



**By**

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**of**

**CATHOLIC RELIEF SERVICES**

**Written Testimony**

**Before**

***THE U.S. SENATE FOREIGN RELATIONS COMMITTEE***

***Joseph R. Biden, Jr., Delaware, Chairman***

**“Perspectives on the Next Phase of the Global Fight  
against AIDS, Tuberculosis, and Malaria”**

**December 13, 2007**

Good afternoon Chairman Menendez, Ranking Member Lugar and Members of the Committee. I commend you for calling this timely hearing and giving Catholic Relief Services the opportunity to share our experiences as an implementer of the President's Emergency Plan for AIDS Relief (PEPFAR) programs.

My name is Ken Hackett, President of 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 in the developing world. CRS has supported HIV and AIDS interventions for more than 20 years, almost since the beginning of the pandemic. Our 250 HIV and AIDS projects in 52 countries provide comprehensive and holistic services for orphans and other vulnerable children (OVC), home based care, antiretroviral therapy (ART), other treatment support, education for religious leaders on HIV and AIDS and stigma reduction, and prevention education for sexually transmitted HIV—focusing on promotion of abstinence and behavior change.

### **Successes of PEPFAR**

First and foremost, let me say that PEPFAR is one of the most outstanding programs our government has ever created. Strong leadership and broad bipartisan support have shown the best possible face of the US government towards our world neighbors, and reflect the overwhelming compassion and generosity of the American people towards those affected by HIV and AIDS.

And above all, PEPFAR is working. In a relatively short time, this massive new program was put in place and is literally saving lives everyday.

I remember returning to Kenya in 1992 after a seven year absence, and hearing that so many of the Kenyans I had known had died. When I asked why, I was told it was tuberculosis, or pneumonia. But when I probed a little deeper, I found they had died of AIDS. It was absolutely shocking. In those days, AIDS was a death sentence.

In contrast, just two weeks ago, during a World AIDS Day commemoration, President Bush embraced someone the Washington Post called “a regal-looking Zambian woman.” Her name is Bridget Chisenga, but everybody who knows her calls her “Auntie Bridget.” She works for CRS in Zambia promoting adherence to ART and fighting stigma associated with HIV. She gave President Bush a message that seemed to move him: “I’ve seen the Lazarus effect,” she said. “I have seen hopes being raised. I have seen people coming back to life. And my message is, ‘We are celebrating life to the fullest.’”

But Auntie Bridget is not just a crusader and implementer for PEPFAR — she is also receiving the same antiretroviral therapy as the people she counsels. Without PEPFAR, Auntie Bridget would not be alive. She is a beneficiary of the PEPFAR transformation.

Now PEPFAR is providing life-saving ART for nearly 1.5 million men, women and children in 15 countries in Africa, Asia and the Caribbean. It has supported outreach activities to more than 61.5 million people to prevent sexual transmission of HIV. It is providing care and

support for more than 2.7 million orphans and vulnerable children, and more than 4 million people living with HIV and AIDS<sup>1</sup>. This is nothing short of astounding! This miracle is being repeated thousand of times as antiretroviral therapy provided through PEPFAR is bringing hope where there was none. A complicated medical solution is now available to the poorest and most vulnerable people living in very remote areas.

And there are other benefits as well. This successful treatment offered through PEPFAR has actually become part of the prevention strategy. The fact that people are beginning to live with this disease, returning to their families and resuming their livelihoods, has reduced stigma in communities and has encouraged others to get tested for HIV.

### **Catholic Relief Services Experience with PEPFAR**

Mr. Chairman, members of the committee, CRS has responded to the emergency of the HIV and AIDS pandemic as we do in all our emergency responses—with deliberate local capacity building of existing partners and with an eye towards long-term sustainable development.

CRS' work is built on a vision rooted in the Church's teaching that values human life and promotes human dignity. The local Catholic Church is often our primary partner, and we work at the invitation of the local Catholic Bishops' conference in each country. However, we also work with partners of other faiths, as well as other nongovernmental and local community-based organizations to serve people based solely on need, regardless of their race, religion or ethnicity.

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<sup>1</sup> From "Statement of Ambassador Mark Dybul U.S. Global AIDS Coordinator Before the Committee on Foreign Relations, United States Senate, Washington, DC, October 24, 2007.  
<http://www.senate.gov/~foreign/testimony/2007/DybulTestimony071024pp.pdf>

CRS works through local church and religious partners because of their extensive network and reach. Every community in the world has a community of faith with credible leadership. Working with them and other local community-based organizations assures that programs are grounded in the local communities' reality. Equally important, this extensive network of contacts ensures the widespread delivery of comprehensive HIV treatment, prevention, and support programs.

