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**BEFORE THE U.S. HOUSE COMMITTEE ON FOREIGN AFFAIRS**

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Full Committee Hearing on  
“PEPFAR Reauthorization: From Emergency to Sustainability”

WRITTEN STATEMENT

Mr. Chairman, Ranking Congresswoman Ros-Lehtinen, Members of the Committee. Thank you for the opportunity to join this important discussion on the reauthorization of the President’s Emergency Plan for AIDS Relief or PEPFAR. There are many reasons to be proud of what PEPFAR has accomplished. The devastation of the HIV pandemic at the dawn of the 21<sup>st</sup> century demanded an urgent response, and the U.S. government rose to that challenge – demonstrating vital leadership, taking determined action and investing unprecedented resources. I congratulate the U.S. government on its leadership, and applaud President Bush’s pledge to amplify the U.S. government’s commitment to fighting HIV and AIDS.

I welcome the keen interest that Members of Congress have shown in the oversight of PEPFAR’s performance and in the development of PEPFAR’s successor. Your engagement is critical: PEPFAR is a precious resource and we must be absolutely sure that its investments will yield optimal, long-lasting results. This moment – of looking back at PEPFAR’s past and looking forward to its future – calls for a spirit of openness, honesty and collaboration. It is in that spirit that I engage with you today.

I speak today on behalf of CARE, an international development and relief organization that has worked for more than 60 years in some of the poorest communities in the world. CARE began working on HIV and AIDS twenty years ago. We now address HIV and AIDS in over 40 countries with support from a range of public and private donors and a multi-year portfolio of HIV and AIDS programs totaling \$183 million. CARE works in 11 out of the 15 PEPFAR focus countries and in four of the five non-focus countries that receive more than \$10 million annually from PEPFAR. CARE's approach to HIV and AIDS is typically community-based and multi-sectoral. We address HIV and AIDS comprehensively as part of the broader landscape of poverty, and focus on addressing the vulnerability of women and girls to HIV and AIDS.

### **FROM EMERGENCY TO SUSTAINABILITY**

When PEPFAR got started, confronting HIV and AIDS with the urgency of responding to a large-scale emergency was important. Make no mistake about it: AIDS is still a crisis of enormous proportions, so that sense of urgency must remain. But we must now *transform PEPFAR into a program that is capable of responding to HIV and AIDS as a protracted challenge that has complex social, economic and cultural dimensions*, in addition to the obvious health dimension. That calls for addressing HIV and AIDS within a development framework, integrated with other key health issues. Otherwise, our investments may effectively address the consequences of HIV and AIDS in the short-term, while making little headway in attacking the underlying drivers of the pandemic over the long-term. This is a marathon, not a sprint: we need a coherent, sustainable strategy for the hard work ahead of us – and that is what we are here to discuss today.

As you know, the Institute of Medicine (IOM) evaluated U.S. global AIDS programming and concluded that PEPFAR must transition from an emergency, short-term results mode to a much greater focus on sustainable impact. Given that sustainability will be the linchpin of PEPFAR's long-term success, it is worth probing what that concept signifies. One type of sustainability relates to a set of activities continuing, even after their initiator exits. Another type refers to the durability of a certain impact: for example, a vaccine that provides immunity to a disease. A deeper form of sustainability is reflected in the ability of societies to maintain processes of economic, social and cultural transformation. In the case of an epidemic like AIDS that cannot be disentangled from the economic, social and cultural factors that drive it, we must pursue all three forms of sustainability, in particular the deepest, most durable form.

Over the years, CARE has learned many hard lessons about sustainability and impact. We have discovered that interventions that advance goals that are easily measurable in the short-term often fail to add up to long-term impact. We have also learned that a variety of well-designed projects may not have impact of much depth or scale unless they fit within a broader framework. These lessons are useful for PEPFAR too. CARE's experience with PEPFAR, often echoed in the IOM evaluation, indicates the following: that PEPFAR's tendency to fund short-term interventions often neglects the social processes vital for real local ownership; that its emphasis on quick results produces incentives to "demonstrate big numbers"; and that its narrow focus and compartmentalized approach to prevention, treatment and care inhibit integrated, comprehensive programming. These are features of PEPFAR that must change, if lasting impact and real sustainability are to be realized.

