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SAVING LIVES: THE DEADLY INTERSECTION OF AIDS AND HUNGER

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SAVINGS LIVES: THE DEADLY INTERSECTION OF AIDS AND HUNGER

TUESDAY, MAY 11, 2004

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

The committee met at 10:02 a.m., in room SD–419, Dirksen Senate Office Building, Hon. Richard G. Lugar (chairman of the committee), presiding.

Present: Senators Lugar, Alexander, Feingold, and Boxer.

OPENING STATEMENT OF SENATOR RICHARD G. LUGAR, CHAIRMAN

The CHAIRMAN. This meeting of the Senate Foreign Relations Committee is called to order.

During the past 16 months, the Foreign Relations Committee, on multiple occasions, has addressed the horrific consequences of the HIV/AIDS pandemic and global hunger. We are charged with overseeing international food assistance and the implementation of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003, which was signed into law last May. This 5-year, $15 billion initiative is unprecedented in its scope and its importance.

In February 2003, we held a hearing on global hunger issues. The hearing reminded us that in many parts of the world, food shortages are resulting in massive loss of life and threatening regional security. At that hearing, the issue of the AIDS crisis and its impact on food security was raised repeatedly. Today we intend to focus specifically on this catastrophic connection between the AIDS pandemic and hunger.

This hearing was originally scheduled for February 4 of this year, but was canceled due to the ricin incident that closed the Senate office buildings. We are fortunate to have another opportunity to pursue this important topic today. I want to thank our distinguished witnesses for their patience and their willingness to work with us in the rescheduling of the hearing.

We welcome today three close friends who have applied their extraordinary talents to bringing hope and relief to people around the world. We will hear from James Morris, Executive Director of the World Food Program; Ambassador Randall Tobias, Global AIDS Coordinator; and Andrew Natsios, Administrator of the U.S. Agency for International Development. It is a personal privilege to introduce fellow Hoosiers Jim Morris and Randy Tobias. Indiana is proud of the work they are doing. I also would extend a very warm welcome to Andrew Natsios who has been a good friend of the For-

eign Relations Committee and is working closely with us on many projects.

I would note parenthetically that Secretary General Kofi Annan sent Jim Morris to head a U.N. humanitarian assessment mission to the Darfur region of Sudan less than 2 weeks ago. His findings have been reported to the Security Council. He may wish to comment, to the degree that he can, on the disturbing situation that has seized the attention of the world in that country.

Given the infrequent opportunity to bring together all three of these well-traveled public servants, our hearing today is devoted to giving committee members an extended opportunity to engage with them. However, we also recognize the critical contributions of private voluntary organizations in addressing the twin problems of AIDS and hunger. Last week committee staff received an extensive briefing on this topic from members of the NGO community, including CARE, World Vision, and Catholic Relief Services. These private voluntary organizations are on the front lines in confronting AIDS and hunger, and we will continue to tap their extensive expertise.

Most of us by now are well aware of the devastation caused by the AIDS crisis. We have heard the figures: approximately 40 million people around the world are currently living with HIV. The epidemic killed more than 3 million people last year. Similarly, many of us know that millions of people go to bed hungry every night and that many, especially children, die of malnutrition caused by food shortages or famine.

What many people do not realize, however, is how each of these two crises exacerbate the conditions that contribute to the other. It is no coincidence that the prevalence of HIV/AIDS is highest in countries where food is most scarce. Because the disease affects people in their productive years, it has decimated the agricultural sector of sub-Saharan Africa, where approximately 80 percent of the population depends upon small-scale subsistence agriculture for their livelihood and food. Since 1985, more than 7 million agricultural workers have died of AIDS in 25 African countries. This places the burden of producing food on children and the elderly. In many places, fields lay untended with no one to work them. The AIDS crisis has left some 14 million orphans without parents to farm or otherwise provide food. In many rural households, AIDS has turned what used to be a food shortage into a food crisis.

This food crisis, in turn, is accelerating the devastation of AIDS. Without high-protein, nutrient-rich food, HIV-positive individuals become weaker, do not respond to drug treatment, and are more susceptible to other illnesses such as tuberculosis. Good nutrition is crucial for helping HIV-positive individuals maintain their strength and productivity as long as possible. This means that parents can continue to care for their children, teachers can continue to teach, and farmers can continue to farm. The head of UNAIDS, Peter Piot, said that when visited by relief workers, often the first thing people with AIDS ask for is not care or drugs or relief from stigma; they ask for food.

Food assistance is essential if we are going to make any headway in the struggle against the virus. Today we have a unique opportunity to explore the relationship between these deadly crises. If we

are serious about battling the AIDS epidemic, it is imperative we fully understand the AIDS-hunger cycle and examine our response to both problems in relation to each other. According to the World Food Program, more than 24,000 people die daily from hunger and related causes. According to USAID, nearly 8,500 people die daily from AIDS, and an estimated 14,000 people are infected every day. Every 14 seconds, as a matter of fact, AIDS turns a child into an orphan. Clearly we cannot afford to waste a single day in developing the most effective response possible.

In addition to exploring the complex dynamic between AIDS and hunger, we will discuss U.S. and multilateral efforts to address these related crises, including those of the Department of State, USAID, and the World Food Program. I am optimistic that today's discussion will enable us to understand more completely the deadly nexus between AIDS and hunger and to move forward on a more effective policy for their eradication.

I will, of course, yield to the distinguished Senator from Delaware, Senator Biden, should he attend later this hearing, for any statement that he may have.

I will ask Senator Boxer, who is here, if she has an opening comment for this hearing.

Senator BOXER. With your indulgence, Mr. Chairman, I would like to take just about 2 or 3 minutes here to thank you so much for holding this important hearing on the relationship between hunger and HIV/AIDS.

While this relationship is often overlooked, I am confident that this hearing will leave little doubt that these two issues are linked. You cannot prevent and treat AIDS without also addressing malnutrition, hunger, and poverty. Malnutrition makes AIDS sufferers so weak that they cannot work in their fields to feed themselves and their families. Lack of food leads to malnutrition and a weakened immune system. A weakened immune system makes one more vulnerable to AIDS. So, Mr. Chairman, what you have hit upon today is this deadly cycle.

The impact of this terrible epidemic is becoming clearer every day. As you said, there are an estimated 40 million people living with HIV/AIDS in the world. I come from the largest State in the Union. We have 35 million people in our State. So you could just think about every single person in my State suffering from HIV/AIDS, what that would do.

In closing, let me just throw a couple of statistics out here. Five million people were newly infected in 2003. Three million people died last year as a result of AIDS. Seven million agricultural workers in Africa have died of AIDS since 1985. And 16 million more agricultural workers in Africa could die by 2020. The most affected African countries could lose up to 26 percent of their agricultural labor force within the next two decades, and last, according to Bread for the World, HIV/AIDS and food insecurity have a disproportionate impact on women. Women are more vulnerable physically and culturally to HIV infection. At the same time, women produce up to 80 percent of the total food supply in sub-Saharan Africa.

So, Mr. Chairman, you have called it a crisis. You are right, but it is almost that there is no word that we could truly use today to

describe this. I just want to again thank you very much for your leadership.

The CHAIRMAN. Thank you very much, Senator Boxer.

We turn now to our three witnesses. First of all, I will mention that the text of your messages will be made part of the record in their entirety. Summarize if you wish or proceed in any way, but the purpose of the hearing really is to hear from you and to have as complete an understanding as possible of the interconnection and the importance of the subject matter.

I would like for the witnesses to testify in this order: first of all, James Morris; second, Randall Tobias; and third, Andrew Natsios. I introduce, first of all, the Honorable James G. Morris, Executive Director of the World Food Program of the United Nations, headquartered in New York, New York, but likewise in Rome, Italy where much of his time is spent. Jim, would you please proceed.

STATEMENT OF HON. JAMES T. MORRIS, EXECUTIVE DIRECTOR, WORLD FOOD PROGRAM, UNITED NATIONS

Mr. MORRIS. Thank you, Mr. Chairman, Senator Boxer. First, thank you both for your extraordinary, insightful opening statements. You have described the problem perfectly. Also, thank you for having met with CARE and World Vision and Catholic Relief, Save the Children. These are extraordinary private voluntary organizations that do remarkable work all around the world, and none of us would be able to achieve our objectives without these exceptional partners.

I appreciate your making some reference to the mission I headed a few days ago. I led the humanitarian mission to the Darfur region of the Sudan, including all of the U.N. humanitarian agencies. My partner was Ambassador Vraalsen from Norway who had been the Norwegian Ambassador to the United States and is the Secretary General's Special Envoy to the Sudan. We spent time conferring with the leadership of the country and then spent 3 days in the field in Darfur. I led the team to west and north Darfur and Ambassador Vraalsen took the team to the south.

I must report to you that this humanitarian crisis is of extraordinary seriousness. Today there are more than 1 million people displaced from their homes. They have been displaced in the most violent, mean-spirited way possible. Their homes have been burned. Their possessions have been taken. Their livestock has been stolen. The women have been raped. It would be hard to overstate how unpleasant this issue is.

I then went for a couple of days on my own just in my WFP role to Chad where I visited camps of another 100,000 refugees, half registered, half have just congregated. The conditions these people are living in are tragic, sad. It would break your heart. I visited a camp in Mornei, 60,000 people in the camp, 17,000 women, 9,000 men, and 34,000 children. Like most tragedies around the world, children are disproportionately affected and at risk.

This is all complicated by the rainy season which is approaching. But the fundamental issue is the government's willingness to provide protection and security, to get the Janjaweed and marauding militia from the north under control. The cease-fire between the rebels in the south and the government is doing pretty well, but

the government has the responsibility under the humanitarian cease-fire to look after and to control and manage the rebels from the north. And that is not happening.

I must tell you that I have never in my life seen a group of people so frightened, people frightened to leave the camp, people frightened to go home.

The rest of Sudan had a bumper agricultural crop this year, but the crop in the Darfur region was lost and the crop in the Darfur region will not be planted next year. So we will be sitting here a year from now with this same crisis on our hands. And the government's ability to get control of the rebels is the key.

We are making progress on humanitarian access. Our folks reported that we are now feeding about 800,000 of the people at risk, but the issues of water and sanitation and shelter and health care—at the same camp, Médecin Sans Frontière from France, just a few people providing all of the health care for the camp. Five weeks ago, a few hundred children under 5 chronically malnourished; today, more than 2,000. So the humanitarian tragedy is enormous.

I must pay tribute to Andrew Natsios and my colleagues at USAID for their extraordinary work in making it possible for the humanitarian community to respond. But this is an issue that is of great tragedy.

When I left, I was asked by the media, Jim, is this most serious humanitarian crisis in the world today? Clearly, 1.2 million, 1.3 million are at risk. By year end, it could be double that. And I said, this is a very serious problem. But in all candor, I have to report in my own view that the crisis of HIV, especially in sub-Saharan Africa, is the most extraordinary humanitarian crisis in the world today. You both correctly point out that more than 40 million people are infected. And 75 percent of them are in sub-Saharan Africa. Seven million farm workers have lost their lives. To put that in context, that is more than twice the entire on-the-farm population of the United States and Canada.

An overwhelming burden on the health care system in Africa, a system that is almost nonexistent, but now overwhelmed by HIV/AIDS. The number of orphans, 14 million today, going to 20 million. And 2.2 million people died in sub-Saharan Africa.

The life expectancy in many parts of Africa has been absolutely cut in half. Years ago, the life expectancy in Zimbabwe was 67 years. Today it is 33. A staggering impact on a population.

Think about a country that has a population of 11 million to 12 million people. Thirty-five percent of the adults are infected with HIV. With 800,000 to 900,000 orphans. A dramatically deteriorated agricultural system. No foreign exchange. Tough weather issues. Challenges of governance. Dramatically diminished health care. Virtually dramatically diminished public finance system. Tens of thousands of households headed by children. It is not uncommon to see a little girl the size of my 8-year-old granddaughter, she is 15, listless, sick, sad, not educated, hungry playing mother and father to a family of five or six children. If it was a few, it would be one thing, but it is there by the hundreds of thousands.

The burden on the elderly, almost beyond comprehension. The 7 million lives that have been lost in agriculture or the 2-plus million

that were lost are the most productive people. You will see a grandmother in her 70s, very slight, often looking after 20 or 30 children, and she has nothing.

WHO would tell you that undernourishment is the most serious health problem in the world. The lack of micronutrients, a top 10 health problem, the lack of iodine, iron, vitamin A, zinc. You correctly state that 24,000 people die of issues related to hunger every day, 18,000 of them children. You need to know that they do not die in high profile crises. The world is focused today on the Sudan. It has been focused on Ethiopia. But 90 percent of people who die of hunger-related issues die off in the back woods on a dusty road somewhere totally unnoticed.

It is easier for us to raise resources for high profile crises. Our great need is to have resources to address hunger and nutrition and now HIV/AIDS in places that do not make the headlines. AIDS has become the sinister element in hunger.

If I could just, as I head into my comments, thank the United States. As an American, I have been overwhelmed the last 2 years with the generosity of cash and resources and caring and brain power of USAID and the U.S. missions around the world. Last year the United States provided well over half our budget of a billion and a half dollars. The President's commitment, which Randy leads, to address AIDS is the single most important step forward that has happened in the history of this crisis. Eighty percent of the research for HIV comes from the National Institutes of Health in the United States.

This committee should take time this year to celebrate the 50th anniversary of Food for Peace started by President Eisenhower in 1954. This initiative now for 50 years has saved millions of lives and enhanced the lives of millions more.

Food and nutrition, critically important. You correctly quote Peter Piot when he says, I go to a village in Malawi and talk about what are the needs of people infected with HIV, and the first thing they ask for is food.

The burden on women is enormous. Women provide 80 percent of the agricultural production in sub-Saharan Africa. They now have close to 60 percent of the HIV infections, and they provide 100 percent of the care in the household. They ask for food.

I think it is always good advice to listen to the people who are most seriously affected by a crisis. They need food, but they also need water, clean water, and they need access to education. AIDS and hunger interact. AIDS dramatically undermines food production. The loss of 7 million agricultural workers, to say nothing of the 16 million on the horizon, and the debilitating effect AIDS has had on people still living and their inability to be productive. Malnourished bodies are more receptive to HIV and more receptive to the opportunistic diseases that follow.

The exploitation of hungry, poor people is enormous. Poverty increases vulnerability to HIV. AIDS increases the risk of poverty.

The stigma attached to all of this is enormous and it makes it much more difficult for us to target direct response to a person infected. We generally find ourselves responding to communities where we know there is a high rate of incidence.

We are very focused on children and orphans, an unbelievable burden on children who have lost their parents to HIV. The psychological loss, much more likely to be malnourished, more vulnerable to abuse, more vulnerable to HIV themselves, less likely to go to school, and less likely to get health care if you are an orphan. Maybe the only thing worse than being an orphan is being the child of a parent who is dying of AIDS, to have that experience. The sacrifices of children for their parents in these circumstances are extraordinary.

I have talked about the impact on the elderly, on grandparents, on the extended family. Africa has a great tradition of the extended family taking care of kids at risk and orphans. But the burden of 14 million HIV orphans, together with 26 million more orphans in sub-Saharan Africa is becoming an overwhelming burden on the extended family.

Food aid is critically important, and there has been a substantial decrease in food aid in the world in the last several years. But food aid is critical to feeding children, especially children in shelters and centers. Food aid is critical as an incentive to bring children in for vocational training. Food aid is critical to help provide support for foster families.

We are very focused on children being enrolled in school. There are 820 million hungry people in the world, more than 300 million hungry children. Half of them do not go to school. Most of those that do not go to school are girls. There is no substitute for the power of the investment of feeding a child to see that a child gets one good meal every day and using that as an incentive for that child to go to school. We know what it has meant to our own country. We know what it has meant to Japan and the rest of the world is no different.

Education ultimately is the hope for addressing the HIV epidemic. Kids come to school. They have a chance for HIV education. More importantly, they have a chance to generally be educated and begin to have some sense of what their lives might be, to have more hope for their lives and who they might become.

And I cannot overstate the importance of this particular issue on young girls. A girl is fed, is incented to come to school. If she only comes for a few years for primary education, her life will never be the same. Her child-bearing habits are different. Her aspirations for her children are different. She will be a different kind of parent. She will be a different kind of citizen.

When you think that we can feed a child in school for $35 a year and for 30 cents provide the medicine to get rid of the worms, there is no more powerful leveraged investment the world can make in the future for its children but for itself than providing food for kids to go to school. School feeding has enormous nutritional impact, and clearly reduces the vulnerability for HIV/AIDS.

The McGovern-Dole school feeding program, which this Congress made possible, provided $300 million to feed 8 million school children in 2001. Today in 2004, you provided $50 million and we are only able to feed 1 million school children. We have done a good job of encouraging the rest of the world to help us with this program. We have numerous countries helping us now, and my hope is that as you think about ways you can help us address the HIV

issue, the orphans issue, that you will be focused on the McGovern-Dole school feeding program. Nothing more important than the well-being of children. The best chance we have to make progress on the HIV/AIDS issue is to educate children between the ages of 5 and 15 about the seriousness, the hazards, the dimensions of HIV, and that best occurs in the school.

Randy will talk in a few minutes, I am certain, about antiretroviral drugs. People in the United States, the NGO community, the pharmaceutical industry, all around the world have done a terrific job in bringing down the price, the cost of antiretroviral drugs, still not within the reach of very, very poor people, but more accessible than historically has been the case.

Antiretroviral drugs [ARVs], medicine generally, only work in a well-nourished human being. For ARVs to work against HIV—the same scenario applies to tuberculosis—a well-nourished body with access to clean water, a strong diet is key to making the ARV situation productive. We can feed a person who is vulnerable, who is going to take ARV for 29 cents a day. Many have said that adequate food and nutrition is the first line of defense in the fight against HIV. A person that has access to food and nutrition and water and antiretroviral drugs has a chance to get back on their feet and to have a prolonged life.

I was in Haiti a few days ago, another tough, tough place, once again a place where the U.S. mission is playing quite a remarkable role. We have a great U.S. Ambassador there. But I had a lady I visited with, working in clinics. The highest HIV prevalence rate in the Western Hemisphere and the largest calorie deficit of any country in the world, by the way. But a lady said, you know, Mr. Morris, "do I spend what I have to feed my children today or do I pay for drugs I need to stay alive for them tomorrow?" A question none of us want to have to answer, but it is a question that lots of people are facing. And we know that at the end of the day, the poorest in the world will be the last to have access to antiretroviral drugs, and the most important investment we can make in them in the interim is access to food and good nutrition.

I do not know what value we put on keeping someone alive, giving someone a few more days or a few more months with their children, but I suspect it is a very high value. So my message is that the HIV crisis, especially in Africa, especially in some countries in the deepest southern part of Africa, the issues are so extraordinarily difficult that it will be curious to know how these places will have a chance to survive and come out of this. They will have no chance without help from the rest of the world. Our investment in food and nutrition is at the base of getting rid of poverty. It is at the base of good health care. It is at the base of gender equity. It is at the base of universal primary education. It is at the base of solving infant mortality and addressing issues of maternal health. And it is absolutely the key issue in getting on top of the HIV crisis and all of the other health issues that stem from it.

The World Food Program operates all over the world. We have special HIV programs in 40 countries, 30 countries in Africa, and we have special programs in 21 of the 25 most heavily affected countries in Africa. I should tell you that we have done all of this without financial incentive or encouragement from anyone in the

world. We have done it because it is at the base of solving the problems of the hungriest and poorest people in the world.

So I am grateful for this chance to tell this story. It is an enormously important story to humanity, but it is likely a story with the right focus and the right resources that we can, over time, get on top of. The United States has been extraordinarily generous, has set the pace. We have negotiated a new partnership with the Clinton Foundation last week to work in Tanzania and Mozambique and that is a good thing.

But as is usually the case, the world will continue to rely on leadership from the United States to solve the toughest of problems, and this is clearly one of them.

Thank you, sir.

[The prepared statement of Mr. Morris follows:]

PREPARED STATEMENT OF HON. JAMES T. MORRIS

Mr. Chairman. During the course of this hearing several hundred people will die from hunger. Most of the victims will be malnourished young children too weak to fight off disease. Their deaths will occur quietly in dusty villages in Malawi, the slums of Mumbai, the highlands of Peru. These deaths will not make the news.

Hunger only captures the headlines at the height of crises caused by politics and natural disasters—the war in Iraq, the violence in Darfur, drought and civil conflict in Afghanistan. The fact is that only 8 percent of the deaths from hunger occur in these types of dramatic food emergencies. It is not that these operations are not urgent—and right now we face severe shortages in funds for Angola and the DPRK—but they are usually far better funded than efforts to combat chronic hunger.

On average, 80 percent of the money donors give to the World Food Program is earmarked for high profile emergencies. There is no clearer confirmation of what people in the humanitarian community call the CNN effect—money follows the media. If there are no horrible images of skeletal babies, no food riots, no mass movements of starving people, the cameras are soon gone. And often, so is the money.

Unfortunately, for over 800 million people, the struggle to find enough food goes on off camera. Hunger and hunger-related diseases still claim more lives than AIDS, tuberculosis and malaria combined.

Of the 10 greatest threats to public health, my colleagues at WHO tell us that undernutrition is still number one and deficiencies in micronutrients like iron, iodine and vitamin A rank number eight. (WHO, 2002) One in 4 of the world's children under 5 years old is underweight—168 million all told; 181 million are stunted from longterm undernutrition, and 51 million are wasted from short-term severe malnutrition. The life of a child is lost every 5 seconds because we have failed to end widespread hunger and malnutrition.

Much of the silent suffering from hunger today is among millions of victims of AIDS and their families. AIDS has added a new, more sinister element to the dynamics of hunger. I have been asked to give you an overview of global food issues and then focus in on the lethal connection between the AIDS pandemic and the growing incidence of chronic hunger in developing countries, especially in Africa.

Before getting into the main portion of my testimony, I must point out that the United States has been—and continues to be—extremely generous to the World Food Program. The US provided nearly $1.5 billion to WFP last year, once again ranking as the top donor.

WFP has also been working closely with our other top traditional donors around the world to increase contributions, while we are aggressively pursuing donations from more non-traditional donor states as well as individuals throughout the world.

The struggle for resources is ongoing—and one that we share with USAID, NGOs and others who are working to reduce hunger and poverty around the world.

HUNGER AND AIDS

Mr. Chairman, we are in danger of falling even farther behind in the battle to end hunger unless we come to grips with the interaction between hunger and the AIDS epidemic in the developing world. We tend to see AIDS through the lens of our own experience here in the United States, while the economic and sociological dynamics are very different in Mozambique, Cambodia, or Zimbabwe.

The AIDS coverage in the media focuses heavily on the demand for anti-retroviral drugs, but if you were to go out and talk to families in southern Africa, the hardest hit region, you would get a very different picture. These people talk about food.

My good friend Peter Piot, head of UNAIDS, often relates a story about one of his first visits to Africa: "I was in Malawi and I met with a group of women living with HIV. As I always do, I asked them what their highest priority was. Their answer was clear and unanimous: food. Not care, not drugs for treatment, not relief from stigma, but food."

Is that so surprising? My colleagues at FAO calculate that 7 million farmers have been lost to AIDS in Africa alone, the continent with the worst food security problems in the world. Eight out of 10 farmers in Africa are women, mostly subsistence farmers, and women are disproportionately affected by the disease.

So my first message on AIDS to the Congress is simple—let's start listening to people living with this horrible disease. As Randy Tobias—a close friend for decades—shapes President Bush's great initiative I know he will listen. Ending AIDS is not a battle we will win with medicine alone—we need proper nutrition, education, clean water. We need integrated packages of assistance or we run the risk of tossing our money away.

AIDS and hunger interact. They feed off one another. Why is food such a big issue for the families affected by them?

• First, the disease is seriously undermining food production. With millions fewer farmers working, there is less food. Weakened HIV-positive farmers who can still work are not as productive and less capable of earning off-farm income as well. As farmers earn less, they cannot afford fertilizers and other farm inputs. Harvests dwindle further and they enter a downward spiral, selling what assets they have and sliding into abject poverty. Soon enough, their families go hungry.

• Then there is the nutritional dimension. Malnourished bodies are more prone to disease, including AIDS. People who are both HIV positive and malnourished are especially susceptible to opportunistic infections, most notably tuberculosis.

• Hungry people are also more vulnerable to exploitation. Prostitution is especially rampant in poor communities where people simply do not know where they will get their next meal. Poverty-stricken families look the other way as uneducated girls earn money in one of the few ways they can.

There is a vicious cycle at work here. Poverty increases vulnerability to HIV infection. AIDS increases the risks of poverty. But for communities seeking to find their way out of the cycle the way forward is anything but clear. For one thing, the stigma of AIDS discourages testing and we usually do not know who is HIV positive and who is not. So successful interventions must often target whole communities where we know the disease is taking its heaviest toll.

There are three specific ways WFP and our NGO and government partners can intervene to help:

First, we must do everything that we can do TODAY to meet the needs of the orphans and vulnerable children—in particular those in the most affected communities.

The number of orphans in sub-Saharan Africa is huge, growing and likely to continue to grow. By 2010, some 20 million children will have lost one or both of their parents to AIDS.

Combined with other causes—including war and other diseases—the total number of orphans is an almost incomprehensible 40 million young people. That may seem a large burden for the world to bear. The real burden is borne by the families and communities on the frontline of the epidemic. And by the children themselves.