HIV and AIDS programming is a major priority for Catholic Relief Services. Our FY 2008 HIV and AIDS budget of \$171 million will account for nearly a third of the agency's annual programmatic expenses overseas.<sup>2</sup> With projects in 12 of the 15 PEPFAR focus countries, we are a major implementer of PEPFAR programs.<sup>3</sup>

Our largest PEPFAR award—AIDSRelief—is a \$335 million CRS-led consortium that includes the Institute of Human Virology of the University of Maryland, Constella Futures, Catholic Medical Mission Board, and IMA World Health. AIDSRelief provides ART in nine PEPFAR focus countries by building the capacity of 164 local partners—the majority of them local faith-based health care providers. As of 31 October 2007, over 90,000 people are on ART and almost 146,000 are enrolled in care and support services. AIDSRelief has exceeded its overall targets each year of the grant to date.

Our model of care trains and mentors local physicians and healthcare staff to better manage high quality treatment services to a growing number of patients. These locally trained

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<sup>2</sup> 57% (\$98 million) projected to come from PEPFAR.

<sup>3</sup> Ivory Coast, Namibia and Mozambique are the only PEPFAR focal countries where CRS does not have PEPFAR programs —because we do not work in those countries at this time.

community health workers and volunteer and paid treatment coaches and expert patients are expanding follow-up and support services for stabilized patients in the community. Many of the healthcare institutions we support now are exhibiting their growing capacity to access resources through the Global Fund locally and through other international donors. However, it will be a long time before the poorest countries of the world can completely and independently take on this burden. Until then, providing these vital services through PEPFAR is the right thing to do.

More than half of the AIDSRelief treatment sites are in rural areas where ART services would otherwise be unavailable. In war torn northern Uganda, where moving around safely is difficult, AIDSRelief is one of the few organizations supporting ART through local faith-based institutions. For the past two years, AIDSRelief has partnered with Dr. Ambrosoli Memorial Hospital in Kalongo where 302 patients are on ART and 1,246 receive care. And in Kasesse District, a remote mountainous area in western Uganda, AIDSRelief was the first to support the delivery of antiretroviral therapy in a health center run by the Banyatereza Sisters. Often walking long distances, the Sisters have developed an extensive community outreach program reaching 324 patients on ART and 725 in care. Without PEPFAR, these people would not have access to this life-saving treatment. In fact, without the ministry and care of this faith-based hospital and this religious community, the local population would probably not have access to health care at all.

Catholic Relief Services currently operates a \$9 million, 5-year, PEPFAR-supported Orphans and Vulnerable Children Program that provides quality services to children in Botswana, Haiti, Kenya, Rwanda, Tanzania, and Zambia. As of 30 September 2007, this

program is reaching 56,066 OVC, exceeding cumulative FY07 targets. The program provides education and vocational training, health care, psychosocial support, food and nutrition, protection services, shelter and care, and economic strengthening.

Our third PEPFAR central award addresses prevention of sexually transmitted HIV programming through age-appropriate abstinence and behavior change among youth in three focus countries—Rwanda, Ethiopia, and Uganda. Drawing upon extensive experience in HIV prevention in the target countries, as well as similar programs in more than thirty other CRS prevention programs worldwide, the “Avoiding Risk, Affirming Life” prevention program works with a broad range of faith- and community-based partners that share CRS’ commitment to equip youth with the values, attitudes, skills, and support to either abstain from sex prior to marriage or recommit to abstinence before marriage, and then to remain faithful in marriage. As of 30 September 2007, the program has provided 346,768 youth and adults with information to help them make informed decisions about sexual behaviors and encourage health seeking behaviors.

In addition to these PEPFAR central awards, we also have received numerous country-specific Mission level grants to provide more or additional HIV services.

### **Challenges and Recommendations**

PEPFAR programs in which CRS is involved have all been successful—often exceeding their targets. They have all faced numerous challenges—and overcome them. However, there are certain broader and more systemic challenges that need to be addressed by Congress as it prepares to reauthorize PEPFAR.