## **POSITIONING PEPFAR WITHIN A DEVELOPMENT FRAMEWORK**

The problems that afflict poor communities are woven together in a complex web. Solving these problems requires changing the weave of that web, rather than addressing each strand one by one. In the case of HIV and AIDS, the disease is often not the top priority for many poor people. Time and again, mothers tell us that feeding their children is their main worry. For girls, it is often going to school or avoiding early marriage. For sex workers, it is often harassment and discrimination. The transformation of this broader landscape – of inequality, violence and hardship – into something more equitable, safe and prosperous is the challenge of development. Doing so is vital to addressing the often synergistic drivers of vulnerability to HIV and AIDS. *That is why sustainable, effective HIV and AIDS interventions must be closely linked to development.*

Addressing HIV and AIDS solely as a medical challenge is like treating the symptom but not the cause. Over the years, CARE has learned that to attack the drivers of the epidemic, we must deploy comprehensive and well-integrated approaches tailored to each context. For example, in Malawi, where adult HIV prevalence is 14 percent, food and economic insecurity is intertwined with HIV and AIDS. So CARE focuses on how our food security and economic development interventions can be platforms to address HIV and AIDS. We organize a diverse set of interventions, including village savings and loans groups, vocational training, food aid as a safety net, training in home-based care, access to HIV testing services, and support groups for stigma reduction. This integrated approach attacks HIV and AIDS from many angles: for example, enhanced food and income security reduce pressure for women to engage in survival sex, and resulting improvements in nutritional status help delay the onset of AIDS in HIV-positive people and improve efficacy of ART. Mai Chautsi, who belongs to a support group for

people living with HIV and AIDS, told us that micro-enterprise skills have enabled members of her group to improve their health and nutrition. She said: “With our profits, we are able to buy nutritious food, especially proteins, which we could not afford in the past. Some members would miss accessing their ARVs at the hospital because they could not afford transport fares. They can now go to the hospital on time.”

Another example is the “5 x 5” model of early childhood development (ECD) that CARE has developed to comprehensively address the needs of OVC under five years. The “5 x 5” model advances interventions in five areas: nutrition, child development, economic strengthening, health and child protection. The model also engages at five different levels: the individual child, the caregiver or family, child care settings, the community (including health services) and the national policy arena (particularly related to health and education). The model seeks to intervene at early childhood to enhance the long-term potential of very young children affected by HIV and AIDS. The child care setting is the entry point but the strength of the “5 x 5” approach is the linking of actors and services, and its strong investment in community ownership.

In Busia, a town along a busy transport corridor in Uganda, some young mothers are children themselves and are far from home. These young women are paired up with “mother mentors” (older mothers) who can coach them on parenting skills, educate them on HIV prevention and link them to family planning services. In Kibera, an urban slum in Kenya, two health centers are formally linked to the ECD centers, and children from the ECD centers receive a variety of health services from immunizations to monitoring for indications of HIV infection. Before these links were made, many people did not even know about the health centers. CARE’s integrated ECD model is promising because it does more than reduce a young child’s

vulnerability and isolation, increase health status and enhance school readiness. The “5 x 5” model also promotes women’s economic empowerment and girls’ education. How? Because so often women cannot work because they are responsible for child care, or girls are taken out of school to look after younger siblings.

## **RECOMMENDATIONS FOR SUSTAINABILITY AND LONG-TERM IMPACT**

There is broad consensus that, in order to optimize the U.S. government’s investment in the global response to HIV and AIDS, PEPFAR must be better focused on sustainability. Based on our extensive field experience with HIV and AIDS programming and our role as a PEPFAR implementing partner, CARE makes the following recommendations:

1. ***Address HIV and AIDS within a development framework.*** The Committee should provide PEPFAR with a long-term outlook and foster comprehensive approaches to HIV and AIDS by making “wraparound” truly effective.
2. ***Focus on the vulnerability of women and girls to HIV and AIDS.*** We should invest in comprehensive approaches that address the multiple factors that drive the vulnerability and low status of women and girls, and integrate HIV and AIDS responses with reproductive health and family planning.
3. ***Invest in scaling up evidence-based HIV prevention strategies.*** Ultimately, we must increase and re-balance funding to scale up comprehensive prevention efforts, while we confront the realities of HIV transmission with evidence-based strategies.

I will discuss each recommendation in further detail, grounding my observations in CARE’s field experience and recent expert analysis.