In addition to their deep psychological loss, orphans between 10 and 15 years old are subject to higher rates of malnutrition, physical and sexual abuse, and exposure to HIV. And they are much less likely than children whose parents are alive and well to go to school or get health care.

These are brutal facts. But one even more jolting is that as bad off as orphans are, many children whose parents are sick with AIDS can be even worse off. They must watch their parents die, grow poor as the household's income dwindles, and deal with the trauma of rejection as neighbors—even some family members—shun them.

These kids are the ones who shoulder the real burden of the pandemic. They are sacrificing their childhoods and futures to nurse sick parents and earning money for their families' survival. AIDS has turned a generation of children into parents—especially in Africa. It is not unusual to see a 10 or 12-year old raising siblings without the guidance of an adult.

Once orphaned, millions of children are shifted from household to household—and sometimes from household to the street. It is the elderly of Africa, especially women, whose backs are further bent under the weight of providing these children with

food, shelter and—in the very best of circumstances—a school uniform and fees so they can resume their education.

Food aid has an important role to play in helping families and communities in supporting orphans and vulnerable children. For example, we use food aid to:

- directly feed children in shelters and centers;
- support vocational training programs;
- make sure that foster parents—including grandmothers who are sometimes looking after a dozen of their grandchildren—can feed them all; and
- bolster the family larder with take home rations so kids can be kids and go to school instead of working the fields or running off to the nearest city.

Right now, we are only scratching the surface. We can do so much more.

Second, we must do everything we can to help children in the most affected communities and countries enroll in school—and attend regularly.

There is such strong agreement that education is our most immediate hope for addressing this epidemic. When it comes to HIV prevention, it's been called the "education vaccine". I'm not just referring to HIV prevention education, as important as that is. I'm talking about something much more powerful than that—the skills and social norms that we learn in a safe and nurturing school environment. It can shape who we are, how we relate to others, and what we are able to do with our lives—for ourselves and others.

Helping children to attend school longer—especially girls—has a proven record for interrupting the spread of HIV. The longer a girl attends school the more knowledgeable she becomes. Knowledge is power and it's that personal power that enables young people to better manage the circumstances around them and better judge the actions of others. This translates into positive and healthy behaviors that last a lifetime.

Mr. Chairman, food aid has an important role to play in strengthening schools, particularly in those communities most affected by AIDS.

- We know that one nutritious meal a day at school can improve enrolment, attendance and academic performance—we have seen enrolment climb up to 300 percent in schools that provide meals.
- We know that where school-feeding programs involve the community, schools become platforms for AIDS awareness and HIV prevention, health and nutrition education, agriculture and skills training.
- And we know that take-home rations for the most vulnerable children can offset the family's cost of sending them to school—a major issue in families where the breadwinner has AIDS.

School feeding both mitigates the nutritional impact the epidemic has directly or indirectly on children and also helps reduce their vulnerability to HIV infection by promoting education. It stands out as one of the few interventions which we can effectively target at communities with high HIV rates—and scale up rapidly.

I am concerned that funding for school feeding has dropped off. The US has always been a generous contributor and we need other countries to do more as well. In 2001, $300 million in USDA funds were allocated to school feeding under the McGovern-Dole initiative and in the FY 2004 budget the figure fell to $50 million. With the $300 million we had in 2001, nearly 8 million children were being fed in school in countries like Afghanistan, Nicaragua, and Kenya by WFP and our NGO friends. Barely 1 million will now be receiving help from this worthwhile program.

Knowing what we do about the benefits, this Congress should actively support a drive to extend school feeding to every school in every community currently most affected by the epidemic.

Congress should also look at funding a full package of assistance needed by hungry, poor people. That is to say—food, water, medicine and shelter are all needed together. All humanitarian organizations, from WFP to UNICEF to our PVO partners, require this full package of assistance to appropriately address the needs of the most vulnerable.

Third, Mr. Chairman, we must do all we can to use food and nutritional assistance to maximize the benefits of therapeutic drugs for AIDS and related conditions.

Medicine only fully works its magic, however, on a well-nourished person who has access to clean water and good diet. In short, those living with HIV/AIDS need food, water and medicine.

Leading nutritionists throughout the world tell us that adequate nutrition is the first line of defense in the battle against HIV/AIDS. We also know that the populations that are the poorest and most food insecure, and currently receiving food aid, are not always the same populations who are infected and affected by HIV/AIDS.

Therefore, WFP and our PVO partners need ADDITIONAL RESOURCES to help feed this highly vulnerable population. In short, we are already stretched thin by dozens of emergencies around the world—from Haiti to Sudan—yet we are serving only 10% of the world's hungry population. We need more resources to expand our efforts to fight the HIV/AIDS pandemic. We cannot reprogram our limited resources that are already deployed around the world to the poorest, most vulnerable areas.

Anti-retroviral drugs can work wonders. So can medications to treat the most common opportunistic infection, tuberculosis. In hard hit communities, these drugs can help put sick people back on their feet again.

Food and nutrition programs have a vital support role to play here. AIDS is no different from any other disease when it comes to one basic fact—our bodies need good nutrition to fight off infection, regain strength and live productively.

Good nutrition can help to make AIDS and TB drugs work their miracles. Especially in symptomatic periods where caloric requirements are greater and capacities to work compromised, food and nutritional support can be critical. In countries like Cambodia, Lesotho and Uganda, WFP has successfully used food rations as an incentive to keep TB patients coming back for the full course of drug treatment which helps prevent mutations that cause everyone concern, even here in the United States.

CONCLUSION

Last month, I was in Haiti visiting our operations there. The island is the worst hit by AIDS in the entire hemisphere and tuberculosis is widespread. I heard a saying Haitians use about TB I found fascinating. "Giving a TB patient medicine with no food is like washing your hands and drying them in the dirt." It's a point we might well remember as we grapple with AIDS.

I don't think any one of us could think of a worse choice than one that faces so many parents with AIDS—"Do I spend what I have to feed my children today or pay for the drug therapies I need to stay alive for them tomorrow?" Imagine that kind of choice in your life.

The World Health Organization, UNAIDS, the world's pharmaceutical companies, private foundations, activists and governments are now doing a tremendous job of reducing the cost of AIDS drugs for the poor.

But now, after having taken the bold leap to help the poorest with ARVs, why would we not want to get the most out of those investments? Why would we not ensure adequate nutrition for those receiving ARVs to strengthen their bodies as they fight the disease? Why wouldn't we ensure the food-security of their families while they regain their strength?

Sadly, for many, anti-retroviral drugs will come too late or not at all. Even under the most hopeful scenarios, millions of people won't have access to them soon. I'm talking about poor people who live in communities with no clean water and no health clinic. Rural villages and poor subsistence farmers may well be last in line once ARV therapies are more widely available and that will further damage agriculture.

Mr. Chairman, when it comes to humanitarian aid, governments don't lead, they follow. Already there are thousands of community and faith-based organizations out there working in the greatest humanitarian tradition, easing the suffering from AIDs and hunger. Before closing I'd like to give you just one example.

There is an NGO that WFP works with in Uganda—the National Community of Women Living with AIDS. One of our beneficiaries is Yudaya Nazziwa, a forty-one year old widow. Yudaya is preparing to die. She has AIDS and each day she writes into a journal something of her family history and practical advice for her oldest daughter. The Ugandans call these journals "Memory Books". Her tale is painful, but sadly, it is not unusual—her husband died of AIDS and his relatives took over her comfortable home and possessions. She and her four children now live in a slum and depend on WFP food aid to survive. Yudaya is tough and wants to hang on as long as she can—to work if possible and pass on what she knows to her children. Food aid is keeping her nourished, helping her fight off diseases. As she puts it: "Now I have to eat for two—for myself and the virus." Maybe one day—let's hope soon—Yudaya will be on anti-retroviral drugs. President Bush's massive multi-billion dollar campaign headed by my good friend Andrew Tobias, holds out that hope. But for today, food aid is helping keep people like Yudaya alive and even if she does get medication soon, we all know that a well nourished patient stands a better chance of survival.

I want to add one more chapter to the Memory Books of these Ugandan women—a chapter about how we all helped keep them alive and their families together.

This is the greatest humanitarian challenge of our time. I am so deeply proud that President Bush has made the enormous commitment he has and called on talented people like Randy Tobias and Andrew Natsios to take this challenge on. All of us at the World Food Program are ready to give it all we've got to help.

The work is not done out there. We can and we should do more for the 800 million people going to bed hungry every night. I know the US Congress has limited choices with fewer dollars available. But, working together—with the White House, with Congress, and with USAID, with USDA, with the State Department, with our private, voluntary partners, and with generous everyday Americans, we can make a difference.

WORLD FOOD PROGRAMME

The Food Aid Organization of the United Nations

NEWS RELEASE—11 MAY 2004

AIDS COMPLICATING BATTLE AGAINST HUNGER, SAYS WFP EXECUTIVE DIRECTOR

WASHINGTON, DC.—James Morris, the Executive Director of the United Nations World Food Program (WFP), today testified before Congress on the growing hunger problem around the world and how it is exacerbated by the AIDS crisis.

More than 40 million people are infected with HIV and some two-thirds of them live in conditions of severe poverty in sub-Saharan Africa. Morris highlighted to Congress the critical role that food aid plays in helping people living with HIV/AIDS fight the disease.

"Ending AIDS is not a battle we will win with. medicine alone—we need proper nutrition, education, and clean water," Morris told the Senate Foreign Relations Committee. "The AIDS coverage in the media focuses heavily on the demand for anti-retroviral drugs, but if you were to go out and talk to families in southern Africa, the hardest hit region, you would get a very different picture. These people talk aboutfood."

People need good nutrition to fight off infection, regain strength and live productively. Malnutrition breaks down people's immune systems, and makes them more prone to disease, including AIDS.

Morris also appealed to Congress to put a greater priority on funds for people suffering from chronic hunger, rather than just on the victims of high-profile disasters and emergencies.

"During the course of this hearing several hundred people will die from hunger," Morris told Congress. "Most of the victims will be malnourished young children too weak to fight off the disease. Their deaths will occur quietly in dusty villages in Malawi, the slums of Mumbai, the highlands of Peru. These deaths will not make the news."

Every five seconds, a child dies from hunger-related diseases, and malnutrition is still the number one public health threat around the world. More people die from hunger-related causes than from AIDS, tuberculosis and malaria combined.

The US government has been the top donor to WFP since its inception in 1963 and continues to be the agency's most generous contributor. Last year, the US government donated nearly US$1.5 billion for feeding programs in countries ranging from Afghanistan to Iraq to Zambia.

Currently, more than 800 million people are chronically hungry, a figure which increased by 18 million in the second half of the 1990s. One in four of the world's children under five years old is underweight—168 million all told. At the same time, WFP is facing a shortfall in 2004 of 1.8 million metric tons of food or $1 billion for critical operations in 2004.

Morris also recommended that Congress provide more food assistance to AIDS orphans—expected to rise to 20 million children by 2010—and increase school feeding programs. WFP provides nutritious school meals to children in 69 countries to attract them to school, increase retention rates and improve learning ability.

"Helping children attend school longer—especially girls—has a proven record for interrupting the spread of HIV," said Morris. "The longer a girl attends school, the more knowledgeable she becomes. This translates into positive and healthy behaviors that last a lifetime."

In his testimony, Morris noted his concerns about the growing humanitarian crisis in the Darfur region of western Sudan, which has led to more than one million people being displaced from their homes and more than 100,000 refugees fleeing to

Chad. Morris led a high-level UN inter-agency assessment mission to Darfur and Chad at the end of April.

"What we witnessed throughout Darfur and in neighboring Chad is a dramatic humanitarian crisis, no doubt one of the worst in the world today. It is a crisis of massive displacement, critical humanitarian needs and extreme levels of violence and fear," said Morris.

* * *

WFP is the world's largest humanitarian agency: in 2003 we gave food aid to a record 104 million people in 81 countries, including 56 million hungry children.

WFP Global School Feeding Campaign—For just US$19 cents a day, you can help WFP give children in poor countries a healthy meal at school—a gift of hope for a brighter future.

Visit our website: www.wfb.org

The CHAIRMAN. Thank you very much, Mr. Morris, for that very compelling testimony.

I want to introduce now the Honorable Randall Tobias, Global AIDS Coordinator, Department of State, Washington, DC. Mr. Tobias, would you proceed.

STATEMENT OF HON. RANDALL S. TOBIAS, GLOBAL AIDS COORDINATOR, U.S. DEPARTMENT OF STATE

Ambassador TOBIAS. Mr. Chairman, thank you and thanks to the members of this committee for the opportunity today to talk about the very important relationship between the global HIV/AIDS pandemic and hunger.

I am particularly pleased to appear this morning with my U.S. Government partner in this effort, Andrew Natsios, and my longtime friend, in fact, my friend for almost 43 years, Jim Morris, the Executive Director of the World Food Program.

Mr. Chairman, I appear before you today, 7 months after my confirmation hearing, my last appearance before this full committee. Since that time, I have had the opportunity to visit many of the countries in which we are focusing our efforts, including South Africa, Uganda, Kenya, Botswana, Zambia, Namibia, Rwanda, Ethiopia, and Mozambique, and I will be leaving in the days ahead for a visit that will include Nigeria, Cote d'Ivoire, and Tanzania.

I am pleased to report that in those 7 months, I think we have made historic progress in beginning to achieve, the President's, the Congress', and the American public's goal of bringing prevention, treatment, and care to millions of adults and children who are courageously living with HIV/AIDS, and these efforts are replacing despair with hope.

Early this year, I submitted to you and to other appropriate congressional committees a comprehensive 5-year strategy to implement the President's Emergency Plan for AIDS Relief. The strategy is guiding our efforts to rapidly expand prevention, treatment, and care, to identify new partners, to build capacity for long-term success, and to amplify the worldwide response of HIV/AIDS by working with other partners.

Let me also note that in February, less than a month after Congress appropriated funds for the first year of the President's Emergency Plan, I announced $350 million in initial, first-round awards to service providers, NGOs and others who are bringing relief to suffering people in some of the countries hardest hit by the HIV/AIDS pandemic. These awards are already rapidly scaling up pro-

grams that provide antiretroviral treatment, prevention programs, including those targeted at youth, safe medical practices programs, and programs to provide care for orphans and vulnerable children.

With just this first round of funds, an additional 50,000 people living with HIV/AIDS in the 14 focus countries of the Emergency Plan will begin to receive antiretroviral treatment which will nearly double the number of people who are currently receiving treatment in sub-Saharan Africa. Today activities have been approved for antiretroviral treatment in Kenya, Nigeria, and Zambia, and patients are receiving treatment in South Africa and Uganda because of the Emergency Plan.

In addition, prevention through abstinence messages will reach about 500,000 additional young people in the plan's 14 focus countries in Africa and the Caribbean through programs like those of World Relief and the American Red Cross' Together We Can program.

The first release of funding from the President's plan will also provide resources to assist in the care of about 60,000 additional orphans in the plan's 14 focus countries. Care will include providing critical basic social services and scaling up basic community care packages of preventive treatment and safe water, as well as HIV/AIDS prevention education.

This is only the beginning of our efforts. Later this week or early next week, Mr. Chairman, we will be providing this committee and other congressional committees with the required notification for the obligation of approximately an additional $300 million which will be our next tranche of funding. I seek your support in ensuring that we are able to move these resources as quickly as possible so we can continue to respond with urgency that these individuals so require.

As we make additional awards, the numbers of persons receiving treatment and care will increase substantially. I also expect an increase in our efforts to strengthen and expand safe blood transfusion and safe medical injection programs, as well as our efforts to strengthen human and organizational capacity through health care twinning and volunteers.

The President's Emergency Plan has three clear goals to be achieved over the next 5 years in 14 countries in sub-Saharan Africa and the Caribbean: first, as you know, it is to treat 2 million HIV-infected people with antiretroviral therapy; second, to prevent 7 million new infections through increased HIV testing and through behavior change; and third, to provide care for 10 million HIV-infected individuals and the children that Jim has mentioned who have been so devastated by this pandemic. This comprehensive and unparalleled approach through integrated treatment, prevention, and care is essential if we are to be successful, as we must be, in this global fight against HIV/AIDS.

But, Mr. Chairman, as important as all of this is, clearly this program, the President's Emergency Plan, is not the whole answer. The President's initiative is intended to be part, but only part, of the potential solution to a very complex and multifaceted set of issues surrounding HIV/AIDS. This is a global pandemic that requires resources well beyond the scope of the President's Emergency Plan, resources focused on additional aspects of human need.

The President's Emergency Plan is largely a health care-based program focused on prevention, treatment, and care. It does not directly address hunger, but as you and others have correctly suggested, hunger and nutrition and a wide range of other issues are clearly linked to successfully addressing HIV/AIDS. We recognize that food security, good nutrition, and clean water are inextricably linked to successfully fighting AIDS. Without access to safe and adequate food, people are less able to effectively respond to AIDS treatment.

Moreover, drug resistance grows if people fail to stay with their treatment regimens. Persons living with HIV/AIDS but without access to sufficient food have less time to focus on care, and they pay less attention to issues of prevention. At the same time, we know that HIV/AIDS exacerbates food insecurity, production shortages, and long-term agricultural knowledge loss.

To succeed in this battle, we must recognize the important relationships between hunger and HIV/AIDS, and we must work together in every way we can within our own government, as well as with other partners, including other governments, international organizations, the private sector, and nongovernmental organizations, to tackle this problem and turn the tide against HIV/AIDS. We must find every possible way to coordinate our efforts with those of other programs that bring resources to address hunger and the other related issues.

One of the most socially and economically destructive aspects of HIV/AIDS is that it predominantly affects the most productive members of society, those between the ages of 15 and 45. This directly impacts the size and the productivity of the labor force, with negative outcomes for family income, assets and agricultural knowledge and productivity. As has been mentioned, 7 million agricultural workers have already died of AIDS in Africa.

The World Health Organization has estimated agricultural productivity losses from AIDS at the village and household level at anywhere from 10 to 50 percent in a selection of sub-Saharan African countries. In fact, a UNAIDS assessment in Zambia showed that families in which the head of household was chronically ill planted an astonishing 53 percent less than was planted by households with a healthy head of household. Families that lose their most productive members and are forced to rely on the elderly or the young often resort to the sale of livestock or the sale of other assets to pay for food, as well as treatment or even funerals.

The short-term consequences of this devastation is often food supply shortages which further lower agricultural productivity and so it goes. But the problem is not only the short term. Over time, agricultural techniques and knowledge are lost potentially further reducing crop yields and overall agricultural output in communities for extended periods of time. Therefore, the better methods of transferring agricultural knowledge between generations and better agricultural techniques that are less labor-intensive are needed to address the impact of HIV/AIDS on hunger and food production.

But, Mr. Chairman, this is merely one side of the equation. The other side is hunger's adverse impact on HIV/AIDS.

We know that adequate nutrition and food bolster the immune system and allow people living with the virus to continue to be pro-

ductive members of society. In combination with the care and the antiretroviral treatments that the President's Emergency Plan will bring to millions of people, farmers can continue to produce food, children can continue to attend school, and parents can continue to provide for their families. I saw this myself recently in Uganda when I visited a program funded by the U.S. Government in a rural area in the Tororo District in which we are already providing antiretroviral medicines to poor families.

In the face of hunger and inadequate nutrition, however, the disease will accelerate, expose the infected to new illnesses, and reduce their ability to respond to treatment and antiretroviral therapies. Hunger can also reduce the amount of time families and others can realistically dedicate to care and it may force people into activities that undermine our prevention efforts. For example, people suffering from hunger often migrate in search of emergency food relief or for employment, a trend that exacerbates the spread of HIV into new and possibly less-affected communities. Some evidence from some countries suggests that hunger drives women and young girls into prostitution to compensate for the lost income of a deceased family member.

The linkages between hunger and HIV/AIDS will require the coordinated attention of many domestic and international partners.

Recognizing that HIV/AIDS is a global emergency, I intend, with your support, to rapidly mobilize resources to prevent the momentum of increasing HIV/AIDS infections and stem the suffering through treatment and care. The focus of the President's Emergency Plan is on achieving those targeted goals within prevention, treatment, and care, and Congress' commitment to this initiative, through its authorization and appropriation of resources, is essential to its success.

And while we maintain our focus on the task at hand, we recognize the complexity of the crisis and that addressing other issues, such as hunger and food security, are absolutely vital in the success of this total effort. It is crucial, therefore, that we in the HIV/AIDS field recognize the importance of coordinating with those who are addressing hunger and nutrition, as well as other issues like gender discrimination and economic development, to achieve success in the fight against the epidemic.

Toward that end, I look forward to working with other U.S. Government agencies such as the Department of Agriculture, Health and Human Services, and the Agency for International Development to ensure that our food aid and HIV/AIDS efforts are mutually reinforcing. And I also look forward to strengthening our relationships with our international partners like the World Food Program and UNAIDS and the Global Fund to Fight AIDS, Tuberculosis, and Malaria, as well as with the World Health Organization.

In fact, I want to take this opportunity this morning to commend Jim and the World Food Program for their recently expanded focus on HIV/AIDS in southern Africa as a clear example of the type of increased response to which we aspire. Under Jim Morris' leadership, beginning last month the World Food Program began adding nutritious food baskets to help those living with HIV/AIDS. The World Food Program is integrating HIV/AIDS prevention programs

into its school feeding programs and it spent nearly $200 million on HIV/AIDS programs in 2002 alone. This is exactly the kind of sustained, coordinated effort that we need.

Mr. Chairman, thank you and thanks to the members of this committee for the opportunity to share my views on the relationship between HIV/AIDS and hunger and to update you briefly on our progress in implementing the President's Emergency Plan. I am grateful to you for your resolve in defeating this pandemic. Your leadership and support has facilitated the speed with which we are responding to people in need and that commitment will help ensure our success, success that over time will be measured in lives saved and families held intact and nations continuing to move forward with development.

Thank you very much.

The CHAIRMAN. Thank you very much, Ambassador Tobias. Thank you especially for illustrating the strong cooperation between your agency and the Department of State, the United Nations, and the World Food Program. You have illustrated the interdependence well.

I would now like to introduce the Honorable Andrew Natsios, Administrator, United States Agency for International Development from Washington, DC, a good friend of our committee. We welcome you. Please proceed.

STATEMENT OF HON. ANDREW S. NATSIOS, ADMINISTRATOR, U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

Mr. NATSIOS. Thank you, Mr. Chairman, members of the committee. Good morning. I am pleased to be with you, along with my good friends, Ambassador Randy Tobias and Jim Morris of WFP, to discuss the relationship between AIDS and hunger.

I do want to testify to the leadership that Jim Morris has brought to WFP and not just in HIV/AIDS, but in emergencies around the world. We are a very close cooperating supporter of WFP. He and I talk often, and he led the team into Darfur, a major focus of USAID right now because a famine is brewing. It has not taken place yet, but we want to avoid it happening. Randy Tobias' leadership in the fight against HIV/AIDS is of critical importance to the U.S. Government.

USAID has long been a leader in fighting both the HIV/AIDS pandemic, going back actually to the mid-1980s, even though it had a very small budget then, and in preventing hunger and food insecurity. I am pleased to report that with USAID's funding we are providing food aid resources for food, prevention education, care, and support to over 700,000 people in African communities that are the focus countries of the President's Emergency Plan for AIDS Relief. In addition, we have prevention, care, and treatment programs for HIV/AIDS across the continent, which of course is the area of the world most severely affected by AIDS. Seventy-five percent of the people who are HIV/AIDS-positive in the world live in sub-Saharan Africa.

The world has recently come to see how deeply these two problems are intertwined. We have a research paper[1] that is at the

[1] The research paper referred to can be found on page 24.

back of the room here on the table that was done with one of our partner organizations, the Academy for Educational Development, and USAID on the effect of poor nutrition on the development of AIDS, which is quite useful I think from a clinical standpoint.

The majority of the world's hungry and food insecure live, unfortunately, where HIV/AIDS is also highest in terms of prevalence, and that is in sub-Saharan Africa. HIV/AIDS and food insecurity are a devastating combination.

On June 1, 2001, almost 3 years ago, I issued my first cable,[2] having just been sworn in as USAID Administrator on May 1, 2001, to our field missions asking them to not just have a health response to the AIDS pandemic but an integrated response that affects and integrates all our funding streams and all our programs in response to this catastrophic epidemic.

In many villages across Africa, HIV/AIDS has wreaked havoc on food production, as Randy just mentioned. When someone is debilitated by disease, the food security of his or her family is in clear jeopardy. All too often families are forced to sell livestock and valuable assets to care for the sick or to pay funeral expenses. This then compromises any future earning potential.

For people living with AIDS, good nutrition is essential for continued good health. It can also slow down or speed up the onset of the actual manifestation of the disease, depending on their nutritional circumstance. For too many people living with AIDS, getting enough to eat adds enormously to life's daily challenges.

We do know in the last decade that chronic malnutrition has increased significantly in sub-Saharan Africa and we know that the AIDS pandemic is exacerbating this problem.

The United States has a long history of support for food programs and has recently made an unprecedented commitment to fighting the AIDS pandemic. This year marks the 50th anniversary of the creation or the passage of what we call Public Law 480, which created the U.S. Food Aid Program. We are going to have a big celebration later this year.

Since the inception of this program, the U.S. Government has provided 100 million metric tons of food aid valued at $33 billion and has affected the lives of over 3 billion people in 150 countries. Last year, the United States provided through my agency almost $1.1 billion of food aid to the World Food Program for their worldwide programs. The rest of our food budget goes to the NGO community. The vast majority of this goes through the Office of Food for Peace in USAID, which includes $6 million we send to WFP for their administrative expenses for emergency programs.

