

**THE PRESIDENT'S PLAN FOR AIDS RELIEF:
IS IT FULFILLING THE NUTRITION AND FOOD
SECURITY NEEDS OF PEOPLE LIVING WITH
HIV/AIDS?**

HEARING
BEFORE THE
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OF THE
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THE PRESIDENT'S PLAN FOR AIDS RELIEF: IS IT FULFILLING THE NUTRITION AND FOOD SECURITY NEEDS OF PEOPLE LIVING WITH HIV/AIDS?

TUESDAY, OCTOBER 9, 2007

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON AFRICA AND GLOBAL HEALTH,
COMMITTEE ON FOREIGN AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:08 p.m. in room 2172, Rayburn House Office Building, Hon. Donald Payne (chairman of the subcommittee) presiding.

Mr. PAYNE. Good afternoon. I would like to officially open this hearing entitled, "The President's Plan for AIDS Relief: Is It Fulfilling the Nutrition and Food Security Needs of People Living with HIV/AIDS?"

First of all, let me begin by indicating that the ranking member is going to be unable to attend the hearing today. And due to the fact that yesterday was a Federal holiday, many of our members who travel in normally are not here. Just to explain to those of you who are here, normally there are very few or no hearings held on Monday in order to allow for members to get back to Washington, DC, from their districts. Practically every member went back to their district to celebrate the Columbus Day holiday, and because there were no votes last night, which there normally would be on Mondays, members are on their way back to Washington to be here by 6:30 votes this evening.

When we scheduled this hearing, we did not take into account that there would be difficulty with members getting here. However, we will proceed. I am sure that the members who are unable to attend will review the record and make their comments.

My name is Donald Payne. I am chairman of the Subcommittee on Africa and Global Health, and our hearing this afternoon is to examine whether or not the United States Government is providing adequate nutritional support as part of our global AIDS program.

As members of the subcommittee are aware from the prior hearings we have held on food security in Africa, the Food and Agricultural Organization, or FAO, estimates that there are 854 million undernourished people in the world. Two hundred and six million live in Africa. And the toll that the HIV/AIDS pandemic is taking on the agricultural sector has been well-documented.

According to the FAO, since 1985, AIDS has killed 7 million agriculture workers in 25 of the countries most heavily affected by

HIV/AIDS. As many as 16 million more may die by the year 2020. This of course has a huge impact on food availability in Africa.

However, the relationship between HIV and food availability—and by extension nutrition—is not limited to the impact only on food production. The impact that poor nutrition has on HIV/AIDS prevention, care and treatment must also be considered. And the relationship, while not unnoticed, remains insufficiently addressed.

People who are not getting enough food are vulnerable to HIV/AIDS. As we know, the infection impacts on them in two ways primarily. Number one, hungry people are more likely to engage in risky behavior in order to get food. Second, malnutrition weakens immunity to infection of all sorts, including HIV. Therefore, I must argue that adequate food and nutrition has a role to play in prevention of HIV/AIDS.

Adequate nutrition also has a very significant role to play in treatment. People who are malnourished when they begin an anti-retroviral regimen are 6 times more likely to die, and they are more likely to suffer from side effects that may cause them to stop taking the medication. Additionally, we must be sure that we are attending to the nutritional needs of those who receive this palliative care.

The Office of the Global AIDS Coordinator has attempted to deal with this issue. OGAC has convened an interagency working group to incorporate nutrition into HIV activities and is funding programs to support pre- and post-school meals, community gardens and some small scale agricultural activities.

As I understand it, the cornerstone of OGAC's approach to integrating food and nutrition is the so-called wrap-around concept, whereby the programs of various U.S. Government agencies are supposed to be jointly planned and programmed at the country and central level so that when needs are identified they can be met by the agency with the greatest ability to do so. And so this inter-agency coordination is extremely important. Based on what I am hearing from our NGO partners on the ground, though, our efforts are not enough.

While OGAC funds a range of activities, it is not clear to me that these activities are regularized, institutionalized and fully incorporated into PEPFAR activities across the board. And while the wrap-around concept may be intellectually sound, when it comes to food aid, it does not work as well in practice as it does in theory. Part of this is because our food aid programs are not as well funded on the development side as they should be, so USAID does not always have adequate resources to respond to the need.

In addition, USAID and the Department of Agriculture are not operational in all of the areas in which PEPFAR programs are located. I know that there are some concerns with the provisions of food as a part of a comprehensive response to the AIDS pandemic. I am under no illusion that food assistance is a silver bullet to HIV prevention. However, I do believe that we must increase our efforts to use it as a means of prevention.

Likewise, we must step up our actions in terms of nutritional support when it comes to treatment. We cannot limit our response to therapeutic feeding in cases where patients have a body mass index of less than 16.5. By doing so, we run the risk that patients

will stop taking life-saving drugs or that drugs will work less efficiently. I am pleased to hear that OGAC is in the process of revising the use of 16.5 as a cutoff for patients to be eligible for therapeutic feeding.

Let me be clear about what I am not suggesting. I am not suggesting that OGAC turn the Food for Peace Office or that the President's Emergency Plan for AIDS Relief becomes the President's Emergency Plan for Food Relief. We know that these are two separate areas; there is no question about it. And we know that our funds are less than adequate for what PEPFAR is intended to do.

However, I think that we need to maximize our efforts so that they are more efficient and effective. What I am advocating is for nutritional and food support to be fully integrated into our prevention, care and treatment programs. I think that we can do more to achieve that aim.

So I am certainly thankful for the witnesses. I look forward to hearing from them today.

And with that, we will hear our first witness. We are very pleased to have the administration witness today, the United States Global AIDS Coordinator, Ambassador Mark Dybul. Ambassador Dybul is responsible for the coordination and implementation of the President's Emergency Plan for AIDS Relief, PEPFAR. Ambassador Dybul's previous post was as Deputy Global AIDS Coordinator. Before coming to the Coordinator's Office, Ambassador Dybul served on the Planning Task Force for the Emergency Plan and was the lead for the Department of Health and Human Services for President Bush's International Mother to Child HIV Prevention Initiative.

Ambassador Dybul obtained his bachelor and medical degrees from Georgetown University, and completed a fellowship at the National Institute of Allergy and Infectious Diseases. He has specialized in HIV/AIDS and HIV treatment and research, especially in resources in poor settings.

We are very pleased that the PEPFAR program is one that has had a tremendous amount of success, and thank you, Ambassador Dybul, for that. Whenever we visit countries in Africa, in particular, people do know about PEPFAR and they are very appreciative about the United States making this the fight against HIV one of our priorities. I look forward to hearing your testimony this afternoon.

[The prepared statement of Mr. Payne follows:]

PREPARED STATEMENT OF THE HONORABLE DONALD M. PAYNE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY, AND CHAIRMAN, SUBCOMMITTEE ON AFRICA AND GLOBAL HEALTH

Good afternoon and welcome. This afternoon the subcommittee will examine whether or not the United States government is providing adequate nutritional support as part of our global AIDS programs.

As members of the subcommittee are aware from the prior hearings we have held on food security in Africa, the Food and Agricultural Organization, or FAO, estimates that there are 854 million undernourished people in the world. Two hundred and six million live in Africa. And the toll that the HIV/AIDS pandemic is taking on the agricultural sector has been well documented.

According to the FAO, since 1985 AIDS has killed 7 million agricultural workers in 25 of the countries most heavily affected by HIV/AIDS. As many as 16 million more may die by the year 2020. This of course has a huge impact on food availability in Africa.

However the relationship between HIV and food availability—and by extension nutrition—is not limited to the impact on food production. The impact that poor nutrition has on HIV/AIDS prevention, care and treatment must also be considered. And the relationship, while not unnoticed, remains insufficiently addressed.

People who are not getting enough food are vulnerable to HIV/AIDS infections in two ways. First, hungry people are more likely to engage in risky behavior in order to get food. Second, malnutrition weakens immunity to infections of all sorts, including HIV. Therefore I would argue that adequate food and nutrition has a role to play in prevention.

Adequate nutrition also has a very significant role to play in treatment. People who are malnourished when they begin an anti-retroviral regimen are six times more like to die. And they are more likely to suffer from side effects that may cause them to stop taking medications. Additionally, we must be sure that we are attending to the nutritional needs of those who are receiving palliative care.

The Office of the Global AIDS Coordinator has attempted to deal with this issue. OGAC has convened an interagency working group to incorporate nutrition into HIV activities, and is funding programs to support pre- and post school meals, community gardens, and some small scale agricultural activities.

As I understand it, the cornerstone of OGAC's approach to integrating food and nutrition is the so called "wrap around" concept, whereby the programs of various U.S. government agencies are supposed to be jointly planned and programmed at the country and central level so that when needs are identified they can be met by the agency with the greatest ability to do so. Based on what I am hearing from our NGO partners on the ground, however, our efforts are not enough.

While OGAC funds a range of activities, it is not clear to me that these activities are regularized, institutionalized and fully incorporated into PEPFAR activities across the board. And while the wrap around concept may be intellectually sound, when it comes to food aid, it does not work as well in practice as it does in theory. Part of this is because our food aid programs are not as well funded on the development side as they should be, so USAID does not always have adequate resources to respond.

In addition, USAID and the Department of Agriculture are not operational in all of the areas in which PEPFAR programs are located. I know that there are some concerns with the provision of food as a part of a comprehensive response to the AIDS pandemic. I am under no illusion that food assistance is a silver bullet to HIV prevention, but I do believe we must increase our efforts to use it as a means of prevention.

Likewise, we must step up our actions in terms of nutritional support when it comes to treatment. We cannot limit our response to therapeutic feeding in cases where patients have a body mass index of less than 16.5. By doing so, we run the risk that patients will stop taking life-saving drugs, or that the drugs will work less efficiently. I am pleased to hear that OGAC is in the process of revising the use of 16.5 as a cut-off for patients to be eligible for therapeutic feeding.

Let me be clear about what I am not suggesting. I am not suggesting that OGAC turn into the Food for Peace Office, or that the President's Emergency Plan for AIDS relief become the President's Emergency Plan for Food Relief. What I am advocating is for nutritional and food support to be fully integrated into our prevention, care and treatment programs. I think that we can do more to achieve that aim.

I thank our witnesses for coming today, and turn to the ranking member for his opening statement.

STATEMENT OF THE HONORABLE MARK R. DYBUL, COORDINATOR, OFFICE OF THE U.S. GLOBAL AIDS COORDINATOR, U.S. DEPARTMENT OF STATE

Ambassador DYBUL. Thank you, Mr. Chairman, and thank you for your leadership. The strong bipartisan support of this committee has been essential in the American people's historic effort on global AIDS these last few years, and we very much enjoyed working with you, the committee members and the staff, to advance the interests of the American people. And thank you for your focus on this important issue. It is a difficult, complicated issue, and I think it is one that we need to talk more about.

I am actually going to deviate from my prepared comments to simply say that I agree with what you said. We do need to do a

better job at integrating; we do need to improve what we are doing. We have been at this for about 3½ years now. I think we have made a great deal of progress, but you are absolutely correct, we can do better, we will do better.

I will go through a couple of things we are working on now to advance our goals collectively and, working with you and your staff, we hope to do an even better job at all of our activities, including on food and nutrition.

In that light just a week ago our PEPFAR country teams completed their fourth annual planning process, a key element in the massive scale-up of prevention, care and treatment services. And due to the continued generosity of American people, we are well on our way to achieving the ambitious prevention, care and treatment targets. I am not going to take time now to enumerate these, but I will just refer you to the written testimony for these.

As you mentioned, one of the reasons we have had such great success is because we fundamentally leverage the core strength of U.S. Government agencies, implementing partners in multilateral institutions, such as the Global Fund and the World Food Program and other international partners. It is partnership that has allowed implementation of unified national plans under the leadership of host country governments in order to achieve success.

We elaborate on this approach to partnership for food and nutrition activities, as you mentioned. As you noted, many of the people infected and affected by HIV/AIDS live in communities that are extremely poor and often are food insecure. And indeed, as you know, there is a very complex relationship between food and security and HIV/AIDS. As people become sick with AIDS they are less able to earn income for themselves and their family. Poverty and hunger, as you know, can lead to high risk behaviors, such as transactional sex, which fuels the transmission of the virus. The virus itself can cause an effect on metabolism and can caused wasting.

On the other hand, we know things work, including adequate nutrition, intervention such as cotrimoxizole, clean water, malaria prevention. All of these things can delay the need for antiretroviral treatment. Importantly, nutrition is vital for many AIDS orphans and vulnerable children, and so it is one of the core areas of the PEPFAR's support for them.

In light of the clear relationship between HIV/AIDS and food, as you know, PEPFAR has worked since its inception to draft issues of food and security in prevention, treatment and care. And the Leadership Act actually provides ample authority for these efforts and we are trying to expand them.

As you know, we convened an interagency multisectoral technical working group. It includes our primary implementing agencies directly involved in food and security, such as USAID's Office of Food for Peace, Bureau for Economic Growth as well as the U.S. Department of Agriculture.

The emergency plan contributes to U.S. Government efforts in this area through its focused effort to integrate food and nutrition into HIV programs, in particular for vulnerable populations. Our highest priority populations to date have been orphans and vulnerable children born to HIV-positive parents, pregnant women, par-

ticularly those enrolled in PMTCT programs, and patients in treatment and care with evidence of clinical malnutrition.

For orphans and vulnerable children and pregnant women our nutritional support activities include nutritional assessments and counseling, micronutrient supplementation, direct food support and in many cases both support for and linkages with livelihood programs, because without livelihood programs we can't have sustainable programs.

For HIV-positive people we support integration of food and nutrition into care and treatment, micronutrient supplements, therapeutic and supplemental feeding for antiretroviral treatment patients and food security assessments with linkages and support for food security and livelihood assistance for patients and their families.

We work closely with ministries of health and other partners, importantly the United Nations World Food Program, to develop national and international policies, guidelines and plans that provide a framework for linking food nutrition with HIV/AIDS programs.

However, as you know, supporting food and nutrition to HIV/AIDS affected and infected populations in what are often chronically food insecure environments poses serious challenges. While people living with HIV/AIDS will identify food as their most pressing needs so do their unaffected neighbors. In the context of widespread food insecurity it is vitally important not to create an environment in which having HIV provides access to long-term food benefits that others in the community also desire. These issues cannot be addressed by any one program or agency. We can only do this through partnerships, as you noted.

One of our central strategies, as you have noted, is wrap-around strategies, whereby our partners jointly plan and implement intervention to meet the full range and needs of individuals, households or communities. Our resources focus food nutrition on our most vulnerable population while other partners bring the expertise and infrastructure to support, sustain food security programs to whole communities. And these programs are proving successful.

Most U.S. Government food resources directed to support HIV/AIDS communities and individuals are actually allocated through the USAID's Food for Peace Program. In 2006, Food for Peace estimates approximately \$50 million will go to support HIV infected and affected PEPFAR beneficiaries. In addition, USDA through Food for Progress, Food for Education, and Marketed Development Assistance Program, as well as the World Food Program provide direct support for food commodities and food security with a focus on overall communities. This investment in food nutrition compliments efforts of PEPFAR's investment.

Preliminary information coming from the countries completing operations plans for 2008 indicates that country teams plan to spend over \$20 million of PEPFAR resources on food and nutrition in 2008. Because wrap-arounds do not and should not come from U.S. Government programs only, we ask our country teams to estimate how much funding comes from other partners; in other words, how we leverage food support.

