efficacy. USAID, HHS, UNICEF, and others are looking into the development of larger scale MTCT programs. These include the availability of voluntary counseling and testing, the provision of the drug, as well as providing health care services for the mother over a longer period of time. Currently, USAID and UNICEF are supporting 11 pilot sites in Africa and in Asia for MTCT. They are currently looking at scaling these up. In addition, USAID and HHS are increasing their support for VCT services and general care and support. We must also keep in mind the stigma issue that prevents women from steeping forward. For example, in Botswana where the government was providing MTCT services and prevention, of all women offered the service, only 17% came forward due to the associated possible stigma.

This has been difficult to change, but we are mobilizing to help countries develop strategies to

GARRETT GRIGSBY, SFRC

QUESTION:

How much is USAID funding programs supporting HIV/AIDS-affected children?

ANSWER:

USAID is deeply committed to providing assistance to children affected by HIV/AIDS. These include the millions of orphans who have lost one or both parents due to HIV/AIDS. It also includes children who are taking care of parents with HIV/AIDS. Some of these children are HIV positive themselves. As the parent(s) die, the children are either cared for by the extended family and community members, increasingly become heads of households themselves, or end up on the streets.

Children affected by AIDS face a variety of short and long-term problems that are unique from those faced by other orphans. Two options are generally recognized for the provision of appropriate care and protection for these children. These options include both orphanages and community-based approaches. While some orphanages provide excellent care for surviving children, these institutions are rare, usually very expensive and can serve only an almost insignificant proportion of the tens of millions of AIDS affected children in need. The history of orphanages in developing countries demonstrates that the vast majority of child-care institutions do not provide an acceptable level of care or protection. USAID's ten years of experience in thousands of communities in many AIDS-affected countries suggests that the special needs of children affected by AIDS are best addressed in communities, where there is communal recognition and support for the children. In these settings, children are in family-living situations including care provided by extended families, traditional variations of foster care or adoption and community group homes.

Since 1988, USAID's Displaced Children and Orphans Fund (DCOF), has spent over $17 million in Africa supporting AIDS orphans programs. DCOF currently supports community-based programs in Malawi, Zambia, and Burkina Faso and will expand to other countries in Africa. This assistance includes many innovative programs.

In FY 1999 Congress appropriated $10 million in supplemental funds for USAID to support activities focusing on children affected by HIV/AIDS. $7 million of these funds have been allocated for activities in African countries, including programs in Cote D'Ivoire, Kenya, Malawi, Nigeria, Rwanda, South Africa, Uganda, and Zimbabwe. The remainder went to Cambodia, India, Nepal, as well as to USAID/Global Bureau to support a program in Haiti as well as monitoring and evaluation efforts and operations research. In FY 1999, USAID provided $250,000 in direct assistance to the Nyumbani Orphanage in Kenya. In addition, USAID provided $87,500 to Catholic Relief Services in Kenya to provide management and technical assistance to Nyumbani. With this

support, Nyumbani is developing a community-based effort to support HIV/AIDS-infected children living in the community.

In FY 2000, with additional increases in HIV/AIDS funding from Congress, USAID is planning to spend $20 million for children affected by HIV/AIDS. This reflects a continuation of the FY 1999 funding level commitment, as well as an additional $10 million in Title II food aid targeted at children affected by AIDS. The Title II program is new and will build on the existing food aid programs. The LIFE initiative includes AIDS orphans and affected children as one of the four critical programmatic areas (along with primary prevention, care and support, and capacity building).

Finally, USAID remains a leader in the effort to prevent the transmission of HIV/AIDS worldwide. It is through primary prevention that children of the future will be protected from the trauma of living with a parent who is ill or experiencing the death of a parent as a result of AIDS

SUPPLEMENTAL AND DCOF FUNDING
FOR CHILDREN AFFECTED BY HIV
COUNTRY TOTALS
FY 1999

COUNTRY	SF	DCOF
ANGOLA		$500,000
BURKINA FASO		$625,000
COTE D'IVOIRE	$200,000	
KENYA	$1,150,000	
MALAWI	$85,000	$372,000
NIGERIA	$815,000	
RWANDA	$1,000,000	$1,385,156
SOUTH AFRICA	$1,450,000	
UGANDA	$1,000,000	$1,000,000
ZAMBIA	$1,000,000	$1,208,875
ZIMBABWE	$300,000	
SUB-TOTAL	$7,000,000	$4,091,031
GLOBAL	$800,000	
HAITI	$200,000	
INDIA	$600,000	
CAMBODIA	$1,000,000	
NEPAL	$200,000	
BUREAU FOR HUMANITARIAN RELIEF	$200,000	
GRAND TOTAL	$10,000,000	$7,650,000

Are you aware of any successful World Bank Trust Funds?