- **Prevention.** HIV infection in Africa is driven mostly by sexual transmission. The prevention of sexually transmitted HIV through promotion of abstinence (delay of sexual debut) and fidelity (partner reduction) is promoted by the Catholic Church and other religious health providers. Current PEPFAR legislation specifically allocates funds for abstinence and behavior change as part of wider ABC approach. As a result, CRS and other religious organizations have been able to expand their prevention programs. Prior to PEPFAR virtually no funding for abstinence and faithfulness was available.

There is widespread consensus among public health experts that fidelity and abstinence are necessary components of any comprehensive approach to reduce the spread of AIDS.

Evidence has shown that condoms alone are insufficient for a generalized epidemic.<sup>4</sup>

According to the Centers for Disease Control and Prevention (CDC), the surest way to avoid transmission of HIV is to abstain from sexual intercourse, or to be in a long-term mutually monogamous relationship with a partner who is known to be uninfected. For persons whose sexual behaviors place them at risk for HIV, correct and consistent use of latex condoms can reduce the risk of HIV transmission. No protective method is 100 percent effective, however, and condom use cannot guarantee absolute protection against any STI, including HIV. In order to achieve the protective effect of condoms, they must be used *correctly* and *consistently*.

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<sup>4</sup> Halperin DT, Epstein H. Concurrent Sexual Partnerships Help to Explain Africa's High HIV Prevalence: Implications for Prevention. *The Lancet* 2004; 363: 4–6.



Partner reduction is considered to have been the single greatest factor in reducing HIV prevalence in Uganda,<sup>5</sup> with an estimated 65% decline in the number of people reporting non-regular partners between 1989 and 1995.<sup>6</sup> Data show that the majority of Africans already practice A or B behaviors and that these behaviors are thus realistic for most people. In African countries for which Demographic and Health Surveys were available, an average of 77% of men and 97% of women ages 15 to 49 had 0 or 1 sexual partners in the past year; and 59% of unmarried young men and 68% of unmarried young women ages 15 to 24 were abstinent in the past year.<sup>7</sup>

The promotion of abstinence-until-marriage and mutual fidelity within marriage has long been the cornerstone of CRS' HIV prevention programming. Abstinence and mutual fidelity reinforce the precise values and norms necessary for mobilizing people to avoid risk, and for reversing the epidemic.<sup>8</sup> In short, these approaches work and work well. Without designated funding these excellent programs will be under-resourced and the high quality faith-based health structures and services in PEPFAR countries will be sidelined in the battle against HIV.

- **Certain Add-on Services:** We are similarly very concerned about efforts to define “comprehensive services” for HIV positive women as necessarily including family planning and reproductive health services. CRS regrets these efforts and asks that such proposals be

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<sup>5</sup> Green, E. 2003. Testimony at Harvard University before the African Subcommittee, U.S. Senate.

<sup>6</sup> Low-Beer, D. and R. Stoneburner. 2003. “Behavior and communication change in reducing HIV: Is Uganda Unique?” *African Journal of AIDS Research*. 2: 9-12.

<sup>7</sup> Demographic and Health Surveys. Available at [www.measuredhs.com](http://www.measuredhs.com)

<sup>8</sup> CRS. 2004. “AB Narrative Final for PEPFAR AB Grant.” Baltimore.

rejected. Moral tenets of religious organizations like Catholic Relief Services prevent them from offering these “comprehensive services.” Our experience is that high quality care, treatment, and prevention can be provided without these additional services. If these services were mandated or given preferential treatment in awarding PEPFAR funds, then Catholic Relief Services and other religious implementers would be unable to participate in PEPFAR. Patients served through our networks, especially in the poorest, most remote areas of the globe, would face interrupted therapy or even cessation of life-saving therapy for lack of qualified providers.

- **Lack of Nutrition and Food Security:** Lack of food—or the money to buy it—is the number one concern expressed by ART patients, OVC and their households. 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 lead to poor nutrition, lack of food, hunger and food insecurity. Women and children are disproportionately affected.

The low nutritional status of many ART patients compromises the effectiveness of their medications. To fully benefit from ARVs, many patients need therapeutic feeding for a limited period of time. PEPFAR provides funding through USAID for therapeutic feeding, through a pilot program called “Food by Prescription.” The program has very clear biometric indicators for determining patient eligibility. However, this program is not available to all due to insufficient funding. Expansion of “Food by Prescription” to all PEPFAR countries providing ART, with commensurate increased funding, is desperately needed.