While the data are preliminary, they indicate that we are leveraging more than dollar for dollar to our partners from the pri-

vate sector or from the non-U.S. Government sectors. This leveraging is very important if we are going to have expansive programs.

Our annual program results should also enumerate beneficiaries of food support for the first time so that we can inform you and the American taxpayer what their resources are going for.

Of course numbers, whether funding or people reached, only tell part of the story. What matters most is what is happening on the ground. And you are going to hear from some those implementing partners.

Just a couple of examples, in Kenya we are supporting a food by prescription approach in which a clinician who diagnoses malnutrition in HIV-positive patients may write a prescription for a fortified food product which is available from the clinic. A similar approach is in Uganda. In Ethiopia, PEPFAR, through World Food Program, collaborated to provide resources to more than 20,000 people affected by HIV/AIDS, including children, caregivers and HIV-positive adults.

Food is an important part of the orphans program, and I think this is a key area. In Haiti we are supporting partners that help children orphaned or made vulnerable by HIV/AIDS using a community-based approach. The program seeks to develop sustainable food sources as well, which is essential. We have to develop more sustainable food systems.

In Cote D'Ivoire partners incorporate income generating activities to build self-sufficiency for 6,000 vulnerable children and their families. So as you said, we must integrate these programs to a broader array to have the greatest effect.

As these examples make clear, our programs focus not only on direct food but on the need for sustainable programs, and securing the future for vulnerable individuals of course goes beyond the immediate provision of food and assistance and requires support for livelihoods and job creation. Many programs have introduced the concept of short-term food with the clear expectation it will be time limited. And in fact AMPATH, one of our principal partners, is working on this. I believe you will hear from them later today.

AMPATH is not only providing people with drugs, but addressing broader needs, particularly food and income generating activities. And PEPFAR is proud to be one of many partners in this program. And for the food and nutrition component, PEPFAR joined USAID and the World Food Program as partners, again a good model of wrap-arounds.

Now despite much progress we remain aware of significant challenges. And as I pointed out, we have been at this for 3½ years. So we share your desire to better integrate and improve in every aspect of our programming, including food and nutrition.

Our expansive guidance concerning support to vulnerable children and women in PMTCT programs has not been taken up as widely as we would hope in the field. And we are working with country teams to address obstacles that they confront at the country level so we can expand these programs. We are also assessing the impact that programs on HIV-positive people in rural care and treatment programs.

As you mentioned, while we currently have a limit of 16 severe malnutrition for body mass index, we have draft guidance in place that will increase that to 18.5, which is the WHO recommendation. And we believe we will be there in a fairly short period of time. This change has been informed by lessons learned in the field and by conversations with your committee and others. And so we are pleased and thankful to those who have contributed to this effort to change that guidance.

Another key challenge is cost. While there is ongoing work in this area, some cost estimates put the average cost per year of supplemental feeding at between \$118 per person per year and \$129 per person per year. Of course in the majority of cases we hope it will take less than a year to rehabilitate someone, but in orphan programs it could be longer. By comparison, the annual cost of antiretroviral therapy for the most commonly used combination is \$89 per year. So significantly less than the cost of food supplementation, and so these are difficult issues we need to work through.

In addition, how a food program graduates a person who has regained healthy weight and nutrition and whether this improved nutritional status is sustainable long term is another area for further investigation, and we are supporting some of our partners, including AMPATH, to evaluate this, because we don't have sufficient data.

As a result of these issues, country programs must consider the difficult trade-off between enrolling more patients into treatment and providing a comprehensive food and nutrition program for those enrolled.

Now, Mr. Chairman, I believe you know the Institute of Medicine has described PEPFAR as a learning organization and the nexus of HIV/AIDS and food nutrition is one the areas where we are learning. Experience and our ability to adapt are being applied. In this way we are directly addressing operational challenges together with our closest partners, like the USAID's Food for Peace program.

But we have a lot to do, and we have a lot to learn, and you are going to hear from some of the partners we are learning most from this afternoon, and we look forward to this learning and ongoing dialogue.

In closing, we believe our focus on the central mandate of prevention, care and treatment of HIV/AIDS has been a key to PEPFAR's success. The entire range of issues confronting the people we serve is often beyond the ability of the single public health program, even PEPFAR, to address. We will continue to deepen our partnerships with the U.S. Government and international partners as we identify challenges and opportunities for better collaboration and targeting of resources to meet the needs of people we serve in a holistic way. And we thank you for encouraging us along this path to better integrate and to improve our programs.

[The prepared statement of Ambassador Dybul follows:]

PREPARED STATEMENT OF THE HONORABLE MARK R. DYBUL, COORDINATOR, OFFICE OF THE U.S. GLOBAL AIDS COORDINATOR, U.S. DEPARTMENT OF STATE

Mr. Chairman and Members of the Subcommittee:

I am grateful for this opportunity to discuss the President's Emergency Plan for AIDS Relief (PEPFAR) and its links to the important issue of food and nutrition.

Just five years ago, PEPFAR was an idea, a vision shared by U.S. legislators and administrators—including some of you who are on this subcommittee today—to intervene in one of the world’s greatest threats to human life and dignity, the HIV pandemic. At that time, HIV was a death sentence in developing countries; only 50,000 people living with HIV in all of Sub-Saharan Africa were receiving treatment, and few mothers had access to therapy to stop transmission of HIV to their babies. The impact on families, communities, and societies was devastating, and many wondered whether prevention, treatment and care could be provided successfully in resource-limited settings. In this context, with leadership from President Bush and strong bipartisan support from Congress, our nation began to lead the world in combating the disease and nurturing hope.

Just one week ago, our PEPFAR country teams completed their fourth annual country planning process, a key element of the largest scale-up of HIV prevention, care, and treatment activities ever achieved globally. Due to the continued generosity of the American people, PEPFAR is well on the way to achieving its ambitious five-year targets of supporting treatment for two million people, supporting prevention of seven million new infections, and supporting care for 10 million people infected and affected by HIV/AIDS, including orphans and vulnerable children. Through March 2007, PEPFAR supported antiretroviral treatment for over 1.1 million men, women, and children. Through September 2006, PEPFAR-supported programs provided HIV testing and counseling to 18.6 million people; delivered antiretroviral prophylaxis during over half a million pregnancies, preventing an estimated 101,000 infant HIV infections; and supported basic care services for an additional 2.4 million adults and 2 million orphans and vulnerable children infected and affected by HIV. Country teams will submit their annual program results data to us shortly, and we expect that the data will demonstrate impressive continued progress.

PEPFAR has achieved this success by leveraging the core strengths of U.S. Government agencies; implementing partners; multilateral institutions such as the Global Fund to Fight HIV, TB, and Malaria and the World Health Organization; and other international partners. Strong partnerships to implement unified national plans under the leadership of host country governments are hallmarks of PEPFAR.

PEPFAR applies this collaborative approach to its food and nutrition activities. Many of the people infected and affected by HIV/AIDS in PEPFAR countries live in communities that are extremely poor and often food-insecure. Indeed, there is a complex relationship between food insecurity and HIV/AIDS. As people become sick with AIDS, they are less able to earn income for themselves and their families. Poverty and hunger can also lead to high-risk behaviors such as transactional sex, fueling transmission of the virus. The virus itself has an effect on metabolism, and can cause progressive wasting. On the other hand, evidence indicates that adequate nutrition, along with interventions such as cotrimoxazole, clean water, and malaria prevention, can help to delay the onset of disease and the need for antiretroviral treatment.

In addition to impacts on people who are themselves HIV-positive, PEPFAR has a key mandate to address the needs of children orphaned and made vulnerable (OVCs) as a result of HIV/AIDS. Our strategy for these children is to ensure that their needs are being met, either by PEPFAR programs or by other U.S. Government agencies and programs, other international partners, United Nations agencies, host Governments, or the private sector, in “six plus one” essential areas. One of the six essential areas is food and nutrition, and the “plus one” is economic strengthening.

In light of this relationship between HIV/AIDS and food and nutrition, PEPFAR has worked since its inception to address issues of food and nutrition within the context of our prevention, treatment and care goals. The Leadership Act provides ample authority for these efforts, specifying that PEPFAR support includes “assistance for the purpose of the care and treatment of individuals with HIV through the provision of . . . therapies for the treatment of opportunistic infections, *nutritional support*, and other treatment modalities.” Sec 104A(d)(2)(c). Moreover, PEPFAR is mandated to work with the U.S. Agency for International Development (USAID) to: “integrate nutrition programs with HIV activities, generally”; “provide, as a component of an antiretroviral therapy program, support for food and nutrition to individuals infected with and affected by HIV”; and “provide support for food and nutrition for children affected by HIV and to communities and households caring for children affected by HIV.” Sec. 301(c).

Recognizing this need and acting under the authority provided by Congress, PEPFAR has convened an interagency, multisectoral technical working group on food and nutrition, to guide incorporation of key components into HIV programs. In addition to our primary PEPFAR implementing agencies, the group includes other

agencies and offices that work directly with issues of food security and nutrition, including USAID's Office of Food for Peace and Bureau for Economic Growth, as well as the U.S. Department of Agriculture (USDA). The group's first task was to develop a food and nutrition strategy through a consultative process, captured in the report to Congress entitled *"Food and Nutrition for People Living with HIV/AIDS."* The group also provides guidance to PEPFAR country teams on integrating food and nutrition activities into HIV/AIDS programs.

A central precept of the U.S. Government strategy on food and nutrition and HIV/AIDS is to build on the comparative advantage of each partner, including U.S. Government agencies, host governments, non-governmental organizations, and international partners, to leverage resources. The Emergency Plan contributes to this strategy through its focused effort to integrate food and nutrition into HIV/AIDS programs and to provide longer term food security support for specific vulnerable populations. Our highest priority populations are orphans and vulnerable children born to HIV-positive parents, pregnant women enrolled in prevention of mother to child transmission programs, and patients in treatment and care programs with evidence of clinical malnutrition.

For orphans and vulnerable children and pregnant women, our nutritional support activities include: nutritional assessments and counseling; micronutrient supplementation; direct food support; and, in many cases, linkages with livelihoods programs.

For HIV-positive people, PEPFAR supports integration of food and nutrition into HIV care and treatment programs; micronutrient supplements for those whose diet may be inadequate to meet vitamin and mineral requirements; therapeutic and supplementary feeding for antiretroviral treatment patients who are clinically malnourished at entry; and food security assessments with linkages and support for food security and livelihood assistance for patients and their families.

To further food and nutrition support in HIV/AIDS programs, PEPFAR country teams also work closely with Ministries of Health and other partners to develop national policies, guidelines, and plans that provide a framework for linking food and nutrition activities within HIV/AIDS programs. For example, PEPFAR funds the development of training curricula; nutrition and dietary assessment tools; and other materials to be used within a given country, as well as health worker training in the use of these tools and materials.

PEPFAR also works closely with multilateral organizations. The United Nations World Food Programme (WFP) is an essential partner at both the global level as well as on the ground in countries like Ethiopia and Mozambique, where it receives PEPFAR funding for interventions linked to PEPFAR programs. PEPFAR also works with WFP, World Health Organization and other international partners to establish global guidelines on food and nutrition. PEPFAR partners on the ground help countries perform the difficult job of translating global guidelines and national policies into functional frameworks and plans at the clinic and community level.

As you know, however, supporting food and nutrition to HIV/AIDS-affected and -infected populations in what is often chronically food insecure environments poses challenging issues. While people living with HIV may identify food as one of their most pressing needs, so do their uninfected neighbors. In a context of widespread food insecurity, it is vitally important not to create an environment in which having HIV provides access to long-term food benefits that others in the community also desire. Thus, these issues cannot be addressed by any one program or agency alone: solutions can only be created through partnerships.

One of PEPFAR's central partnership strategies is "wraparound" programming, whereby partners jointly plan and implement interventions to meet the full range of needs of an individual, household or community. Thus PEPFAR focuses resources for food and nutrition on our most vulnerable target populations, while other partners bring the expertise and infrastructure to support sustained food security programs to communities as a whole.

These approaches are proving successful. From the perspective of resources, we are increasingly able to account for funding applied to support food, nutrition and sustainable livelihoods for HIV-infected and -affected individuals and communities. Most U.S. Government food resources directed to support HIV-affected communities and individuals are allocated through USAID's Food for Peace programs. In Fiscal Year 2006, Food for Peace estimates that it provided approximately \$50 million in support of HIV-infected and -affected PEPFAR beneficiaries. Additionally, USDA, through its Food for Progress, Food for Education and market-development assistance programs, as well as WFP, provide direct support for food commodities and food security with a focus on overall communities. A notable example of USDA investments is support for the Humana People to People program in Mozambique,

which reaches close to a million beneficiaries in a comprehensive program of food and nutrition support, income generation and HIV/AIDS prevention and care.

PEPFAR investment in food and nutrition complements these efforts. Although we have not historically tracked food and nutrition activities in PEPFAR, for the first time the Fiscal Year 2008 Country Operational Plans (COPs) estimate both PEPFAR and other partner resources going to food and nutrition. Preliminary information coming from the countries completing COPs indicates that country teams plan to spend over \$20 million of PEPFAR resources on food and nutrition in Fiscal Year 2008. Country teams were also asked to estimate how much funding from other partners they were leveraging for food support. While this data is preliminary and more analysis is required, every focus country except Ethiopia reported leveraging food support from partners at more than dollar for dollar. While these budget numbers may change over the course of the year, the country plans demonstrate a significant and growing commitment by PEPFAR to support food and nutrition activities that support HIV/AIDS prevention, treatment and care.

Also for the first time, in Fiscal Year 2008 our annual program results reports will enumerate beneficiaries of food support. As with our improvements in planning, this step forward in reporting will soon provide more information, not only on how much is spent, but on how many people are being served with various food initiatives. This data will better inform our programs in the field as they continue to identify best practices.

Of course, numbers—whether funding or people reached—only tell part of the story. What matters most is what is happening on the ground. In Kenya, the Emergency Plan is supporting a “food by prescription” approach, in which a clinician who diagnoses malnutrition in an HIV-positive patient may write a prescription for a fortified food product which is available and dispensed at the clinic. A similar approach is in place in Uganda, through a partnership with USAID’s Food For Peace program. In Ethiopia, the U.S. Government has established a strong multisectoral team; PEPFAR and WFP recently collaborated to provide food resources to more than 20,000 people affected by HIV, including children, caregivers, and HIV-positive adults.

As noted earlier, food and nutrition is one of the key areas for orphans and vulnerable children in many of PEPFAR’s programs. As with our food and nutrition programming for other vulnerable groups, support for children comes not only in form of direct food delivery, but also in sustainable approaches for community support. For example, in Namibia, one of our programs focuses not only on food support for 3200 children but also on training 1000 caregivers in nutrition.

In Haiti, the Emergency Plan works with partners to support children orphaned or made vulnerable by HIV/AIDS using a community-based approach, including a school nutrition program using USAID Food For Peace resources. This program also seeks to develop sustainable sources of food, so it has aggressively supported community gardens primarily for children’s consumption, and also to generate revenue through the marketing of vegetables. In Cote D’Ivoire, partners incorporate income-generating activities to build self-sufficiency for 6000 vulnerable children and their families, with links to school feeding programs in collaboration with other partners.

There are many more examples of innovative interventions PEPFAR supports to strengthen nutrition and food security for vulnerable children and their caregivers. Drip irrigation programs increase production for backyard gardens. Animal husbandry provides not only access to food, but can be an income-generating activity as well. Community gardens are another way communities address nutritional needs of high numbers of children. Finally, many of PEPFAR’s programs provide pre- and post-school meals. Across these programs, PEPFAR’s range of support is extensive, and in Fiscal Year 2008 and beyond, we look forward to bringing even more programs to scale.