Yes. The Onchocerchiasis Control Program Trust Fund (River Blindness) has been a very successful program. This trust fund has combined financial management by the World Bank and implementation by an African based program. Donors contribute a total of approximately $40 million to the trust fund annually; USAID provides $3.5 million. The private sector does not contribute to the fund, but do make free contributions separately of the key medication, ivermectin (Merck). Whereas the Bank provides overall management of the funds, the implementing agency is the WHO Onchocerchiasis program based in Burkina Faso. They manage the training, distribution of the medication, and monitoring interventions. Three years ago, donors established the African Program for Onchocerchiasis Control (APOC), also based at WHO Burkina, that now increases granting to NGOs, as well as to expand operations in 27 additional countries. Results have been dramatic with very large decreases in the incidence of river blindness.

In the case of OCP, donors have used the trust fund as their primary mechanism and the intervention is a relatively effective and straightforward one. With respect to HIV/AIDS, there are numerous donor and private sector mechanisms, and interventions to control HIV/AIDS are much more complex than that for OCP.

Do you believe that there is a need for a Trust Fund to encourage the World Bank and other donors, public and private, to contribute funds?

There are numerous mechanisms by which donors can contribute funds to the international fight against AIDS. These include bilateral programs, UNAIDS and their unified budget that distributes funds to other UN agency cosponsors, and direct contributions to UN agencies. The private sector has contributed funds in a number of ways. The World Bank is actively trying to step up its own HIV/AIDS program lending. It is not clear to us whether a World Bank trust fund is the answer or some other arrangement of an independent foundation could be of greater utility to meet the needs of multiple stakeholders. We are exploring various options at this time.

Would the US Government contribute to a World Bank Trust Fund?

To date, the primary US Government assistance for HIV/AIDS internationally has been delivered through bilateral arrangements. USAID's missions have been very effective in working collaboratively with countries to develop, implement and monitor HIV/AIDS prevention and care interventions that are tailored to the individual country needs. What has distinguished the U.S.' leadership in this field has been its strong field presence. The same holds true for HHS and other USG agencies active in this area. USAID works very closely with UN agencies such as UNICEF, UNDP, and WHO that are active in countries, as well as the World Bank. The USG contributes $15 million per year to UNAIDS, via USAID, to assist with international coordination. We do not expect a change in how USG assistance is channeled to implementing country based HIV/AIDS programs.

Question:

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

Answer:

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

Question:

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

Answer:

Question:

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

Answer:

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

Question:

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

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

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

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

Answer:

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

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

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

Question:

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

Answer:

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

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

Question:

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

Answer:

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

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

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

Question:

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

Answer:

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

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

Question:

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

Answer:

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

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

U.S. Department of State
Bureau of Oceans and International
Environmental and Scientific Affairs
Washington, DC 20520

Facsimile Transmittal

TO: USAID – Paul Delay (216-3046)
USAID – Alan Getson (216-3046)
USAID – Alex Ross (219-0506)
Commerce – Bill Hurt (482-2565)

FROM: OES/E/EID- Nancy Carter-Foster NCF by KL

SUBJECT: Clearance on Q&A for Amb. Holbrooke

DATE: March 6, 1999

We appreciate, of course, today's multiple top priority AIDS-related projects. Best as you can, please add this one to your list. Attached is the draft Q&A for Amb. Holbrooke in preparation for his testimony. We need to submit the final draft to his office by COB – **please clear the attached by 4 pm today**. We'll assume your clearance if we don't hear from you. Thanks.

Q's & A's for Amb. Holbrooke

Question:

What is the size of the AIDS problem in Africa? How many people have the virus and what countries/areas are hardest hit? Why is the problem so widespread?

Answer:

For some years, it has been clear that Africa - especially south of the Sahara - is the area of the world worst affected by HIV and AIDS. Infection levels are highest, access to care is lowest, and social and economic safety nets that might help families cope with the epidemic are badly frayed, in part because of the epidemic itself. To date, almost 70% (or 23.3 million) of the 33.6 million persons worldwide with HIV infection or AIDS live in sub-Saharan Africa. Sub-Saharan Africa is home to 13.7 million of the 16.3 million people worldwide who have died of AIDS since the beginning of the epidemic. In addition, projections indicate that by 2010, 40 million children worldwide will have lost one or both parents to AIDS - 95% in sub-Saharan Africa.