The Bush administration has provided unprecedented support for the fight against HIV/AIDS through the President's Emergency Plan for AIDS Relief. USAID is helping fight the pandemic from a health perspective, as well as through our agriculture, education, and food aid programs. In fact, I mentioned earlier this cable that was sent out. We now have 3 years of experience in how to integrate these programs together.

The Office for Food for Peace in USAID has invested $17 million for 40,000 metric tons of food through NGOs for the most part to

[2] The cable Mr. Natsios refers to can be found on page 32.

almost 700,000 HIV/AIDS infected children and adults in Haiti, Ethiopia, Kenya, Mozambique, Rwanda, South Africa, Uganda, and Zambia. We are doing grants to treat HIV/AIDS and to prevent HIV/AIDS and to care for people with HIV/AIDS simultaneously to the same NGOs and the same community-based organizations in the same regions. This allows for more integration of these three functions together.

One of the families we support is that of Pascasie Mukamana who is an orphan. She lives in Rwanda and she cares for her two sisters, one of whom is HIV-positive. With our funding, Catholic Relief Services provides a monthly food ration to her and her sisters.

In addition to responding to the AIDS pandemic and to food emergency, USAID is addressing the long-term consequences of food insecurity. Through the President's Initiative to End Hunger in Africa, we are working toward fulfilling the Millennium Challenge goal of halving the number of hungry Africans by 2015. We are doing this, of course, through sustainable agricultural growth and efforts to augment rural family incomes, which usually means agriculture in sub-Saharan Africa. We believe, over the longer term, the best way to deal with food insecurity in Africa is for Africans to grow their own food.

Through USAID's Harvest Plus Program, researchers are developing new varieties of wheat, rice, maize, and cassava to enhance the nutrient content, quality, and yield of these important staple crops. What we are doing is breeding into, working with the World Bank subsidiary, the CGIAR network of agricultural research stations, different micronutrients into different food crops where there is evidence that in the normal diet of these people, there is a micronutrient deficiency.

Just one example of this, there is a serious problem with vitamin A deficiency in the Mozambiquean diet, which is why there is high child mortality rates. So what we did is we introduced a regular sweet potato, not an improved variety, which is very high in vitamin A—into the food chain. We taught people, women particularly, how to cook this and how to grow it. Using 125 community-based organizations, we introduced this crop into Mozambique. It has now taken off and it is part of the agricultural system of Mozambique. Through the agricultural system, not through vitamin supplements, we are actually getting vitamin A now into the Mozambiquean diet working with the Ministry of Agriculture in that country.

HIV/AIDS also, unfortunately, is heavily prevalent. I think there is an 18 percent prevalence rate in Mozambique. So you see, by combining agricultural programs with the nutrition programs and with HIV/AIDS programs, you can, in an integrated fashion, address the pandemic.

We are in a unique position because of our integrated programming at the mission level. Three-quarters of our staff at USAID are in the field, not in Washington. We have a highly decentralized program. I leave it to our mission directors as to how to do this technically. But by building on these strengths, we can ensure that assistance gets to the neediest in a timely and transparent fashion.

Without the World Food Program, I want to add, as the wholesaler, in terms of doing the massive requirements needed both for development food but also particularly for emergency food, we could not function. Without the World Food Program, we could not be doing what we are doing now in Darfur province, for example, which is in terms of emergencies, the worst in the world, apart from the AIDS pandemic itself.

Thank you for allowing us to testify today.

[The prepared statement of Mr. Natsios follows:]

PREPARED STATEMENT OF HON. ANDREW S. NATSIOS

Mr. Chairman, members of the Committee.

Good morning. I am pleased to be with you, along with Ambassador Randy Tobias and Jim Morris, to discuss the relationship between AIDS and hunger. The U.S. Agency for International Development has long been a leader in both fighting the AIDS pandemic and in preventing hunger and food insecurity. The world has recently come to see how deeply these two problems are intertwined. The majority of the world's hungry and food insecure live where HIV prevalence is highest—in sub-Saharan Africa, where HIV and food insecurity are a devastating combination.

I am pleased to report that with USAID's funding, we are providing food aid to 700,000 people in African communities heavily impacted by HIV/AIDS. In addition, we have prevention, care and treatment programs for HIV/AIDS across the continent, as well as food aid programs for millions of Africans.

There is much to be done. Unlike other diseases, AIDS strikes people in the prime of their lives. This has profound effects on families, communities and nations. As Secretary of State Colin Powell has pointed out, "the disease decimates a society's most productive members. It sickens those . . . who take care of the very young and the very old. It destroys those who teach and trade, support their families and otherwise contribute to their nation's development. AIDS saps global growth. Unchecked, AIDS can lay waste to whole countries and destabilize entire regions of the world."

In many villages across Africa, HIV/AIDS has wreaked havoc on food production. When someone is debilitated by disease, the food security of his or her family is in jeopardy. All too often families are forced to sell livestock and other valuable assets to care for the sick or to pay funeral expenses. This then compromises any future earning potential.

For people living with HIV/AIDS, good nutrition is essential for continued good health. Yet, for too many people living with AIDS, getting enough to eat adds enormously to life's daily challenges.

A lack of food can sometimes cause the epidemic to spread. We have heard too many stories of mothers who will trade the only resource they have—themselves—in exchange for food to feed their hungry children.

HOW FOOD AND AIDS INTERRELATE

Chronic malnutrition is increasing in sub-Saharan Africa. And the AIDS pandemic is exacerbating it.

Let me take this opportunity to praise Jim Morris's leadership in responding to last year's food crisis in southern Africa. In his role as the UN Secretary General's Special Envoy, he helped alert the world and made an emergency request for funding. I'm proud that the U.S. Government took the lead in responding to the crisis and provided 880,000 metric tons of food aid for the region, valued at $529 million over the past two years.

We need to draw lessons from such experiences and apply them to our fight against the AIDS pandemic. We now realize that HIV/AIDS exacerbates food insecurity. But there is still much to be learned about the causes and consequences of this relationship. As we expand anti-retroviral treatment for people living with AIDS, there will be further issues to explore.

We do know that HIV/AIDS affects a household's ability to produce food and earn income in several ways by:

- Reducing labor for farming due to illness, death and additional caregiving responsibilities;
- Depleting food reserves, savings and productive assets, such as livestock;

- Increasing household expenses, due to the costs of caring for a chronically ill person or children orphaned by AIDS.

Food assistance is the number one request made by people living with AIDS. It is key to improving overall health and quality of life. Malnutrition worsens the effects of HIV by further weakening the immune system and increasing susceptibility to infections. Good nutrition helps people living with HIV/AIDS manage symptoms and effectively respond to treatment.

Conversely, HIV compromises the nutritional status of infected individuals. It creates additional nutritional requirements, causing symptoms that limit food intake and reducing the use of nutrients by the body.

The World Health Organization believes that better nutrition increases survival rates, primarily because of its effects on immune functions. Increased caloric intake is recommended for HIV-infected adults because of their higher energy requirements. Once they have symptomatic HIV and full-blown AIDS, caloric intake needs to increase by 20 to 30 percent. For HIV positive children, once a child begins to experience weight loss, he or she must increase consumption by 50 to 100 percent.

Good nutrition is also important for patients receiving antiretroviral drugs, or ARVs, which are potent medications that often need to be taken with food. The use of the right combination of food and ARV treatment is important to ensure drug compliance and effectiveness.

We know that food insecurity and HIV/AIDS have profound consequences for nation states. We are only just beginning to appreciate the implications of the halving of adult life expectancy and the massive loss of human capital in many countries. In the most affected countries, HIV/AIDS has the potential to cripple the socioeconomic and political infrastructure, which is vital for stability as well as development.

USAID AND PRESIDENTIAL INITIATIVES

President Bush launched the Initiative to End Hunger in Africa in 2002. It is a multi-year effort designed to help fulfill the Millennium Development Goal of halving the number of hungry Africans by 2015. We are urgently addressing the need to rapidly increase sustainable agricultural growth and augment rural incomes in sub-Saharan Africa. This approach will reduce the need for future food aid to the continent.

Last year, P.L. 480 programs to prevent HIV and care for HIV-infected children and their families reached at least 2.2 million people. Approximately 110,000 thousand tons of commodities, valued at $51 million, went into these programs.

I would like to take this opportunity to note that this year marks the 50th anniversary of Food for Peace. P.L. 480 was enacted on July 10, 1954, and for 50 years Title II has affected over 3 billion lives in over 150 countries. Since the inception of this program, which is implemented by USAID's Office of Food for Peace, the U.S. Government has provided over 100 million metric tons of food aid, valued at more than $33 billion, to reach people around the world. This is a program we can all be proud of because of its central role in helping save lives and alleviate suffering.

USAID has been involved in the fight against AIDS since 1986, and today more than 100 countries around the world receive assistance from USAID in this fight.

As President Bush has said, "fighting AIDS on a global scale is a massive and complicated undertaking." That's why, just over a year ago, he announced the President's Emergency Plan for AIDS Relief, a visionary plan to increase spending on AIDS to $15 billion over 5 years. I'm pleased that USAID is a key part of the team implementing this emergency plan. We are working closely under the leadership of the Global AIDS Coordinator, Ambassador Randall Tobias, who you will also hear from today.

PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF

The Emergency Plan sets out three key goals to be achieved by 2008 in 14 focus countries: Provide treatment to 2 million people, prevent 7 million new infections, and provide care and support to 10 million people living with and affected by AIDS, including orphans and other vulnerable children.

Today, I would like to discuss how USAID is assisting President Bush and Ambassador Tobias in meeting each of these goals, as they relate to food and HIV/AIDS.

As we expand anti-retroviral treatment for people living with AIDS, there is much we can do to ensure a good relationship between food, nutrition and ARVs. We know that interactions between ARVs, food and nutrition can influence the success of

treatment by affecting drug efficacy, adherence to drug regimens, and nutritional status of people living with HIV and AIDS.

By strengthening food access and coping strategies of households and communities affected by HIV/AIDS, USAID is contributing to the goal of preventing seven million new HIV infections. In the area of food and nutrition, USAID programs are strengthening household resiliency through food-for-work programs and other income-generation activities. Food assistance is used for education and vocational training programs for children. And HIV/AIDS prevention messages are incorporated in all of these programs.

Food and nutrition are critical components in the care of people living with HIV/AIDS and their families. Nutritional support has the potential to delay the beginning of life-threatening infections and ultimately prolong the lives of HIV-positive individuals. Family members who may depend on an infected person benefit as well.

USAID is supporting a variety of activities to care for people living with AIDS, including:

- Food aid and nutrition counseling for people living with AIDS and their families;
- Improved infant and child feeding for HIV-affected households;
- Food aid to assist in management of opportunistic infections such as tuberculosis; and
- Direct food aid to orphans and vulnerable children and families looking after them.

USAID's Office of Food for Peace invested over $17 million and approximately 40,000 metric tons of food aid to almost 700,000 HIV-infected and affected adults and children in Haiti, Ethiopia, Kenya, Mozambique, Rwanda, South Africa, Uganda and Zambia—all focus countries of the President's Emergency Plan for AIDS Relief.

Pascasie Mukamana is an orphan in Rwanda's Gitarama province. After her parents died of AIDS, she was forced to quit school to provide for her two sisters, one of whom is HIV-positive. With USAID funding, Catholic Relief Services provides a monthly food ration to Pascasie and her sisters. This is the story of just one of the 29,000 people USAID funding supports in Rwanda.

In Uganda, for example, our partners report that in communities receiving food aid, school attendance is improving, there are fewer underweight children and people are able to work more regularly.

The Consortium for Southern Africa Food Security Emergency is made up of World Vision, Catholic Relief Services and CARE. They focus on reducing food insecurity in targeted communities in Malawi, Zambia and Zimbabwe. Approximately 76,000 adults and children who are infected and affected by HIV/AIDS receive food through this consortium funded by USAID.

USAID's agricultural programs are also important in addressing the HIV/AIDS prevention response by ensuring that food is available to vulnerable households throughout the year. Other programs assist small farmers in accessing agricultural technology, or help them diversify their livelihoods to improve their food and nutrition security.

For example, USAID supports the Regional Network of HIV/AIDS, Rural Livelihoods and Food Security in sub-Saharan Africa. The Network is analyzing the impact of AIDS on small farmers and focusing on how to maintain the productivity of staple crops in Malawi and analyzing the impact of AIDS on the agricultural programs in Uganda.

Often, people do not have access to enough food to meet their basic daily caloric needs. Through the Harvest Plus Program, researchers are developing new varieties of wheat, rice, maize and cassava to enhance the nutrient content, quality and yield of these important staple crops. USAID is also supporting highly regarded universities in the U.S. and abroad who are turning their considerable expertise toward these issues.

The Agriculture and Nutrition Advantage Program supports strategies that bring together national governments, non-governmental organizations, and research institutions to combat poverty, hunger and under-nutrition. It is critical to include these different stakeholders in efforts to address the complex challenges of food security, nutrition and HIV/AIDS.

USAID is working with Michigan State University and Kenya's Egerton University to examine the relationship between AIDS and agriculture. Other research we've sponsored has found that relatively poor households do not recover quickly from head-of-household deaths.

PARTNERSHIP WITH WORLD FOOD PROGRAM

USAID has a long history of partnership with the World Food Program to provide food aid, and is the single largest donor to WFP. Last year, USAID's Office of Food for Peace provided over a billion dollars of food aid resources to the WFP. In addition, WFP receives support from USAID through the Joint United Nations Programme on HIV/AIDS, the umbrella organization for all of the U.N.'s work on HIV/AIDS, which will receive $26 million from my agency this year.

Just last year, USAID's Office of HIV/AIDS entered into a new project partnership with WFP to specifically work on food aid for children affected by AIDS and their families. USAID is funding a unique partnership between the World Food Program and World Vision that is designed to use food to help keep children in school and reinforce and expand home-based care programs. WFP will provide food assistance that will complement World Vision's work and be linked to efforts to improve the overall family situation.

CONCLUSION

I am proud of the work USAID is doing in the global fight against AIDS, poverty and hunger. By working through many different areas, USAID will help President Bush and Ambassador Tobias achieve a historic success.

USAID is in the unique position of having technical expertise in development, health and emergency response, as well as an extensive network of programs throughout the developing world. By building on these strengths, we will ensure that assistance gets to the neediest in a timely and transparent manner.

I appreciate the opportunity to testify today on this important topic.

NUTRITION AND HIV/AIDS: EVIDENCE, GAPS, AND PRIORITY ACTIONS

In Africa, where more than 25 million people are living with HIV/AIDS, malnutrition and food insecurity are endemic. Today, nearly 40% of African children < 5 years old are stunted due to chronic nutritional deprivation.[1] Underweight, an indicator of chronic and acute malnutrition, was the leading cause of mortality worldwide, responsible for 3.7 million deaths in 2000.[2] Nearly half of these deaths (48.6%) occurred in sub-Saharan Africa.

The effects of malnutrition on the immune system are well known and include decreases in CD4 T-cells, suppression of delayed hypersensitivity, and abnormal B-cell responses.[3–4] The immune suppression caused by protein-energy malnutrition is similar in many ways to the effects of HIV infection.[5] This document summarizes the evidence, gaps, and priority actions related to nutrition and HIV/AIDS.

NUTRITION AND HIV/AIDS: THE EVIDENCE AND GAPS

HIV-infection increases energy requirements. HIV infection affects nutrition through increases in resting energy expenditure, reductions in food intake, nutrient malabsorption and loss, and complex metabolic alterations that culminate in weight loss and wasting common in AIDS.[6–7] The effect of HIV on nutrition begins early in the course of the disease, even before an individual may he aware that he or she is infected with the virus.[8–10] Asymptomatic HIV-positive individuals require 10% more energy, and symptomatic HIV-positive individuals require 20%-30% more energy than HIV-negativc individuals of the same age, sex, and physical activity level.[11]

The impact of pre-existing malnutrition on HIV susceptibility and disease progression is difficult to study, and knowledge in this area is still limited. A systematic review of the literature is now underway by the World Health Organization (WHO).[11] Early studies demonstrated that weight loss and wasting were associated with increased risk of opportunistic infections [12] and shorter survival time in HIV-positive adults, independent of their immune status.[13 14] Other studies showed that clinical outcome was poorer and risk of death was higher in HIV-positive adults with compromised micronutrient intake or status.[15–20]

Micronutrient deficiencies may contribute to disease progression. Deficiencies of vitamins and minerals, such as vitamins A, B-complex, C, and E and selenium and zinc, which are needed by the immune system to fight infection, are common in people living with HIV.[9 21] Deficiencies of anti-oxidant vitamins and minerals contribute to oxidative stress, a condition that may accelerate immune cell death[22–23] and increase the rate of HIV replication.[24–26]

Daily micronutrient (antioxidant) supplementation improved body weight and body cell mass [27] reduced HIV RNA levels; [28] improved CD4 cell counts;[28] and reduced the incidence of opportunistic infections [29] in small studies of adults with AIDS, including those on antiretroviral therapy. Larger clinical trials demonstrated that daily micronutrient supplementation increased survival in adults with low CD4 cell counts; [30] prevented adverse birth outcomes when given during pregnancy; [31] and reduced mother-to-child HIV transmission in nutritionally vulnerable women with more advanced HIV disease.[32] The optimal formulation of a daily multiple micronutrient supplement for HIVpositive individuals requires further study.[11]

Antiretroviral therapy improves nutritional status, but ARVs may also have side effects and metabolic complications. Highly active antiretroviral therapy (HAART) improves nutritional status, independent of its effects on viral suppression and immune status,[33] although wasting still develops in some patients.[34] ARV side effects such as nausea and vomiting may affect adherence to therapy, particularly in the first months of treatment.[35] Additional metabolic complications such as derangements in glucose and lipid metabolism, bone metabolism, and lactic academia have been associated with the use of certain ARV drugs.[36] Research on the metabolic consequences of ARV therapy and appropriate strategies for their management is a growing field in industrialized countries. Further research is needed in resource-limited settings, where management options and follow-up monitoring may be more limited.

HIV-exposure and infection exacerbates problems of child malnutrition. Children living with HIV or born into families affected by HIV are a high-risk group with special needs. HIV-positive women have a higher incidence of preterm and low birth weight deliveries, and, as a result, HIV-exposed infants may start life with impaired nutrition.[37–38] HI V-positive infants experience slower growth and are at greater risk of severe malnutrition.[39–40] Studies show that severe malnutrition in HIV-positive children can be reversed with hospital and home-based therapeutic feeding, though the time to recovery is longer than with uninfected children.[41] Studies also indicate that periodic vitamin A supplementation reduces morbidity and mortality in HIV-positive children and improves their growth.[42–44]

Optimal infant and young child feeding practices are crucial in the context of HIV/AIDS. Breastfeeding practices may also affect the health of HIV-exposed children. The risk of HIV transmission through breastfeeding is directly related to the health, viral load, and immune status of their mothers. Infection occurs at an average rate of about 8.9 HIV transmissions per 100 child-years of breastfeeding.[45] HIV-positive mothers are recommended to avoid breastfeeding if replacement feeding is feasible, affordable, and safe.[46] In many resource-limited settings, this cannot be assured, and many HIV-positive women initiate breastfeeding.[47–48] For these women, exclusive breastfeeding and early breastfeeding cessation are recommended.[46] Infants who are not breastfed or who stop breastfeeding early and do not have access to safe and nutritious replacement foods are at increased risk of malnutrition, diarrhea and other illnesses, and death.[49]

LIVELIHOODS, FOOD SECURITY, AND HIV/AIDS: COMPLEX INTERACTIONS

Food security is the state in which all people have both physical and economic access to sufficient food to meet their dietary needs for a productive and healthy life at all times.[50] Achieving this state is contingent on food being available, accessible, and utilized by the body. The relationship between HIV/AIDS, livelihoods, and food and nutrition security is complex and multidimensional.

Food insecurity and poverty may lead to high-risk sexual behaviors and migration, increasing the risk of acquiring HIV infection.[51–2][52] HIV/AIDS, in turn, significantly undermines a household's ability to provide for basic needs. Livelihoods are diminished when HIV-infected adults cannot work and food production and/or earnings decrease. Healthy family members, particularly women, are often forced to stop work to care for sick family members, further reducing income for food and other basic needs. Household labor constraints can cause reductions in cultivated area, shifts to less labor- or cash-intensive crops, and depletion of livestock.[53]

Food-insecure households frequently struggle to meet ordinary household needs without the added stress of HIV. Their capacity to absorb the costs associated with HIV-related illnesses, to provide enhanced nutritional support, and to participate in community programs is severely restricted, and many find themselves in a rapid downward economic spiral.[54] The spiral is made worse when disabled parents are unable to pass on practical crop and livestock knowledge,[51 55] and when children are withdrawn from school because of difficulty paying fees or the need for the young to care for ill family members, jeopardizing their future income-earning potential.

HIV/AIDS is impacting entire communities, with rippling effects, particularly in areas that are highly dependent on labor. For example, in rural Kenya, when HIV affects a relatively wealthy household and spending on health care increases, money to hire laborers declines. Poorer households become increasingly more vulnerable—food insecure, less able to send their children to school, and less able to meet their own health needs—when they can no longer find work because the wealthier families can not afford to hire them.[56] Entire communities are weakened by HIV, not just individuals, and traditional community safety nets are being stretched to their limit in highly affected areas.

PRIORITY ACTIONS

Nutrition counseling, care, and support are integral to comprehensive HIV care, including care given to HIV-positive individuals and orphans and vulnerable children (OVC). There are several nutrition and food-related interventions to consider. Appropriate actions depend on the local conditions, the HIV-positive individual's lifecycle state (e.g., child, pregnant or lactating, other adult), degree of disease progression (e.g., asymptomatic, symptomatic, AIDS), and whether they have initiated ARV therapy. Integrating nutritional care and support interventions strengthens home-, clinic-, and community-based care, ARV services, OVC activities, and national policies and strategies addressing the pandemic. Nutrition interventions may improve the quality and reach of care and promote successful treatment.

The main nutrition interventions are counseling on specific behaviors, prescribed/targeted nutrition supplements, and linkages with food-based interventions and programs. Three different types of nutrition supplements are considered: food rations to manage mild weight loss and nutritional-related side effects of ARV therapy and to address nutritional needs in food-insecure areas; micronutrient supplements for specific HIV-positive risk groups; and therapeutic foods for rehabilitation of moderate and severe malnutrition in HIV-positive adults and children. Priority actions are:

Nutrition for positive living. This includes nutrition counseling and support to improve food intake and maintain weight during asymptomatic HIV infection and to prevent food and waterborne infections. Food rations may be provided in food-insecure areas and for nutritionally vulnerable pregnant and lactating women. Daily multiple micronutrient supplements may be provided to HIV-positive pregnant women in areas where malnutrition rates are high, although the optimal formulation for such supplements is not yet known.

Nutritional management of HIV-related illnesses. This includes counseling to manage nutrition-related symptoms of common HIV-related illnesses/opportunistic infections (e.g., loss of appetite, oral sores, fat malabsorption). Home-based care programs, community efforts, and clinical services can provide counseling to help HIV-positive individuals and their households optimally use available foods to manage symptoms and maintain food intake. Guidance and materials to support nutritional management of symptoms, developed with USAID assistance, are already available in many countries.

Management of ARV interactions with food and nutrition. This includes providing information and support to help ARV clients manage side effects such as nausea and vomiting and prevent drug-food interactions. Side effects and interactions can negatively affect medication adherence and efficacy. Supporting ARV clients in appropriate dietary responses to manage these conditions helps ensure successful treatment. In addition to nutrition counseling, food rations may be provided in food-insecure areas, particularly in cases where lack of food is interfering with treatment adherence and among those experiencing weight loss that is not reversed after treatment is initiated.

Therapeutic feeding for moderately and severely malnourished HIV-positive children and adults. This includes hospital-based stabilization and home- or community-based care using therapeutic (nutrient-dense) foods, per WHO or local nutrition rehabilitation protocols. The foods and protocols used to treat severe malnutrition in the general population may be used for HIV-positive patients, although some adaptations may be required for adults and those experiencing severe symptoms.

Infant and young child nutrition for HIV-exposed children. This includes counseling on feeding options for HIV-exposed children, including orphans, and support for safer breastfeeding or replacement feeding, per WHO or local protocols. Food rations, therapeutic foods, and micronutrient supplements may also be provided, depending on local circumstances such as food availability, diet quality, and malnutrition rates. Vitamin A supplementation is recommended, per WHO protocols.

Palliative care and community coping mechanisms. This includes nutrition counseling and supplements for HIV-positive and HIV-affected households delivered

through home-, clinic-, and community-based care programs and strengthening links to social support organizations, building community food stocks, sharing labor, modifying costly customs (funerals, marriages), and providing food assistance and training to widows, orphans, and vulnerable children. The U.S. Government, through USAID, has Title II programs providing this type of assistance in several countries, including Ethiopia, Haiti, Kenya, Mozambique, Rwanda, Uganda, and Zambia. The USAID-funded C-Safe Program is linking Title II food to HIV home-based care programs in Zambia, Malawi, and Zimbabwe.