As these examples make clear, our programs focus not only on direct food support but also on sustainability. Securing the future for vulnerable individuals, of course, goes beyond the immediate provision of food assistance and requires support for sustainable livelihoods and job creation. While there has been considerable attention to food, there has been less focus on the equally important issue of livelihoods. Many programs have introduced the concept of short-term food support, with the clear expectation that it will be time-limited. The ability of these programs to truly wean people off of food aid, however, is relatively unproven and highly dependent on other income sources for these individuals. Even more important than the short-term support, then, is the long-term transition into a healthier sustainable livelihood.

Comprehensive approaches provide important models that we can build on and we believe will play an important role as we move forward. A key example is AMPATH, or the Academic Model for the Prevention and Treatment of AIDS, in Kenya, whom you will hear from today. AMPATH partners Moi University in Kenya with Indiana

University and other U.S. academic institutions. Its comprehensive prevention, care, and treatment program includes a sustainable model that offers work at one of its three training farms; food from the harvest for patients who need it; and education to help people live positively. In other words, AMPATH is not only providing people with drugs, but comprehensively addressing other needs, such as for school fees, food, and income-generating activities. PEPFAR is proud to be one of many partners in this program.

Another key to true sustainability is commitment from the private sector, both in the U.S. and in developing nations, so we are working to develop models for public-private partnerships. Earlier this year we convened a meeting of U.S. Government agencies and businesses to consider opportunities for public-private partnerships, which resulted in a commitment to collaborate on food fortification, which we are now working to implement.

Despite much progress, we remain aware that significant challenges remain. Our very expansive guidance concerning support to vulnerable children and women in PMTCT programs has still not had as wide uptake in the field as we might have expected, and we are working with country teams to address the obstacles they confront at the country level.

We are also assessing the impact of programs on HIV-positive people enrolled in care and treatment programs. While our current guidance limits support to individuals with a low “body mass index” indicative of severe malnutrition, we are considering changes to the guidance to align it with WHO guidance. We now have draft guidance with these changes in review by PEPFAR implementing agencies.

Another key challenge is cost. While there is ongoing work in this area, some cost estimates put the average cost per person rehabilitated through a basic supplemental feeding at between \$118 per person/year (in Kenya) and \$129.60 per person/year (in Mozambique). (It should be noted that these cost estimates noted are based on a year’s worth of supplemental or therapeutic food, which is longer than general nutritional rehabilitation would normally require.). For comparison, the cost of the most commonly used three-in-one first-line antiretroviral treatment regimen—\$89 per year, which is available through the Partnership for Supply Chain Management and is the lowest price available for that product from any source.

Also relevant to the issue of costs is the issue of how a food program “graduates” a person who has regained healthy weight and nutrition, and whether this improved nutritional status is sustainable over the long term. Further evidence is needed in this area. PEPFAR programs are also confronting the question of what are the most effective delivery mechanisms for supplemental food support and whether heavy reliance on the health care system to actually deliver food supplements is the most cost efficient, feasible, and reliable approach in the context—which many of you have seen—of dire shortages of health care workers. We don’t yet have all the answers we need, and thus we have launched Public Health Evaluations to address these questions. As a result of the combination of issues of high cost, unpredictable duration, and limited capacity, country programs must consider the difficult trade-off between enrolling more patients into treatment and providing a comprehensive food and nutrition program for those enrolled. This is why PEPFAR stresses the importance of linking HIV/AIDS programs supported by PEPFAR funds with other programs that focus on food and nutrition.

The Institute of Medicine has described PEPFAR as a “learning organization,” and the nexus of HIV/AIDS and food and nutrition is one area where our learning, experience and ability to adapt are being applied. We are, for example, directly addressing operational challenges together with our closest partners, like USAID’s Food for Peace, where we face issues of having different priority countries, target populations, procurement practices, reporting indicators and even calendar cycles for action. To address these issues we have established HIV/AIDS/food and nutrition interagency working groups at the country level. In Haiti, Ethiopia, Mozambique and Zambia these teams are working on more cohesive programming across the sectors.

Also promising is the “HIV and Food Security Conceptual Framework” on which PEPFAR and USAID’s Office of Food for Peace and Bureau of Global Health have collaborated. This document outlines practice and policy recommendations and proposes a host of joint activities, including mapping out current Food For Peace and PEPFAR programs for improved programming and monitoring and evaluation.

We believe our focus on the central mandate of prevention, care and treatment of HIV/AIDS has been a key to PEPFAR’s success. We recognize the entire range of issues confronting the people we serve are often beyond the ability of a single public health program, even a large one like PEPFAR, to address. We will continue to deepen our partnerships with U.S. Government and international partners as we

identify challenges and opportunities for better collaboration and targeting of resources to meet the needs of the people we serve in a holistic way.

Much remains to be done; the epidemic and the suffering it causes are far from over. But with the continued bipartisan support of Congress, the President, and the American people, we believe PEPFAR and its partners can do even more. We can succeed together in meeting the needs of millions of people around the world who are struggling with the combined challenges of food and nutrition and HIV/AIDS.

Thank you very much.

Mr. PAYNE. Thank you very much for your testimony. As I indicated earlier and have continually, the one program that I find in my travels, in particular through Africa, that people know about is PEPFAR. Heaven knows where we would be without the PEPFAR program, and I have continually commended the Congress and President Bush for the initiative.

As we recall, early on there was a discussion about only engaging in prevention activities, and very little that we saw that was being prescribed early on for treatment because people said, well, we can't treat our way out of it. The cost of course at that time was even higher for drugs related to dealing with the virus. And so we certainly have evolved tremendously from the initial notion that prevention was the only thing that we could do.

However, as I indicated earlier, we do know, as you have mentioned, the cost of the antiretroviral—for the drugs in general is \$89 per year and the cost of food is \$118, \$129. So we know that once again we really have a serious question when we talk about the nutrition part because the money has to come from somewhere.

But let me try to get a couple of basic points. I wonder, do you believe that there is a medical or a therapeutic benefit to the provision of food as a part of our AIDS treatment program or is it your position that food is not a medically essential part of the AIDS treatment? In other words, it is good if we can do it, but not necessarily medically essential? I was just wondering what your opinion is.

Ambassador DYBUL. Well, I think it is an excellent question and one for which we need more data. There is some data to indicate—there is no question in severe malnutrition beginning antiretroviral therapy, that there is a link, there is no question that some drugs require some food supplement, an empty stomach will make the drugs more difficult to take. But I think the question for us is what is the essential component and what is not, and I think that is one of the reasons we originally had a body mass index of 16 and why we are moving toward 18.5 as we have gotten more experienced.

So there are definitely data that support the links, but I don't think we know the specifics. In other words, at what point should you start? At what point can you stop? These are things that are being evaluated. We are supporting some of the evaluation. And I think as we learn more we will be able to give you a better answer to that. But I think for now what we can say is there is a link, there is certainly a link for severely and maybe even moderately malnourished people. Perhaps if you give food supplementation to some people in those areas, they would actually delay the time by which they need antiretroviral therapy.

So there are links. I think it is the specifics of the implementation that we are struggling with and the evaluations, and that is why we are supporting some of these public health evaluations so

we can get from the more general picture to the specific implementation issues. And the cost will then become an issue. If it comes down to a limited budget and do you support antiretroviral therapy or food supplementation, then it becomes a little more tricky in the field. And this is why we need partnership so we can bring all of those pieces to bear.

I think if you are someone in the field and you are sitting in front of someone who is telling you their biggest problem is food, it is a very difficult thing to say, well, I am sorry, I can't provide that. The difficulty is if you went to the person next door who is not HIV infected and asked them, they would say the same thing, and so food is just a problem where we are working. I think that is why we are bringing the partnerships together. There is no question there is a link, and we just need to understand it better and we need to understand the specifics of what that means for implementation. And again, we are learning all the time and will continue to learn, and I think you will be hearing from some of the partners who are providing us with those pieces of information and increasing the data so we can do a better job of improving our programs, which is all of our goal.

Mr. PAYNE. And we know it is a new area that we are moving into, but you mentioned a number of initiatives, programs related to nutrition that receive PEPFAR support, but I am still a little confused about how institutionalized that support is. One, are PEPFAR funded treatment implementing partners required or requested to carry out an assessment of the nutritional and food security status of every patient enrolled in U.S.-funded treatment programs in PEPFAR's 15 focus countries, and are they required to ensure that nutritional counseling is provided to all patients? Is it a goal for the U.S. Government to provide, as a component of ARV therapy, support for food and nutrition to HIV/AIDS-infected individuals and their families who need it without exception?

Ambassador DYBUL. I am going to have to give you a somewhat complicated answer. The legislation of course gives us authority in all of those areas, and the way we operate is somewhat different. We actually from centrally in Washington don't require a lot of things, despite what people may say. What we generally do is provide an allotment to countries in terms of resources and allow them to develop the programs that are appropriate in country and provide guidance. So our guidance does suggest all of those things be done, does encourage all of those things be done.

But it is difficult for us in Washington to know the circumstance on the ground. So if in the clinic the health workforce is so strained that they can barely get the key components of prevention, care and treatment out even though we encourage them to have nutritional assessments at visits and incorporate that, they may not be able to because they don't have the capacity. So we leave the implementation and those decisions to the in-country folks. You are going to hear from some people who have the capability and are in fact integrating those pieces into the programs, but I can't say it is universal.

Because this is such an important issue, one of the things we try to do is understand where guidance is being implemented and where it is not being implemented so that we can support countries

better. And so that is why this time for the first year in our operations plans we actually ask countries to provide us data on where they are and are not implementing these key components of guidance, so we can work with the countries where there are gaps to expand these programs. And this is one of the things we felt would be of use to your committee as well, to have some sense of where things are occurring and the types of support we are providing, specifically for food.

Another example is just in PMTCT clinics. One of the key areas for food that we do know is important is for pregnant women, particularly those infected with HIV/AIDS. And we know for infants and vulnerable children this is a key area of our guidance as well, yet despite our encouragement we have had some difficulty in having full uptake. And again what we are trying to do now is learn why the program implementation is not catching up to the guidance, whether or not there are barriers in country we can help overcome so that we can do that.

So we don't require very much because we are not in the country. What we try to do is provide guidance and resources and then try to capture data so we can see where there are gaps and support the country so we can go from guidance to implementation.

Mr. PAYNE. The report, Food and Nutrition for People Living with HIV/AIDS, released in May 2006 by your office states that a key precept of the emergency plan is to remain focused on HIV/AIDS and to provide support for food only in limited circumstances. And I know you were talking about the cost and you have gone over that, but I just wondered if you have a definition for the limited circumstances. I am trying to get a clear idea of whether you are opposed to integrating food and nutrition assistance into PEPFAR treatment programs or is it that you simply want to get more information, because also the report states that there is little empirical evidence that interventions to address food and security improve the nutrition and health outcomes of beneficiaries.

What exactly does that mean? Is there still uncertainty? Were you trying to say that food assistance as a part of HIV/AIDS treatment is not the best use of limited funds because, as you have indicated, there is perhaps a third more cost to provide food to persons as is the cost of the medication?

Ambassador DYBUL. Again, I think these are very complicated issues and things we are learning our way through and trying to get more data on so we can make better informed decisions. First, I want to be clear on the food supplementation. That is for fortified food products. That is not lettuce and cabbage and carrots and things. That is fortified food supplementation that is produced by a factory or some other mechanism. There is a combination of programs. We support a lot of farms, for example, in Kenya and a few other places that would cost less than those fortified food products. But to build someone's strength up quickly as they begin treatment sometimes you need the fortified food products, which cost more.

We are not at all opposed to integrating food. In fact we are very strongly in favor of integrating food and nutrition into HIV/AIDS programs, as we are strongly supportive at integrating family planning and many other things into HIV/AIDS programs. It is a mat-

ter of the resources and what bucket of money it comes out of and who has the expertise there. And so you will hear about the programs today, AMPATH, where we pay for part of the food, USAID pays for part of the food and World Food pays for part of it, together the pieces come together.

You will hear perhaps about a program in Mozambique with Catholic Relief Services where the USDA and PEPFAR and USAID are all engaged.

So it is more to us putting the appropriate pieces together than anything. It is not an opposition to integration. We are very much in favor of integration, but in this kind of partnered approach. We also believe the U.S. Government itself is not responsible for all of the activities, that we need to have other partners and other leveraged resources. And so that is why I think it is important that we have the data for every dollar the U.S. Government is putting in. Our partners are leveraging at least in many places another dollar to support food programs.

In terms of the evidence, as I mentioned, there are data, clear data to suggest the importance of food in a number of areas, particularly pregnant women and orphans. There are some data on early food supplementation and people that have a certain level of malnutrition to delay the need for antiretroviral therapy. So it is taking all those pieces of data and all the partnerships and putting it together.

But I think it is just a complicated area. I mean, there is no question we have a similar circumstances with clean water, there is no question we have a similar circumstance with job security or job creation, there is no question we have a similar circumstance with general economic development, there is no question we have a similar circumstance with health care workforce.

The problem is there isn't a single area of HIV/AIDS that doesn't relate in a very fundamental way with other pieces of development and we simply as PEPFAR cannot, in our view should not, in effect supplant USAID and other development programs and be doing everything. Rather, what we are trying to do is see where our piece fits and where the rest of the pieces fit.

So we are trying to integrate but not just as us but as part of all these other partnerships both within and outside of the government. And that is our goal, it is something we need to do a lot more work on and at the same time collect the information so we can make the best judgments together, Congress, the administration, all of the implementing partners, to make the best judgments on the optimal use of resources to save the largest number of lives. And that is what it comes down to, the optimal use of resources to save the largest number of lives, and those are difficult judgments and that is why we tend to leave them mostly to the field.

Mr. PAYNE. Well, let me just one last, I guess, question regarding the \$20 million. You did mention that the country team planned to spend over \$20 million on resources for food nutrition. Do you know how many people that might benefit, or once again is it difficult to quantify? Because if we know how many it is going to help, then it will just show how many are not going to be covered. So you probably don't want to answer that question—all right, I will withdraw that one.

I think it is clear and I do——

Ambassador DYBUL. I actually would like to answer that question.

Mr. PAYNE. Yes.

Ambassador DYBUL. I think this is the case in everything we do, whether it is treatment or prevention or care. All of the numbers, if you look at the total need, while they are expanding rapidly, there is still a lot more need, but we have actually asked for those data and we will have them for you. Something we couldn't provide you with previously, but we can, because our view is you need the data to make informed decisions. So even where the data may not look favorable, our approach is to collect it and provide it so that we can make the best decisions and together make the best decisions on how to most effectively use the resources to save lives.

So we never shy away from data, even if it is not what we would hope to see, because we need it if we are going to make intelligent decisions and fulfill our objective, as the Institute of Medicine called us, to be a learning organization.

Mr. PAYNE. Just on the instance of food partners and the wrap-around, have there been any attempts to deal with the other organizations that are primarily organizations that provide food? Is there any way to see whether what they are doing is adequate as it relates to the virus? In other words, is there any way to measure how effective the other programs are?

Ambassador DYBUL. I think there is a way, and that is what we are trying to do, and you will actually hear from a number of partners who are integrating the pieces, the PEPFAR pieces, the USAID pieces, the Food for Peace and other mechanisms, U.S. Department of Agriculture, World Food Program. Our view is each has a specific role in each country.