Higher infection levels among women and mother-to-child transmission contribute to the severity of the epidemic in sub-Saharan Africa. Recent studies by UNAIDS, conducted in rural and urban areas in nine different African countries, suggest that between 12 and 13 African women are infected for every 10 African men. There are a number of reasons why female prevalence is higher than male in this region, including the greater efficiency of male-to-female HIV transmission through sex, the younger age at initial infection for women, the lower status of women which severely restricts their power to make informed and safe choices and behavioral practices embedded in societal norms. As a result, more than half of all new infections in sub-Saharan Africa are among women and 80% of the 14 million HIV positive women of childbearing age live in Africa. Africa also has the lead in mother-to-child transmission of HIV. As prevention efforts elsewhere reduce the number of infants acquiring HIV, the number of child infections in Africa is staggering.

Question:

What are the relative death figures for malaria, TB, and AIDS? Which disease has killed more people)?

Answer:

In 1999, HIV/AIDS surpassed both malaria and tuberculosis (TB) in annual deaths.

AIDS - 2.6 million annual deaths
16.3 total deaths since beginning of epidemic

TB - 16 2.3 million annual deaths

Malaria - 1 million annual deaths
300-500 million clinical cases per year

Question:

What is the amount of USG funding for AIDS prevention worldwide?

Answer:

In FY-1999 the United States, through USAID, allocated $125 million to international HIV/AIDS, including $[illegible] million, or 25% of the funding, for the United Nations Joint Programme on AIDS (UNAIDS) in its efforts to coordinate UN agency activities to prevent HIV/AIDS. In July 1999, President Clinton announced the Leadership and Investment in Fighting an Epidemic (LIFE) initiative to address the global AIDS pandemic. As part of the LIFE initiative, the USG committed an additional $100 million in FY-2000 to fight HIV/AIDS in Africa and India. President Clinton is seeking an additional $100 million for the prevention and treatment of AIDS in Africa, Asia, and other areas of the world in the FY-2001 budget proposal submitted to the U.S. Congress, bringing the total USG commitment to the fight against AIDS to $325 million.

Question:

What is the amount of international funding (private, other countries, and US) for combating AIDS worldwide?

Answer:

There are not specific numbers for the amount of international AIDS funding worldwide, however in sub-Saharan Africa, where almost 70% of people living with HIV and AIDS live, all donors combined are currently contributing less than $350 million.

Question:

What are the best estimates we have about the level of worldwide funding needed to reverse the growth of AIDS?

Answer:

Although there are not comprehensive worldwide estimates of the funding needed to reverse the growth of HIV/AIDS, in sub-Saharan Africa alone, UNAIDS estimates that it will take $1 billion annually to establish an effective HIV prevention program. In addition, UNAIDS estimates that it will take a minimum of another $1 billion to begin to deliver even the most basic care and treatment to people living with HIV and AIDS in Africa.

1-2

Question:

Much of this discussion has focused on the crisis in Africa, but if HIV infection rates in Southeast Asia translate into cases of full-blown AIDS, we may be looking at a crisis of similar or even greater magnitude. What is being done to prevent the tragedy in Africa from repeating itself in Asia?

Answer:

One effort currently underway in Asia is the Secretary of State's diplomatic initiative on HIV/AIDS. U.S. ambassadors have been instructed to meet with their host governments to discuss HIV/AIDS not just as a health issue, but also as an economic, political, and security issue. It is a challenge to focus attention on AIDS at the highest level of government to garner critical national political awareness and support for HIV/AIDS prevention and treatment. In India, HIV infection rates, at less than 1% of the total adult population, are still low by the standards of many countries. However, India has the highest number of HIV/AIDS cases in the world. USAID has an active mission that has engaged GOI in a range of health (including emerging infectious disease) projects. In 1999, with a $41.5 million funding effort, USAID expanded its HIV/AIDS initiatives from Tamil Nadu into the state of Maharashtra, which accounts for more than 50 percent of all reported HIV and AIDS cases in India.

USAID is also working in Indonesia, the Philippines, Vietnam, Laos, Cambodia, Nepal, and Sri Lanka on primary prevention programs. The epidemic is nascent and programs are targeted at the highest risk populations (commercial sex workers and migrant men). USAID also supports study tours of Asian leaders to Africa to witness how serious the situation can become and to heighten awareness of the problem in an effort to stimulate national action.