Summary of Nutrition Interventions According to HIV Disease Progression

Interventions	HIV+ Asymptomatic	HIV+ Symptomatic	AIDS	Families Affected by an HIV-related Death
Counseling/care	Nutrition education and counseling for positive living.	Nutrition management of HIV-related opportunistic infections (OI), symptoms, and medications.	Nutrition management of ARV therapy (where available). Nutrition management in home-, clinic- and community-based, palliative care.	Counseling on special food and nutritional needs of orphans and vulnerable infants and young children.
Prescribed/targeted nutrition supplementation	For high-risk groups only (e.g., pregnant and lactating HIV+ women, HIV-exposed non-breastfed children).	For high-risk groups. For persons who are losing weight or do not respond to medications. Therapeutic feeding for moderately and severely malnourished HIV+ adults and children.	Therapeutic feeding for moderately and severely malnourished HIV+ adults and children.	For high-risk groups (e.g., HIV-exposed non-breastfed children < 2 yrs or HIV-exposed children with growth faltering).
Other food interventions	To prevent nutritional deterioration for HIV-affected families living in highly food-insecure communities.	To improve adherence/participation in OI treatment programs.	To improve adherence/ participation in ARV and OI treatment programs. To use in home-, clinic-, and community-based care programs.	To protect the health of orphans and vulnerable children and for surviving family members when livelihoods are compromised because of HIVrelated sickness or death.

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TAGS:
SUBJECT: HIV/AIDS PANDEMIC

FROM THE ADMINISTRATOR
1. COMBATING THE HIV/AIDS PANDEMIC IS ONE OF MY TOP PRIORITIES FOR USAID. AND I NEED YOUR HELP IF WE ARE TO CONTINUE TO BE SUCCESSFUL GLOBAL LEADERS IN THE FIGHT AGAINST THIS DISEASE. IN MANY COUNTRIES,

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HIV/AIDS HAS REACHED SUCH CATASTROPHIC LEVELS THAT IT IS DECIMATING ENTIRE SOCIETIES, DEVASTATING FAMILIES, CREATING MILLIONS OF ORPHANS AND SETTING BACK SOCIAL AND ECONOMIC DEVELOPMENT. IN SOME COUNTRIES, LIFE EXPECTANCY HAS BEEN REDUCED BY 30 YEARS.

2. USAID HAS BEEN THE GLOBAL LEADER IN FIGHTING THE HIV/AIDS PANDEMIC SINCE 1986. OUR EFFORTS TO DATE HAVE SAVED MILLIONS OF LIVES. BUT THIS IS A NEW ERA, AND WE NEED TO BUILD ON THESE SUCCESSES AND REDOUBLE OUR EFFORTS. HIV/AIDS IS ONE OF THE BIGGEST CHALLENGES TO DEVELOPMENT THAT WE HAVE EVER FACED.

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OUR RESPONSE MUST BE AGENCY-WIDE. THE HIV/AIDS PANDEMIC IS NOT JUST A HEALTH SECTOR ISSUE; IT IS THE BUSINESS OF EVERY OFFICER IN EVERY SECTOR IN THE AGENCY. IT IS IMPERATIVE THAT USAID STAFF IN HEAVILY AFFECTED COUNTRIES CONSIDER HIV-PREVENTION PROGRAMMING

IN ALL SECTORS AND NOT JUST AS PART OF THE MISSION#S HEALTH PROGRAMS. THE DESIGN OF ACTIVITIES IN ALL SECTORS SHOULD TAKE INTO ACCOUNT THE IMPACT OF THE HIV/AIDS PANDEMIC ON HUMAN AND INSTITUTIONAL CAPACITY IN THE SECTOR. IN COUNTRIES WHERE THE VIRUS IS NOT YET WELL ESTABLISHED, MISSIONS NEED TO BE COGNIZANT OF RISK FACTORS AND SHOULD TAKE STEPS TO PREVENT THE SPREAD OF THE DISEASE. AS WE EXPAND OUR EFFORTS, FIELD MISSIONS AND WASHINGTON MUST WORK EVEN MORE CLOSELY TOGETHER TO RESOLVE PROBLEMS, REMOVE BARRIERS TO EFFECTIVE IMPLEMENTATION, AND SHARE LESSONS LEARNED BROADLY. THERE IS NO TIME TO REINVENT THE WHEEL.

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3. USAID HAS AN AGENCY STRATEGY (AVAILABLE ON THE INTRANET) FOR AN EXPANDED RESPONSE TO THE PANDEMIC WITH WHICH ALL STAFF SHOULD BECOME FAMILIAR. IN ADDITION, ALL OF YOU MUST BE KNOWLEDGEABLE ABOUT THE HIV/AIDS SITUATION IN YOUR COUNTRY. YOU MUST BE ABLE TO EXPLAIN HOW HIV/AIDS FITS WITHIN YOUR DEVELOPMENT STRATEGIES AND PROGRAMS TO VISITING CODELS AND STAFFDELS AND TO HILL AND ADMINISTRATION COLLEAGUES WHEN ON CONSULTATION IN WASHINGTON. MISSIONS AND REGIONAL PROGRAMS IDENTIFIED IN THE AGENCY STRATEGY AS EXPANDED RESPONSE #INTENSIVE FOCUS AND RAPID SCALE-UP# PROGRAMS NEED TO HAVE CLEARLY ARTICULATED HIV/AIDS STRATEGIES AND REPORT TO WASHINGTON REGULARLY ON PROGRESS. OUR HIV/AIDS PROGRAM MONITORING AND EVALUATION EFFORTS, AS NOTED IN A RECENT GAO REPORT, NEED TO BE IMPROVED AND INTENSIFIED. WE NEED TO HEAR FROM YOU FREQUENTLY BECAUSE OF INTENSE CONGRESSIONAL AND ADMINISTRATION INTEREST AND THE AGENCY#S NEED TO RESPOND TO NUMEROUS REQUESTS FOR INFORMATION. AS A MEMBER OF THE PRESIDENT#S TASK FORCE ON HIV/AIDS CO-CHAIRED BY SECRETARIES POWELL AND THOMPSON, I AM REGULARLY ASKED TO REPORT ON OUR EFFORTS AND PROGRESS. BOTH SECRETARY POWELL AND I HAVE BEEN REQUIRED TO RESPOND TO MANY QUESTIONS ABOUT HIV/AIDS IN OUR RECENT CONGRESSIONAL HEARINGS, AND I WILL BE TESTIFYING AGAIN ON HIV/AIDS BEFORE THE HOUSE INTERNATIONAL RELATIONS COMMITTEE ON JUNE 7, 2001.

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4. AT EVERY MAJOR INTERNATIONAL MEETING, INCLUDING THE LDC III MEETING I RECENTLY ATTENDED, HIV/AIDS IS A MAJOR TOPIC. THOSE OF US WHO ATTEND THESE MEETINGS
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NEED TO BE EQUIPPED WITH ACCURATE AND CURRENT INFORMATION ABOUT WHAT YOU ON THE FRONTLINES ARE DOING TO ADDRESS THIS DREADFUL DISEASE. THE ATTENTION FOCUSED ON HIV/AIDS HERE IN WASHINGTON AND IN INTERNATIONAL FORA IS INTENSE AND WILL ONLY INCREASE.

I NEED YOUR HELP SO THAT WE CAN ADEQUATELY REPRESENT THE AGENCY AND MAINTAIN OUR LEADERSHIP ROLE IN THIS AREA. WE WILL BE WORKING INTENSIVELY WITH YOUR MISSIONS TO ENSURE THAT YOU HAVE THE NECESSARY SUPPORT TO REFINE AND IMPLEMENT YOUR STRATEGIES AND PROGRAMS AND THAT WE HAVE THE INFORMATION WE NEED TO ENSURE ACCURATE REPORTING TO CONGRESS AND OTHERS ABOUT OUR PROGRESS.

5. WITH SO MANY LIVES AT STAKE, EVERY DOLLAR WE SPEND MUST BE SPENT WELL, AND WE MUST REACH AS MANY PEOPLE WHO ARE AT-RISK OR AFFECTED AS POSSIBLE. WE HAVE COMMITTED TO HELPING MEET INTERNATIONAL TARGETS SET BY THE GLOBAL HIV/AIDS COMMUNITY-#REDUCING PREVALENCE IN HIGH-PREVALENCE COUNTRIES, MAINTAINING PREVALENCE BELOW ONE PERCENT IN LOW PREVALENCE COUNTRIES, AND ENSURING CARE FOR PEOPLE INFECTED WITH HIV AND CHILDREN AFFECTED BY AIDS. THESE ARE COUNTRY TARGETS FOR USAID IN INDIVIDUAL COUNTRIES TO ACHIEVE IN COLLABORATION WITH OTHER PARTNERS. THESE TARGETS ARE AMBITIOUS, AND IT SHOULD BE CLEAR THAT USAID IS PART OF A CONCERTED INTERNATIONAL EFFORT TO ACHIEVE SUCH IMPACT.

6. AS PART OF THE USG#S INVOLVEMENT IN A GLOBAL
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PARTNERSHIP TO COMBAT HIV/AIDS, PRESIDENT BUSH ANNOUNCED ON MAY 4, 2001, THAT THE USG WILL CONTRIBUTE $200 MILLION IN FY 2002 TO A GLOBAL FUND TO ADDRESS HIV/AIDS, TUBERCULOSIS, AND MALARIA. USAID IS WORKING CLOSELY WITH OTHER PARTNERS TO HELP DEFINE AND DEVELOP THE DETAILS OF HOW THIS FUND WILL OPERATE. I WANT TO MAKE IT CLEAR THAT THIS GLOBAL FUND IS ENVISIONED TO SUPPLEMENT, NOT REPLACE THE CRITICALLY IMPORTANT WORK THAT USAID IS SUPPORTING THROUGH ITS BILATERAL

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PROGRAMS.

7. THE CHALLENGE OF THE AIDS PANDEMIC IS ONE WE MUST ALL FACE TOGETHER. WE HAVE BEEN GIVEN AN OPPORTUNITY TO MAKE A DIFFERENCE, AND WE CAN. I ASK EACH OF YOU TO WORK WITH YOUR AMBASSADORS TO GIVE THIS ISSUE THE POLICY LEVEL ATTENTION THAT IT DESERVES. OTHER USG AGENCIES AT POST, HOST COUNTRY COLLEAGUES, AND OTHER DONORS ARE ALSO KEY PARTNERS IN OUR EFFORT TO ADDRESS THIS PROBLEM. I EXPECT ALL OF YOU TO USE EVERY OPPORTUNITY TO ADDRESS THE
PROBLEM OF HIV/AIDS BY ENCOURAGING POLICY DIALOGUE, PUBLIC DISCUSSION, AND

PUBLIC AND PRIVATE SECTOR INTERVENTIONS. I LOOK

FORWARD TO WORKING WITH ALL OF YOU AND HEARING FROM YOU FREQUENTLY ABOUT YOUR CHALLENGES AND SUCCESSES.
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The CHAIRMAN. Well, thank you very much for that testimony.

Let me ask Senator Alexander. Do you want to raise a question before you depart?

Senator ALEXANDER. No, thank you, Mr. Chairman. I did want to come and hear the testimony and commend you for your focus, and I have been following very carefully sub-Saharan Africa through Ambassador Tobias. I thank you for the chance to hear the testimony. Thank you, Mr. Chairman.

The CHAIRMAN. Well, thank you. Senator Alexander serves, as you know, as the chairman of our Subcommittee on African Affairs. Also, the distinguished ranking member, Senator Feingold, is with us.

I will defer my questions and recognize Senators Feingold and Boxer with perhaps a 10-minute limit on our first round.

Senator FEINGOLD. Thank you very much, Mr. Chairman. I thank the witnesses very much for your important testimony.

Mr. Morris, I appreciate your expertise on the issues before us and your consistent efforts to call the world's attention to the linkages between food security, HIV/AIDS, and nutrition, but I want to take this opportunity to just followup a little bit on the specific humanitarian crisis that has already been discussed today, the situation in Darfur. You acknowledged it, as did the chairman, obviously because it is such a desperate and urgent situation.

Will you just lay out a little bit more for the record today how many people are at risk of malnutrition in the region? At this point, is the WFP able to get urgently needed relief supplies to displaced people in Darfur, and what specific conditions must change to enable the WFP to deliver needed supplies to these vulnerable people?

Mr. Morris.

Mr. MORRIS. Thank you, Senator.

Today in the three provinces of Darfur, west, south, and north, there are 1 million internally displaced people. There are another 100,000 people affected by the conflict still in Darfur. We believe that the number by the end of the year, given the fact that this year's harvest will be lost, will increase by another 800,000 people. Today there are 53,000 refugees in camps in Chad in five camps, another 42,000 people who are living on the perimeter of the camps in ramshackle conditions.

One of our great concerns is the number of refugees. People are leaving the Sudan to Chad for security reasons. People are very frightened and justifiably in the Sudan. They are afraid to venture out of the camps. They know if they go to Chad and live in the camps there, that security issue will be diminished. Chad had anticipated five camps. The numbers are so large that they will now have 10 camps because the water available per camp is not adequate to handle the numbers that are there now.

We have a rainy season ahead of us in a matter of days. We will be able to preposition the food we need to preposition in Chad. It will be something in the neighborhood of 7,000 metric tons of food. It will be difficult. We will move part of it across from Cameroon, and we now have a new understanding with the Libyans that we can move food down from Libya into Chad and the Chad Government has said that is acceptable.

Senator FEINGOLD. What about those in Darfur?

Mr. MORRIS. I am coming to that. This is more difficult. Half the people in Darfur are living in camps and half are living in the hills or simply wandering about. As you drive through the area, you see village after village that has been destroyed. The homes have been burnt. The landscape is strewn with pots and pans. Their clothing has been taken. The livestock is gone. Maybe a village that once had 300 families today might have three older men, each weighing about 75 pounds. Really tragic.

The report I read this week suggests that we have been able to provide food for about 800,000 people in Darfur. That is a substantial increase. We are working very, very hard to get food prepositioned for the rainy season. It will be difficult to do that job either satisfactorily or perfectly. We will do a lot of it. USAID has food that will arrive toward the end of the month. USAID has made another commitment in support of our work. We have also had new commitments from the European Community from Luxembourg, from the United Kingdom, and several other places. We have committed resources from our own internal emergency response account to buy sorghum which is available in the country. We sort of have $30 million set aside to do that now.

So we are working very hard to get it prepositioned. We know that we are going to have to airlift some of that. The World Food Program also operates the United Nations Humanitarian Air Service, and so we provide air support for all of the U.N. family, all of the NGO family. It is more expensive, but we get in very difficult circumstances and we will use it to air drop or transport by air some food.

Senator FEINGOLD. Thank you, Mr. Morris. I appreciate your answer. I just want to get in one more question of Mr. Tobias, but I am grateful for your response and I will followup with you afterward.

I have worked with Senator Brownback and Senator Alexander and other members of the committee, including the chairman and the ranking member, to pass a resolution last week addressing this issue that you were very effectively addressing, Mr. Morris. I think it is critically important that we not let this issue slip off our radar screen.

Mr. MORRIS. I forgot that my comments took part of your 10 minutes. So forgive me.

Senator FEINGOLD. They were incredibly important things you were discussing and I did want some of that information on the record. So I thank you.

Ambassador Tobias, it is good to see you again. I appreciate your consistent efforts to be available to this committee and to Members of Congress to ensure that the vast coalition committed to fighting AIDS does not fray.

The last time we spoke, you were testifying at an African Affairs Subcommittee hearing on implementation of the Emergency Plan for AIDS Relief, and we discussed the issue of generic fixed-dose combination therapy. As you know, I and many others have been concerned about the administration's unwillingness to use drugs that are prequalified as safe and effective by the World Health Organization, which are actually easier to use and cheaper than drug

regimens that we are buying. You indicated then that you were hopeful that we would be able to move forward on this issue and to answer the underlying questions that have led to this problem.

Would you please provide me with an update for the committee on the progress that has been made since that hearing to resolve that issue?

Ambassador TOBIAS. Well, Senator, I continue to be optimistic that we are making progress on getting our hands around this problem. As we have discussed before, the World Health Organization's prequalification program is just that. It is a prequalification program. It serves a very useful purpose in those parts of the world where there is not a stringent regulatory process.

But as we gear this up, we are dramatically expanding the number of people who will be under treatment in the world, and we are also going to dramatically expand, I suspect, the number of entrants who are coming into this market. I have had two heads of state in Africa tell me that they intended to go into this business themselves, and we need to ensure that we have a process in place that will provide assurances of safety and effectiveness to the patients who will be treated. I have spoken to a number of officials and medical people in Africa who are as concerned about that as we are.

But I am even more, let me say, optimistic than when you and I last talked that we are on a path that in the weeks ahead we are going to have processes in place that will permit us to take a good, hard, scientific look at the safety and efficacy of drugs from all over. I certainly look forward to having that done.

Senator FEINGOLD. Well, I thank you for your update. This is so incredibly urgent that I hope this can move as quickly as possible, and I am interested in each and every step forward that we can take.

Thank you, Mr. Chairman.

[The prepared statement of Senator Feingold follows:]

PREPARED STATEMENT OF SENATOR RUSSELL D. FEINGOLD

I thank Chairman Lugar and Senator Biden for holding this important hearing, and I thank all of our witnesses for being here today.

In July 2002, in the midst of the horrible headlines about food crisis in Southern Africa, I asked the General Accounting Offices to look into the underlying causes of the crisis and the U.S. response. Their report, issued in June 2003, made clear that one cannot look seriously at food security issues in Africa without also considering the consequences of the HIV/AIDS pandemic. The report found that AIDS had exacerbated the food crisis by reducing productivity and agricultural output and by dramatically limiting the capacity of communities to cope with hardships like a bad harvest, or rising food prices. In other words, AIDS has made already vulnerable communities more vulnerable, such that setbacks that might not have been catastrophic before can now push people over the edge into crisis.

At the same time, no one who has been on the ground to look at the nature of the AIDS crisis can escape the conclusion that good nutrition and food security are necessary ingredients for the success of initiatives to fight AIDS. Medical interventions must occur in a context of sound nutrition if they are to succeed, and, more broadly, overall economic insecurity, including food insecurity, can render specific populations, like women and girls, especially vulnerable to contracting AIDS.

We can all be proud of the efforts that the U.S. Government has made thus far to fight hunger and to fight AIDS around the world. This hearing is a good opportunity to explore how we might make our taxpayer dollars go further by ensuring that our efforts on these interrelated fronts are well thought out and well coordinated.

I look forward to exploring these important issues today.

The CHAIRMAN. Thank you very much, Senator Feingold.

Senator Boxer.

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

I am going to take this opportunity to make a statement about another issue for 5 minutes and then direct an important question to the Honorable Randall Tobias.

Mr. Chairman, we have three individuals sitting before us who exemplify the best in what America is all about, giving themselves to an issue that needs leadership for the most vulnerable people on the face of the Earth right now. And I am very proud that you have asked them up here.

Now, in another part of the world, sadly to our horror, we see other Americans with different agendas and different values, albeit in a different job. I just want to take this chance because this committee has been in many ways prescient on the issue of Iraq, both sides saying where is the plan, where is the plan.

I just want to take this moment to put into the record an article [3] that appeared today in the Los Angeles Times, if I might. A double ordeal for female prisoners. It is written by Tracy Wilkinson, who is a reporter that I've known for many years, actually covered one of my races, my first race many years ago, and now has been covering the Iraqi situation, got injured in a blast in a restaurant and is still there reporting. That is Tracy Wilkinson.

So I just want to read you one or two paragraphs of this story, and keep in mind that in the Muslim culture—and, Mr. Chairman, you know this—where it is forbidden to remove your scarf in front of a strange man, "One woman told her attorney she was forced to disrobe in front of male prison guards. After much coaxing, another woman described how she was raped by U.S. soldiers. Then she fainted.

"A U.S. Army report on abuses at Abu Ghraib prison documented one case of an American guard sexually abusing a female detainee, and a Pentagon spokesman said Monday that 1,200 unreleased images of abuse at Abu Ghraib included 'inappropriate behavior of a sexual nature.'

"Whether it was one or numerous cases of rape, many Iraqis believe that sexual abuse of women in U.S.-run jails was rampant. As a result, female prisoners face grave prospects after they are released: denial, ostracism or even death.

"A woman who is raped brings shame on her family in the Islamic world. In many cases, rape victims have been killed by their relatives to salvage family honor, although there is no evidence this has happened to women who have been prisoners in Iraq.

"'It is like being sentenced to death,' said Sheik Mohammed Bashar Faydhi, a senior cleric based at Baghdad's largest Sunni mosque."

The reason I took the time to read this is because I know, Mr. Chairman, that you were working hard to set a hearing next week on Iraq, and I am hoping that you can have some witnesses at that time from very high up who could talk about what kind of restitution and help we are going to give these women. They face a special stigma in that culture, and since Secretary Rumsfeld had talked

[3] The article referred to can be found on page 57.

about restitution, I think this is something they ought to be prepared to discuss perhaps, if you agree with me, in their opening remarks. If not, I will bring it out in the questions.

The CHAIRMAN. I can respond quickly to the Senator. We have been in touch with the Pentagon and the State Department. We are advised that Secretary Wolfowitz and Secretary Armitage will be with us.

Senator BOXER. That is wonderful.

The CHAIRMAN. So I will convey to them your questions so they will be prepared.

Senator BOXER. Thank you so much. And I will make available this article to them.

Mr. Chairman, now getting to the issue before us today. Again, thank you to our witnesses, all.

I would ask unanimous consent to place in the record a letter that was sent to Ambassador Tobias on March 26, 2004, signed by 370 U.S. and international organizations.[4] So I would ask that that be included in the record.

The CHAIRMAN. It will be included in the record in full.

Senator BOXER. My question, Mr. Ambassador, is this. One important link between hunger and HIV/AIDS is the high cost of antiretroviral drugs. That forces people to sell their farmland, thereby making food more scarce. Yet, there are charges that the administration has worked to block the use of affordable generic HIV/AIDS medicines that have been approved by the World Health Organization. So this group—and I will not read the entire letter—has in their last paragraph—and I would like you to comment on this, whether you agree, disagree, and where you stand on this—"Rather than disregarding the drug procurement policies of developing nations to create expensive new barriers that benefit U.S. drug companies, your office should accept the WHO's internationally recognized drug quality standards and promote access to affordable medications. We object to any and all efforts by the administration and your office to block the use of WHO prequalified generic medications, and any efforts to discredit the standards of WHO's prequalification project that would impose new barriers to generics entering the global market."

So, the charges in this letter by some of the most respected organizations in this country and abroad are strong. How do you respond to this charge given that only 50,000 Africans now have access to AIDS treatments and that 8,000 people are dying from AIDS every day? Ambassador, your answer to this question is really important. It may link to what you said to Senator Feingold, but frankly, I found that answer to be so vague.

Could you tell me when you are going to respond to this issue? Is there hope that this administration would back the WHO plan? Because it is all well and good and we all bemoan what is happening and it is all heartfelt, but if we are withholding lifesaving medicine from people, Mr. Chairman, I do not know how we can go to sleep at night, to tell you the truth. So could you respond to that?

Ambassador TOBIAS. Senator, thank you.

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[4] The letter to Ambassador Tobias can be found on page 58.

The issue of the availability of antiretroviral drugs as a component of making more broadly available treatment for patients is obviously critically important. Right now, it is not the limiting factor in expanding treatment. The limiting factor in expanding treatment is the availability of physical facilities and medical personnel, and we are working very hard on all of these issues.

The WHO process, which plays a very important role, as does the WHO, in the total effort to fight HIV/AIDS, I think has been misconstrued by a number of people as an approval process, and it is not. The WHO's own program has a caveat saying that drugs that are listed on this prequalification list are not warranted as to their safety and efficacy.

We need a more stringent process and we are working with the WHO, with other officials in international agencies around the world in a very cooperative effort to get a process in place that can provide the kind of regulatory scrutiny that we have come to expect here in the United States. We are about to scale up. We are in the midst of scaling up treatment on a very massive scale, and it is very, very important that we get this right.

I am obviously very aware of the letter that you refer to. I have other letters from other people, including a letter I received yesterday from physicians at Stanford University urging that we do exactly what we are doing. I think that shows that reasonable people can disagree on what the proper approach is here.

But no one is working any harder than I am to move this as rapidly as we can because there will come a time when the availability of drugs will be the limiting factor. That is not really yet the case, but we need to move as quickly as we possibly can and that is certainly what we are doing, Senator.

Senator BOXER. If I could just say this to you, I am a person suffering, lost, sitting in some house with my oldest child trying to raise my family and I have no drugs, yes, I want the safest drugs. I want the safest, but if I have nothing, I am in a worse situation.

I would just say to my friend—and I respect you very much—when I look at the people who signed this—you said you got letters from other people—this is not people. These are thousands of people. The people who signed this letter: the International Association of Physicians in AIDS Care, Oxfam, the Ecumenical HIV Initiative in Africa, World Council of Churches, African Jesuit AIDS Network, Episcopal Church USA, Presbyterian Church USA, Unitarian Universalist Association of Congregations, Amnesty International, American Foundation for AIDS Research, ActionAid International USA, American Medical Students Association, Church Women United, Commission on Social Action of Reform Judaism. And it goes on and on. Operation USA. This is just in America, not to mention the world.

So I would just say to my friend please understand that it is all important, getting the medicine to the people, getting the medicines approved, getting affordable medicines. It is all important and I would just suggest to my friend that this is a pretty powerful letter here, and there are charges out here that there are drug companies that do not want to see this happen. This is about an American value. So if there is anything I can do to work with you

on this, please let me know because I know that you want us to be successful here.