For example, in some countries a year and a half ago food insecure people were not where the HIV-infected people were, and so the original plans had the other partners working in areas where we didn't have PEPFAR partners. So it took some time to work together to make sure that we had appropriate overlap. And that just is an experiential time, how we fit the pieces together, integration as you pointed out. I would say again, we are not there by any stretch of the imagination. What we are trying to do is put these pieces in place just as we are trying to expand all of our programs most efficiently. So we are trying to judge the effectiveness of these programs when you put the pieces together and learn from them. That is what we are in the process of doing.

I don't think it is a question of authorities. The authorities are there. It is a question of making sure those pieces work together, and that is what we are working on. Again, we can improve, no question about it. I think the progress in these areas has been dramatic, just as the progress and treatment and prevention have been dramatic. It just is something that will take more time because of hurdles and we are trying to understand more what the barriers are to bringing all the programs together in the most effective way. We can certainly do better at it and that is what we are trying to do, and that is why we appreciate you and your initiative to have such a hearing and to focus on it because it reminds us again and again to remain focused on it.

So we thank you for that. This is an important area. It is an area that we intend to continue to improve in and to continue to learn from so that we can optimally use taxpayer dollars to save the largest number of lives.

Mr. PAYNE. Let me thank you once again for the work that you are doing. As you mentioned, these issues are all interwoven. If we take seriously the Millennium Challenge goals of halving abject poverty by 2015, we integrate many of the problems of poverty. And we heard at a hearing several weeks ago about how to try to prevent HIV/AIDS, and someone mentioned that women who have no means of income and has several children to feed many times have to turn to prostitution, and therefore risky behavior once again because of poverty and the food insecurity or lack of school fees or potable water push people into behaviors, women in particular, that they would not be involved in had it not been for the abject poverty or the lack of any other means for providing for basic food or shelter for their children.

And so I couldn't agree with you more, it is all connected. The whole question of attempting to deal with this abject poverty is something that I think we need to devote more attention to.

And I do have an answer for how we can integrate more food into—and other areas that need to be addressed, that perhaps rather than double the goal for PEPFAR maybe we need to triple the amount in reauthorization. Maybe the \$30 billion is not enough. Maybe we ought to be looking at \$45 billion for reauthorization. So that is certainly something that you won't have to vote on, but it is something that we may try to start to kick around. It is definitely inadequate funding. We can't do it alone, there is no question about it. But we need to figure out a way that we can more seriously address this pandemic. No doubt the \$15 billion over the 5-year period that PEPFAR is—and I think it probably will exceed that, perhaps it will be about \$19 billion. And that is a broad step in the right direction. I do believe that we can do more. We do intend to perhaps double hopefully the reauthorization in the '09, '08 when it comes up, but perhaps we need to look beyond this number because the pandemic requires even more.

Once again thank you very much, very much for your testimony. We look forward to continuing to working very closely with your office.

I am very pleased to have our second panel with us. The first witness on our second panel is Dr. Robert Einterz, associate dean of international affairs and professor of clinical medicine for the Indiana University School of Medicine. Dr. Einterz is also the director of the Indiana-Moi Partnership. The Indiana-Moi Partnership is a consortium of United States medical schools that partner with the Kenya Minister of Health to address the HIV/AIDS crisis in sub-Saharan Africa.

Through his partnership over 50,000 HIV-positive patients are treated across Kenya and 30,000 individuals are fed each week. Their medical services go beyond simply treating patients for the symptomatic medical issues associated with HIV/AIDS. They also provide income generating services, job training, general child health care and often outreach programs, a real comprehensive program.

Dr. Einterz remains a practicing physician and has authored many articles on international medicine. We welcome you.

Our second panelist witness will be Mr. Walleligne Beriye, country director for Project Concern International of Ethiopia. Project Concern International's mission is to save lives by building healthy communities through the provision of medical services, clean water and nutritional foods.

Mr. Beriye oversees all aspects of project concerns work in Ethiopia, including oversight with their Orphans and Vulnerable Children Project. With over 40 years of experience in both government and public sectors, he has extensive knowledge on issues affecting the livelihoods of people in poor communities. And we welcome you.

Our final witness on this panel is Ms. Annemarie Reilly. Ms. Reilly is the chief of staff to Catholic Relief Services' president, Ken Hackett. She oversees the president's office and ensures clear and effective implementation of the agency's strategy and directives from the president through the five executive vice presidents.

Her key areas of expertise include emergency preparedness and response, as well as strategic planning and implementation. Ms. Reilly created and managed CRS' emergency response team in 1999. Charged with the building the agency's overall capacity of high quality emergency preparedness, prevention, mitigation and response programs, the team responded to a variety of high profile crises, including Kosova, the 2001 earthquake in India and Afghanistan, and the food security crisis in Southern Africa in 2002.

We welcome all of our witnesses, and we will begin with Dr. Einterz.

STATEMENT OF ROBERT EINTERZ, M.D., DIRECTOR AND CO-FOUNDER, INDIANA-MOI PARTNERSHIP

Dr. EINTERZ. Good afternoon, Chairman Payne, Ms. Watson. Thank you for inviting me to share my perspectives with you. It is my privilege to give this testimony on behalf of my Kenyan and American colleagues and our respective institutions, Moi University and Moi Teaching and Referral Hospital in Eldoret, Kenya, and the consortium of U.S medical schools lead by Indiana University.

Before I begin my testimony I ask that my longer written statement be entered in the record in its entirety.

Mr. PAYNE. Without objection.

Dr. EINTERZ. Our successful treatment of the young Kenyan medical student dying of AIDS in 2001 inspired us to formulate a systemic response to the pandemic. Leveraging the power of our academic medical partnership, we established the Academic Model for the Prevention and Treatment of HIV/AIDS, or AMPATH.

AMPATH has quickly become one of the largest and most comprehensive HIV control systems in sub-Saharan Africa. We deliver services in the public sector through hospitals and health centers run by Kenya's Ministry of Health.

As you mentioned, AMPATH has treated over 55,000 HIV-positive patients at 19 urban and rural health centers and clinics across western Kenya, currently enrolling nearly 2000 new patients every month. AMPATH feeds up to 30,000 people weekly, helps thousands of orphans and vulnerable children by providing school

fees, clothing and shelter and delivers antenatal services aimed to prevent the transmission of HIV in nearly 35,000 pregnant women annually.

Through our prevention activities, AMPATH touches the lives of nearly 2 million individuals. Most recently we have successfully initiated a home-based counseling and testing program where we are going home to home testing for HIV and TB with the aim of ensuring that every person in every community knows their HIV status.

Starting an HIV care system from scratch and expanding it to its current size in 6 years was a daunting task. We have successfully crafted responses to a number of challenges, including stigma, food and income insecurity, inadequate facilities, insufficient number of trained personnel, impoverished medical systems and deficient administrative processes. Given the focus of this hearing, I will concentrate my comments on AMPATH's response to the challenge of food insecurity.

It is becoming increasingly apparent to those of us on the front lines of HIV care in sub-Saharan Africa that food security and poverty reduction are essential components of a meaningful response to the havoc wrought by the HIV pandemic. Responses targeting only the rapid scale-up of antiretroviral therapy will not meet the needs of many of the patients we serve.

Early on we became acutely aware of the impact hunger and poverty was having on patients and their households, most notably children. AMPATH decided to provide full nutritional support for all food insecure patients and dependents within their home.

The mechanics of our nutrition program are as follows. Using standards criteria, a nutritionist completes a standardized initial encounter form on all new patients at each AMPATH site. When food and security is established the patient and all dependents in the home automatically qualify for food support for 6 months. We include dependents because a mother with hungry children will inevitably share her food with her children. The nutritionist writes a food prescription that entitles them to a month supply of food. The patient must return to the nutritionist monthly for a new prescription.

The 6-month limit on food support is reinforced by the nutritionist at every monthly visit. The proportion of patients meeting eligibility for food support varies from 20 percent at some of our sites to as high as 80 percent at some of our other sites.

AMPATH meets the demand for food through a combination of production, purchase and donations. Our own food production is a key component. We currently manage six farms. Four are high production, continuous irrigation farms, and the remaining are teaching or demonstration farms. The combined monthly output of the continuous irrigation farms is in excess of 20 metric tons of fresh produce. We also purchase up to 3,000 eggs per day from a network of chicken houses managed by our patients.

The major source of donated food is the World Food Program and USAID. The World Food Program provides commodities, consisting of beans, corn, corn-soy blends and cooking oil. As I mentioned, the World Food Program commitment supports up to 30,000 participants.

Distributing the food at the right time to the right place to the right person required us to develop a computerized nutrition information system, a transportation system, and storage and packing centers. We train and employ our HIV-infected patients to serve as food distribution workers.

The design of the AMPATH nutrition system anticipates that 6 months of food support coupled with restoration of the immune system with antiretrovirals will enable many patients to return to an adequate level of food security. When it appears that additional food support will be needed beyond 6 months, the patient is evaluated by one of our social workers. If the social worker feels that continued food support is warranted, food will be continued while the patient is referred to another important arm of AMPATH which hosts an array of programs aimed at enhancing income security. For our urban patients, this may take the form of microenterprise training or micro financing. For rural patients it involved linkage with AMPATH agriculture extension workers.

As members of this committee likely know, there are no funding sources explicitly targeting food security for HIV-infected patients and their dependents. AMPATH has been able to support its nutrition program with a combination of funding sources, as has Ambassador Dybul referred to. The President's Emergency Plan for AIDS Relief was the first to provide partial support of our pilot model of nutrition support. The World Food Program, USAID and philanthropic donations have added critical funding every step of the way.

Obviously, we in our passions are enormously grateful to the American citizens and the leaders of our Government for every nickel of this life saving support.

An immediate concern regarding food support is the prospect of dependency. It is unrealistic to think that one can feed patients until they have regained their health and then expect all of them to return to their prior means of securing food for themselves and their dependents. Some do, but for others food security remains illusive, even when their immune status has returned to normal. In large part this is because their own infection and/or their spouse's illness were diagnosed too late, resulting in too many jobs lost, too many spouses dead, too many assets eroded and too many patients hungry.

AMPATH will rely on the increasing strength of our social services and income security programs to work with our families where food security seems like a goal beyond their reach. The fact that so many of our beneficiaries have come off food support is very encouraging. Sustainability of food support on a scale now operational in AMPATH is possible, but every facet of our nutrition program is vulnerable. Funds that support our farms are from private donations and PEPFAR. Continuing donations from World Food Program compete with endless pressure on an organization constantly facing some of this world's most daunting challenges. And the infrastructure and staff so essential to distribution of food depend on a patchwork of contributions from many supporters of AMPATH.

It is difficult to envision the sustainability of the AMPATH nutrition program or replication to other programs unless new commitments from the international donor community emerge. These com-

mitments will need to support food security with the same vigor as those currently targeting universal access to antiretrovirals in sub-Saharan Africa.

At this moment in the history of AMPATH, every food insecure patient and every child within that patient's family has access to food. If nothing else, AMPATH has demonstrated that it can be done. Other than access to antiretrovirals, it is hard to think of a priority more essential to those devastated by HIV than access to food.

Thank you.

[The prepared statement of Dr. Einterz follows:]

PREPARED STATEMENT OF ROBERT EINTERZ, M.D., DIRECTOR AND CO-FOUNDER,
INDIANA-MOI PARTNERSHIP

Chairman Payne and members of the committee: Thank you for inviting me to share my perspectives with you. It is my privilege to give this testimony on behalf of my Kenyan and American colleagues and our respective institutions Moi University and Moi Teaching Referral Hospital in Kenya, and a consortium of US medical schools led by Indiana University.

Our successful treatment of a young Kenyan medical student dying of AIDS in 2001 inspired us to formulate a systemic response to the pandemic. Leveraging the power of our academic medical partnership, we established the Academic Model for the Prevention and Treatment of HIV/AIDS (AMPATH). AMPATH has quickly become one of the largest and most comprehensive HIV/AIDS control systems in sub-Saharan Africa, providing a comprehensive system of care that has been described as a model of sustainable development. Delivery of services occurs in the public sector through hospitals and health centers run by Kenya's Ministry of Health.

AMPATH treats over 55,000 HIV-positive patients at 19 urban and rural clinical sites across western Kenya, currently enrolling nearly 2,000 new patients each month. AMPATH feeds up to 30,000 people weekly; helps thousands of orphans and vulnerable children by providing school fees, clothing and shelter; and delivers antenatal services that aim to prevent mother to child transmission of HIV in nearly 35,000 pregnant women annually. Through prevention activities like community engagement, education, experience sharing by persons infected with HIV and counseling and testing, AMPATH touches the lives of nearly two million individuals. Most recently, we have successfully initiated a home-based counseling and testing program where we are going home to home, testing for HIV and TB, with the aim of ensuring that every person in every community knows their HIV status.

Starting an HIV care system from scratch and expanding it in six years to serve comprehensively more than 55,000 patients and their communities was a daunting task. We have successfully crafted responses to a number of challenges including stigma, food and income insecurity, inadequate facilities, insufficient number of trained personnel, impoverished medical information systems, and deficient administrative processes. We believe the tri-partite academic medical center mission of care, training and research made this partnership perfectly suited to the challenges of rapidly scaling up a care program that also bolsters the long-term capacity of the indigenous health system. We are confident that targeted support for other U.S.-African academic medical center partnerships would yield similar success stories.¹ Given the focus of this hearing, I will concentrate my comments on our response to the challenge of food insecurity.

The interplay between HIV, poverty, and food insecurity is increasingly recognized as a major contributor to the devastation now challenging much of sub-Saharan Africa.^{2,3,4} It is unlikely that any combination of surveys can depict the actual cost to a society burdened by the death of young adults, endless numbers of widows, unparalleled numbers of orphans, falling school attendance by vulnerable children, and

¹Einterz RM, Kimaiyo S, Mengech HNK, Khwa-Otsyula BO, Esamai F, Quigley F, Mamlin JJ. Responding to the HIV pandemic: the power of an academic medical partnership. *Academic Medicine*. 2007; 82:812-818

²Kadiyala S, Gillespie S. Rethinking food aid to fight AIDS. *Food Nutr Bull*. 2004 Sep; 25[3]:271-82.

³Anabwani G, Navario P. Nutrition and HIV/AIDS in sub-Saharan Africa: an overview. *Nutrition*. 2005 Jan; 21 [1]; 96-9.

⁴Wanke C. Nutrition and HIV in the international setting. *Nutr Clin Care*. 2005 Jan-Mar; 8 [1]: 44-8.

an expanding proportion of undernourished children. Responses targeting only the rapid scale up of antiretroviral therapy are unlikely to meet the needs of many of the patients they serve. It is becoming increasingly apparent to those of us on the front lines of HIV care in sub-Saharan Africa that food security and poverty reduction are essential components of a meaningful response to the havoc wrought by the HIV pandemic.^{5 6}

Early on, we became acutely aware of the impact hunger and poverty was having on patients presenting for care and the vulnerable members of their household, most notably children. AMPATH decided to provide full nutritional support for all food insecure patients and dependents within their home. That decision alone initiated a series of challenges for AMPATH that have proven just as challenging as scaling up one of Kenya's largest antiretroviral delivery programs

THE AMPATH NUTRITION PROGRAM

Eligibility

A nutritionist completes a standardized initial encounter form on all new patients at each AMPATH site. The interview focuses on level of immune suppression, Body Mass Index, poverty level and access to adequate food. When food insecurity is established, the patient and all dependents in the home automatically qualify for food support for six months. The nutritionist writes a *food prescription* that entitles the patient and dependents to a one month supply of food. The patient must return to the nutritionist monthly for a new prescription until the six months are completed. This six month limit on food support is reinforced by the nutritionist at every monthly visit. Depending on supply, the nutritionist will provide 100% of caloric needs for the patient and dependents. We include dependents because a mother with hungry children will inevitably share her food with her children.