Question:

What, in your view, are the advantages and/or disadvantages of creating a World Bank trust fund?

Answer:

Complete testimony

Final testimony as submitted

Testimony by

Sandra Thurman
Director, Office of National AIDS Policy

Before the

House Of Representatives
Banking and Financial Services Committee

March 8, 2000

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Initiative focuses on four key areas:

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

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

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

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

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

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

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

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

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

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

Thank you.

Global AIDS Legislation

Member	Bill	Purpose	Committee
Boxer – Smith – Kennedy	S. 2026 "Global AIDS Prevention (GAP) Act of 2000"	Authorizes $2 billion over 5 years for the Global AIDS program at USAID ($300, 350, 400, 450, 500 million). Not less than 50% for Africa. Funds are available until expended.	Senate Committee on Foreign Relations
Durbin	S. 2030 "AIDS Orphans Relief Act of 2000"	Permanently authorizes $50 million above funds currently authorized for AIDS or microfinance for microenterprise programs linked to AIDS programs in areas heavily impacted by AIDS; and $50 million for food assistance to individuals, households and communities affected by AIDS.	Senate Committee on Foreign Relations
Kerry – Durbin	S. 2033 (H.R. 3519 companion) "World Bank AIDS Prevention Trust Fund Act"	Directs the Secretary of Treasury to negotiate the creation of an AIDS Trust Fund at The World Bank with the Bank, member nations and other interested parties. Authorizes $100 million annually above funds currently authorized for multilaterals. (See Leach below)	Senate Committee on Foreign Relations
Moynihan – Feingold	S. 2032 "Mother-to-Child Prevention Act of 2000"	Authorizes $25 million annually for 5 years above current spending on reducing mother-to-child transmission to increase coordination and scale up effective programs. Funds are available until expended.	Senate Committee on Foreign Relations
Jackson	H.R. 2700 "Highly Essential Lifesaving Pharmaceuticals (HELP) for Africa Act"	No funds can be used to conduct clinical research in sub-Saharan Africa unless done in accordance with ethical standards and, if treatments are found safe and effective, would be made accessible to those in need. No funds for the revocation of intellectual property policies that comply with TRIPS.	House Committee on International Relations
Leach	H.R. 3519 "World Bank AIDS Prevention Trust Fund Act"	Directs the Secretary of Treasury to negotiate the creation of an AIDS Trust Fund at The World Bank with the Bank, member nations and other interested parties. Authorizes $100 million annually above funds currently authorized for multilaterals. (See Kerry above)	House Committee on Banking and Financial Services
Lee (+76)	H.R. 2765 "AIDS Marshall Plan Fund for Africa Act"	Create a new AIDS Marshall Plan Fund for Africa Corporation to provide grants for AIDS research, prevention and treatment and to solicit contributions from other nations and the private sector. Authorizes $200 million + 25% of contributions of others annually for 5 years. Appointments by the POTUS with Senate confirmation.	House Committee on International Relations

Legislative schedule:

Hearings: **Feb. 23 – Africa Subcommittee; Senate Committee on Foreign Relations**
March 8 – House Committee on Banking and Financial Services

Markups: **March 15 – House Committee on Banking and Financial Services**
March 22 – Senate Committee on Foreign Relations

106TH CONGRESS
2D SESSION

H. R. 3519

To provide for negotiations for the creation of a trust fund to be administered by the International Bank for Reconstruction and Development or the International Development Association to combat the AIDS epidemic.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 24, 2000

Mr. LEACH introduced the following bill; which was referred to the Committee on Banking and Financial Services

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A BILL

To provide for negotiations for the creation of a trust fund to be administered by the International Bank for Reconstruction and Development or the International Development Association to combat the AIDS epidemic.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ``World Bank AIDS Prevention Trust Fund Act''.

SEC. 2. FINDINGS AND PURPOSES.

(a) FINDINGS.Ð The Congress finds the following:

(1) According to statistics of the International Bank for Reconstruction and Development (World Bank), more than 90 percent of all adults and children with human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) live in the developing worldÐ 62 percent in Sub-Saharan Africa, 24 percent in Asia, and 6.9 percent in Latin America and the Caribbean.

(2) In Africa, the death toll from AIDS has reached 13,000,000, while 23,000,000 others live with the disease, and more than 10,000,000 children have been infected or orphaned by it.