And this is a question, Mr. Chairman, of our values. It seems to me if we are caught in a values battle over providing medicine to people versus protecting pharmaceutical companies, I know where you would come down and I know where I would come down. This is very worrisome to me. That is what these people are saying and they are not people who do not think hard. So I am very worried and I will continue to work with my chairman on this in the hopes that we can get these generics out there as soon as possible.

Thank you.

The CHAIRMAN. Thank you very much, Senator Boxer.

Let me begin my questioning by asking Mr. Morris about the Zimbabwe life expectancy figure that you mentioned. If I got the notes correctly, you indicated life expectancy at some point was at 67 and this is now 33. Is that correct?

Mr. MORRIS. That is correct.

The CHAIRMAN. This is, just on the face of it, an awesome result in one country. You made the point strongly, but it may just simply float over most of us—that we are really talking about the future of some countries on this Earth when you have that dramatic a change in the life expectancy in a relatively short period of time. This denotes that at least half of the population is likely to be gone in a much shorter period of time than anyone could have anticipated.

We have heard testimony on this subject from our ambassadorial nominees. The committee asks each one, just simply because their orientation now gets into malnutrition and HIV/AIDS, about life expectancy, about the number of persons infected in the countries. These statistics mount up as we have each round of Ambassadorial nominees. So there is a comprehension on the part of the Congress and the American people of the severity of this, but it is so large that it is almost beyond our understanding in a way.

We commented, I think, when we last had a hearing in which you were involved that essentially, if anybody reported a battle today somewhere on Earth in which a few hundred people lost their lives, this would be of enormous significance in our 24-hour news coverage. From almost every angle, the devastation of those lives and the circumstances would be very, very important. But as you point out in your testimony, here we have a situation in which approximately 24,000 people are losing their lives every day from malnutrition, and an additional 7,000 to 8,000 people from HIV/AIDS, or a combination of that and tuberculosis, a lack of immunity. They are passing away without notice every single day.

As I said, the enormity of this figure is so large that many people, before they even get into the issue, conclude that this is beyond our ability to affect. You have not taken that position, nor has our government. The purpose of the hearing today is both to illustrate what we are doing, but even more importantly to encourage the cooperation between agencies of our government, the United Nations, and private voluntary organizations that play such a vital role in this respect, because that often is not evident. I just wanted to use the Zimbabwe case as an especially dramatic example.

We have commented, for instance, on national security hearings, during which we deal with Russia. Russia has had a disturbing trend in terms of life expectancy. Some Russians would say that that has been arrested. Male life expectancy has declined over the course of the last 20 years from somewhere in the mid-1960s to the mid-1950s. It may have leveled off in the high 1950s for the average Russian male, but for a country of that size and scope to have that kind of demographic change already leads many Russians to believe that there will be many fewer Russians, and that the population of the country is already in decline. This comes at a time in which burgeoning economies in Asia, for example, are gaining a huge population, in addition to experiencing per capita growth of significant percentages year by year, thus changing the whole perspective both demographically and with regard to national security issues for those countries.

This hearing is meant to illustrate and to serve as a benchmark for the seriousness of the problem.

Now, second, Mr. Tobias. The normal questioning of the AIDS program by Members of Congress comes down to two issues. First, the President, in the State of the Union Address, and then in subsequent messages, has talked about $15 billion of expenditure over 5 years of time. During the debate that we had on the Senate floor, many Senators were critical of the fact that the initial request was for $2 billion. People say, well, do the math. Take 15, divide by 5, it is 3. It is not 2.

Now, at the time—this is before you came along, and before your confirmation—why, administration people said not to worry. There is only so much you can do. We are gearing up in the first year. Therefore, it makes sense not to promise more than we can deliver, and besides, $1 billion is $1 billion. You do not want to commit it and spend it before you really are geared up to do that.

In any event, we debated this all year in one forum after another. And at the end of the day, the 2 was raised to about 2.4 or thereabouts.

Now, the second year comes along and once again, the figure is somewhere in the 2's, not 3. So members are saying, well, all right. You had a year to gear up and yet we are not batting very well. Friends of the program, such as the singer Bono, came through. He is a good friend of the committee. We visit frequently. I mention him as one who would say, why not? Why do the math again and so forth? This is one area I want you to address.

The other area was touched upon by Senator Boxer. Despite all protestations, there is simply a fundamental conflict here between the pharmaceutical companies, not just American companies, but companies all over the world, who have a profit objective. All of you talking here today, you have a humanitarian objective. The people that we are talking about are dirt poor. There is just no money involved, not very much in the governments. Paying for these drugs and/or treatments, as well as the infrastructure, which as you say, may be the limiting factor now, is very expensive.

This comes over into our domestic debate frequently on Medicare. We go back and forth over this subject. Why do senior citizens go to Canada? Why do they go elsewhere to buy drugs more cheaply? And why do we not price our drugs differently? The pharmaceutical

companies testify about their research budgets and the need to amortize this. We go round and round.

When we come to the AIDS business, and people dying in these numbers, as the Senator had mentioned, and the gaps there, why, this becomes especially acute.

Why do we not spend $3 billion a year? Why is this dispute persisting? If there is cooperation from the pharmaceutical companies, tell us more about it. If there are problems, discuss that too and how we could be constructive.

Ambassador TOBIAS. Senator, I am just back from Mozambique, a country with a population of something between 17 million and 18 million people and physicians in Mozambique numbering somewhere between 500 and 600. Those physicians are almost entirely located in the urban areas. That is an equation that illustrates the problem, a ratio of 1 physician on average, if they were spread out all across the population, of something between 1 and 20,000 to 30,000 people.

The CHAIRMAN. This is all the doctors there are in Mozambique.

Ambassador TOBIAS. All the doctors there are in Mozambique. Mozambique, because of the language, the Portuguese language, is not losing doctors to other countries as is the case in some other parts of Africa. For example, there are more physicians who are Ethiopian citizens living in Chicago, Illinois, than the entire country of Ethiopia.

So the problem that we face in getting treatment programs geared up is not, with all due respect to concerns expressed by many people, today largely one of the availability of drugs or the price of drugs. It is in getting the infrastructure and the people in place to deliver this treatment. Drugs are very important to this, and I will come to that in a second. But it is right now more an issue of getting the infrastructure in place, getting different models in place. We need to get models in place where physicians are saying to themselves, what am I doing that does not absolutely have to be done by a physician and we can bring someone else into the equation to help get that done.

The CHAIRMAN. Just on that point, is there data that the committee could have on how many physicians there are in each of the African countries?

Ambassador TOBIAS. Yes, there is.

The CHAIRMAN. And then beyond that, as you mentioned, how many nurses or other health professionals? This would help Members of Congress to begin to get a perspective of this delivery problem in a way that clearly many of us do not yet have.

Ambassador TOBIAS. We can make that data available.

[The following response was subsequently supplied.]

UNITED STATES DEPARTMENT OF STATE,
Washington, DC, May 24 2004.

The Honorable RICHARD G. LUGAR, *Chairman,*
Committee on Foreign Relations,
United States Senate.

DEAR MR. CHAIRMAN:

During Ambassador Randall L. Tobias's May 11 appearance before the Committee to testify on the important issue of HIV/AIDS and hunger, you and Ambassador

Tobias discussed the challenge that the lack of human capacity among the healthcare infrastructure presents to effective delivery of HIV/AIDS treatment, care and prevention in the focus countries of President Bush's historic Emergency Plan for AIDS Relief.

We are pleased to provide the enclosed tables that provide additional information on the estimated numbers of physicians and nurses in the twelve Emergency Plan focus countries in Africa. Please note that some data are dated and not especially reliable. The most current comprehensive list of health personnel per 100,000 population is the database compiled by the World Health Organization's Statistical Information Service (WHOSIS) in 1998. Figures are from one point in time during any year between 1994-1998. Health personnel may be counted who are not practicing, i.e. Minister of Health is a medical doctor and counted but not practicing. We have updated several of those estimates for countries for which we have more recent reports from U.S. Government staff.

Key findings, shown in the attached tables (for physicians and nurses respectively), are that:

1. The estimated staffing of health care workers is dramatically lower than the United States, in some cases approximately 100-fold lower, and

2. There is a substantial variation among the African focus countries in the Emergency Plan.

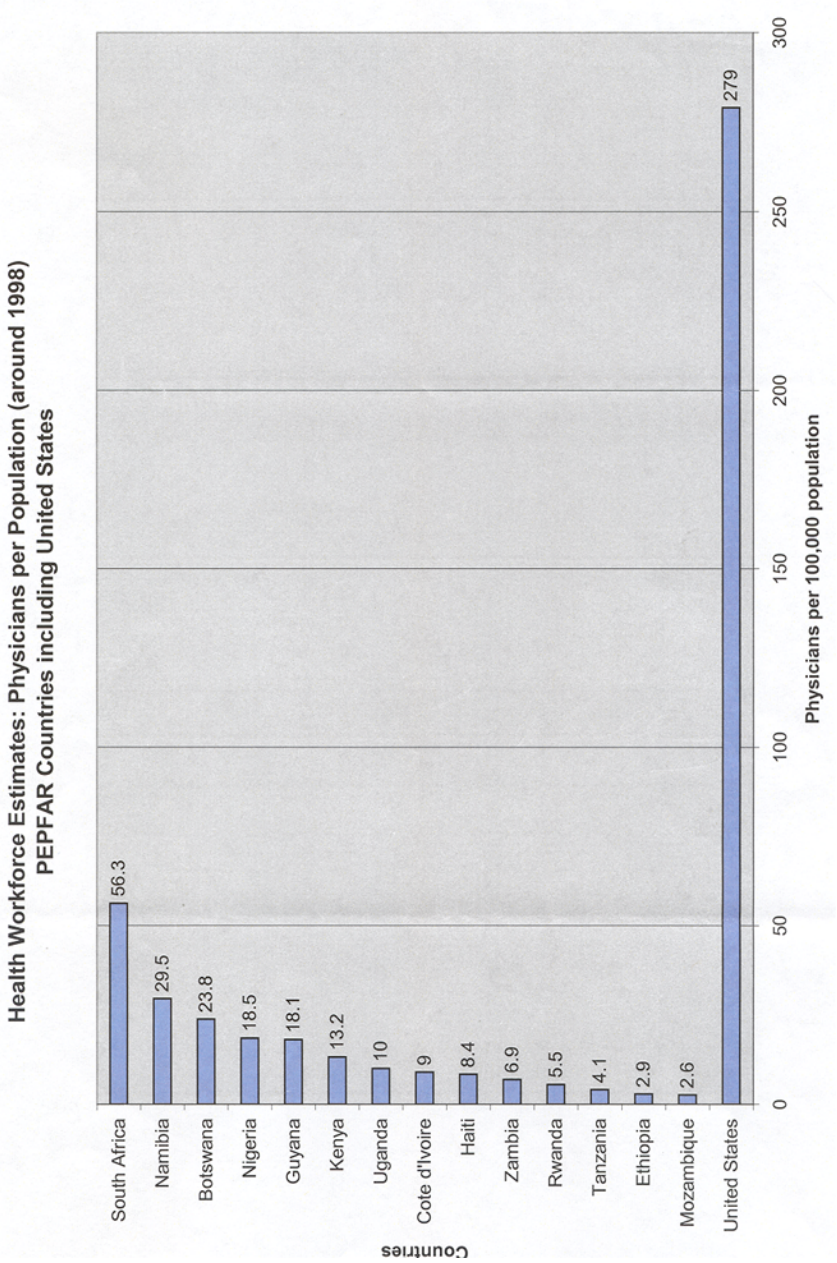
As we implement the Emergency Plan for AIDS Relief, over the next several months we will be working to obtain updated estimates for this critical element of the Emergency Plan. We will update you and others as these new estimates become available. As you know, under the Emergency Plan we are committed to developing sustainable HIV/AIDS healthcare networks. We recognize the limits of health resources and capacity in many, particularly rural, communities. To more effectively address that shortfall, we will build on and strengthen systems of HIV/AIDS healthcare based on the "network" model. Prevention, treatment, and care protocols will be developed, enhanced, and promoted in concert with local governments and ministries of health. With interventions emphasizing technical assistance and training of healthcare professionals, healthcare workers, community-based groups, and faith-based organizations, we will build local capacity to provide long-term, widespread, essential HIV/AIDS services to the maximum number of those in need.

Thank you again for your continuing leadership on international HIV/AIDS issues and your support for the success of the Emergency Plan.

Sincerely,

PAUL V. KELLY,
ASSISTANT SECRETARY,
Legislative Affairs.

[Enclosure: As stated.]


Health Workforce Estimates: Physicians per Population (around 1998)
PEPFAR Countries including United States
Countries
South Africa
Namibia
Botswana
Nigeria
Guyana
Kenya
Uganda
Cote d'Ivoire
Haiti
Zambia
Rwanda
Tanzania
Ethiopia
Mozambique
United States
56.3
29.5
23.8
18.5
18.1
13.2
10
9
8.4
6.9
5.5
4.1
2.9
2.6
279
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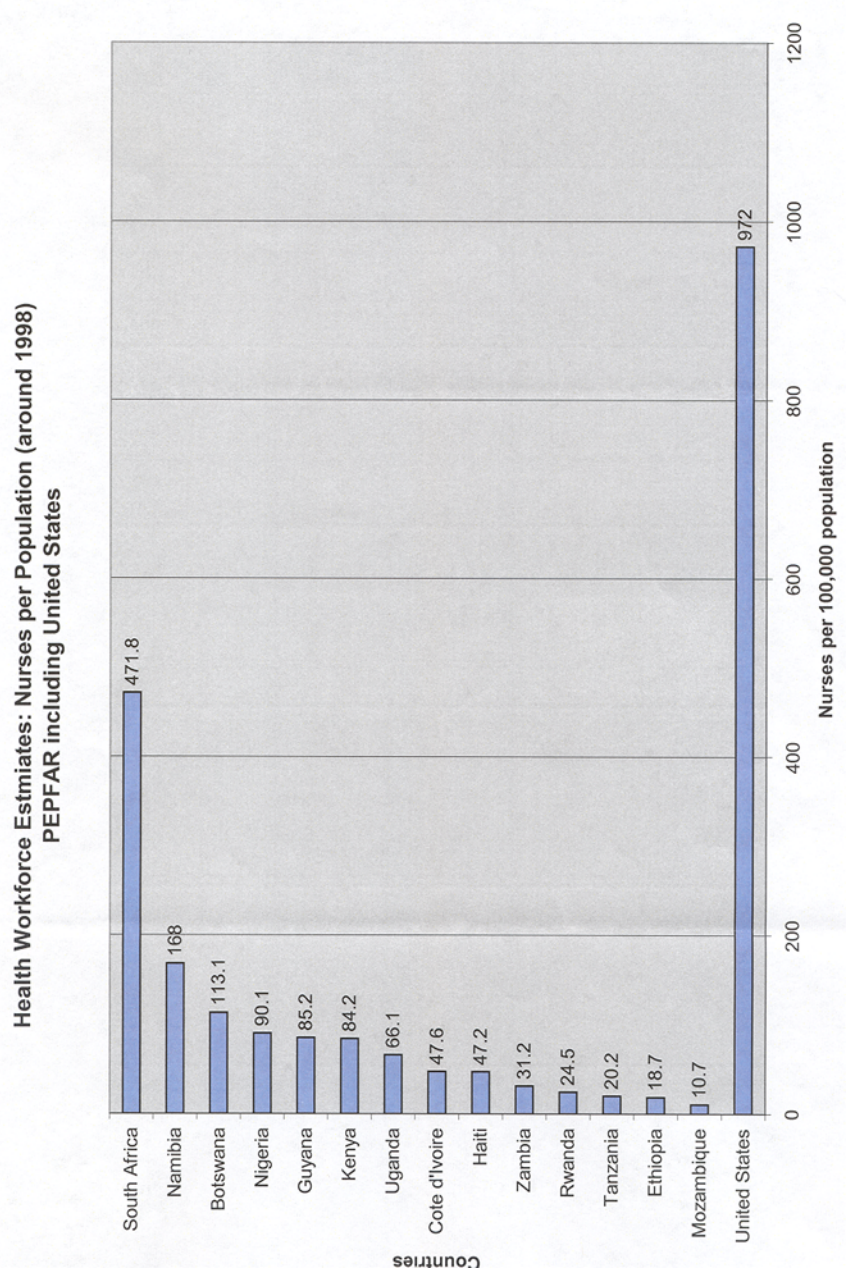
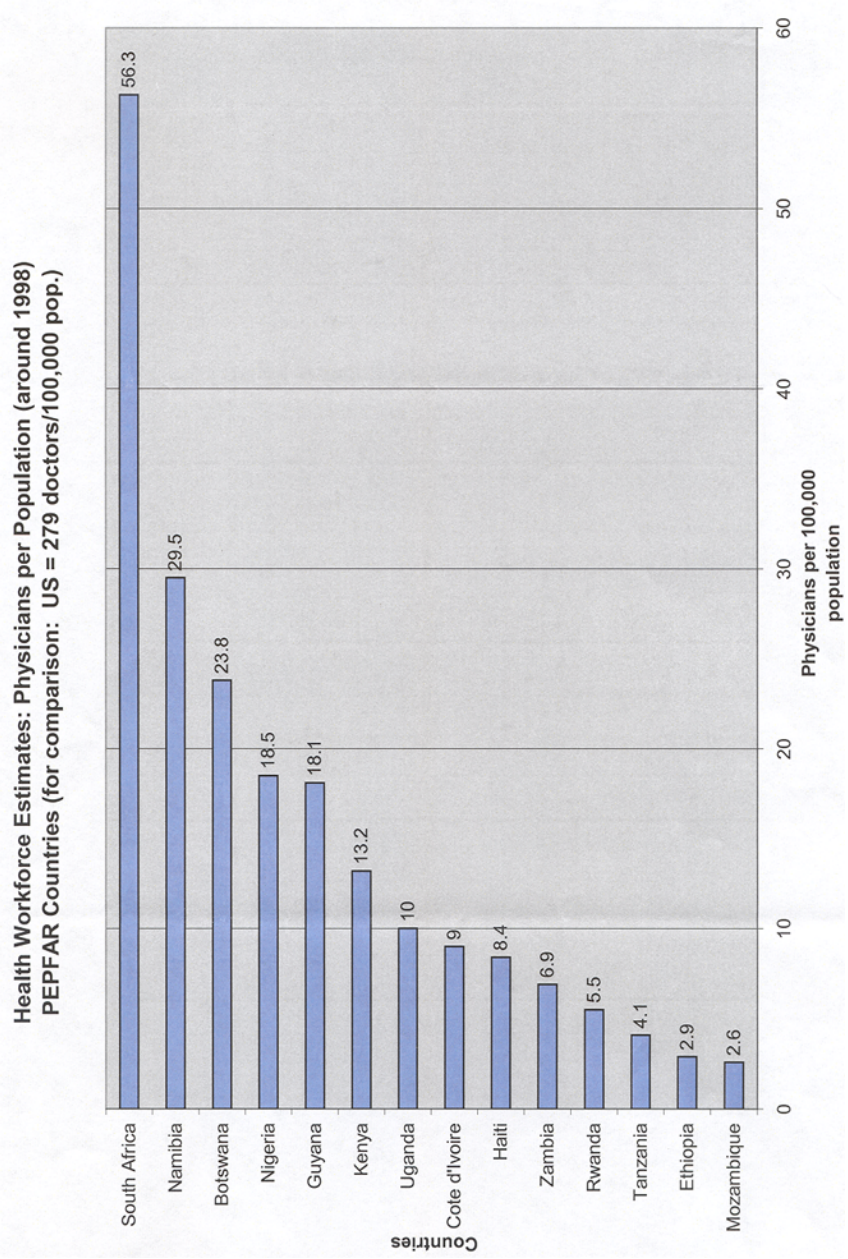
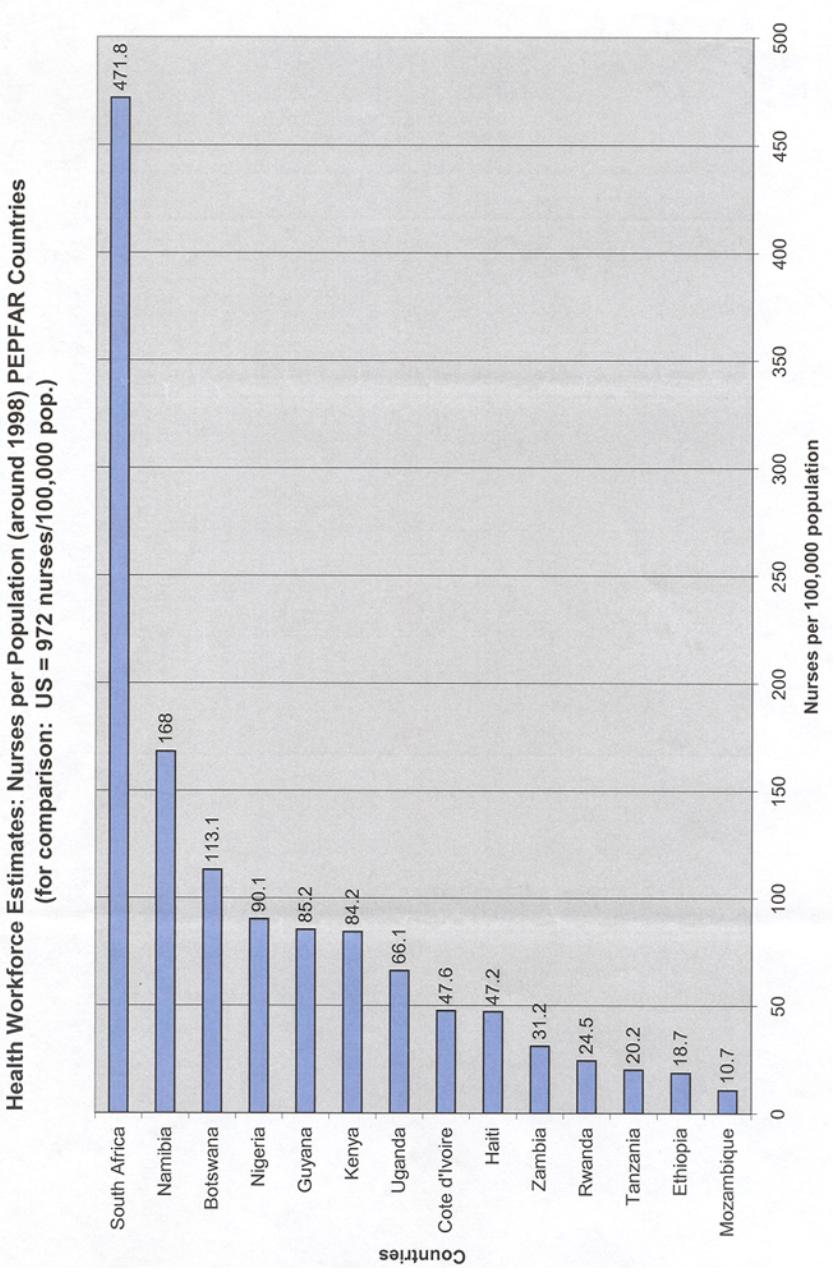
50
100
150
200
250
300
Physicians per 100,000 population


Health Workforce Estmiates: Nurses per Population (around 1998)
PEPFAR including United States
South Africa
Namibia
Botswana
Nigeria
Guyana
Kenya
Uganda
Cote d'Ivoire
Haiti
Zambia
Rwanda
Tanzania
Ethiopia
Mozambique
United States
471.8
168
113.1
90.1
85.2
84.2
66.1
47.6
47.2
31.2
24.5
20.2
18.7
10.7
972
0
200
400
600
800
1000
1200
Countries
Nurses per 100,000 population


Health Workforce Estimates: Physicians per Population (around 1998)
PEPFAR Countries (for comparison: US = 279 doctors/100,000 pop.)
South Africa
Namibia
Botswana
Nigeria
Guyana
Kenya
Uganda
Cote d'Ivoire
Haiti
Zambia
Rwanda
Tanzania
Ethiopia
Mozambique
56.3
29.5
23.8
18.5
18.1
13.2
10
9
8.4
6.9
5.5
4.1
2.9
2.6
Countries
0
10
20
30
40
50
60
Physicians per 100,000 population


Health Workforce Estimates: Nurses per Population (around 1998) PEPFAR Countries
(for comparison: US = 972 nurses/100,000 pop.)
South Africa
Namibia
Botswana
Nigeria
Guyana
Kenya
Uganda
Cote d'Ivoire
Haiti
Zambia
Rwanda
Tanzania
Ethiopia
Mozambique
471.8
168
113.1
90.1
85.2
84.2
66.1
47.6
47.2
31.2
24.5
20.2
18.7
10.7
Countries
0
50
100
150
200
250
300
350
400
450
500
Nurses per 100,000 population

Countries	Physicians	Nurses	Clin. Officer	Pharmacists	Lab Techs
United States	279	972		—	
Mozambique	2.6	10.7		—	
Ethiopia	2.9	18.7		—	
Tanzania	4.1	20.2		—	
Rwanda	5.5	24.5		—	
Zambia	6.9	31.2		—	
Haiti	8.4	47.2		—	
Cote d'Ivoire	9	47.6		—	
Uganda	10	66.1		—	
Kenya	13.2	84.2		—	
Guyana	18.1	85.2		—	
Nigeria	18.5	90.1		—	
Botswana	23.8	113.1		—	
Namibia	29.5	168		—	
South Africa	56.3	471.8		—	

Ambassador TOBIAS. So in part, we are addressing this using a program called twinning, by matching up medical schools in the United States, medical centers in the United States with counterparts in the countries in Africa that can help them by loaning them people, sending residents, developing programs that can help in that regard. We have authorized a study that the Institute of Medicine is conducting to look at how we can best do that.