The proportion of patients meeting eligibility for food support varies between AMPATH sites, from 20% at some sites to nearly 80% in other sites. Food insecurity is more prevalent in AMPATH's more western sites.

Food Demand

The sum of the food prescribed by nutritionists for all patients and their dependents throughout AMPATH quantifies the total *demand* for food required for a given day, week or month. Each food prescription records the quantity and type of food required for each household along with the day and location of anticipated pick up of food.

Food Supply

Food sufficient to meet the demand represents one of AMPATH's greatest challenges. AMPATH meets this challenge with a combination of production, donation and purchase.

AMPATH's own food production is a key component of AMPATH's Nutrition Program. AMPATH currently manages six farms. Four are high production, continuous irrigation farms and the remaining are teaching/demonstration farms. With a continuous source of water, these farms are able to produce a reliable, year round supply of culturally compatible fresh vegetables. The combined monthly output of the continuous irrigation farms is in excess of 20 metric tons of fresh produce. As orchards come online, these same farms will add an additional metric ton of fresh fruit each week.

The major source of donated food is the World Food Program [WFP] and USAID. WFP provides commodities consisting of beans, corn, corn/soy blends and cooking oil. The WFP commitment supports up to 30,000 recipients. USAID provides vitamin enriched corn/soy blends for an additional 2,000 recipients.

AMPATH purchases up to 3,000 eggs per day from a network of chicken houses managed by its own patients. Packets of fermented milk are purchased from a local dairy farm. Fermented milk is preferred due to its approximately ten day shelf life in the absence of refrigeration. The supply of food now available provides a culturally acceptable food basket consisting of fresh vegetables, fruit, eggs, milk products, an occasional chicken, corn, beans, corn/soy blends and cooking oil.

⁵ Chopra M, Darnton-Hill I. Responding to the crisis in sub-Saharan Africa: the role of nutrition. *Public Health Nutr.* 2006 Aug; 9 [5]: 544–50.

⁶ Au JT, Kayitenkore K, Shutes E, Karita E, Peters PJ, Tichacek A, Allen SA. Access to adequate nutrition is a major potential obstacle to antiretroviral adherence among HIV-infected individuals in Rwanda. *AIDS*, 2006 Oct 24; 20 [16]: 2116–8

Food Distribution

The daily measure of supply and demand must be translated into a delivery system capable of getting the right food at the right time and to the right place for individual patients spread over much of western Kenya. In response to this challenge, industrial engineers from Purdue University have joined with AMPATH to create a computerized Nutrition Information System [NIS]. Each day, the food prescription for each patient is entered in the NIS along with an estimate of the total supply of food available. The NIS then creates daily work logs detailing the amount, type and location of food that needs to be moved. In addition, the NIS will list individual patients scheduled to pick up food by day and site. Moving the food requires a transportation system and access to appropriate storage and packing centers. Distribution on site demands adequate space and distribution workers. Most distribution workers are specially trained AMPATH patients.

Transition to Food Security

The design of the AMPATH nutrition system anticipates that six months of food support coupled with restoration of the immune system with antiretrovirals will enable many patients to return to an adequate level of food security. When it appears that additional support will be needed beyond six months, the patient is evaluated by an AMPATH social worker. If the social worker feels that continued food support is warranted, food will be continued while the patient is referred to another important arm of AMPATH, the Family Preservation Initiative, which provides an array of programs aimed at enhancing income security for AMPATH patients. For urban patients, this may take the form of microenterprise training with or without the assistance of micro financing. For rural patients, this often involves linkage with AMPATH agriculture extension workers for consideration of improved farming techniques, planting new crops or participation in cooperatives with other rural patients to grow high value produce.

Cost

Food support is an important and necessary addition to HIV care; but, currently, there are no funding sources explicitly targeting food security for HIV-infected patients and their dependents. Beyond the costs of growing food, there are additional costs in managing large food donations. Significant investments must be made in computer support systems, physical facilities, vehicles and distribution staff. AMPATH has been able to support its nutrition program with a combination of funding sources. The President's Emergency Plan for AIDS Relief [PEPFAR] was the first to provide partial support of AMPATH's effort to bring up a pilot model of nutrition support as a component of comprehensive HIV treatment. The World Food Program, USAID and philanthropic donations have added critical funding every step of the way.

Dependency

An immediate concern regarding food support is the prospect of dependency. It is unrealistic to think that one can feed patients until they have regained their health and then expect all of them to return to their prior means of securing food for themselves and their dependents. In fact, many patients regain the means to food security; but for others food security remains elusive even when their immune status has returned to normal. In large part, this is because their own HIV and/or their spouse's illness were diagnosed too late resulting in too many jobs lost; too many spouses dead; too many assets eroded and too many patients hungry. AMPATH will rely on the increasing strength of its social services program and expanding income security capability to work with our families where food security seems like a goal beyond their reach. The fact that most of our beneficiaries have been able to come off food support since January 2006 is encouraging.

Sustainability

Early in the history of the AMPATH program, leadership identified food insecurity as a pervasive companion of HIV-infected patients in western Kenya. Subsequent nutritional assessments have borne out this impression at each AMPATH site. While many might caution against an attempt to scale up nutrition support for food insecure HIV-infected patients until research provides supporting evidence, AMPATH proceeded with the full conviction that the intuitive sense that food is necessary demanded a response. Simply stated, AMPATH decided it was ethically preferable to be found providing food when evidence determines it is unnecessary than to proceed without nutritional support and eventually realize food support was in fact a vital component of care.

Having made the commitment to feed all food insecure patients and their dependents, AMPATH fully understood the gap between fairly straightforward goals and

actual practice in sub-Saharan Africa. Even with adequate funding in hand, scaling up robust antiretroviral therapy of large populations proved to be a formidable challenge. Many of the same barriers to rapid scale-up of antiretroviral therapy in sub-Saharan Africa are equally capable of frustrating the best intended nutrition program. Yet, this report clearly documents that the demand for food by individual patients and their dependents can be determined. And that demand can be met by a combination of food production, donations and distribution infrastructure.

Sustainability of food support on a scale now operational in AMPATH remains a concern. Every facet of the AMPATH nutrition program is vulnerable. Funds supporting AMPATH's farms are from private donations and PEPFAR. Continuing donations from WFP compete with endless pressure on an organization constantly facing some of this world's most daunting challenges. And the infrastructure and staff so essential to distribution of food depend on a patchwork of contributions from many supporters of AMPATH. It is difficult to envision the sustainability of the AMPATH nutrition program or replication to other programs unless new commitments from the international donor community emerge. These commitments will need to support food security with the same vigor as those currently targeting universal access to antiretrovirals in sub-Saharan Africa.

Best practices

Though AMPATH has demonstrated success so far in balancing food demand with food supply, we are striving to maximize the effectiveness and efficiency of the various components of AMPATH's nutrition program and to understand fully the impact of the nutrition program on the community. AMPATH is committed to becoming a laboratory for the highest quality of investigation. The research most capable of telling the story of food security will need to go beyond the impact of food support on HIV-infected patients and their dependents. To fully understand the impact of food support on the well being of a community, nutritionists and medical researchers will need to be joined by social scientists, educators and economists.

Concluding remarks

AMPATH proceeded with food support for its patients with the full conviction that impoverished HIV-infected patients who are hungry require food as an integral component of care. This conviction was not set aside until evidence confirming the role of food in HIV care was in hand. These same values encourage replication without apology while the research community gathers the critical evidence that is currently lacking. Delay in replication continues to put hundreds of thousands of patients and their dependents at risk.

At this moment in the history of AMPATH, every food insecure patient and every child within that patient's family has access to food. If nothing else, AMPATH has demonstrated that it can be done. Other than access to antiretrovirals, it is hard to think of a priority more central to those devastated by HIV than access to food. One is unlikely to successfully tackle the daunting task of income security until food is secure.

Mr. PAYNE. Thank you very much.

Mr. Walleligne Beriye.

STATEMENT OF MR. WALLELIGNE A. BERIYE, COUNTRY DIRECTOR, ETHIOPIA, PROJECT CONCERN INTERNATIONAL

Mr. BERIYE. I am Walleligne Beriye, and I am from Ethiopia. It is a great privilege to be here before you today. I am also thankful to you, honorable Members of the United States Congress, who will listen to my testimony as you craft an important new piece of legislation on nutrition and HIV/AIDS. What I have to say will help you to see that nutrition and HIV/AIDS is connected and that they must be treated together.

I work as the country delegate for Project Concern International, a non-profit, humanitarian organization working in Africa, Asia and the Americas. Over the last half century, Project Concern International has worked to prevent disease, improve community health and promote sustainable development by supporting communities to take control of and improve their own lives.

In the title of this hearing, the committee asked if the President's Emergency Plan for AIDS Relief or PEPFAR is doing enough to fulfill the nutrition and food security of people living with HIV/AIDS. Answering this question is both simple and at the same time very difficult. In some ways, the answer is simple because the needs of people living with HIV/AIDS are so enormous that no single government, no matter how great or generous could ever do enough. It is also simple because we know that the United States Government has demonstrated unprecedented leadership and great generosity in addressing the plight of people living with HIV/AIDS. I can speak on behalf of all Ethiopians when I say that we are grateful and deeply indebted for everything the American Government has done and continues to do through the PEPFAR program. I thank Ambassador Dybul also and extend personal thanks to him from the people of Ethiopia for his compassionate and committed leadership at the helm of PEPFAR.

But the answer is also complex. PEPFAR began as an emergency response and at the same time—and the sense of urgency allowed for unprecedented accomplishments in very focused areas. That PEPFAR has put well over 1 million HIV-positive people on anti retro-viral treatment is simply a miracle. Quickly putting so many people on treatment required a very focused mandate.

As the institute of medicine has recommended in their evaluation of PEPFAR, however, we now must move beyond the emergency phase. We need to deal with other important dimensions of this epidemic, and one of the most important is the linkage between malnutrition and HIV/AIDS. Every day in Ethiopia, I am reminded of how AIDS can lead to hunger and malnutrition. I am also reminded that hunger and the desperation that it brings can drive decent people to take terrible risks, to trade their own bodies for money to buy food and, in doing so, expose themselves to HIV/AIDS.

I remember a couple with four children, and I wish I could have brought the pictures of this family with me today. You would have seen how full of joy and hope they once were. As it happens with many millions of families across the continent, both parents died of AIDS. The children were left to fend for themselves. The eldest son was the first to leave his brothers and sisters. He went to look for work in the streets and then just disappeared. We never found out what became of him. The second child was a girl, and she took to prostitution to feed her younger siblings. After her degrading life in the streets, she became infected with HIV and eventually died. The two youngest children, a boy and a girl, have now also been lost to the streets. We don't know where they are or what has become of them.

What I have also seen in my country is that people who are HIV-positive need food. Because of the way the disease ravages the body, an HIV-positive adult will need 30 percent more food, and children may require twice as much as those who are not infected. They need this extra food to maintain their strength. This was the case with an HIV-positive woman named Alemitu that I met at a clinic. Pregnant with her third child, she lost her husband earlier in the year to AIDS. Although she is fortunate to be on treatment, she goes hungry on days when she does not get food supplements

from the clinic that dispenses her drugs. On these days, she told me, her strength is drained. You can only imagine how hard it must be for her to take care of her two children when she is hungry and weak.

The lack of food not only accelerates the decline into fully symptomatic AIDS, but it also means the patients have to start taking AIDS drugs years earlier. And they will die earlier, too. HIV-positive malnourished patients who begin treatment are six times more likely to die than those who are adequately nourished. By including the provision of food and nutrition security in PEPFAR's mandate, we can help people with AIDS delay treatment, and we can help assure that they will remain healthy and productive members of society for a long period.

Honorable Members of Congress, if you are to expand the mandate of PEPFAR to include nutritional support, there are many concrete things that could be done immediately.

First, and as Project Concern International is already doing in some places, we could greatly expand programs that provide nutritious meals to schools where orphans and other vulnerable children are.

Second, we could expand programs that provide food at centers where pregnant women are counseled and tested for HIV. Providing this food to malnourished mothers not only helps assure that they keep coming to the clinic but to also protect the health of their unborn children.

Third, our programs could greatly expand the provision of food at HIV/AIDS treatment centers. We already know that many people who are on treatment are malnourished and need food. There is no reason to let them go hungry.

Fourth, we can create economic opportunities for people who are affected by the AIDS epidemic. We can help them start gardens and organize small savings collectives or businesses to meet their many economic needs.

While I know there may be other ways to link nutrition and HIV/AIDS, the most important thing that we can do, honorable Members of Congress, is to assure that the mandate of PEPFAR is expanded to include nutritional support for both HIV-positive adults and children, as well as family members whose lives have been devastated by the disease. Expanding PEPFAR's mandate will help us tear down the unnecessary wall between nutrition and HIV programs, and it will go far to improve the lives of millions of people who suffer from the ravages of AIDS around the world. Thank you very much for giving me this opportunity to speak to you today.

[The prepared statement of Mr. Beriye follows:]

PREPARED STATEMENT OF MR. WALLELIGNE A. BERIYE, COUNTRY DIRECTOR,
ETHIOPIA, PROJECT CONCERN INTERNATIONAL

I am Walleligne Beriye, and I am from Ethiopia.

It is a great privilege to be here before you today. I am also thankful that you, honorable Members of the United States Congress, will listen to my testimony as you craft an important new piece of legislation on nutrition and HIV/AIDS. What I have to say will help you see that nutrition and HIV/AIDS are connected, and that they must be addressed together.

I work as the Country Director for Project Concern International, a non-profit, humanitarian organization working in Africa, Asia and The Americas. Over the last

half century, Project Concern International has worked to prevent disease, improve community health, and promote sustainable development by supporting communities to take control of and improve their own lives.

In the title of this hearing, the Committee asked if The President's Emergency Plan for AIDS Relief (or PEPFAR) is doing enough to fulfill the nutrition and food security needs of people living with HIV/AIDS. Answering this question is both simple, and at the same time very difficult.

In some ways the answer is simple because the needs of people living with HIV/AIDS are so enormous that no single government, no matter how great or generous, could ever do enough.

It is also simple because we know that the US Government has demonstrated unprecedented leadership, and great generosity in addressing the plight of people living with AIDS. I can speak on behalf of all Ethiopians when I say that we are grateful, and deeply indebted for everything the American Government has done and continues to do through the PEPFAR program. Ambassador Dybul, I also want to extend personal thanks to you, from the people of Ethiopia, for your passionate and committed leadership at the helm of PEPFAR.

But the answer is also complex. PEPFAR began as an emergency response, and the sense of urgency allowed for unprecedented accomplishments in very focused areas. That PEPFAR has put well over a million HIV positive people on anti retroviral treatment is simply a miracle.

Quickly putting so many people on treatment required a very focused mandate. As the Institute of Medicine has recommended in their evaluation of PEPFAR, however, we now must move beyond the "emergency" phase. We need to deal with other important dimensions of this epidemic, and one of the most important is the linkage between malnutrition and AIDS.