The majority of CRS' 250 HIV and AIDS projects that target food insecure people living with HIV as well OVC include an integrated food element. Where possible, CRS partners with USAID Title II Food for Peace (FFP) and the World Food Program (WFP) to provide necessary food and nutrition. Where public resources are not available, CRS uses private resources to meet this need. In addition, CRS supports increased funding for nutrition support in ART programs. Congress needs to evaluate on a priority basis with the Office of the Global Aids Coordinator (OGAC) and USAID the requirements for additional food aid resources.

- **Healthcare Workforce:** Care and treatment involves complex interventions that can either strengthen or weaken the health care systems in PEPFAR countries. The pandemic has greatly stretched the existing healthcare workforce, especially professionals—doctors, nurses, and pharmacists. Many AIDSRelief local partner treatment facilities will soon be unable to serve additional clients because of the lack of trained staff. PEPFAR needs to provide additional resources to increase the number of healthcare professionals, appropriately train for task shifting of care and treatment, as well as provide for training, supervision and remuneration of other non-professional community and volunteer healthcare workers
- **Commitment to Meeting Pediatric ART Targets:** HIV is eroding gains made in child survival. Mortality and morbidity is high: 50% of HIV infected children below two years of age die without care and ART. In order to improve the outcome of pediatric HIV infection, programs that address prevention of maternal to child transmission (PMTCT) need to be

strengthened and a definitive diagnosis of HIV-exposed infants needs to be made as soon after birth as possible. Moreover, health care professionals will require additional training in order to provide care and treatment for infected children and care; pediatric ARV formulations are not readily available, and affordable pediatric treatment programs need to be put into place.

PEPFAR is results-driven and implementers of antiretroviral therapy (ART) projects are evaluated based on their ability to deliver ART to specific targets—10-15% for pediatric ART. Achieving this target is challenging for a number of reasons. Pediatric ART dosing according to complicated regimens based on changing age, weight, and height of growing children is very challenging. Also, pediatric formulations are more expensive than ART regimens for adults. Implementers are more likely to initiate adults on ART because it is easier and cheaper and thus they are more likely to achieve their “number of people on ART” targets.

If PEPFAR implementers are to meet or exceed a 10% pediatric ART goal, as they should, they will need targeted funding.

- **High Numbers of Orphans and Vulnerable Children:** 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. A most disturbing phenomenon is the reality of young girls forced into transgenerational sex to meet their own and their family’s food needs. Younger children of school age often never even start school. Those lucky enough to

attend school often don't have enough to eat. Linkages with WFP in Tanzania and USAID FFP in Kenya and Haiti enable us to provide critical nutritional support for these children. As Congress reconsiders PEPFAR reauthorization, there is an urgent need for increased funding for OVC support as well as a requirement to systematically link PEPFAR programming with food programming. Unfortunately, in other countries, rigid regulations, program requirements, or other bureaucratic problems have made it impossible to link PEPFAR OVC support with other funding for nutrition, education or other critical needs.

As Congress reconsiders PEPFAR reauthorization, there is an urgent need for increased funding for OVC support as well as a requirement to systematically link PEPFAR programming with food, education, and other programming.

- **Complicated PEPFAR Funding Mechanism:** The number of USG agencies involved in PEPFAR, the multiple levels of programming and budget consultation, decision-making, and grant management procedures (Central and Mission-level), and the number of countries involved, all contribute to increased costs and complicated/cumbersome reporting, cash disbursement, and decision-making. The CRS-led AIDSRelief ART project is a centrally awarded 5-year cooperative agreement through HRSA, but administered in the field by both CDC and USAID. Since year 2, a static portion of AIDSRelief funding continues to be obligated centrally through HRSA, while another increasingly larger portion is awarded each year through the Country Operating Plan (COP) at the local USG Mission. The onerous COP process combined with late obligation of funds causes particular challenges for implementing partners in the field 10 months of the year.

Furthermore, since we cannot predict out-year resources in the context of the current “annually renewable commitment” COP funding mechanism, long-term planning is extremely difficult. This affects the confidence of our partner sites to continue expanding their activities to meet their targets. As a result, many sites have taken a very conservative approach to scale-up due to fears that funding will be reduced or cut, and will result in the sites themselves needing to bear ongoing treatment costs—which most cannot afford.

PEPFAR needs to institute multi-year funding for multi-year awards; strengthen the centralized funding mechanism,; change the funding cycle to correspond to the fiscal year, and streamline/standardize the COP process.