*1. Address HIV and AIDS within a development framework.*

PEPFAR's current orientation – of rapid results, short-term funding, narrow focus and numeric outputs – is not well-suited to addressing the multi-faceted links between HIV and AIDS and development. Let me give you an example from CARE's experience in Rwanda, where genocide and AIDS have produced large numbers of OVC. With three-year funding from the European Union, CARE set out (in 2003) to provide comprehensive care to OVC in communities affected by HIV and AIDS, especially child-headed households. From the outset, we wanted the approach to be sustainable, community-based and capable of responding not only to children's material needs but also their psychosocial and protection needs. The model that emerged was of volunteer community mentors (Nkundabana) – organized into associations, recognized in their communities, trained and supported, and chosen by the children for their integrity – being parent figures, providing mentoring and counseling, facilitating access to basic services, and advocating for OVC needs and rights. The approach invested heavily in community participation and ownership, taking the time to cultivate a feeling of responsibility toward OVC, giving OVC the confidence and opportunity to articulate their own needs, and engaging Rwandan organizations in helping OVC claim their rights and recover from trauma.

Our model remained flexible and open to change; it evolved considerably over three years, with many of the changes initiated by OVC or Nkundabana. The results have been very promising in terms of mitigating the impact of HIV and AIDS: OVC are more integrated into their communities; they have better access to schools, health care and nutrition; they are more secure from violence, especially girls vulnerable to sexual abuse; they know more about HIV and family planning; they have reclaimed property lost in “land grabs” to which OVC are typically

vulnerable; and older OVC are earning incomes as a result of vocational skills and savings and loans groups. At the end of the project, 95 percent reported better relationships with community members and 96 percent that local authorities would look out for them if they had problems, major progress for a segment of the population generally facing widespread exclusion and marginalization.

In 2005, we received PEPFAR funding to replicate the Nkundabana model and soon realized how challenging it was to align a comprehensive, community-oriented model with PEPFAR's way of doing things. Short-term funding and pressure to meet numerical targets focused attention on implementing activities quickly and limited CARE's ability to assure that this approach to caring for OVC was fully integrated within and owned by the community, so that it could be sustained over time. CARE is no longer a major implementing partner for PEPFAR's OVC care and support interventions in Rwanda, but we did secure further EU funding to work with partners to continue developing the Nkundabana model and to replicate it in the northern part of the country. The pressure within PEPFAR to deliver quickly and on a large scale is in constant tension with the goal of sustainability. PEPFAR reauthorization must address this challenge by:

A. Articulating a *long-term outlook* for PEPFAR.

- Require *long-term, integrated, multi-sectoral strategies for the U.S. government response to HIV and AIDS* in each country. These strategies would position HIV and AIDS within the broader development setting and be aligned with the plans of national governments.
- Provide multi-year funding that fosters a sustainability mindset. *Three-year funding commitments* should be a minimum.

- Focus on achieving long-term impact rather than generating quick results.<sup>1</sup> *Impact measures* must address *social processes* that underpin the social, cultural and economic transformations needed to disable the AIDS epidemic, to validate that our interventions are effective, and to hold all of us accountable.

B. Making “wraparound” work in order to advance coherent, integrated programs.

- Ensure that there are other viable funding streams to wrap around PEPFAR. Funding for family planning, education, micro-finance and food security, for example – essential to integrate with an HIV and AIDS response – must be enhanced.
- Improve coordination among U.S. government agencies through stronger inter-agency planning, budgeting, and monitoring and evaluation.
- Harmonize USG plans and investments with those of national governments and other donors for maximum synergy and complementarity in the pursuit of shared goals.

***2. Focus on the Vulnerability of Women and Girls to HIV and AIDS.***

The face of the AIDS epidemic is female – and increasingly young. In sub-Saharan Africa, 60 percent of the people living with HIV and AIDS are women; and for each young man newly infected with HIV, three young women are infected.<sup>2</sup> This not only reflects the acute vulnerability of women and girls to HIV and AIDS, but also the failure of the global response to address the complex factors that drive their vulnerability. Women are biologically more

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<sup>1</sup> This does not, in any way, translate to weaker accountability or negate the need for regular monitoring of results.

<sup>2</sup> UNAIDS, 2006 Epidemic Update, p 4.

susceptible to contracting HIV and socially less able to negotiate safe sexual encounters. Far too many girls are coerced into first sex or forced into early marriages with older men. Far too many women are pressured into “survival sex” out of sheer poverty. When women are known to be HIV-positive, they are often blamed and ostracized, even though they so often contract the virus from their unfaithful husbands. When a family member is HIV-positive, women and girls shoulder the burden of caring for the sick. The property of AIDS widows is frequently expropriated by their in-laws. The multiple ways in which women are affected by HIV and AIDS lay bare their vulnerability due to social norms that relegate them to a subordinate status in relation to men.