Every day in Ethiopia, I am reminded of how AIDS can lead to hunger and malnutrition. I am also reminded that hunger, and the desperation that it brings, can drive decent people to take terrible risks, to trade their bodies for money to buy food, and in doing so expose themselves to AIDS.

I remember a couple with four children, and I wish I could have brought a picture of this family with me today. You would have seen how full of joy and hope they once were. As it happens with so many millions of families across my continent, both parents died of AIDS. The children were left to fend for themselves.

The eldest boy was the first to leave his brothers and sisters. He went to look for work on the streets, and then just disappeared. We never found out what became of him.

The second child was a girl, and she took to prostitution to feed her younger siblings. After a degrading life on the streets, she became infected with HIV, and eventually died. The two youngest children, a boy and girl, have now also been lost to the streets. We don't know where they are, or what has become of them.

What I have also seen in my country is that people who are HIV positive need food. Because of the way the disease ravages the body, an HIV positive adult may need 30% more food, and children may require up to twice as much as those who are not infected. They need this extra food to maintain their strength.

This was the case with an HIV positive woman named Alemitu that I met at a clinic. Pregnant with her third child, she lost her husband earlier in the year to AIDS. Although she is fortunate to be on treatment, she goes hungry on days when she does not get food supplements from the clinic that dispenses her drugs. On these days, she told me, her strength is drained. You can only imagine how hard it must be for her to take care of her two children when she is hungry and weak.

The lack of food not only accelerates the decline into fully symptomatic AIDS, but it also means that patients have to start taking AIDS drugs years earlier. And they will die earlier, too. HIV positive, malnourished patients who begin treatment are six times more likely to die than those who are adequately nourished.

By including the provision of food and nutritional security in PEPFAR's mandate, we can help people with AIDS delay treatment, and we can help assure that they will remain healthy and productive members of society for a longer period.

Honorable members of Congress, if you were to expand the mandate of PEPFAR to include nutritional support, there are many concrete things that could be done immediately.

First, and as Project Concern International is already doing in some places, we could greatly expand programs that provide nutritious meals at schools where orphans and other vulnerable children are enrolled.

Second, we could expand programs that provide food at centers where pregnant women are counseled and tested for HIV. Providing this food to malnourished mothers not only helps assure that they keep coming to the clinic, but it will also protect the health of their unborn children.

Third, our programs could greatly expand the provision of food at HIV/AIDS treatment centers. We already know that many people who are on treatment are malnourished and need food. There is no reason to let them go hungry.

Fourth, we can create economic opportunities for people who are affected by the AIDS epidemic. We can help them start gardens and organize small savings collectives or businesses to meet their many economic needs.

While I know there may be other ways to link nutrition and HIV/AIDS, the most important thing that you can do, honorable members of Congress, is to assure that the *mandate* of PEPFAR is expanded to include nutritional support for both HIV positive adults and children, as well as family members whose lives have been devastated by the disease. Expanding PEPFAR's mandate will help us tear down the unnecessary wall between "nutrition" and "HIV" programs, and it will go far to improve the lives of millions of people who suffer the ravages of AIDS around the world.

Thank you very much for giving me this opportunity to speak to you today.

Mr. PAYNE. Thank you very much. We appreciate your testimony.
Ms. Annemarie Reilly?

**STATEMENT OF MS. ANNEMARIE REILLY, CHIEF OF STAFF,
CATHOLIC RELIEF SERVICES**

Ms. REILLY. Good afternoon, Chairman Payne, Representative Watson. Thank you for calling this important hearing to give Catholic Relief Services the opportunity to share our experiences as an implementer of PEPFAR programs. And thank you, Chairman Payne, for your well informed comprehensive opening remarks. We concur with many of your conclusions and recommendations.

My name is Annemarie Reilly, chief of staff for Catholic Relief Services. CRS has been responding to the emergency, humanitarian and development needs of people around the world for over 60 years, and we currently have operations in more than 100 countries. Catholic Relief Services has been involved in HIV and AIDS interventions for more than 20 years, almost since the beginning of the pandemic. With the committee's permission, please allow me to summarize my written statement which I ask to be included in the record.

Mr. PAYNE. Without objection.

Ms. REILLY. Among the 250 HIV projects CRS supports around the world, the largest, AIDS Relief, provides antiretroviral therapy and care and support services to over 200,000 people living with HIV. Our comprehensive and holistic projects provide mainstream interventions, such as HIV and AIDS awareness, prevention, education and abstinence and behavior change programming. Other important elements include support for orphans and vulnerable children, home-based care and the provision of antiretroviral therapy and related services.

The number one issue that we hear raised by the people living with HIV and AIDS and their families is lack of food and the money to buy it. All aspects of food security are exacerbated by high rates of HIV and AIDS. The chronic and debilitating progression from HIV infection to full blown AIDS accompanied by loss of work and income while seeking treatment leads to poor nutrition, lack of food, hunger and food insecurity.

I would like to underscore the impact of food security in particular on children and orphans and AIDS-affected households. Older children in AIDS-affected households are often forced to quit school because of deteriorating family finances and/or because they need to care for their ailing parent. Younger children of school age

often never even start school. Those lucky enough to attend school often don't have enough to eat.

CRS' PEPFAR central grant directly supports 56,000 orphans and vulnerable children in five countries. In its implementation, we have created linkages with the World Food Programme office in Tanzania and Title II Food for Peace programs in Kenya and Haiti. These linkages enable us to provide critical nutritional support to our PEPFAR programs. But in many cases, we encounter program rigidity or resistance to supporting nutrition-based HIV projects. CRS AIDS relief in Kenya provides both ARVs and limited nutritional support to PEPFAR-supported patients through our food by prescription program. This innovative approach allows CRS to use USAID mission funds to purchase food for distribution, but to a select category of patients only and with no rations for their household. This limitation is due to insufficient funding, the high degree of malnutrition in the area and widespread need.

Almost all of CRS' 250 HIV and AIDS projects have an integrated food element. We integrate nutrition-based HIV with the wider health and food security needs of vulnerable communities. Where possible, CRS accesses public resources like USAID Title II and WFP food programs.

Where these public resources are not available, CRS uses private resources to meet the need. The CRS Return to Life project in Zambia exemplifies this integrated approach. This project provides income-generating activities and food production in concert with ART. For example, where agriculture is the main livelihood activity, the household receives an ag pack containing crop seeds, information on soil improvement practices, fertilizer and/or agricultural tools.

Mr. Chairman, Representative Watson and members of the subcommittee, as we look forward to the reauthorization of the United States Leadership Against HIV/AIDS, Tuberculosis and Malaria Act, we urge you to consider the following recommendations to improve the integration of nutrition and food security and PEPFAR supported programs: First, require greater collaboration, integration and flexibility among key USAID programs such as PEPFAR, Title II and Child Survival, in particular utilize the recently released Conceptual Framework for HIV and Food Security as a path forward.

Two, provide a budget for nutritional support in PEPFAR and revise the criteria for which patients can receive "food by prescription" so more recipients will be eligible.

Three, increase the Title II budget itself to direct more funds and food commodities specifically for the purpose of providing nutritional support to people living with HIV.

Four, focus more broadly on assisting the entire household to reduce food insecurity by increasing livelihood strategies and approaches to sustain household security.

Five, increase funding for OVC support, including food baskets for the household to keep children in school and prevent the need for young girls to engage in transgenerational sex to meet their own and their family's food needs.

Again, Chairman Payne, Representative Watson, thank you for holding this hearing to respond to the nutrition needs of those liv-

ing with or affected by HIV/AIDS. As I previously noted, the number one issue raised by those affected by HIV is the lack of food and the money to buy it. Our experience shows that increased resources and flexibility are needed to integrate nutrition and HIV treatment and care. Only then will PEPFAR be able to best serve the millions of vulnerable people. I would be pleased to respond to any questions the committee may have. Thank you.

[The prepared statement of Ms. Reilly follows:]

PREPARED STATEMENT OF MS. ANNEMARIE REILLY, CHIEF OF STAFF, CATHOLIC RELIEF SERVICES

Good afternoon Chairman Payne, Ranking Member Smith and Members of the Subcommittee. I commend you for calling this timely hearing and giving Catholic Relief Services the opportunity to share our experiences as an implementer of PEPFAR programs. We are especially concerned about the nutrition and food security needs of people living with HIV (PLHIV).

My name is Annemarie Reilly, Chief of Staff for Catholic Relief Services (CRS). For over 60 years and currently operating in more than 100 countries, CRS—the international relief and development agency of the United States Conference of Catholic Bishops—has been responding to the needs of people around the world in emergencies, humanitarian crises, and in development—especially for the poor, marginalized, and disenfranchised. Catholic Relief Services has been involved in HIV and AIDS interventions for more than 20 years—almost since the beginning of the pandemic. In 1986, our first HIV project supported a local congregation of Catholic sisters in Bangkok, to provide HIV and AIDS awareness, HIV prevention education, as well as compassionate care and support services among HIV positive sex workers and their children. By 2002, CRS had supported more than 300 HIV and AIDS projects.

Today CRS supports over 250 HIV projects in 52 countries. Local Catholic Church-based organizations are our principal and priority partners; however CRS also partners with other faith-based and community-based organizations, as well as with other local and international NGOs, Ministries of Health and national AIDS control entities. CRS' largest project—AIDSRelief—supports 140 local partners in 9 countries to provide antiretroviral therapy to more than 84,000 PLHIV and care and support services to another 140,000 PLHIV not yet eligible for antiretroviral therapy (ART). Our comprehensive and holistic HIV and AIDS projects provide mainstream interventions such as HIV and AIDS awareness education, abstinence and behavior change programming, support for orphans and other vulnerable children (OVC), support for PLHIV, home-based care, and the provision of antiretroviral therapy and related services. Many of our projects also include agriculture, microfinance, education, health, and water and sanitation activities. Monitoring and evaluation and operations research are important components of our programming. CRS projects give preference to women and girls, orphans, and other poor and marginalized populations in the countries in which CRS works. We and our partners are thankful to be able to partner with PEPFAR in 12 of the 15 focus countries.

First of all, I would like to thank Ambassador Dybul and colleagues at the Office of the Global AIDS Coordinator and the United States Agency for International Development for developing the conceptual framework on HIV and Food Security released in September. The background and analysis that inform the conceptual framework and the resulting recommendations reflect the reality that we as implementers face. Many of the following remarks serve to illustrate and support the findings and recommendations of the conceptual framework.

The *number one issue* that we hear from people living with HIV and AIDS and their families in the 52 countries where we have HIV specific programs, is *lack of food and the money to purchase it*. All aspects of food insecurity—availability, access and use of food—are exacerbated by high rates of HIV and AIDS. The chronic and debilitating progression from HIV infection to full-blown AIDS (if untreated or treated late) accompanied by the loss of work and income while seeking treatment leads to hunger, poor nutrition, and food insecurity.

The Food and Nutrition Technical Assistance Project of World Food Program has accurately summarized the pernicious results when HIV meets hunger.

HIV significantly undermines a household's ability to provide for basic needs because HIV-infected adults may be unable to work, reducing food production and/or earnings. Healthy family members, particularly women, are often forced to stop working to care for sick relatives, further reducing income for food and other basic

needs. The households may have trouble paying costs associated with health care and nutritional support. They also may be severely restricted in participating in community activities. Children may be withdrawn from school because families cannot afford school fees because of the need for the children to care for ill relatives. This affects the opportunities for future generations.¹

As a result of this HIV-to-poverty or poverty-to-HIV cycle, the quantity and quality of diet diminishes for both the PLHIV and other household members. The interaction between nutrition and ART is well documented.^{2,3} Inadequate nutrition causes malabsorption of some ARVs. Some medications have to be taken on an empty stomach, while others with a fatty meal. Preliminary evidence from the 140 CRS AIDSRelief ART sites suggests that patients initiating ART with access to food respond to treatment better than those lacking adequate nutrition. Continued data collection is important for a more comprehensive picture.

I would also like to underscore the impact of food insecurity on children and orphans in AIDS-affected households. Older children in AIDS-affected households are often forced to quit school because of deteriorating family finances and/or because they need to care for their ailing parent. Younger children of school age often never even start school. Those lucky enough to attend school often do not have enough to eat. Recent evaluation of CRS' PEPFAR-supported OVC program was conducted in five countries. In Haiti where food supplements are provided, 96% OVC reported that they "always have enough to eat." However, in Zambia where no food supplements are provided by the program an average of only 5% OVC reported "always having enough to eat."⁴ Furthermore, with fewer adults to earn income or farm, these households have fewer resources for food and adequate nutrition.

CRS' PEPFAR central grant directly supports 56,000 orphans and vulnerable children (OVC) in five countries (Haiti, Tanzania, Kenya, Rwanda, and Zambia). In its implementation we have created linkages with the World Food Program (WFP) office in Tanzania and Title II Food for Peace (FFP) programs in Kenya and Haiti. Inflexible requirements for PEPFAR and Title II have greatly complicated addressing linkages between food insecurity and HIV. For example, in Tanzania during the early years of PEPFAR, WFP allotted food to different regions of the country than those covered by CRS' OVC project. While this particular problem was eventually fixed, we encountered similar constraints in other countries.

CRS' AIDSRelief program in Kenya provides ARVs to nearly one in nine PEPFAR-supported patients in the country through 19 local treatment partner facilities. Patients meeting certain criteria receive food and nutrition supplements for a limited period of time through "Food by Prescription." This innovative approach allows CRS to purchase food using PEPFAR funds for food distribution to patients only—with no ration for their households.

From our almost 50 years of food aid experience with Title II, when food is given only to the patient, we have observed that individual food rations are usually shared with the rest of the household—diminishing the intended benefit to the individual. As a result, CRS strives to use other resources—from Title II, WFP, and our private funds—to distribute basket rations to families and households affected by HIV.

Almost all of CRS' 250 HIV and AIDS projects have an integrated food and nutrition element. We also integrate our nutrition-based HIV response with efforts to address the wider health and food security needs of vulnerable communities. To this end, CRS' OVC and PLHIV support programs frequently include training in better agricultural techniques, nutrition education, and cooking demonstrations.

For example, the Scaling Up Community Care to Enhance Social Safety-nets (SUCCESS) Project in Zambia, improved the palliative care and support to people living with HIV (PLHIV) through multiple interventions, including home based care, community-based counseling and testing, prevention of parent to child transmission, targeted nutritional interventions, referral to ART, and adherence support. SUCCESS home based care initially provided food rations to PLHIV who were not strong enough to work. The project, and its successor the Return to Life project, then added income generating activities and food production combined with life-saving ART. Where agriculture is the main livelihood activity, the household also receives an ag-pack containing crop seeds, information on soil improvement practices (agroforestry

¹Food and Nutrition Technical Assistance (FANTA) Project and World Food Programme (WFP). *Food Assistance Programming in the Context of HIV*. Washington, DC: FANTA Project, Academy for Educational Development, 2007.

²Castleman, Tony, Eleonore Seumo-Fosso, and Bruce Cogill. *Food and Nutrition Implications of Antiretroviral Therapy in Resource Limited Settings*. Washington, DC: Food and Nutrition Technical Assistance Project, Academy for Educational Development, 2003.

³World Health Organization (WHO). *Scaling Up Antiretroviral Therapy in Resource-Limited Settings: Guidelines for a Public Health Approach*. Geneva, June 2002.