But in the meantime, we are off and going with the first $350 million out the door and another $300 million coming up here very shortly. So I am pleased with that, and even my friend Bono has been very complimentary about the speed with which we are getting these programs going.

Let me say a word about the drug issue because it is far more complicated than one might assume on the surface. Those of us here in the United States have come to understand what is meant by the term "generic drug." It means that if a physician writes a prescription and you or I take that prescription to our local pharmacy and get it filled, whether it is filled with a generic drug or a drug that was manufactured by the research-based pharmaceutical company that originally made it, from our point of view as a patient, what we are going to receive is exactly, precisely, identically the same. It is the same because the FDA has processes to ensure that it is the same.

When people describe generic AIDS drugs in Africa, they are not generic drugs in that context. These are drugs that are copies that have been manufactured by other companies without the same access to the data and so forth that happens when a drug is no longer under patent protection.

The World Health Organization has put together a process that is called their prequalification list, through which they do a paper review of data that is provided to them under a confidentiality agreement by companies who wish to have their drugs reviewed for this list. The World Health Organization reviews that dossier. They make a visit to the manufacturing site where it is to be manufactured and they make a preliminary stipulation to countries who do not have regulatory processes that this is a list that they should

look at to acquire drugs. There are many who believe that is good enough.

As we gear up this program, we are going to have not only a lot of newcomers coming, but great risks of being sure we do this right. So we have been working with scientific technology people from the World Health Organization, from the Southern African Development Community, from a number of nations to try to determine what is the process we can use to ensure that the drugs we are providing for the patients in Africa are, in fact, safe and effective.

Nobody wants to move this along any more quickly than I do. As I have said on a number of occasions, our policy is and will be to buy the least expensive drugs we can find from wherever we can find them as long as we have some reasonable assurance of their safety and effectiveness and we are moving ahead rapidly to get that kind of a process in place.

The CHAIRMAN. I thank you.

Mr. Natsios.

Mr. NATSIOS. May I just add another subtlety to this discussion about treatment and care for people with HIV/AIDS?

I think the presumption in Washington is that somewhere in the world where there is high incidence of HIV/AIDS is a list of all the people in the country that have the disease. That is not true. Only about 6 to 10 percent of the people who are HIV/AIDS-positive know they have the disease because they have been tested. The other 90 percent have the disease and may not be at a stage where there is any manifestation of symptoms or they may have symptoms but they may not know it is HIV/AIDS. And in some cases, they may be later in the disease and not want to tell anyone they have the disease because in some areas of the world, if you tell people, they kill you or they will throw you out of the village or your house because there is a terrible stigma attached to being ill.

Now, you can do a prevention program generically through the news media to tell people how you can prevent getting infected because you do not have to know who gets it or does not get it. You do it through the news media. But if you want to feed someone or you want to provide ARVs, you have to know individually who the person is. And 90 percent of the people who have the disease we do not have a list of. We do not know who they are and they do not know who they are.

The CHAIRMAN. On that point, now, how do we know that that many people have the disease?

Mr. NATSIOS. We extrapolate the data from health clinic surveys that are done in different countries. What will happen is the NGOs that have grants and contracts from the Department of Health and Human Services [HHS] and USAID and Randy's office or other countries that provide funding will go in to a particular health clinic and they will test everybody voluntarily but they will test them. And they will get a percentage.

The CHAIRMAN. I see.

Mr. NATSIOS. And they will do this at 10 different clinics around the country and then they will extrapolate the data based on sound principles of public health.

The CHAIRMAN. This is a sampling almost like a political poll in a way.

Mr. NATSIOS. Exactly. I have never heard it compared that way, Senator, but that is a good comparison. It is the same principle. Yes.

The CHAIRMAN. It is part of our craft. We do these things from time to time.

Mr. NATSIOS. Yes. But the complication for us, until we have the systems set up that Randy talked about to do the testing, we cannot very well treat people generically. We have to treat people specifically. We cannot treat people as a group. You treat them individually. So having the health care infrastructure to do the testing first, then to do the treatment and the care is a complex area.

In some of the areas we are working in, Senator, there are no roads. There are no helicopters. There are no boats to get to these people. They live in remote areas in villages where the disease has spread, but they are very inaccessible. It is not just that there are no doctors. There are no health workers. There are no clinics and there are no hospitals. So you have to train people on how you take the test properly, and then you have to train them in how you administer the drugs properly. Then you have to target them in order to provide the food aid to them.

So it does not mean we cannot do it. We are going to do it. We are already doing it to a substantial degree, but it is more complex than it looks, which is why Randy properly said and Jim has said, that we have to have the absorptive capacity in place to absorb the resources we are directing toward this. We can do it. We are doing it. We are setting up the systems now, but it is not easy.

The CHAIRMAN. Well, now, trace for the record, Mr. Natsios, since this is one of the purposes of our hearing, how USAID and/or the new Millennium Challenge program intersect in these areas. You have indicated the huge numbers of people being fed through the World Food Program. USAID is interested in feeding, and also in assisting with the treatment of HIV/AIDS. Clearly we have a program that Mr. Tobias is heading, but you are involved in this. Your people are involved in these programs.

One of the questions that Americans have is, is there duplication? Do people talk to each other? Are they supporting each other? Do they take various specific pieces of the project, to avoid duplication? How would you describe the organized effort governmentally, given the fact that you have different agencies and also the United Nations involved? It is obviously not a United States agency, but it is backed very considerably by American gifts to the World Food Program.

Mr. NATSIOS. The respective roles of the World Food Program and the NGOs and USAID and other donors are actually quite defined. USAID does not actually go out and physically feed people. We rely on our partner organizations to do that, and our partners, in the case of food aid, are the World Food Program and the NGO community and faith-based groups at the village level who actually go door to door and distribute assistance.

WFP is the wholesale distributor, which is to say if we have a huge program in a country, we will go to WFP and say, we want you to organize the national effort in *x* country. They will work

with the NGOs to do the retail distribution. But in terms of the actual planning of the whole campaign nationally, WFP does that with our planning staff and then they do the logistical systems at the port facilities to off-load the food, make sure it is cared for, and it is not diverted. Then they put it on trucks. Their logisticians, by the way, are the best logisticians in the U.N. system. In fact, not just the U.N. system, I would say in the world. It is an excellent organization from a logistics and planning point of view.

Our role is to do assessments, to determine what the need is, working with other organizations, to target food assistance, to develop the components of the food basket. In some societies, some food is more appropriate than others. It has to be nutritionally balanced. And each of us has our role. We have our role. WFP has its role and the NGOs have their role. If one of us dropped out, the system would not work. But there is no overlap in it. And I think it works actually in a very integrated way and a very efficient way. I do not know if you want to disagree with any of that, Jim.

Do you have a comment, Mr. Morris?

Mr. MORRIS. Senator, I agree that it works really superbly well, especially on the ground. It works extra-effectively as it relates to the HIV/AIDS issue because everyone understands it takes all of the ingredients to get at this. No one approach will solve the problem. And I think you would generally be very pleased to see the way that UNICEF and UNAIDS and WFP work with Save the Children and World Vision and the Red Cross and Catholic Relief and CARE, the way we work with USAID. Their counterpart in the UK DFID is also very good.

Of course, the magnitude is so enormous that we are only getting at a piece of it, and we do not run over each other. In southern Africa, as Andrew said, they have come to us to manage the port issues so that we do not have six people competing for port pricing and manage the distribution on rail links or trucks to points where the NGOs receive the food and distribute it. They have the best expertise to work community by community. We have 1,500 partners, NGOs, 300 international, 1,200 local, and some of the best international NGOs are working very hard to partner with local NGOs so that capacity gets stronger.

The CHAIRMAN. Both of you have defined the fact that USAID and the World Food Program work on a national plan for whatever the country may be, and then the wholesale delivery comes from the World Food Program. The retail delivery comes from the private organizations. They carve out those spaces where they can be of service. Mr. Natsios has pointed out that obviously a hunger problem carries a different burden from HIV/AIDS. You have to know that you have a patient, first of all, in the case of HIV/AIDS, as opposed to an extrapolation of a problem. This may involve social stigma or even denial by politicians in high leadership positions in some African countries until recently. This creates real problems. Nevertheless, in your comprehensive planning, you take all this in consideration.

How do you define how the AIDS program works with USAID? What are the carve-outs or responsibilities there?

Mr. NATSIOS. Well, Randy is in charge and he makes the assignments. He allocates the budget. He sets the policies. We meet with him weekly; our staffs do.

We have a global health bureau. I had a count done worldwide. We have 400 people working on this who are USAID staff people. These are not people who work for the NGOs or the U.N. or the ministries of health. These are USAID public health officers. As I said, three-quarters of our staff are in the field. We have USAID missions around the world. In all but one of the PEPFAR countries, the 14 target countries, there is a USAID mission. It has been there, in many cases, for many years. They know the networks. They know the villages. Half of our worldwide staff are not Americans. They are Mozambiqueans. They are Zambians. They are Brazilians. They are Colombians. We call them Foreign Service nationals [FSNs] but they are a critical part of our staff. Many of them are physicians or public health officers, and they are the ones who carry these programs out at the national level.

But Randy is in charge and I have told all our staff that we are to take his leadership on this. We contribute, I think, technical expertise, research data, our networks, our procurement systems, our officers in the field to carry out the decisions that he makes.

The CHAIRMAN. Randy.

Ambassador TOBIAS. I might just add that while we have put together the strategy that has been submitted to the Congress here in Washington, the implementation of what we are doing is very much driven on a country-by-country basis where the U.S. Chief of Mission has been asked to—and they each have done a fine job—step up to provide integrated leadership, bringing together the people in USAID, CDC, and the other U.S. Government organizations on the ground. And that local orientation, I think, better enables us to coordinate the prevention and particularly the treatment and care aspects of what we are doing with other programs that are available through USAID or elsewhere, so that we are combining with our treatment and care efforts the nutrition needs and the other needs that are requirements of fighting this disease.

The CHAIRMAN. You have identified another especially important aspect. The Chief of Mission is often our ambassador to the country. This gives some idea of how, in a diplomatic way, the State Department Secretary deals with ambassadors, USAID, the U.N. agency and the World Food Program. The reason I have tediously gone through this is that this is not well understood. It is the purpose of our hearing today to delineate the parameters more carefully so that members will have some idea of how this works, and that it works well. And if it does not work well, we will have some way of trying to get a handle on the problem to help you make sure that it will work better.

I just want to ask one further question. Mr. Natsios, you offered very valuable testimony as the committee considered the Millennium Challenge idea. You were there to celebrate with the President yesterday the announcement of the first 16 nations that will be major participants in the program.

Now, how do things change if you are a Millennium Challenge account, as opposed to being a normal recipient, let us say, of for-

eign aid or however we want to describe the assistance our country gives? Are there some new definitions of the problem?

Mr. NATSIOS. The existing foreign aid program of the United States comes out of half a dozen spigots of money, which is heavily earmarked and directed by the Congress. We can debate whether that is useful or not, but it has a lot of specificity as to how we will spend the money. Population money, a $435 million earmark, must be spent on population programs.

The money for the Millennium Challenge Account is unearmarked. There are no directives. There are no earmarks by sector, by region, or anything else.

The CHAIRMAN. So it goes to the State of Georgia, for instance.

Mr. NATSIOS. That is right. The country of Georgia.

The CHAIRMAN. Yes, the country of Georgia. Pardon me.

Mr. NATSIOS. I do not want to think Atlanta is getting our foreign assistance program.

The CHAIRMAN. Good point.

Mr. NATSIOS. Not that they need it.

But let us say it was the country of Georgia, which is one of the 16 eligible countries. The way this will work, according to Paul Applegarth, who is the Director of the program and is the CEO of the Millennium Challenge Corporation. I sit on the board. He will decide with his staff which countries will use which mechanisms for implementation. He is not going to be the implementing agent in the sense of actually carrying things out. He has said in public testimony I think before this committee. He said to me, can we in some countries use the USAID mission as the implementing agent with the ministries of the government in the country, and the answer is yes. Whatever he wants us to do, we will do.

The CHAIRMAN. That would be their choice.

Mr. NATSIOS. That is their choice.

Now, the most important thing about the Millennium Challenge Corporation program, which relates directly to what we are talking about here, is this. There are certain things where there really is not a lot of international funding, for example, roads. The banks got out of doing roads. We got out of doing roads except in Afghanistan where we are doing roads. We do roads here and there, but there is not an enormous amount of funding and there are no earmarks or directives to do them.

If you ask people in the developing world what is the most important thing they need in the rural areas, they need roads. Why is that? They cannot move. They grow extra food and it rots. Why? Because they cannot move it to the food-deficit areas. They cannot move seed in. They cannot move fertilizer in. They cannot move their kids to a hospital if they are sick or to a clinic, or they cannot move their kids easily to school.

So many countries are telling us they want this money invested in infrastructure. They are going to make the decision through the compact that they draft with the U.S. Government. Paul Applegarth's staff will have to approve or not approve the compacts. Then the board of directors will be involved in that.

But this is country-driven, and it will be country-implemented with some assistance from perhaps other institutions like USAID

or OPIC or other institutions within the U.S. Government that might be carrying out parts of this program.

But I think what we will see is that in many cases the areas that they cannot get donors to give money, but they need desperately like infrastructure, which has been neglected for too long, you will see these proposals, these compacts, coming back heavily focused in an area. Not entirely. Some of them may decide they want to build school buildings and they want to train more teachers. That is up to them to decide. We will help implement it as they wish. But again, Paul Applegarth is in charge.

Whatever they do with it I suspect will facilitate the work that all of us are doing. If they build rural roads, it is much easier for Randy and me to get the AIDS clinics built and the pharmaceuticals delivered properly, and Jim and I will have an easier time delivering the food assistance because there is now a way to get to it much more efficiently.

One of Jim's biggest costs is trucks. Some of the roads that they get through now, you cannot even imagine they are roads that are so unbelievable. In some areas there are no roads whatsoever.

So these things do work together particularly at the country level which is where, to put it crassly, the rubber meets the road.

The CHAIRMAN. Let me indicate that reluctantly I am going to bring the hearing to a conclusion because the Senate is about to have an important rollcall vote, which hopefully will expedite our business on the floor.

My colleagues, Senator Feingold and Senator Alexander, as our chairman and ranking member of the African Affairs Subcommittee, asked Mr. Morris about the Sudan and his travels there. To say the least, this is an extraordinarily dangerous situation, quite apart from a humanitarian one.

I was impressed that five members of our committee were privileged to have breakfast with our Secretary of Defense, Mr. Rumsfeld, and General Myers this morning at the Pentagon. They were describing how difficult it was to either get people to the peace process or to extract them from the peace process, leaving aside the roads that Mr. Morris described that carry any humanitarian food, the 800,000 people, for example. The feat of trying to feed people in Sudan presently is prodigious. So is the fact that it can be done at all under these conditions, which are daunting even to our military as it attempts to bring peace.

That is true for each of you in the work that you are doing. The terrain that you are covering is not easy. I appreciate Mr. Natsios' point that we do not do roads anymore, although the Millennium Challenge countries may decide we have to do roads in order to have the kind of delivery that we want. All of these are factors in the humanitarian predicament, quite apart from the infrastructure of the country.

I thank each one of you very much for your forthcoming testimony, your statements, and your response to our questions. We look forward to renewing this conversation at future hearings when we have some more benchmarks along the road.

With that, the hearing is adjourned.

[Whereupon, at 12:01 p.m., the committee adjourned, to reconvene subject to the call of the Chair.]

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

[From the Los Angeles Times, May 11, 2004, Tuesday Home Edition]

IRAQ PRISON SCANDAL; A DOUBLE ORDEAL FOR FEMALE PRISONERS

(By Tracy Wilkinson, Times Staff Writer)

One woman told her attorney she was forced to disrobe in front of male prison guards. After much coaxing, another woman described how she was raped by U.S. soldiers. Then she fainted.

A U.S. Army report on abuses at Abu Ghraib prison documented one case of an American guard sexually abusing a female detainee, and a Pentagon spokesman said Monday that 1,200 unreleased images of abuse at Abu Ghraib included "inappropriate behavior of a sexual nature."

Whether it was one or numerous cases of rape, many Iraqis believe that sexual abuse of women in U.S.-run jails was rampant. As a result, female prisoners face grave prospects after they are released: denial, ostracism or even death.

A woman who is raped brings shame on her family in the Islamic world. In many cases, rape victims have been killed by their relatives to salvage family honor, although there is no evidence this has happened to women who have been prisoners in Iraq.

"It is like being sentenced to death," said Sheik Mohammed Bashar Faydhi, a senior cleric based at Baghdad's largest Sunni mosque.

Some Iraqi women said they were struggling to come to terms with the alleged abuses of female detainees at Abu Ghraib and other U.S.-controlled lockups. Few female inmates will talk about it. Their lawyers lower their voices when the subject of rape comes up.

"I hope it's not true, because were it to be true, it is just too horrible to imagine," said Rajaa Habib Khuzaai, an obstetrician who is one of three women on the Iraqi Governing Council.

This week, Khuzaai was allowed access to a detention center housing women—a privilege rarely granted to outsiders before the scandal.

But female lawyers who visited the prison in March said their clients provided accounts of abuse and humiliation.

To enter the prison west of Baghdad, the attorneys waded through dirt and coils of barbed wire, and waited for hours.

Inside, they met with nine female detainees—four of whom, they said, had not been charged with any crime. U.S. military officials said at the time that there were 10 or 11 women being held at Abu Ghraib.

One lawyer, Sahra Janabi, said her clients found it difficult to talk about their experiences in prison. Seemingly minor actions by U.S. soldiers, such as removing a woman's head scarf, represented a violation to these Muslim women.

A prison translator was present in the meetings and took notes, Janabi said.

"We could not talk freely," she said. "The women were devastated. They broke down crying."

According to Janabi, only one prisoner, a middle-aged owner of a cigarette stand, would speak openly, and said she did not care if the guards punished her.

She told the lawyers that she had been forced to disrobe in front of male guards, an action that an Iraqi translator found so disgraceful he turned his head away in embarrassment.

Janabi and her colleagues said many women who had been detained are wives or relatives of senior Baath Party officials or of suspected insurgents. U.S. Army officials have acknowledged detaining women in hopes of persuading male relatives to provide information. The lawyers said interrogators sometimes threatened to kill detainees.

Dozens of people—lawyers, Iraqi officials, Iraqi and foreign human rights activists—have sought access to the prisons during the last year with minimal success. Stories of physical and sexual torture were rampant for much of that time. Iraqi officials and lawyers say U.S. military and governmental secrecy created a climate that allowed abuses.

Women represented a small percentage of about 40,000 detainees processed by U.S. authorities.

Once the women are freed, a new trauma begins, Iraqis say.

Khuzaai, the Governing Council member, said most female detainees cannot talk about what they've been through. They and their families try to pretend nothing ever happened, she said.

Another lawyer, Amul Swadi, said her client fainted before providing further details of being raped and knifed by U.S. soldiers.

Five former detainees described to their lawyers having been beaten. But they did not say they had been raped.

"They are very ashamed," Janabi said. "They say, 'We can't tell you. We have families. We cannot speak about what happened.' "

In Iraq, silence may be their best protection.

Faydhi, the cleric, said an Iraqi man cannot acknowledge having had a female relative in prison. The shame, he said, is bad enough if the woman was in an Iraqi jail. To have been taken by the Americans compounds the humiliation.

Her life may be in danger especially if the woman is from a large, prominent tribe, he said, and her family believes she has been raped, Faydhi said.

Faydhi, an official with Iraq's Board of Islamic Clergy and a professor at the Islamic University, said a man will be discouraged from killing his female relative who has been released from prison if he seeks permission of an imam to restore the family's honor. But the cleric also said imams have limited ability to prevent this kind of murder.

"I would remind him that she is a victim, and ask, how can we victimize her even more? I would tell him to keep it secret, but that if word gets out, I would try to convince him that she should be seen as a patriotic symbol," Faydhi said. "But it is really difficult to convince an Iraqi to think in such a manner."

Khuzaai said the stigma would be unbearable.

"Like any woman who is raped, there is the mental, psychological breakdown and everything that is related to the self," she said. "But then there's the family and society. If a rape has happened, a family will never talk about it, not to the public, and maybe not even among themselves."

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26 March 2004.

Ambassador RANDALL TOBIAS
Global AIDS Coordinator,
U.S. Department of State,
Washington, DC.

DEAR AMBASSADOR RANDALL TOBIAS,

We, the undersigned organizations, are writing to express our serious concerns about efforts by the Bush administration and by your office to block the use of affordable generic HIV/AIDS medicines in U.S.-financed programs in poor countries. In order to mount a rapid and successful response to the growing AIDS pandemic, we call upon you to ensure that programs use the most affordable medicines available, and accept the current drug quality standards of World Health Organization's drug prequalification program.

We are particularly concerned about the U.S.-initiated "Conference on Fixed-Dose Combination (FDC) Drug Products: Scientific and Technical Issues Related to Safety, Quality, and Effectiveness," 29-30 March 2004 in Gaborone, Botswana. This meeting needlessly casts doubt upon the clinically proven quality of generic AIDS medicines, and disregards the WHO's internationally recognized Drug Prequalification Program. The meeting is intended to justify the use of expensive, more complex branded treatment regimens, and will be used by the US as the minimum basis to justify its efforts to use bilateral assistance programs to lock generics out of developing countries. Of particular concern is your attempt to discredit the use of urgently needed fixed-dose combinations (FDCs) of antiretroviral AIDS medications.

Single-pill combinations promote adherence, decrease the risk of resistance, and facilitate stock and procurement management, and are widely recognized as a core element in efforts to scale up ARV treatment in developing countries. FDCs are strongly preferred over blister packs and other multi-pill regimens. In addition to ease of use and other advantages, FDCs, which are taken in the form of one pill twice a day, are also by far the least expensive option: today, triple FDCs from generic manufacturers are available for less than $140 per person per year. The same combination from brand-name companies costs a minimum of $562 per person per year and must be taken in the form of six pills a day. Forcing people with HIV/AIDS to accept higher pill burdens, wasting limited taxpayer resources on brand

name products, and, most importantly, using scarce resources to treat one person when the same amount of money could treat four is unacceptable.

If the ambitious goals of the President's Emergency Plan for AIDS Relief (PEPFAR), and the WHO's "3 by 5" initiative are to be met, triple combination FDCs pre-qualified by WHO must be made widely available. FDCs are recommended in WHO treatment guidelines, and several generic FDCs have been certified by WHO as meeting stringent international standards for drug quality, safety and efficacy through its Prequalification Project. The WHO's standards for prequalification are supported by UNICEF, the World Bank, the Global Fund to Fight AIDS. TB, and Malaria, Columbia University's MTCT-Plus program, many national governments in developing countries, international humanitarian organizations such as Médecins Sans Frontières (MSF), and other programs with experience treating people living with HIV. Clinicians in resource poor settings are already using triple combination generics with tens of thousands of patients, with efficacy and adherence rates equal-to-or-better than treatment success and adherence rates in the United States.

Rather than disregarding the drug procurement policies of developing nations to create expensive new barriers that benefit US drug companies, your office should accept the WHO's internationally recognized drug quality standards and promote access to affordable medications. We object to any and all efforts by the Bush Administration and your office to block the use of WHO prequalified generic medications, and any efforts to discredit the standards of WHO's prequalification project that would impose new barriers to generics entering the global market.

