countries. The lack is real, and the brain drain continues. But one reason doctors flee Africa is that they lack the tools of their trade. AIDS funding offers us a chance not only to help scientists and nurses in underserved regions, but also to train community health care workers to supervise care, for AIDS and many other diseases, within their own communities. Training and neighborhood-based health training should be undertaken even in places where physicians are abundant, since community-based, closely supervised care represents the standard of care for chronic disease, whether in the First World or the Third. And community health care workers must be compensated for their labor if these programs are to be sustainable.

Fourth, extreme poverty makes it difficult for many patients to comply with antiretroviral therapy. Indeed, poverty is the biggest and away the greatest barrier to the scale-up of treatment and prevention programs. Our experience in Haiti and Rwanda has shown us that it is possible to remove many of the social and economic barriers to adherence but only with what are sometimes termed “wrap-around services”: food supplements for the family, transportation to clinics, child care, and housing. In many rural regions of Africa, hunger is the major concern for patients with AIDS or tuberculosis, and these consumptive diseases cannot be treated effectively without food supplementation. Coordination among initiatives, whether the President’s Emergency Plan for AIDS Relief, the Global Fund to Fight AIDS, Tuberculosis, and Malaria, and the World Food Program of the United Nations can help in the short term; fair-trade agreements and support of African farmers will help in the long run.

Fifth, investments in efforts to combat the global epidemics of AIDS and tuberculosis are much more generous than they were five years ago, but funding must be increased and sustained if we are to slow these increasingly complex epidemics. One of the most ominous recent developments is the advent of highly drug-resistant strains of both causative pathogens. “Extensively drug-resistant tuberculosis” has been reported in the United States, Eastern Europe, Asia, South Africa, and elsewhere; in each of these settings, the co-presentation of HIV has amplified local epidemics and almost untreatable strains. Drug-resistant tuberculosis is now common worldwide, extensively drug-resistant HIV disease will surely follow, and massive effort will be needed to treat these diseases ethically and effectively will be needed. We have already learned a great deal about how best to expand access to second-line antituberculous drugs while increasing control over their use; these lessons must be applied in the struggles against AIDS, malaria, and other infectious pathogens.

Finally, there is need for a renewed basic-science commitment to vaccine development, more reliable diagnostics (the 100-year-old need to diagnose tuberculosis is neither specific nor sensitive), and new classes of therapeutics. The research-based pharmaceutical industry has a critical role to play in drug development, even if the overall goal is a segmented market, with higher prices in developed countries and generic production with affordable prices in the Third World.

There has been a heartening increase in basic-science investments for tuberculosis and malaria; funding for HIV research at the National Institutes of Health remains robust. But yet the fruits of such research will not arrive in time for those now living with, and dying from, AIDS and tuberculosis. New tools needed to battle these diseases, and new classes of therapeutics, will be added to the stockpile of other potentially lifesaving products that do not reach the poorest people, unless we develop an equity plan to provide them. Right now, our focus must be on improving access to the therapies that are available in high-income countries. The past few years have shown us that we can make these services available to millions, even in the poorest reaches of the world.

The unglamorous and difficult process of increasing access to prevention and care needs to be our primary focus if we are to move toward the lofty goal of equitably distributed medical services in a world riven by inequality. Without such goals, the slogan “One World, One Hope” will remain nothing more than a dream.

AMERICA’S OLDEST MAIL ORDER CATALOGUE COMPANY CELEBRATES ITS 150TH ANNIVERSARY

HON. BERNARD SANDERS
OF VERMONT

IN THE HOUSE OF REPRESENTATIVES

Thursday, September 7, 2006

Mr. SANDERS. Mr. Speaker, Charles F. Orvis founded the Orvis Company in 1856 to sell high quality fly-fishing equipment. The Orvis Company is the oldest fishing rod manufacturer in the world, selling rods made in Vermont all over the globe. And its catalogue business is older than that of any other company. Orvis mails out over 50 million catalogues a year—help generate the company’s remarkable sales of over $250 million annually.

Orvis has deep, deep roots in Vermont, but it has shown the flexibility to adapt to a growing international market. It has distributors in 25 countries, and sells widely in both England and Japan. Although Orvis has its head quarters in Manchester, Vermont, where its flagship store of 23,000 square feet is also located, Orvis has 30 retail stores across the country. In 26 annual catalogues—Orvis mailed out over 50 million catalogue copies a year—Orvis has shown the flexibility to adapt to a growing international market. It has distributors in 25 countries, and sells widely in both England and Japan. Although Orvis has its headquarters in Manchester, Vermont, where its flagship store of 23,000 square feet is also located, Orvis has 30 retail stores across the country. In 26 annual catalogues—Orvis mailed out over 50 million catalogue copies a year—help generate the company’s remarkable sales of over $250 million annually.

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