⁴In publication. Catholic Relief Services, (2007)

or green manures), fertilizer and/or agricultural tools. Where livestock plays a larger role in supporting livelihoods, the program gives households a male/female pair of cattle, goats or chickens under a revolving loan agreement where one female offspring is later returned for distribution to another family.

In Malawi, the rural poor suffer from chronic food insecurity as a result of poor access, inadequate availability and poor utilization of food. Moreover, AIDS and related diseases are the leading cause of adult morbidity and mortality in Malawi. Approximately 15 percent of adults are HIV-positive, and more than one-third of all children under the age of 15 have lost at least one parent to the disease. There are approximately 740,000 people living with HIV in Malawi. Most live in the southern and central regions, where food insecurity and vulnerability are most intense.

Through the PL 480 Title II-supported I-LIFE program (Improving Livelihoods Through Increasing Food Security), CRS and its partners provide food assistance to the chronically ill (most of whom are PLHIV) and their households. This helps entire families maintain a healthy nutritional status, provides for increased calorie and protein needs of those infected, eases the time and resource constraints of caregivers, and allows other members living in vulnerable households to pursue productive livelihoods. I-LIFE also provides community education programs that incorporate information about HIV prevention, health and nutrition, and challenge the stigma associated with the disease. Through these interventions CRS and its partners reduced food insecurity and eased the effects of the HIV and AIDS epidemic in the region. Unfortunately, many beneficial Title II-supported programs like I-LIFE have either ended or are in their last year because of Title II funding cuts.

Despite some initial achievements and many efforts to integrate nutrition and HIV programming, much work remains to be done:

- 1) Short-term food/nutrition supplements and household basket rations, while necessary, do not address underlying food insecurity. What happens after a client receives food rations for several months and they are still without a means of livelihood?
- 2) Food and nutrition and HIV activities are not well integrated across USG agencies and programs. Title II programs are targeted to regions with the greatest food insecurity, which does not always allow us to reach food insecure OVC and PLHIV living in other regions. In addition, interagency coordination and integration of services is not always consistent across countries.
- 3) The inability to purchase food with PEPFAR funds where Title II or other resources are not available prevents addressing nutritional needs. CRS AIDSRelief ART Project provides "Food by Prescription" to ART patients in a part of Kenya where FFP resources are not available. This creative approach is not currently possible everywhere.
- 4) Cutbacks in Title II funding have exacerbated the challenge. Successful projects like I-LIFE, RAPIDS, SUCCESS, and Return to Life in the southern Africa region have led to better integration of HIV and nutrition programs with sustainability by targeting the causes of food insecurity. All have NOT received continued or expanded funding because of Title II cutbacks. A recent SUCCESS (Scaling Up Community Care to Enhance Social Safety-nets) evaluation report shows the overwhelmingly positive impact of nutritional supplements on HIV-positive home based care clients not taking ARVs that also met household food insecurity criteria for targeted nutritional supplementation.
- 5) Even when approved, breaks in the Title II food supply pipeline have reduced the effectiveness of the response as temporary commodity shortages result in an incorrectly balanced nutrition and food ration.
- 6) Shortages of healthcare workers, including nutritionists, limit the time and ability of existing staff to provide food/nutrition counseling.
- 7) Cutbacks and elimination of Title II food programming have caused programs to revert to "length of time on ration" as exit criteria for people receiving food. FFP programs like C-SAFE and I-LIFE in southern Africa used other more successful measures of household food security to trigger transition and exit strategies. These programs helped families affected by HIV sustain their nutritional needs through agriculture or other income generating activities which will allow them to buy nutritionally valuable foods. In an environment of Title II resource cutbacks, programs do not have the ability to implement these strategies.
- 8) Infant and young child feeding has not been adequately addressed. USAID funded Child Survival programming is not well integrated with PEPFAR-supported Prevention of Mother To Child Transmission programs (PMTCT). Many partners follow pregnant women through antenatal clinics and then follow up with their

children with Child Survival and other health promotion programming. Lack of integration across USG funded programs has resulted in PEPFAR not exploiting antenatal clinics for counseling and testing of pregnant women, provision of identified HIV positive pregnant women with PMTCT services, and follow-up of children with more preventive services (cotrimoxazole prophylaxis) and infant and child feeding counseling (for the HIV positive mother) with provision of appropriate food supplements for mother and child. There are several missed opportunities in this sequence. Future PEPFAR interventions must provide resources for nutritional counseling for parents as part of an integrated package of services that bridge Child Survival and PMTCT.

Recommendations

Chairman Payne and members of the committee, CRS believes that access to food is a fundamental human right. It also is critical to maximizing the sizable and successful investment our government is making in responding to the needs of persons living with HIV. Catholic Relief Services submits the following recommendations to improve integration of nutrition and food security into the PEPFAR-supported programs:

- 1) *Provide a budget for food in PEPFAR* and revise the criteria for which patients can receive "Food by Prescription" so that more recipients will be eligible.
- 2) *Increase the Title II budget* in order to direct more funds and food commodities specifically for the purpose of providing nutritional support to PLHIV.
- 3) *Require greater collaboration, integration, and flexibility of USG programs and funding mechanisms* to meet the livelihood needs of the participants in PEPFAR-funded programs so that there can be longer term prospects for sustainability of people's nutritional status.
- 4) *Focus more broadly on assisting households to reduce food insecurity* by increasing livelihood strategies and approaches to sustain household security, in addition to addressing more community level systemic factors that contribute to poverty and food insecurity.
- 5) *Increase funding for OVC support*—including food basket to the household—to keep children in school and prevent the need for especially girl children to engage in transgenerational sex to meet their own and their family's food needs.

In conclusion, I want to once again thank you Chairman Payne, Ranking Member Smith and all members of the subcommittee for holding this hearing to respond to the nutrition needs of persons living with or affected by HIV and AIDS. Our recommendations are a sincere effort to improve the effectiveness of a PEPFAR program that is indeed saving lives and providing hope for millions. Thank you, Chairman Payne. I would be pleased to respond to any questions that the Committee may have.

Mr. PAYNE. Let me thank the panel very much for your testimony.

Ambassador Watson, if you are prepared, since you were not here for the opening statement, I would yield to you for questions at this time.

Ms. WATSON. And I just would like to thank you very much, Mr. Chairman, for continuing our focus and our priority through this subcommittee. It is very, very important that we stay focused on the HIV/AIDS epidemic which threatens the well being of millions of children in the developing world. In sub-Saharan Africa alone, there are more than 15 million children orphaned by AIDS and countless more affected by HIV/AIDS. With the epidemic eroding the capacity of families and communities to meet the needs of these orphaned and vulnerable children, they are especially high risk to a number of problems, and I think they have been articulated here by our witnesses, including hunger and malnutrition.

And so the strategies PEPFAR is using to address both short- and long-term food security and nutritional issues for these orphans and vulnerable children need to be broadened, and I would

just like to hear from all of you as to what you really need us to do. Now there has been a commitment of fund, but as far as I know, Mr. Chairman, you can correct me, only \$4.5 billion has gone forward. I remember several years ago, the President committed \$14 billion. As we negotiated through the committee, very little of that money has reached out. So I would like the three of you to tell us how we can assist you. You know the issues. You have articulated them. We have a program set up, and I think, Catholic Charities, you are there when needed. We appreciate that. But how can we further assist you?

Ms. REILLY. Thank you. The particular issue of orphans and vulnerable children is, of course, front and center to much of what we do, given their vulnerability at that young age. First of all, I would like to say that we are quite happy with the support from PEPFAR. It has been tremendous. We can't emphasize that enough. One of my fellow panelists acknowledged how life changing it has been, particularly for the ART recipients where you literally see somebody at that stage coming back to life. But we have also seen great support for OVC programming, as well. Nevertheless, of course, it can increase. We could always increase. The need is huge. So I think any kind of request for additional funding would be very, very welcome. We know we have the capacity as PVOs to reach out to more children. We know we do. It is limited resources.

Ms. WATSON. Specifically where should the funding go? Do we need more personnel? And I know the need for diet, food and so on and water, et cetera. Where would you like to see part of that money—

Ms. REILLY. I think it is hard to say specifically because every situation is different. What we would very much like to emphasize is flexibility and agility and respect for assessments done at the local level in terms of identifying needs. For example, a child, just as an adult living with HIV, isn't just an individual living in a vacuum. They are part of a household in the community. And we have seen in some circumstances, for example, that children are being very well taken care of in the community with some additional resources to help pay for school fees, some food support, that kind of thing. But we have also seen other areas in other countries where the child is not being taken care of by the community, you need even broader, farther reaching kind of support services. So I wouldn't want to say that anything very specific needs to be focused on in terms of the legislation or the authorization of increased funds, but that this overall approach we have been talking about today of increasing flexibility and agility around these different funding mechanisms, that that goes forward as well as an overall increase in funding.

Ms. WATSON. And kind of use the local models is what I am hearing.

Ms. REILLY. Building on local capacities.

Ms. WATSON. Exactly. And letting them with the resources then develop the programs that work best in their areas?

Ms. REILLY. Yes.

Ms. WATSON. Okay.

Mr. BERIYE I would say more funding needed for patients to have nutritious diets so that their medicines can really work. Patients

who are really going to clinics and we—they tell us that they don't have enough to eat, and for the medicine to work, they need this nutritious support. That is what they are telling us. Whenever they take the medicine without food, they tell us that it will come out. Whenever they eat, they are okay. And that is why we are saying that nutrition support is very important in this——

Ms. WATSON. Do you have sufficient medication?

Mr. BERIYE. Medication is better than the lack of nutrition. The medication is there. But what is lacking is the nutrition support.

Ms. WATSON. I understand. Thank you.

Dr. EINTERZ. If you doubled our funding, I would bet that we could cut this pandemic at its knees in the area that we cover in western Kenya. We could double the number of patients we are currently treating, and we would introduce an aggressive home-based counseling and testing program that would be key to preventing the pandemic's progression in the future as well as enable us to continue to respond to even more the needs of even more orphans and vulnerable children and households. I would agree wholeheartedly with what Ms. Reilly said, that flexibility is key and enabling the program at the local and regional level to determine how best to spend those funds.

Ms. WATSON. There is a great concern that I have, and probably it is joined by the chair as well, and that is educating the people. We are up against traditions and customs that have been long lasting in different parts of Africa. I know they have different concepts as how you eliminate AIDS. What role does education come in? Is it working? How do we get people to change their behavior? You talked about the women who went to the streets. How do we get to them and change their behavior? Any of you.

Dr. EINTERZ. I think the way to do that is to enable the community to engage with the problem, engage and embrace persons with HIV and AIDS which, first, of course, means slashing stigma and then, second, to really embrace the problem. And the solutions for this pandemic are out there, and they rest in the hearts and minds of the community.

Ms. WATSON. Are they getting them? That is my thought. Are they really getting them, the solution? How do we prevent?

Dr. EINTERZ. I think this is what treatment, both ARVs as well as nutrition, has enabled. So the two together have demonstrated to the community the power to control the epidemic, and that part has enabled us to slash stigma. And then as stigma diminishes, we are then able to get the community themselves or empower the community, if you will, to engage the problem. So it is a little bit of everything.

Ms. REILLY. I would agree it needs a comprehensive approach. And I would just emphasize to add to my fellow panelists, the need at the policy level, the government level to engage more directly and very publicly in the issue. We have seen evidence in Uganda where that level of engagement has made a difference. It doesn't mean that you can't have equal levels of engagement at the local level and regional levels, but in many parts of sub-Saharan Africa, we have seen at that policy level and governmental level, it has been lacking.

Ms. WATSON. What I sense is that our men throughout still are exhibiting the same behavior, and I think we are getting to the women because they understand that they are the ones who could pass it onto the unborn. And I am wondering how well we are getting the message over as to how to prevent the spread of AIDS. Anyone want to address that?

Ms. REILLY. I would just add, I am not expert on behavior change. I do know it takes time. It takes a tremendous amount of time. So that is one factor that we just have to keep—that longer-term horizon I think. There is also—I think what it comes down to fundamentally again is poverty and chronic poverty. You look at the particular situation of women in terms of their lack of empowerment in the household and in the community, in many respects, which leads to a higher rate—higher vulnerability level for them. But I think the point that I would like to make is just that the underlying cause is poverty. That we have to look at this issue comprehensively, also keeping the long-term perspective in terms of how long it does take to really change people's behavior.

Ms. WATSON. I also have been concerned about, say, big companies, oil companies, they go out to the villages, and they recruit workers to come in, and they keep them there for periods of 1 year or 2 years at a time. And the risk of spreading AIDS or catching AIDS seems to be enhanced by the amount of time they are away from their spouses. So I think there is some culpability, too, on the parts of businesses that go in and exploit the men, particularly in the villages, and then customs and traditions with the women also impact. So if we could really tackle and understand what to do to prevent, I think, in not just money but to go in and change the way people think about HIV and AIDS and how it is spread, we might be able to reduce the risk.

Ms. WATSON. Okay. Thank you very much, Mr. Chairman.

Mr. PAYNE. Thank you very much.

Let me ask, Ms. Reilly, you recommended that we require greater collaboration, integration and flexibility of U.S. Government programs and funding mechanisms to meet the livelihood needs of the participants in PEPFAR funded programs so that there can be longer-term prospects for sustainability of people's nutritional status. Would you elaborate on that? What programs are you referring to, and how should they be made more flexible?

Ms. REILLY. Thank you, Chairman Payne.

I think one example that immediately comes to mind is that of Title II Food for Peace resources being directed in particular countries to the most food insecure areas which makes perfect sense given their mandate. But with the way the PEPFAR program then rolled out where it was focused on the highest prevalence area, we basically had a disconnect happening. As Ambassador Dybul has mentioned, things are getting better, and we can, I think, acknowledge that. I do acknowledge that much of that was because of the rapid startup of PEPFAR and some of the intensity of just getting these programs started up in a high quality way. That took a lot of time and the energy of a lot of people. But it became very evident fairly quickly early on in these programs that there was a disconnect happening there. It is changing. We see that. We see that there is acknowledgement now on the part of Food for Peace and

PEPFAR that they need to look at this comprehensively. So we have high hopes. I think one aspect also that I would second in terms of a recommendation of Ambassador Dybul is that the decision making stay at the local and regional level as much as possible and not be made back here.

The mission staff know what is happening on the ground. They know the capacity of the PVOs. They know the capacity of local partners, and we think giving them a bit more flexibility and agility to figure out, you know, how to pull these various resources together to have the most comprehensive response would be very welcome.

Mr. PAYNE. Would you have also recommend that we focus more broadly on assisting households to reduce food insecurity by increasing livelihood strategies and approaches to sustain household security—in other words, should we be doing that with PEPFAR funds or should we be trying to improve linkages between PEPFAR and USAID livelihood programs or WHO programs or whatever?

Ms. REILLY. I think it is improving those linkages with a variety of actors, but I would also emphasize, as we have said here before your committee in the past, that we feel very strongly that additional resources need to go to Title II. They know food. They know what it takes, and it is a complicated business. We would rather see increased budget go to Title II than increasing or changing the PEPFAR budget to have PEPFAR get into the food business. Again, it is a complicated business. I think there is a role for PEPFAR in terms of very targeted nutritional supplement, but the larger kind of community focus—looking at a community based livelihood strategy—we would want to see increased resources going to Title II.

Mr. PAYNE. In many instances we transport U.S. agriculture products to our food programs, and those programs continue. Do you think if we could focus on purchasing locally that that would be a way to increase the availability of food since evidently food costs seem to be the big stumbling block? There is a strong support by the agriculture community that we continue to retain the manner in which U.S. agriculture products are disseminated in our food program. I am not suggesting we alter that. But if there could be funds made available because probably without transportation costs and perhaps buying in the region, you may be able to get two to three times as much for the cost. What do you think about that or any one of you?