Signed,

International Organizations

International Association of Physicians in AIDS Care (IAPAC), Int'l
Partners In Health, Int'l
Oxfam International
International Council of AIDS Service Organizations (ICASO), Int'l
International Planned Parenthood Federation, Western Hemisphere Region, Int'l
CAFOD International—Catholic Agency for Overseas Development, Int'l
AIDSETI–AIDS Empowerment & Treatment International, Int'l
Ecumenical HIV Initiative in Africa, World Council of Churches, Int'l
European AIDS Treatment Group (EATG), Int'l
Health Action International, Int'l
Health Alliance International, Int'l
ILGA—International Lesbian and Gay Association, Int'l
International Community of Women (ICW) living with HIV/AIDS, Int'l
People's Health Movement Global Secretariat, Int'l
Red Centroamericana de Personas que Viven con VIH/SIDA (REDCA+), Int'l
Third World Network, Int'l—Malaysia
African Jesuit AIDS Network, Int'l
Artists for a New South Africa, Int'l/USA-CA
Asociación para la Salud Integral y Ciudadanía de América Latina (ASICAL), Int'l
COLEGA, La Federación Espãola COLEGAS de Lesbianas, Gays, Bisexuales y Transexuales, Int'l
Comite Latinoamericano y del Caribe para Defensa de los Derechos de la Mujer (CLADEM), Int'l
International Health and Development Associates, Int'l
International Peoples Health Council, Int'l
INTERSECT Worldwide, Int'l
Joint Mongolian-German Reproductive Health Project, Deutsche Gesellschaft fir Technische Zusammenarbeit (GTZ), Int'l
Kenya AIDS Intervention Prevention Project Group (KAIPPG) Int'l
Latin American and Caribbean Women's Health Network, (LACWHN), Int'l
Movimiento Latinoamericano y del Caribe de Mujeres Positivas (MLCM+), Int'l
Pastoral de la Esperanza Iglesia Catolica CentroAmericana, Int'l
People's Health Movement East Africa, Int'l
Red de Salud de las Mujeres Latinoamericanas y del Caribe (RSMLAC), Int'l
The River Fund, Int'l
Ukimwi Orphans Assistance, Int'l
Voluntary Services Overseas (VSO), Int'l
WE-ACT—Women's Equity in Access to Care & Treatment, Int'l

U.S. National Organizations

Episcopal Church USA
Presbyterian Church, USA

Unitarian Universalist Association of Congregations, USA
Amnesty International, USA
American Foundation for AIDS Research (AmFAR), USA
National Gay and Lesbian Task Force, USA
ActionAid International USA
Africa Action, USA
AIDS Treatment News, USA
AIDS Vaccine Advocacy Coalition (AVAC), USA
American Jewish World Service, USA
American Medical Students Association (AMSA), USA
Center for Health and Gender Equity (CHANGE), USA
CHAMP, USA
Church Women United, USA
Commission on Social Action of Reform Judaism, USA
Consumer Project on Technology, USA
Essential Action, USA
Gay Men's Health Crisis (GMHC), USA
Global AIDS Alliance, USA
Global Exchange, USA
Health GAP (Global Access Project), USA
Jubilee USA Network, USA
Maryknoll Office for Global Concerns, USA
National Minority AIDS Council (NMAC), USA
Our Bodies Ourselves, USA
Physicians for Human Rights, USA
POZ Magazine, USA
Project INFORM, USA
Reformed Church in America Mission Services Program in Africa, USA
Student Global AIDS Campaign, USA
TII CANN—Title II Community AIDS National Network, USA
Treatment Action Group, USA
Washington Office on Africa, USA
Women's International League for Peace and Freedom, United States Section
50 Years Is Enough: U.S. Network for Global Economic Justice, USA
Adrian Dominican Sisters, USA
Africa Faith and Justice Network, USA
AIDS Treatment Data Network, USA
The Praxis Project, USA
AIDS.ORG, USA
Corporate Responsibility Program, Province of St. Joseph of the Capuchin Order, USA
Health Professional Student AIDS Advocacy Network, USA
Institute for Agriculture and Trade Policy, USA
Keep A Child Alive, USA
Maryknoll AIDS Task Force, USA
Medical Mission Sisters' Alliance for Justice, USA
Missionary Oblates, Justice/Peace & Integrity of Creation, USA
National Association for Victims of Transfusion-Acquired AIDS (NAVTA), USA
Operation USA
Share International USA
South Africa Development Fund, USA
Universities Allied for Essential Medicines, USA

Foreign Country Organizations

Act Up-Paris, France
Agua Buena Human Rights Association, Costa Rica
AIDES, France
Bread for the World, Germany
Deutsche AIDS-Hilfe, Germany
Grupo de Incentivo à Vida, Brazil
Royal Tropical Institute, Holland
Treatment Action Movement, Nigeria
Action for Southern Africa (ACTSA), UK
Advancement of Rural People And Nature (ARPAN), India
African Research Institute, LaTrobe University, Australia
African Services Committee, Ethiopia
Agency for Cooperation and Research in Development (ACORD), UK
AGIHAS PLWHA Support group, Latvia

AIDS ACCESS Foundation, Thailand
AIDS Access Foundation, Thailand
AIDS Council of New South Wales (ACON), Australia
AIDS Law Unit, Legal Assistance Centre, Namibia
AIDS Task Force (HIV/AIDS Division of Africa Japan Forum), Japan
AKINA MAMA, Sweden
Alnaemissamtökin á Íslandi, The AIDS Organization of Iceland, Iceland
AMAS/AFAS, Mali
APPRENDE, Peru
Asian-Pacific Resource & Research Centre for Women (ARROW), Malaysia
Asoc. Gente Positiva (GP), Guatemala
Asociación ACCRAD, Argentina
Asociacion Amigos de Ayacucho, Spain
Asociación Atlacati Vivo Positivo, El Salvador
Asociacion Comunitaria Anti SIDA, Spain
Asociación Coordinadora de Sectores de Lucha Contra el SIDA (ACSLCS), Guatemala
Asociación Costarricense De Personas Viviendo Con VIH/SIDA, Costa Rica
Asociación de Mujeres Contra la Violencia Intrafamiliar, México
Asociación por la Vida (ASOVIDA), Venezuela
Associção Brasileira Interdisciplinar de AIDS (ABIA), Brazil
Associção de apoio a pessoas corn VIH/SIDA (ABRAÇO), Portugal
Associção Justiça, Paz e Democracia (AJPD), Angola
Association Bondeko, France
Association de Lutte Contre le SIDA (ACLS), Morocco
Association Kénédougou Solidarité, Mali
ATTAC Japan, Japan
Australasian Society for HIV Medicine, Int'l/Australia
Australian Federation of AIDS Organisations, Australia
Australian People for Health, Education and Development Abroad (international humanitarian agency of the Australian Council of Trade Unions), Australia
Australian Red Cross, (Lao PDR Office), Australia
AVERT—Averting HIV and AIDS Worldwide, UK
Begin (learning & living with HIV), UK
BolivaGAY.com, Bolivia
British Columbia Persons With AIDS Society (BCPWA), Canada
Campagne pour les Droits de l'Homme au Congo (CDHC), Congo
Campaign for Improved Access to Treatment for AIDS in resource poor countries (ImpAcTAIDS), Scotland
Canadian African Partnership on AIDS (CAP-AIDS), Canada
Canadian Hiv/AIDS Legal Network, Canada
Canadian Union of Public Employees (CUPE), Canada
CARE Raks Thai Foundation, Thailand
Casa del Paso del Peregrino, Argentina
CASI—ComitÉ d'Action Sociale et Internationale of the UniversitÉ de MontrÉal, Canada
Catholics for AIDS Prevention & Support (CAPS), UK
Center for Health and Gender Equity (CHANGE), Peru
Center for Information and Advisory Services in Health, Nicaragua
Centers of Excellence—Substance Abuse & HIV/AIDS, India
Centre for International Health (Cih) of the Macfarlane Burnet institute for Medical Research and Public Health, Australia
Centro Regional de Farmacovigilancia, Argentina
Cheshire Homes, South Africa
ChildrenFIRST, South Africa
Children's Rights Centre, South Africa
Christian Health Association of Nigeria (CHAN), Nigeria
Christian Medical Association of India
CICOP Argentina
CIIEMAD/National Poytechnic Institute, Mexico
Citizen's Health Initiative, Malaysia
Coalicion ONGSIDA y de la Licda, Dominican Republic
Comité Ciudadano Anti-Sida de Castilla-La Mancha, Spain
Comite Dominicano de los Derechos Humanos CDH, Dominican Republic
Comité Orgullo Mexico
Committee of Arab and African Families United to Survive AIDS, France
Community Health Cell, India
Consultants for Health and Development, The Netherlands

Consumer Education Trust (CONSENT), Uganda
Coordinadora de AnimaciOn Socio Cultural (CASCO), Dominican Republic
COPROMOR, Burundi
Dame Una Mano, Chile
Departamento Acceso a Tratamiento Via Medidas Cautelares (DATVMC), Dominican Republic
Department of Pharmacology, School of Medicine, National University of La Plata, Argentina
Difaem—German Institute for Medical Mission, Germany
Discipline of Clinical Pharmacology, Faculty of Health, University of Newcastle, Australia
d'Unis-Cité, France
Ecumenical Pharmaceutical Network, Kenya
EDU-PRO Foundation, Albania
Egyptian Initiative for Personal Rights, Egypt
Family Aids Caring Trust, Zimbabwe
FarmacEuticos Mundi (ONL), Spain
Farmacia Siglo XXI Foundation, Spain
Farmamundi Extremadura, Spain
Five Loaves of Bread Christian Community for Homosexuals, Hungary
Foundation For Social Concerns Inc., West Indies
Foundation for Studies and Research on Women (FEIM), Argentina
Freedom Foundation, India
Fundación CIPRESS (Centro de Investigación y Promoción de la Salud y la Sexualidad), Chile
Fundación Henry Ardila, Colombia
Fundación Nimehuatzin, Nicaragua
Fundación para el Desarrollo Humano y Social de la Region del Pueblo Mam (FUNDAMAM), Guatemala
Fundacion para la Prevencion del VIH/SIDA (PRESIDA), Nicaragua
Fundacion PRESIDA, Nicaragua
Fundación Proyecto Gente, Columbia
Fundacion Schorer, The Netherlands
Genesis Panama+
Ghana AIDS Treatment Access Group (GATAG), Ghana
Gram Bharati Samiti, India
Green Scenery, Sierra Leone
Grupo Argentino Uso Racional de Medicamentos (GAPURMED), Argentina
Grupo de apoyo de personas viviendo con VIH-SIDA (FUNDASIDA), El Salvador
Grupo De Mujeres De La Argentina
Grupo Desde el pié, Argentina
Grupo Desida Por La Vida, Argentina
Grupo Português de Activistas sobre Tratamentos de VIH/SIDA (GAT), Portugal
GTP+ grupo de Trabalhos em Prevenção Posithivo, Brazil
Health Issues Centre, Australia
Helpless Rehabilitation Society (HRS), Nepal
HIV i-Base, UK
Human Genome Analysis, Wellcome Trust Sanger Institute, UK
Imbiza Intersect Coalition, South Africa
Interact Worldwide, Int'l—UK
Interchurch Organisation for Development Cooperation (ICCO), The Netherlands
International Cooperation Area, Foundation Institut Catala de Farmacologia, Spain
International Family Health, UK
International Gender Equality Network (IGEN), Hungary
Ipas Mexico A.C., Mexico
Irish Missionary Union, Ireland
Jamaica-Japan Network, Japan
Jana Arogya Andolana (PHM—Karnataka), India
Kenya AIDS Intervention Prevention Project Group (KAIPPG), Kenya
Kenya Treatment Access Movement, Kenya
KwaZulu Natal Intersect Coalition, South Africa
l'Association des Femmes Avocates au Congo (AFEAC), Congo
LGBT Organization of Venezuela
Liga Colombiana De Lucha Contra el SIDA, Columbia
Living Hope Organization, Nigeria
LOCOST (Low Cost Standard Therapeutics), India
Massive Effort Campaign, Switzerland
McGill International Health Initiative, Canada

MCS-Consult, Utrecht, The Netherlands
MICHOACANOS POR LA SALUD Y CONTRA EL SIDA, Mexico
Misiones Diocesanas Vascas, Spain
Mulher e Saúde—Centro de Referência de Educação em Saúde da Mulher, Brazil
Myarimar Buddhist Association of South Africa (MBASA), South Africa
National Association of People Living With HIV/AIDS (NAPWA), Australia
National Forum of People Living with HIV/AIDS Networks and Organisations, Uganda
Nazareth Hospital-Holy Family Center, Kenya
Network Earth Village Japan, Japan
Network of People Living with HIV/AIDS in Nigeria (NEPWHAN), Nigeria
Network of Sex Work Projects, Int'l—Brazil
Organización de Apoyo a una Sexualidad Integral frente al SIDA (OASIS), Guatemala
Organization for Social Development of Unemployed, Bangladesh
Pan-African Organisation in Sweden
People Living With HIV/AIDS New South Wales, Australia
People's Health Coalition for Equitable Society, South Korea
Point of View, India
Positive Life Association of Nigeria (PLAN), Nigeria
Positive Living, Malaysia
Positive Movement, Belarus
Positive Women Victoria, Inc., Australia
Prodemur significa Promoción de la Mujer Rural, Argentina
Programa de Prevención y Atención a las personas afectadas por eli VIH-SIDA en Asturias (PAVSA), Spain
Programa de Soporte a la Autoayuda de Personas Viviendo con VIH (PROSA), Peru
Progressive Organization of Gays in the Philippines (PROGAY), Philippines
Proyecto de Vacunaciòn y Desarrollo Comunal de Nicaragua (PROVADENIC), Nicaragua
Public Personalities Against Aids Trust, Zimbabwe
Radio Rhino International Africa, Germany
Reach Out Mbuya HIV/AIDS Initiative, Uganda
Red Argentina de Género, Ciencia y Tecnología (RAGCyT), Argentina
Red Colombiana de Mujeres por los Derechos Sexualers y Reproductivos, Colombia
Red Hispana de Derechos Humanos en vih—sida y minorias sexuales, Columbia
REDBOL, Bolivia
REDVIHDA, Bolivia
Regional AIDS Initiative of Southern Africa (RAISA) initiative of VSO, Zimbabwe
Regional Committee for the Promotion of Community Health, Nicaragua
Reproductive Health Matters, UK
Reseau des associations des PVVIH, Togo
Réseau du Burundi des PVVIH (RBP+), Burundi
RESULTS, Canada
RNP+ Núcleo RJ, Brazil
Salud Integral para la Mujer, A.C. (SIPAM), Mexico
SAPES Trust, Zimbabwe
Sección Sindical de la Confederación General del Trabajo del Ministerio de Fomento, Spain
Sida Info Service, France
SIDACTION—Ensemble Contre le SIDA, France
Social Welfare Association for Men (SWAM), India
Sociedad Wills Wilde, Venezuela
Society for Women and AIDS in Africa—Cameroun (SWAA), Cameroon
Solidarité Sida, France
Southern African AIDS Information Dissemination (SAfAIDS), Zimbabwe
Spanish National Community Advisory Board (CACSIDA), Spain
Spiritia Foundation (Indonesian Peer Support Network for PLHAs), Indonesia
St. Joseph's Matale Youth Organization, Uganda
Synthesis, Greece
Tanzania Network Of Organization Of People Living With HIV/AIDS (TANOPHA), Tanzania
Targeted AIDS Interventions, South Africa
Tertulia Feminist Magazine, Guatemala
Thandanani Childrens Foundation, South Africa
The Ark Foundation, Ghana
TREE, Training & Resources in Early Education, South Africa
Trócaire, Ireland

Tuyakula Group, Namibia
Uganda Coalition for Access to Essential Medicines, Uganda
UK Coalition of People Living with HIV and AIDS (UKC), UK
United Nations Association Of Uganda
University of Manitoba Medical Students' AIDS Outreach, Canada
University of Toronto International Health Program, Canada
Vanguardia Mexicana de Personas Afectadas por el VIH/SIDA (VANMPAVIH), Mexico
Vida Positiva Quilpue, Chile
VIH/SIDA de la Iglesia Catolica de Honduras
Waverley Care Trust, Scotland
Wemos Foundation, The Netherlands
Western Cape Intersect Coalition, South Africa
Wits Pediatric HP! Working Group, South Africa
Women on Waves, The Netherlands
Women's Dignity Project, Tanzania
WTO Watch Qld, Australia
Xtending Hope Partnership, St. Francis Xavier University, Canada
Youth (OSDUY), Bangladesh
YWCA of Albania

US Local and Regional Organizations:

ACT UP Cleveland, OH
ACT UP East Bay, CA
ACT UP New York, NY
ACT UP Philadelphia, PA
ActionAIDS Philadelphia, PA
Africa Bridge, OR
African Services Committee, NY
AIDS Action Baltimore, MD
AIDS Foundation of Chicago, IL
AIDS Policy Project, PA
AIDS Survival Project, GA
Balm in Gilead, NY
Blood: Water Mission, TN
Brown University Center for AIDS Research, RI
Catholic Mission Office, Diocese of St. Cloud, MN
Citizens for Consumer Justice, PA
COLOURS Organization, PA
Concerned Medical and Health Care Professionals, MD
Drexel University (Public Health Interest Group) PHIG, PA
George Washington University Student Global AIDS Campaign, DC
God's Love We Deliver, NY
HIV Law Project, Inc, NY
Housing Works, NY
International AIDS Empowerment, TX
Liberty Research Group, NY
Loyola AIDS Awareness Coalition, MD
Lutheran Campus Ministry at the University of Arizona, AZ
Migration & Refugee Services, Diocese of Trenton, NJ
NCATA (NW Coalition for AIDS Treatment in Africa), WA
New Mexico POZ Coalition, NM
New York AIDS Coalition, NY
Office of Religion, Catholic Diocese of Scranton, PA
PA Civil Rights Initiative, PA
Pacientes de SIDA pro Politica Sana, PR
Pediatric HIV/AIDS program at The Children's Hospital of Philadelphia, PA
Pennsylvania Lesbian and Gay Task Force (PLGTF), PA
Philadelphia College of Medicine Public Health Club, PA
Philadelphia International Action Center, PA
Philadelphia NORML, PA
Planet Poz, NM
Positive Health Clinic, PA
Prevention Point Philadelphia, PA
Princeton Student Global AIDS Campaign, NJ
Priority Africa Network (PAN), CA
Queers For Racial & Economic Justice, NY
Rescue Childhood, PA

RESULTS Seattle, WA
Rochester Area Task Force on AIDS, NY
Rochester Global AIDS Project, NY
Sisters Mobilized for AIDS Research and Treatment (SMART University), NY
Sisters of St. Joseph of Carondelet, St. Louis Province, MO
Starfish Project, New York Presbyterian Hospital, NY
Survive AIDS, CA
The Washington State Africa Network, WA
Universities Allied for Essential Medicines, University of Minnesota, MN
Village Care of New York AIDS Day Treatment Program, NY
Vukani Mawethu Choir, CA
Washington Biotechnology Action Council, WA
Women's Environment and Development Organization (WEDO), NY
Yale AIDS Network, CT
Youth-Health Empowerment Project (Y-HEP), PA

POSITION STATEMENT OF CATHOLIC RELIEF SERVICES

IMPACT OF NUTRITION ON HIV/AIDS AFFECTED COMMUNITIES

Many communities in sub-Saharan Africa are experiencing a food crisis. This crisis has been accelerated by the HIV/AIDS epidemic. AIDS-affected households have dramatically decreased their capacity to maintain farms, thus they are increasingly dependent on food aid for survival. In the past, these communities have demonstrated resilience in the face of drought and poverty. The deaths of the adult members of these communities have created a permanent loss of valuable human resource that will be difficult to nearly impossible to replace.

While we recognize the enormous benefit of the President's Emergency AIDS Fund, we are concerned that malnutrition will hamper our efforts to reduce the morbidity and mortality associated with HIV. Malnutrition and the concomitant infections are common health problems experienced by people who live in countries hardest hit by the HIV/AIDS epidemic. These conditions significantly compromise the immune system of those who are also infected with HIV, and as such, they are medically fragile. Nutritional deficiencies hamper immune function and, as such, the viral replication is accelerated. This process increases the rate of progression to AIDS and to death.

People with HIV/AIDS have greater macronutrient and micronutrient requirements. These nutrients are required to restore the immune system, to improve response to (absorption of) anti-retroviral therapy, and to restore the muscle mass of those who experience body wasting due to HIV infection. It is estimated that the energy can increase by 10-15% and protein requirements by 50% in persons living with HIV/AIDS. Individuals living in communities where malnutrition is endemic are likely to experience vitamin and mineral deficiency. While these deficiencies may not be clinically apparent at an early stage, their presence will have a direct adverse effect on one's ability to fight infections. Such deficiencies compound the level of immune dysfunction experienced by those infected with HIV. It is evident that micronutrients deficits will speed the progression of HIV infection to AIDS, and are predictive of AIDS mortality.

Weight loss and wasting in HIV infection is due to the interaction of several processes:

- Decreased food intake (due to anorexia, fatigue and oral diseases such as esophagitis).
- Poor absorption of nutrients (due to diarrhoea, intestinal infections and intestinal abnormalities which result in malabsorption of fat and vitamins).
- Metabolic alterations (there is increased energy and protein requirements caused by altered production of production of hormones such as glucagons, insulin, and cortisol).

Most patients in resource-poor countries continue to present for care during the late stages of the HIV disease, where there is already severe wasting. Severe wasting requires a more complicated and expensive approach to restore patients to their nutritional state, and it may be difficult to reverse the vicious cycle of malnutrition and HIV disease that exists stage. These patients may benefit from high protein, high-energy diets, containing special supplements rich in vitamins and minerals. It is therefore our opinion that a more practical strategy, involving community food aid and early HIV intervention be implemented as a more cost-effective approach.

Still, these efforts will need to be maintained and coordinated with a larger strategy to treat HIV/AIDS in Africa and the Caribbean.

As antiretroviral therapy becomes increasingly available in Africa and the Caribbean, we must consider that inadequate diet can decrease the effectiveness of antiretroviral therapy. Intestinal dysfunction in the malnourished, HIV-positive patient leads to reduced absorption of medications and hence limited effectiveness of the prescribed drug regimen. Many antiretroviral medications have GI side effects such as nausea and vomiting, that directly impact the amount of drug that is absorbed. Some medications require special dietary preparations to maximize their effectiveness, such as a full stomach. Antiretroviral therapy requires adherence to rigid dosing schedules to decrease the chances of developing drug resistance. These requirements will be impossible to realize in communities struggling to secure enough food for survival. Therefore, a successful antiretroviral program must consider nutritional intervention as a core component of the essential HIV/AIDS care package.

Clearly, our efforts to provide emergency assistance with ART will not succeed without additional financial support for food distribution. Those communities that have struggled with high rates of malnutrition now have the added burden of an HIV/AIDS epidemic. We therefore believe that funding should be expanded to address the special nutritional needs of those in the early stages of the disease and those with full-blown AIDS. Evidence proves that this will result in an enhanced ability to fight infection and an improved response to drug therapy.

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FOOD AID AND HIV/AIDS PROGRAMMING: LESSONS FROM CRS FIELD EXPERIENCE

NUTRITIONAL AND FOOD SECURITY ISSUES WHERE AIDS IS PREVALENT

Nutritional Issues

- Food insecurity increases vulnerability to HIV/AIDS—physiologically and behaviorally (zinc, vitamin A deficiencies increase risk of STDs; iron deficiency reduces resistance to disease; harmful coping strategies to address food insecurity result in increased exposure to HIV).
- HIV/AIDS increases food insecurity and poor nutrition (illness, demands of caregiving reduce production and cash; health care costs cause HH to eat fewer meals of lower quality foods).
- People with HIV/AIDS have greater macronutrient and micronutrient requirements (more Kcal, protein, micronutrients).
- Poor nutrition speeds progression of HIV/AIDS.
- Inadequate diet can decrease effectiveness of anti-retroviral (ARV) treatment—affects absorption, metabolism, distribution or excretion of the drugs.
- ARV therapy can increase nutrient tosses and affect food consumption.

Other Food Security Issues

- AIDS attacks the most productive segment of the population. One result: reduced labor for farm work—in Ethiopia one study found that households spend between 1/2 and 2/3 less time on agriculture than households not directly affected by HIV/AIDS. Programs must work with communities to develop alternative production that is less labor-intensive, produces more nutritious and more high-value crops, located closer to family homes and carried out on a scale that can be managed by children.

- As productive adults become ill and die, there are fewer teachers for schools, few staff to provide government services, so new approaches are needed to fill the gaps. Support for community-based foster care and for alternatives to government service provision are essential. Building capacity of local community organizations becomes critical.
- Orphaned children have no parents to teach them how to become productive adults. Programs must help communities develop new family structures, and new ways to transfer livelihood knowledge to the next generation. Comprehensive programs must provide children and youth with life skills as well as marketable skills. Affected families have often lost all assets to medical and funeral bills. Approaches to rebuilding food security need to address the broader livelihood security concerns as well, developing assets that will protect and support children both now and in the future.

HOW CURRENT HIV/AIDS PROGRAMMING MECHANISMS ADDRESS THESE ISSUES

One major issue with HIV/AIDS funding is that much of it is currently stovepiped. ARV funding is for drugs. OVC funding is for orphans and vulnerable children. Palliative care funding will be for home-based and community-based care. . . . There is no clearly identified mechanism for promoting the integration of funding and other resource streams that the complex responses on the ground require. Addressing HIV/AIDS at the community level requires coordination and program design that will ensure the multiple needs of affected communities are met. Otherwise, funds spent for ARV therapy without incorporation of appropriate food and nutrition is not only wasted, but also detrimental due to increased drug resistance. Provision of drugs and food to affected adults doesn't meet the current and future needs of their children.

HOW FOOD AID PROGRAMS CAN ADDRESS THESE ISSUES

Increased availability of and access to micronutrient-fortified food is needed to

- decrease transmission of HIV,
- reduce progression of the disease in those living with HIV
- reduce mother to child transmission and improve health of children born to HIV+ mothers
- increase effectiveness of ARV therapy

HIV/AIDS & FOOD PROGRAMMING

May 2004

CRS is invoWed in state-of-the-art and innovative programs targeted at reducing food insecurity among those affected and infected by HIV/AIDS in various regions in Africa, Latin America and Asia. Below are examples of current CRS food security and HIV/AIDS programs.

Project LISTEN (Livelihood Strategies Eliminating Needs)

Countries: Malawi and Zambia (FY 2004)
Program Area: HIV/AIDS, Food Security, Integral Human Development
Total Cost: $556,890
Total Beneficiaries: 21,500

Description:

Project LISTEN complements existing food aid programs in Malawi and Zambia by stimulating agriculture production as a short-term intervention while also building the capacity in 30 communities to mitigate risk in the long-term. The community resilience approach of Project LISTEN helps households adapt positive coping strategies to shocks by analyzing existing assets and resources that households can access to improve their livelihoods. Project LISTEN complements existing developmental relief and recovery programs, namely C-SAFE and JEFAP II, which are necessary in helping communities recover and rebuild assets lost due to shocks.