(3) The World Bank, declaring AIDS not just a public health problem but the ``foremost and fastest-growing threat to development'' in Africa, has launched a new strategy for HIV/AIDS in Africa, declaring it a top priority for the Bank on that continent.

(4) The World Bank estimates that for Africa alone $1,000,000,000 to $2,300,000,000 annually is needed for prevention in the region in contrast to the modest $160,000,000 a year in official assistance currently available for HIV/AIDS in Africa.

(5) AIDS, like all diseases, knows no boundaries, and there is no certitiude that the scale of the

problem in one continent can be contained within that region.

(6) Accordingly, United States financial support for medical research, education, and disease containment as a global strategy has beneficial ramifications for millions of Americans and their families who are affected by this disease, and the entire population which is potentially susceptible.

(b) PURPOSES.—The purposes of this Act are to prevent human suffering and to ensure the viability of economic development, stability, and national security in the developing world by advancing research to understand the causes associated with HIV/AIDS in developing countries and to assist in the development of an AIDS vaccine.

TITLE I—NEGOTIATIONS FOR THE CREATION OF A WORLD BANK TRUST FUND TO ASSIST IN AIDS PREVENTION AND ERADICATION

SEC. 101. NEGOTIATIONS FOR THE CREATION OF A WORLD BANK TRUST FUND TO ASSIST IN AIDS PREVENTION AND ERADICATION.

The Secretary of the Treasury shall seek to enter into negotiations with the International Bank for Reconstruction and Development or the International Development

Association and with the member nations of such institutions and with other interested parties for the creation of a trust fund which could accept contributions from governments, the private sector, and nongovernmental entities of all kinds and use such contributions to address the AIDS epidemic in countries eligible to borrow from the International Development Association.

TITLE II—UNITED STATES FINANCIAL PARTICIPATION

SEC. 201. LIMITATIONS ON AUTHORIZATION OF APPROPRIATIONS.

In addition to any other funds authorized to be appropriated for multilateral or bilateral programs related to AIDS, there are authorized to be appropriated to the Secretary of the Treasury $100,000,000 for each of fiscal years 2001 through 2005 for payment to the trust fund established as a result of negotiations entered into pursuant to section 101.

TITLE III—REPORT

SEC. 301. REPORT TO THE CONGRESS.

Not later than 3 years after the date of the enactment of this Act, the Secretary of the Treasury shall submit to the Committees on Banking and Financial Services and on International Relations of the House of Representatives and the Committees on Banking, Housing, and

Urban Affairs and on Foreign Relations of the Senate a written report on the trust fund established pursuant to section 101, the goals of the trust fund, the programs, projects, and activities, including any vaccination approaches, supported by the trust fund, and the effectiveness of such programs, projects, and activities in reducing the worldwide spread of AIDS.

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4 - March 8

U.S. HOUSE OF REPRESENTATIVES

COMMITTEE ON BANKING AND FINANCIAL SERVICES

ONE HUNDRED SIXTH CONGRESS

2129 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6050

(202) 225-7502

March 16, 2000

Ms. Sandra L. Thurman
Director
White House Office of National AIDS Policy
736 Jackson Place
Washington, DC 20503

Dear Director Thurman:

Thank you for testifying at the March 8, 2000 hearing on the global AIDS crisis and on legislation (H.R. 3519) to create a new World Bank AIDS Prevention Trust Fund, held by the Committee on Banking and Financial Services.

A copy of your transcript has been provided should you wish to make any corrections. Please indicate these corrections directly on the transcript and return it **within fifteen (15) business days** to:

Committee on Banking and Financial Services
2129 Rayburn House Office Building
Washington, D.C. 20515
ATTN: Janice Zanardi

Rule XI, clause 2(e)(1)(A) of the Rules of the House and Rule XII, clause (3) of the Rules of the Committee state that the transcript of any meeting or hearing shall be "a substantially verbatim account of the remarks actually made during the proceedings, subject only to technical, grammatical, and typographical corrections authorized by the person making the remarks involved." We, therefore, ask that you keep your corrections to a minimum.

If there are no corrections to your transcript, please contact Janice Zanardi at (202)226-0464.

If during the hearing you: 1) offered to submit additional material; 2) were requested to submit additional material; or 3) were requested to respond to written questions, please return that material with the transcript.

Thank you for your cooperation and, again, for your testimony.

Sincerely,

Anthony F. Cole

Anthony F. Cole
Staff Director