In identifying what it would take to shift PEPFAR toward sustainability, the IOM evaluation noted that “most of the factors that contribute to the increased vulnerability of women and girls to HIV/AIDS cannot be readily addressed in the short-term” and recommended that PEPFAR focus on “factors that put women at greater risk of HIV/AIDS”.<sup>3</sup> The recent report of the Global HIV Prevention Working Group, of which I am co-chair, argues that an effective strategy would need to reduce women’s vulnerability by fostering women’s empowerment – including helping women secure rights to property and inheritance, increasing their economic independence, advancing universal education for girls, preventing sexual violence and developing new HIV prevention methods that women can control.<sup>4</sup> Engaging men and boys, and shifting gender norms over time, is also vital. CARE endorses these recommendations. Our experience points to the need to address women’s vulnerability in comprehensive ways, focusing not only on their HIV-related needs but also on their ability to make independent decisions (e.g. accessing health services), their confidence to negotiate in relationships (e.g. with husbands,

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<sup>3</sup>*PEPFAR Implementation: Progress and Promise*, Institute of Medicine, March 2007, p 7.

<sup>4</sup>*Bringing HIV Prevention to Scale: An Urgent Global Priority*, Global HIV Prevention Working Group, June 2007, p 9.

village chiefs, service providers), laws and institutions that protect women's rights (e.g. in relation to property and inheritance rights) and opportunities to link women together to promote solidarity and collective action.

In Kenya, CARE implements a PEPFAR-funded program that aims to prevent mother-to-child transmission (PMTCT) of HIV in Nyanza province, which has the highest HIV prevalence rate in the country (15 percent). This work began with a narrow focus on testing women and making ART available to mother and baby, but it is continuously becoming more comprehensive. As such, we believe it is a worthy model for PEPFAR to evaluate more deeply. To prevent a child saved from HIV dying of a preventable diarrheal disease, CARE facilitated access to safe water systems. To deal with the reality that pregnant women who test HIV-positive often do not return for ART (out of fear of violence or stigma, or because she cannot afford transport), we organized support groups for HIV-positive mothers, mobilized communities against HIV-related stigma and linked women with micro-credit services. Since 2003, uptake of nevirapine at thirteen anti-natal clinics in Siaya district, CARE's main focus area, increased from 35 percent to 94 percent. Recognizing that the most cost-effective PMTCT method is to avoid unintended pregnancy in the first place, the program is now linking with family planning services.

We welcome the steps that the Office of the Global AIDS Coordinator (OGAC) has taken to address gender issues. OGAC now collects sex-disaggregated data, has five priority gender strategies, convenes an inter-agency Gender Technical Working Group, and has allocated \$8 million toward gender-related initiatives. These are promising trends, and PEPFAR reauthorization should push for deeper impact on women and girls' vulnerability by:

- A. Advancing comprehensive programs that address the *social, economic and cultural factors* that enhance the vulnerability of women. Since the low status of women is itself a driver of vulnerability, *women's empowerment* should be embraced by PEPFAR as a desired endpoint. Recognizing that transforming gender norms and relations is a slow process, such results must be pursued within long timeframes. Otherwise, we run the risk of doing more harm than good.
- B. Integrating and linking *HIV and AIDS and reproductive health* programs, and strengthening efforts to reduce unmet family planning needs among HIV-affected women.
- C. Developing *mandatory operational guidance* for country programs on gender-responsive programming. This guidance should help country teams and implementers conduct analysis, planning and evaluation to meaningfully integrate gender dimensions into all of PEPFAR's work.
- D. Investing in independent impact studies that provide a sharper sense of "*what works*" (what gender interventions are most effective in impacting HIV outcomes in the long-term) and scaling up effective approaches for maximum impact.