Title II PL 480 Development Assistant Program

Country: Ghana (FY 2004-2008)
Program Area: Nutrition, Safety Net, HIV/AIDS, TB DOTS
Total Cost: $19,523,227
Total Beneficiaries: 427,601

Description:

The safety net portion of the program targets 15,000 vulnerable persons throughout Ghana each year. Primary beneficiaries include individuals infected with or affected by HIV/AIDS, TB patients, and orphans. Working through the Christian Health Association of Ghana, the Ghana National Association of People Living with HIV/AIDS, and MOH TB/AIDS wards, CRS/Ghana provides wet rations to institutionalized HIV/AIDS and TB patients, home-based People Living with AIDS, and those under the Directly Observed Therapy program. Take home rations are designed to supplement daily intakes and will provide 20 percent of the caloric requirements of an average Northern Ghanaian family. For TB patients, food assistance will provide needed nutritional support during the time of recovery, and provide an incentive to patients to comply with the DOTS regimen.

St. Joseph's Catholic Youth Group HIV/AIDS "Siyakekela" Youth Support Project

Country: South Africa (FY 2002-2004)
Program Area: Life skills, Food and other support, Youth affected by HIV/AIDS
Total Cost: $9,796
Total Beneficiaries: 2,500

Description:

The Community Outreach Center at St. Mary's Hospital runs an HIV/AIDS Community support program that offers counseling services and support. In the past, services at this center were designed for adults. This program is geared toward children affected by HIV/AIDS between the ages of seven and eighteen. A youth group has been formed and trainings have been given on taking care of themselves and those ill at home. In addition to these awareness campaigns and trainings, psychological and material support (i.e. nutritional support) are included as part of the comprehensive package. Life skills are also promoted through business and computer skill building as a component of the youth group.

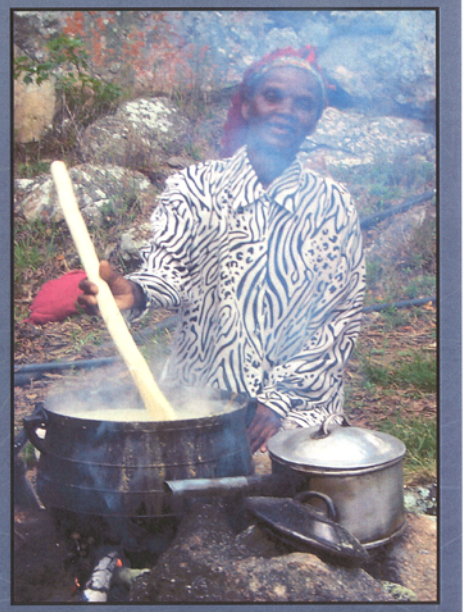
HIV/AIDS & Food Aid:

A Case Study from CRS/Zimbabwe
May 5, 2004

Gaye Burpee, PhD
Senior Technical Advisor for Agriculture & Risk Management
Catholic Relief Services
209 West Fayette
Baltimore MD 21201-3443

Mutare, Zimbabwe

- Nuns of Mutare support 23 parish hospitals
- AIDS awareness training & home-based care
- Case study: village of 13 families
- All husbands – HIV+
- AIDS orphans included in remaining families



Village Response to Training

"Thank to the Sisters, we learned all there is to know about HIV/AIDS. We know how to prevent it and how to care for people when they are sick.

Now what we need most is credit to support farming and other activities."

Impact of Training

- AIDS was de-stigmatized throughout Mutare in hundreds of villages
- This led to partner- and community-driven initiatives to reduce the heavy costs of AIDS, costs for medicine and lost food production
- Initiatives: Support groups, joint income generating activities and community AIDS gardens

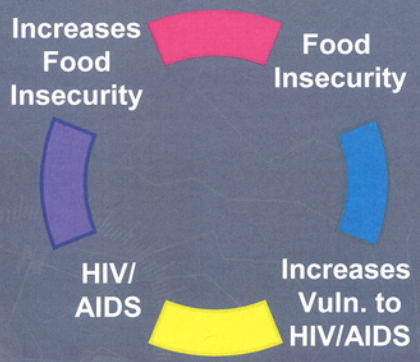
Community AIDS Gardens

- Community labor – "contribute when you are well"
- Vegetables – nutrient-rich foods, immune system enhancers (garlic & greens, legumes, tomatoes)
- Harvest produce – AIDS-affected families & orphan-headed households
- Excess produce – Sold, profits for medicine & school tuition fees for orphans & children in AIDS families

Impact of AIDS Gardens

- Nutrient-rich diet & access to palliative medicines for infections & AIDS' symptoms increases productive life
- Increased productive life ⟶ more time to ensure current survival & prepare children for future productive, healthy lives

Food Security, Nutrition & HIV/AIDS



- AIDS increases nutritional requirements
- ARV therapy can increase nutrient losses
- Malnutrition can decrease effectiveness of ART
- Malnutrition can increase resistance to ARVs

Mutare & Livelihood Security

- Villagers: *What can we do now to ensure our children will survive when we are gone?*
- Current livelihoods – farming
- Future livelihood – orphans' fish pond
- Training in fish farming (tilapia)

Livelihood Security through Easy Pickin'

- Orphans' orchard
- Apple, pear, citrus – long-term benefits
- Protea – immediate gains
- Obtained loans for seedlings
- More credit, larger orchard

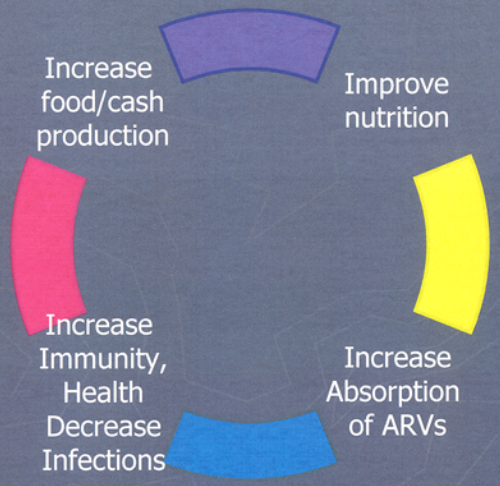
Livelihood Security through Sweet Innovation

- Beekeeping training
- Eucalyptus groves
- Cradle beehives
- Anti-animal
- Pro-children
- Honey profits repay loans for fruit tree saplings

How Food Aid Could Have Helped

- By freeing adults from production of staples in order to establish child-friendly, low-labor livelihood options for the future
- By ensuring better nutrition for AIDS-affected adults ⟶ longer survival & higher productivity
- By freeing up family savings/cash for essentials – medicine, keeping children in school, preventing harmful coping strategies

Virtuous Cycle



The Problem

- AIDS attacks the main productive segment of the population
- AIDS consumes critical livelihood assets – land, pastures, trees, savings (cash, jewelry, livestock), children are pulled out of school & futures severely compromised
- Family & community institutions disintegrate as coping strategies are exhausted & adults die

The Case for Integrated Programs

Lessons from Mutare:

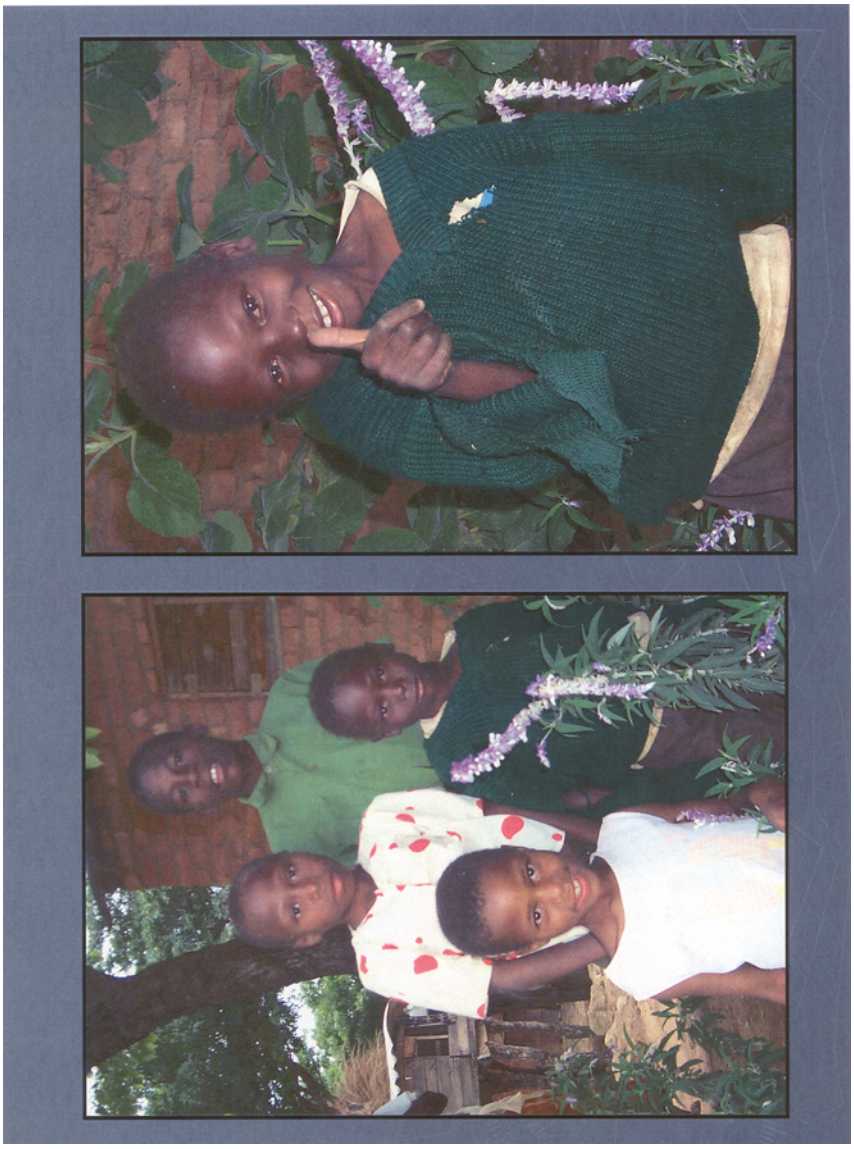
- We cannot tackle only one piece of a complex problem
- Villagers need food aid, credit & training to modify livelihood and income activities (low labor & increased income)
- Villagers modified gardening/farming to meet increased nutritional needs
- Village youths needed life skills training as they were thrust into leadership positions prematurely

Miracles for Mutare

- HIV/AIDS does not have to be a death sentence
- With appropriate nutrition interventions to support ARV therapy, adults can extend productive lifespan for many years
- AIDS as chronic, not terminal
- AIDS and behavior change awareness + ARV therapy + targeted food aid + livelihood support + food security = prolonged lives + essential protection for the uninfected

Coordinating Funding for HIV/AIDS & Food Aid

- Flexible funding, not stovepiped
  - AIDS funding – OVC, ART, palliative care
  - Title II – more flexible – use it to fill the gaps – not just food
- More Title II funding should be made available for integrated HIV/AIDS programs – combine food aid, ART, palliative care, life skills training, livelihood security & food security
- Increased T II resources needed per person for affected populations – need greater quantity & quality of food, causing cost of food to increase
- Key – help communities cope now to care for the ill and protect the futures of the healthy in order to prevent an irreversible catastrophe



COALITION FOR FOOD AID,
1201 F STREET, N.W., SUITE 1100,
Washington, DC, April 27, 2004.

The Honorable RICHARD G. LUGAR, *Chairman*
Senate Committee on Foreign Relations,
United States Senate,
Washington, DC 20010.

DEAR CHAIRMAN LUGAR:

The Coalition for Food Aid welcomes the opportunity to submit this letter and attached information for the record for the May 11, 2004 hearing on HIV/AIDS and hunger. The Coalition is comprised of sixteen US private voluntary organizations and cooperatives (jointly referred to as "PVOs") that conduct food aid programs overseas to improve the health, living conditions and incomes of millions of people who live in poverty and suffer from hunger. All of the members do much more than deliver food—they implement developmental and relief programs in cooperation with local communities, governments and organizations.

Food aid is the expression of American goodwill through "people-to-people" programs. American farmers produce the food, American businesses process, package and transport the food, and American PVOs make sure it is used effectively to help people in need. US food aid programs have great reach and impact among the poor and disenfranchised, helping people overcome despair and improving people's lives. The PL 480 Title II program, which focuses on food security needs of vulnerable populations, is the largest US food aid program and PVOs are the primary partners for the implementation of Title II developmental programs.

Nutrition and food security are critical and integral issues to address in the HIV/AIDS pandemic. Since US Government HIV/AIDS funds focus on particular treatment, care and prevention goals, PVOs find that it is necessary to identify other sources of funds to address nutritional and food security needs. They raise private funds and in some cases are able to use PL 480 Title II resources for these purposes, as explained in the attachments. However, much more could be done to expand the amount of funding available under Title II for HIV/AIDS and to make it easier to integrate food and cash resources.

If Title II was administered as intended by law, the United States could provide additional assistance to help people who suffer from chronic hunger, which is greatly needed in communities with high prevalence of HIV/AIDS. Many communities that had promise 10 years ago are falling behind today because of the HIV/AIDS pandemic. Income-earners in the community who are infected become weak and many die, family incomes plummet, agricultural fields lie fallow, children often quit school to work or care for siblings, and extended families that serve as caregivers fall into poverty. Poor diets hurt many in the community, and children and people living with HIV/AIDS are particularly vulnerable. PVOs are ready to expand Title II nutritional and food security programming for HIV/AIDS-affected communities. This disease threatens people's lives as much as any emergency.

Attached are illustrative examples of how PVO food aid programs are used to address special needs dues to the prevalence of HIV/AIDS.

Of the funds appropriated for Title II, more must be used to expand non-emergency programs from 1,000,000 metric tons to the 1,875,000 metric ton statutory level in order to address chronic hunger. PL 480 Title II requires 1,875,000 metric tons of food aid to be provided for non-emergency programs each fiscal year in order to reduce chronic hunger. Despite this mandate, in FY 2004, we expect only 1,000,000 metric tons of Title II will be used for non-emergency programs—about half of the minimum requirement. Yet, chronic needs are growing due to the prevalence HIV/AIDS and other chronic diseases and setbacks caused by natural disasters, civil strife and economic downturns. Currently, the Office of Management and Budget (OMB) is seeking both to limit the amount of tonnage used for these programs and to cutback program duration from five-years to three-years, even though studies have shown that five-year programs are more effective.

Addressing nutritional and food security problems associated with HIV/AIDS and helping communities that are prone to emergencies are two tangible examples of the types of non-emergency programs that need to be expanded. These programs would be in addition to current Title II non-emergency programs that have proven results in poor communities, such as increasing agricultural productivity and diversifying production, decreasing chronic under-nutrition among children, and improving the nutritional status of women.

It is important to have adequate funds for emergencies, but Title II was not intended to be an emergency reserve. Instead, the Bill Emerson Humanitarian Trust

Act provides contingency funds and commodities for emergencies. The BEHT can be tapped before USAID cuts into the 1,875,000 metric tons of Title II commodities available for non-emergency programs.

In this time of international stress, US assistance programs conducted by PVOs directly show America's care and compassion to people in developing countries. PVOs are supported by Americans through private contributions, which cover general operations and enable them to have a strong presence in many developing countries. However, private donations cannot supply the level of funding needed for procuring, transporting, implementing, monitoring and administering food aid programs. Thus, US Government funding for food aid is critical. PVOs provide expertise in program development and implementation; transparency and accountability for the use of US Government resources; strengthen the management capabilities of local institutions so efforts can be sustained; provide a network of local contacts and relationships; and encourage entrepreneurship and private sector development.

Mr. Chairman, we appreciate the opportunity to submit these comments and the attached information on HIV/AIDS programs and hunger. Thank you very much for helping to assure that the US response to HIV/AIDS is comprehensive and field-driven, seeking solutions within affected communities and supporting the implementation of successful strategies for long-term impact. We would be pleased to answer any questions you may have.

Sincerely,

ELLEN S. LEVINSON, *Executive Director.*

[Attachment.]

EXAMPLES OF TITLE II PVO FOOD AID PROGRAMS THAT ADDRESS NUTRITIONAL AND FOOD SECURITY PROBLEMS ASSOCIATED WITH HIV/AIDS

The first column shows how food rations can be used. Because food aid must be integrated with other activities to have a long-term impact, the second column describes the types of complementary activities that would be funded through monetization or from other sources.

Food is Provided as:	*Activities Funded by Monetization or Other Sources:*
• An incentive for people to receive HIV/AIDS testing and counseling.	• HIV/AIDS prevention education programs conducted by community-based organizations and health facilities.
• Part of home-based care for people living with HIV/AIDS and their families.	• Training village health workers and caregivers in home-based care and support, including preventing mother-to-child transmission of HIV/AIDS.
• Part of community-based nutrition programs, i.e. to meet the nutritional needs of people living with HIV/AIDS, people receiving anti-retroviral treatment, and orphans and vulnerable children.	• Care and support of orphans and vulnerable children, i.e. providing school fees and child care for younger siblings so school-aged children can attend class and providing access to psychosocial counseling, health care and social services.
• An incentive to participate in agricultural and work programs that increase family incomes and assets and improve community infrastructure.	• Training and support for the implementation of community-based nutrition, education, agricultural and work programs.
• An incentive for participation in treatment programs for TB patients.	• Coordination with HIV/AIDS service providers to increase access to critical services, such as voluntary testing and counseling, medical care and social services.

World Vision

Integration of Food Security and HIV/AIDS Programming:

A Rapid Review of World Vision's Experience and Lessons Learned

Carol Jenkins
Director of Food Resources, World Vision

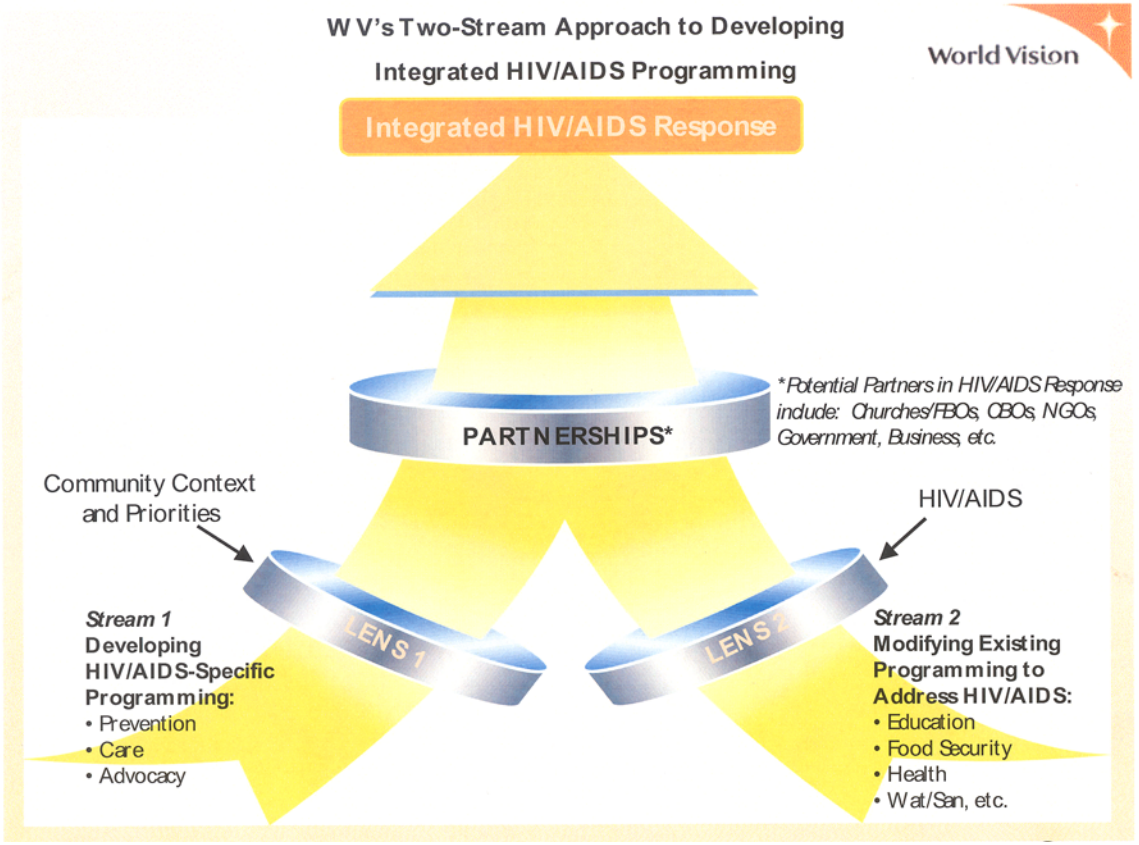
Briefing for Senate Foreign Relations Committee Staff

May 5, 2004

World Vision

The Context

- Currently, over 40 million people are living with HIV/AIDS
- By 2010, the # of orphans in sub-Saharan Africa is expected to reach **42 million**, almost half of whom will be orphaned by AIDS
- The 2nd leading cause of HIV transmission in sub-Saharan Africa is mother to child transmission, which is exacerbated by inadequate nutrition


WV's Two-Stream Approach to Developing
Integrated HIV/AIDS Programming
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Integrated HIV/AIDS Response
PARTNERSHIPS*
*Potential Partners in HIV/AIDS Response include: Churches/FBOs, CBOs, NGOs, Government, Business, etc.
Community Context and Priorities
HIV/AIDS
LENS 1
LENS 2
Stream 1
Developing HIV/AIDS-Specific Programming:
• Prevention
• Care
• Advocacy
Stream 2
Modifying Existing Programming to Address HIV/AIDS:
• Education
• Food Security
• Health
• Wat/San, etc.

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Overview of Key Lessons Learned

- Intentional integration of HIV/AIDS response and food security programming is essential and mutually reinforcing
- Food aid is critical in responding to the HIV/AIDS pandemic
- Interactions between ARV and food/nutrition can significantly influence the success of ART by affecting drug efficacy, adherence to drug regimens and the nutritional status of PLWHA

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Overview of Key Lessons Learned

- PVOs are critical to making the necessary linkages with Community Based Organizations, Faith Based Organizations, and local governments to:
  - integrate HIV/AIDs funding and food aid resources
  - build local capacity
  - ensure sustainability

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WV's Program Methods

WV's experience integrating food security programming and HIV/AIDS:

- **Prevention**
- **Care**
- **Advocacy**

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WV's Program Methods: Prevention

- Develop and distribute short, clear prevention messages in local languages to farmer groups, aid recipients, etc.
- Support local youth to perform drama promoting HIV prevention at distributions, market days, and other occasions on which large numbers of people gather
- Support farmer-to-farmer peer education (provide training, etc.)

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WV Program Methods: Care

- Promote labor-saving, highly nutritious crops
- Provide labor-saving tools and technologies
- Train home-based care providers in preparation of more nutritious meals using available foods
- Address food and nutrition requirements of PLWHA, particularly as ART interventions scale up

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WV Program Methods: Care

- Train vulnerable children/adolescents in farming, marketing, and management skills
- Support school feeding and school gardens in heavily HIV/AIDS-affected communities
- Provide food aid (supplementary feeding, micronutrients, etc.) and agricultural inputs through existing community care structures where possible: local home-based care initiatives, community care coalitions, etc.

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WV's Program Methods: Advocacy

- Expand use of food security/food aid resources in heavily HIV/AIDS-affected areas
- Protect widows' and orphans' land tenure and inheritance rights
- Prevent stigmatization and discrimination of PLWHA within staff and communities

Lifecycle Approach

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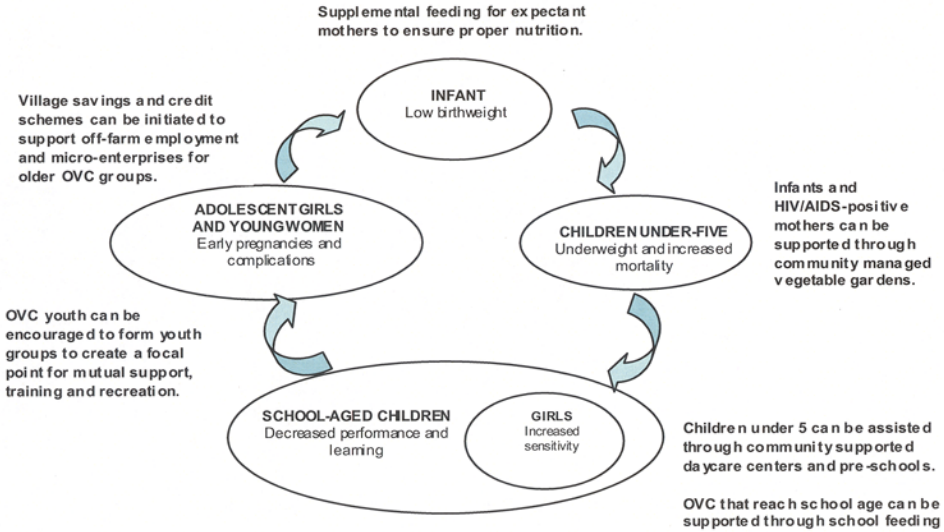

Adapted from 'Nutrition through the Life Cycle' by Nina Sens, ACCJ SCN, 2000.

World Vision

Recommendations

In order to reach the PEPFAR goals,
FOOD SECURITY must be an integral part of the plan:

- Promote integrated food security programs -- medicine alone is not the answer
- As a matter of urgency, address the impact of the pandemic on OVC, particularly in southern Africa in a way that is commensurate with the need
- Provide adequate food aid resources to complement cash resources – both are needed – current food resources are insufficient within USAID's Title II food program
- Offer long-term funding commitments