- **The Global Fund:** Through Round 7, only 5 – 6% of the total funding channeled through the Prime Recipients (PR) of the Global Fund for AIDS, TB and Malaria (GF) were faith-based organizations. Even including sub-recipients of Government or secular prime recipients, less than 15% of GF-support programs are faith-based organizations.<sup>9</sup> The nascent “dual track” financing mechanism hopes to put civil society on equal footing with national governments in the country coordinating mechanism (CCM)—Churches Health Association of Zambia is a poster-child for this innovation. However, the idea of pairing an NGO principal recipient with a government one is only a recommendation by GF to national CCMs. Religious health care providers account for 30 – 50% of health care services done in

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<sup>9</sup> “Distribution of Funding after 6 Rounds” on [http://www.theglobalfund.org/en/funds\\_raised/distribution/](http://www.theglobalfund.org/en/funds_raised/distribution/)

many developing countries—up to 70% in some countries.<sup>10</sup> Many religious health care providers report that they do not have access to the CCMs to help plan and achieve the national plan responding to AIDS, TB, and malaria. The huge potential of religious health care providers is not being adequately recognized and engaged in the fight. Since the US government is providing one-third of the resources for the Global Fund, Congress should take steps to make sure that local religious health care providers are meaningfully engaged in their countries' CCM and adequately resourced to participate in achieving their countries' national plan. This will insure the most productive allocation of scarce resources to achieve the maximum impact possible in terms of lives saved and protected.

## **Conclusion**

Finally, CRS strongly supports increased funding for PEPFAR—above \$30 billion. The program, however, must maintain its focus on HIV, malaria, and TB and should not be expected to fund the many other related development needs that poor HIV-affected communities have. Similarly, an expanded PEPFAR must not come at the expense of urgently needed increases in other core poverty development accounts, including Child Survival, Title II Food for Peace, agriculture, and microfinance.

I would like to once again express my appreciation to Chairman Menendez, Ranking Member Lugar and all the members of the Committee for calling this hearing to discuss the next phase of this highly successful program. We urge timely reauthorization for this initiative that preserves the best and most effective elements of this program that is so vital for the health of

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<sup>10</sup> African Religious Health Assets Programme. 2006. *Appreciating Assets: The Contribution of Religion to Universal Access in Africa*. Report for the World Health Organization. Cape Town: ARHAP, October 2006.

some of the world's poorest and most vulnerable people. We and our partners stand ready to continue and expand the lifesaving work that PEPFAR has enabled us to accomplish. I would be happy to respond to any questions the Committee may have.



**Table 1: CRS-led AIDSRelief ART Patient Enrollment (as of October 31, 2007)<sup>11 12</sup>**

Country	Current # of LPTFs*	Current # of Patients on ART	Current # of Pediatric Patients (<15 years old) on ART (% of total)	% of total PEPFAR-funded ART patients who are enrolled through AIDSRelief**	Cumulative # of Patients in Care
Guyana	3	524	47 (9.0%)	22%	1,462
Haiti	8	2,347	479 (20.4%)	18%	7,471
Kenya	20	17,795	1,808 (10.2%)	11% ***	38,499
Nigeria	22	11,706	492 (4.2%)	10%	31,819
Rwanda	13	1,553	155 (10.0%)	5%	3,174
Shared w/ MAP	5	1018	76 (7.5%)	--	3,126
South Africa	26	12,900	1,092 (8.5%)	6%	30,523
Tanzania	31	13,825	993 (7.2%)	16%	35,993
Uganda	16	13,788	1,037 (7.5%)	17%	49,133
Zambia	14	15,407	990 (6.4%)	11%	35,242
<b>TOTAL</b>	<b>153</b>	<b>90,638</b>	<b>7,169 (7.9%)</b>	<b>11%</b>	<b>233,699</b>

\* LPTF = Local Partner Treatment Facility

\*\* This column calculated based on September 30<sup>th</sup> 2007 PEPFAR and AIDSRelief data

\*\*\* This is also the total % of patients on ART in Kenya.

<sup>11</sup> “World AIDS Day 2007: The Power of Partnerships,” Factsheet. PEPFAR, U.S. Government, December 1, 2007 available at: <http://www.pepfar.gov/documents/organization/96070.pdf>

<sup>12</sup> “HRSA Monthly Report, October 2007” Approved report available at: S:\PQSD\ART Program\AIDSRelief Reports\Monthly Reports (HRSA)