### ***3. Invest in Scaling Up Evidence-Based HIV Prevention Strategies.***

Despite a six-fold increase in financing for HIV programs in developing countries between 2001 and 2006, the effort to reduce new HIV infections is faltering.<sup>5</sup> For every patient who began ART in 2006, another six people were infected with HIV. Such results will not lead to success or sustainability. There is an urgent need to focus on comprehensive, evidence-based strategies and take those strategies to scale. Half of the infections projected to occur by 2015

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<sup>5</sup> Ibid, p 1.

could be averted, if the right interventions are focused on the right people at the right scale – and this degree of success is likely to disable the epidemic and push it toward long-term decline.<sup>6</sup>

I want to underscore the importance of thinking in terms of *the right interventions, the right people and the right scale*. We need to match our responses to the specific epidemiology of each country; there is no “one size fits all” solution and our mix of interventions should be quite different in generalized epidemics and concentrated epidemics, for example. Investing in prevention at the *right scale* is an enormously important factor, which has not received adequate attention. There are many barriers to scaling up, beginning with insufficient and uncertain funding. The scale up of funding for treatment, and the resulting steady increase in numbers of people on ART, demonstrates that dramatic progress that can be achieved, when political will is strong. Given the high need that remains, we must keep up the progress on treatment access even as we scale up comprehensive prevention efforts to a level that can halt the growth of the AIDS pandemic. Significantly ramping up HIV prevention spending now would not only avert half of the new infections projected to occur between now and 2015, but also yield net financial savings in terms of treatment and care costs avoided.<sup>7</sup>

In identifying what it would take to move PEPFAR toward sustainability, the IOM report noted that, “partly in response to legislative mandates, [PEPFAR] has supported some preventive interventions that are not firmly evidence-based [and] addressed sources of HIV transmission in disproportion to their expected contribution to the ultimate goal of preventing new infections.”<sup>8</sup> PEPFAR’s approach to prevention of sexual transmission, symbolized by the abstinence-until-marriage earmark in the Global AIDS Act of 2003, has drawn both sharp criticism and ardent

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<sup>6</sup> Ibid, p 1.

<sup>7</sup> Stover et al. The Global Impact of Scaling Up HIV/AIDS Prevention Programming in Low- and Middle-Income Countries. *Science*. 2006: 311: 1474-1476.

<sup>8</sup> Institute of Medicine, p 6.

approval. CARE’s experience with the ABC approach is that U.S. government country teams implement the ABC approach unevenly, some allowing considerably more latitude for implementers than others. The result is that the heavy emphasis on AB and the polarization of the prevention debate into “AB versus C” often misses the reality that even a balanced ABC approach offers limited options to the most vulnerable people, especially women and girls; ultimately, it is the “ABC *plus*” approach that we must advance.

We endorse the recommendations of the Global HIV Prevention Working Group, and call for a package of comprehensive prevention interventions – from HIV testing to condom promotion, from PMTCT to interventions for injecting drug users, and from behavior change to anti-stigma measures – to be fully scaled up in each focus country. PEPFAR reauthorization must invest in scaling up evidence-based prevention strategies by:

- A. *Funding the scale-up* of comprehensive prevention efforts. CARE recommends that Congress assign universal access to prevention as PEPFAR’s highest priority and that it provide sufficient funds to ensure U.S. fair-share support to scale up prevention programming in focus countries and other affected low- and middle-income countries, as appropriate, to combat the AIDS pandemic.<sup>9</sup>
- B. Tailoring prevention strategies to *match the epidemiology* of each country. This necessarily means *removing arbitrary restrictions* in order to allocate resources to areas where the largest number of new infections can be averted. CARE recommends that the PEPFAR reauthorization avoid budget allocations and restrictions such as the abstinence-until-marriage earmark and the anti-prostitution pledge requirement, since they tend to work against evidence-based prevention approaches being deployed in the most strategic manner.

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<sup>9</sup> Stover et al.

- C. Advancing an *ABC plus approach* to address underlying vulnerabilities. This includes confronting social norms that put women and girls at risk, as well as targeted efforts to prevent gender-based violence, enhance food and economic security, secure property rights and improve access to reproductive health services.
- D. Deploying evidence-based strategies to curb HIV transmission in *high-risk groups* including sex workers, injecting drug users, men who have sex with men, and prisoners. In much of Asia and Eastern Europe, these groups account for the majority of new HIV infections. In order to have a global impact, PEPFAR must employ more effective, evidence-based strategies to prevent transmission among high-risk groups.

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Mr. Chairman, Members of the Committee. You have a singular opportunity to make an extraordinary difference throughout the world by ensuring that millions of lives are saved and PEPFAR is even more effective over the next five years. I thank you for the opportunity to contribute to this important discussion.

I would be pleased to answer any questions.