Ms. REILLY. I would just agree absolutely that would be a very good use of resources. We have used our own private resources for example, to buy local commodities in Zambia to mix together to make a product called HEPS, high energy protein supplement, which is made specifically for people suffering from HIV. And there was even a group of HIV-positive women who mixed the commodities and bagged them and sold them. It is definitely an important option that we should keep in our arsenal.

Mr. PAYNE. Mr. Beriye, you mentioned that Project Concern provides food to school children and to women who are counseled and tested for HIV and AIDS. Where does your organization get the resource to carry out these activities?

Mr. BERIYE. The school programs were providing meals, are done together with WFP. WFP provides the food and project concern international provides the compliments of that so that the schools can have better capacity to enroll more orphans and more vulnerable children. On the other hand, we also provide nutritional support to children who are under 12 years of age and treatment in one region, and we get this from international food relief partnership, that is Food for Peace. So this is going to a specific group of people who are on RT. And that is really helping these people. But still the amount of resources that is approved is very limited, and we are addressing very limited group of people.

Mr. PAYNE. If you had additional funding, you think that you could expand your program, that the need is definitely there?

Mr. BERIYE. We have requested an additional resource that has been approved for 1 year, but the program is still a 1-year program and a limited resource with 75 metric tons of dehydrated lentils mixed with rice and carrots, and that is highly nutritious, but it is still very limited.

Mr. PAYNE. Let me ask—thank you. Let me ask any of you who might want to respond: Ambassador Dybul said a person with HIV/AIDS needs nutrition, but the neighbors need nutrition also, and that to provide it, you know, for the person that is infected with the virus was kind of alluding to the fact that, well, the neighbors would be a little disturbed. What do you think about that concept? Or how could that be worked on, or in fact, is that indeed a serious question?

Dr. EINTERZ. Yes. That, of course, is a problem that we come up with periodically. And it is a situation that we have faced on a number of occasions. It is expected, and I think a part of the solution, of course, is understanding that we are going to come up against it. To a large degree, we can address this again by engaging community leaders and opinion leaders in all that we do. And that is a necessary step. In addition, though, another side of this would be the nutrition itself for the family of the HIV-infected individual as well as for the HIV-infected individual, him or herself, likely not only benefits that individual, but likely as well benefits the community as a whole in the sense that they are becoming more economically productive, et cetera. And so I think there are ways to address it. We need to be cognizant of it and expect it.

Mr. PAYNE. Anyone else like to comment? Well, I think, as you said, we find that problem—for example, in a refugee situation where you do find—in Chad, you had Darfurians that went to Chad, and because they are refugees, they were provided for by the United Nations High Commission for Refugees. The people in that region were also very poor, so it created a problem and a situation. However, I think that, in all these instances, I think we are able to, through education and even sometimes sharing, not refugee commodities, but somehow to involve the community in understanding and maybe some partnership, I think the program problems can be eliminated.

I just wonder, Dr. Einterz, what is it about your program that makes it work? In other words, how were you able to establish an HIV/AIDS care system in 6 years that serves so many people so

comprehensively, and what lessons should the United States Government be learning from the AMPATH example?

Dr. EINTERZ. I think there are a number of reasons why our program has been successful. As I mentioned in my testimony, it is rooted in academic partnership between institutions here in the United States of medical schools and a medical school in Kenya and a teaching hospital in Kenya. So we have engaged most the ministry of health and the ministry of education at the institutional level, and so that is a very important—one very important reason. The second reason is that the Kenyans—the Kenyan leadership is incredibly talented. They are gifted, and they can do this if given the tools to do it. And I think we have—we, Indiana University and our partners here in the United States, have served as catalysts. But by and large, the vast amount of work has been done by our Kenyan colleagues, and they have done a wonderful job of it.

Mr. PAYNE. There are critics who suggest that perhaps the AMPATH model is too unique and too costly to replicate. What do you say about that?

Dr. EINTERZ. Not having seen any cost figures, but I can treat somebody for \$1 a day. We do in our program. And I think in fact we are relatively cost-effective. I think that the lessons that AMPATH have shown indeed are replicable, and the nutrition program would be one example of that. I think as well that quite a number of other academic institutions could join with their counterparts in sub-Saharan Africa to do the same sort of thing we have done. It is true that much of our relationship was in place before we embraced the HIV problem, but the basic principle, that is one of developing counterpart relationships based upon mutual trust and mutual respect I think are very much replicable. What we have done in AMPATH is we have purposefully set out to create a care system that would host the research and training mission of any academic medical center. And that also I think is replicable. We are not suggesting every care system needs to host the research and training mission. But what we have been able to do is create one, an alpha program, if you will, that can do that and to a degree that may in fact be more costly than other programs, although I have yet to see those numbers to prove that. In fact, I think in many ways by the virtue of the fact that we are so comprehensive, by virtue of the fact that we are bringing up—we, especially my Kenyan colleagues are bringing up leadership for the next generation of Kenyans, in fact we are going to be less costly than almost every other program out there.

Mr. PAYNE. So one of the important components of a successful program is the local acceptability and talent to do the program. Would you, therefore, say that there are places where it would be very difficult to move the program along?

Dr. EINTERZ. First, I think there is an inherent power, a latent power that we recognize within our own academic medical centers here in the United States that by and large is not realized in much of sub-Saharan Africa. And yet it is there. It is there, and if it can be awakened, it can be a wonderful asset for virtually every country in sub-Saharan Africa. I am sorry. I caught—

Mr. PAYNE. When you mention all of the needs and even, I think, you did also Dr. Einterz, the need for sanitation and clean water, the question of nutrition and someone was going over the number of problems we have. You know, I think it was President Thabo Mbeki who talked about the fact that there was—with the debate as relates to HIV and AIDS, was saying that this is just another problem that should be handled just like other problems because he did—I think what he was trying to say is that healthcare system itself is inadequate and that there needs to be assistance from World Health or U.N. related agencies to try to fix the healthcare system in general. And I just wonder if anyone wants to comment on that. Yes?

Ms. REILLY. Yes, I can see the point he was making, and I agree with it, that there is a fundamental problem with healthcare, in the healthcare system in sub-Saharan Africa, particularly, and in many developing nations as well. And we see it in AIDS Relief in terms of sustainability, the longer-term sustainability of the program. To whom do we hand patients over ultimately if not to a government clinic, government-supported clinic or another kind of clinic that can maintain the long-term sustainability of that program and support to that patient? So it definitely is an issue, and we are grappling with it today. And there are some places, such as South Africa, where actually we can hand over patients, and we are. We have a very good partnership with the government, but there are other countries where they don't have that capacity, and we need to look at that more carefully as we go on in terms of the longer-term sustainability of the program. Nevertheless, HIV and AIDS, the pandemic itself is unique. It is powerful. It is having a tremendous impact on communities, and it is also contributing to even more poverty. So it has to be looked at in and of itself as a particular phenomenon but within the larger phenomenon of poverty. So you do have to look at systems for the most comprehensive response to this.

Mr. PAYNE. Mr. Beriye, would you concur regarding the capacity of the healthcare system in general? You have been saying Ethiopia needs to have a transformation through a number of areas to deal with health in general.

Mr. BERIYE. The healthcare system—I don't—I didn't try to say that it is well established and it can take care of everything. But the worst problem we are facing is, of course, nutrition. The healthcare system—there are gaps that are not being decentralized to the local level, and that has to be established far better, and systems should be really—have to reach to the ground level. And we are also faced with trained manpower, which is a critical issue with the health system of the country. And that is also a critical system. When you compare the number of health professionals with the number of—the population, that is really a tremendous gap, and one area that can be looked at is the strengthening the capacity of the health system.

Mr. PAYNE. Well, we couldn't agree with you more, and I think that that is an area that our committee is interested in, the healthcare system, the healthcare professionals, many of the problems we have with the—even safe blood, for example, is something that we need to deal with because many instance—in some in-

stances, transmission of the virus happens through that mechanism. So we certainly realize that there is a tremendous amount of work to be done. The whole question of health professionals, sometimes we create with some of our programs, programs that siphon off healthcare professionals from the local government, the local national programs and leave the local programs at a disadvantage because of perhaps higher salaries with an internationally run program. So we have a number of problems. There is no question about it. We are going to continue to grapple with solutions. We certainly don't have them yet, but we are going to strive toward attempting to come up with solutions. We have had 16 hearings so far, 17 hearings to date by the subcommittee. We do intend to take up other issues. We have dealt with potable water. We have dealt with the whole question of climate change. We have dealt with nutrition. We will talk about education, higher education. So we intend to try to come up with solutions to certainly try to educate our constituency in this country about the need.

And once again, I certainly appreciate the valuable testimony that each of you was able to give us today. And before I adjourn, I would like to acknowledge the Ambassador from Lesotho, Ms. Rapolaki.

Thank you for being with us.

And Ambassador Diakite of Angola is also here. Thank you. Very nice to see you.

We would certainly like to, once again, thank the witnesses, and I ask unanimous consent that a written statement submitted by Wendy Johnson, director of the New Initiatives Health Alliance International be a part of the hearing record. Hearing no objection, so ordered.

Thank you very much. The meeting stands adjourned.

[Whereupon, at 3:54 p.m., the subcommittee was adjourned.]

A P P E N D I X

MATERIAL SUBMITTED FOR THE HEARING RECORD

STATEMENT FOR THE RECORD FROM MS. WENDY JOHNSON, M.D., MPH, DIRECTOR OF
NEW INITIATIVES, HEALTH ALLIANCE INTERNATIONAL

Mr. Chairman and members of the Subcommittee:

On behalf of Health Alliance International, I would like to thank Congressman Payne for this opportunity. I would also like to commend the Congressman and the Committee for recognizing the vital importance of this issue as Congress begins its deliberation on the reauthorization of the PEPFAR program.

I am a public-health physician who has been working in underserved communities since graduating from medical school over 10 years ago. From 2004 to 2006, I worked for Health Alliance International (HAI) in the central provinces of Mozambique, supporting the Ministry of Health in its effort to scale up HIV treatment services. HAI is one of the largest PEPFAR partners in Mozambique. Through the government public health system, we support 11,000 people on anti-retroviral treatment in 40 HIV treatment centers. Through antenatal care clinics, we help provide HIV testing for pregnant women and treatment for those infected, helping them to protect their children from contracting the virus, and by treating their illness, to raise those children in good health.

More than one in six Mozambicans is estimated to carry the virus in their blood, one of the highest prevalence rates in the world. The country's population is also overwhelmingly poor, about half of them living in conditions of absolute poverty or severe deprivation, with inadequate access to water, sanitation, shelter, health, and nutrition.¹ More than half of children under 2 years of age have their physical and psychological development compromised by insufficient food intake.² The spread of HIV in Mozambique, then, is no mystery. It is impossible to understand the tenacity of this plague, let alone to counteract it, without understanding and addressing the attendant plagues of poverty, hunger and the array of other illnesses that combine to make life precarious.

Others have submitted testimony to this Committee addressing the importance of nutritional support in HIV treatment more generally. HIV infection compromises the nutritional status of those who are infected and, in turn, poor nutritional status can further the progression of HIV. I would like to address the importance of nutrition and food support for HIV-positive mothers. The fastest-growing infection rates of HIV in Sub-Saharan Africa are in women of childbearing age. Pregnant women's nutritional needs are greater than those of the general population. If women do not receive adequate nutrition during pregnancy, their immune systems are weakened, making them more vulnerable to concurrent infections such as malaria or tuberculosis, and contributing to a faster progression of HIV. It is probably the case that undernourished HIV-positive mothers, like those with malaria and other co-infections, are more likely to pass the virus on to their children during pregnancy or during breastfeeding.

HIV positive women in Mozambique and many other poor countries must choose between formula supplementation and breastfeeding during the first 6 months of life before children can take solid food. Infant formula, however, is problematic in many locations: formula is expensive and inaccessible for most women and water supplies (needed to mix with dry formula) are unsafe—formula-fed children may be

¹ UNICEF. Analysing Child Poverty in Mozambique. 2004. available [http://www.unicef.org/evaluation/files/fa5_mozambique_analysing_chid_poverty\(1\).doc](http://www.unicef.org/evaluation/files/fa5_mozambique_analysing_chid_poverty(1).doc)

² Mozambique Comité de Analyse de Vulnerabilidade. Emergency Vulnerability Report. November–December 2002. Available <http://www.odi.org.uk/Food-Security-Forum/docs/Dec2002VAC.pdf>.

more likely to die from water-borne, diarrheal diseases than breast-fed children are from AIDS transmitted through breast milk.³ Thus, the infant children of HIV-positive women in countries like Mozambique greater risk not only of contracting HIV, but diarrheal disease as well. If mothers are undernourished, both of these risks are magnified.

Because the risk of transmitting HIV through breast milk increases significantly after the first six months of life, current guidelines call for HIV-positive mothers to wean their children at that time if possible. In a study we conducted in central Mozambique, most mothers were unable to provide sufficient food for their children after weaning at six months. This makes their children more susceptible to all illnesses, and for those that were HIV-infected, more likely to progress to full-blown AIDS. Many HIV-positive mothers in Sub-Saharan Africa and other poverty-stricken regions face an impossible choice—continue to breastfeed knowing that the risk of passing HIV to their children rises every month, or wean their children knowing that they cannot adequately feed them without breast milk. It is quite possible that the additional burden of malnutrition contributes to the high mortality rates of HIV-positive children under 2 years of age, which is over 50 percent in Mozambique.

In conjunction with the Ministry of Health, HAI has been coordinating with the World Food Program to provide nutritional supplements to people receiving antiretroviral treatment. This program, however, is not designed for the specific needs of pregnant women (most of whom do not yet need antiretrovirals) and food supplies are unreliable. Since any sustainable intervention against HIV is dependent on the prevention of transmission, including preventing transmission of HIV from mothers to children, the need to find, and fund, better solutions is urgent.

In Mozambique and elsewhere, the PEPFAR program has led to extraordinary advances, offering lifesaving intervention for thousands of individuals and leading to real improvements at the population level. But while encouraging, experience over the last four years have shown that future achievements will require a broadening of our understanding of the problem to be addressed. Biologically speaking, HIV is a single pathogen but from a public-health perspective AIDS is an interdisciplinary sickness, a “synergy of plagues.” It should be common sense that being adequately nourished—not suffering from hunger—is a prerequisite for health, yet very few people in many parts of Africa know the luxury of having enough food most of the time. In the case of pregnant women with HIV, providing food support helps to both treat and prevent HIV disease for mothers and their children. Food is a necessary component of treatment for mothers and HIV-positive children. Good nutritional support and safe water supplies for pregnant and breastfeeding women can potentially help prevent transmission to their newborns. Expanding the flexibility of PEPFAR funds to cover nutritional support for people living with HIV and their families; including pregnant women, mothers and infants; could be decisive in determining the success or failure of America’s contribution to the global struggle against HIV.

Thank you very much for allowing me to submit this written testimony on behalf of Health Alliance International. We welcome the opportunity answer questions or provide more information to the Committee or any of its members.



³Kuate Defo B. Causes et déterminants de la mortalité avant l’âge de deux ans en Afrique subsaharienne. Application des modèles à risques concurrents. *Cahiers Québécois de Démographie* 1997 Spring; 26(1): 3–40.