The President's Emergency Plan for AIDS Relief

Statement of
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Mr. Chairman, Senator Lugar, Members of the Committee and staff: let me begin by thanking you for your leadership and commitment on global HIV/AIDS, for your actions in 2003 to pass the authorizing legislation for the President's Emergency Plan for AIDS Relief (PEPFAR), and for your actions leading to today's hearing on reauthorization of this historic legislation and program.

Just five years ago, many wondered whether prevention, treatment and care could ever successfully be provided in resource-limited settings where HIV was a death sentence. Only 50,000 people living with HIV in all of Sub-Saharan Africa were receiving antiretroviral treatment.

President Bush and a bipartisan, bicameral Congress reflected the compassion and generosity of the American people as together you led our nation to lead the world in restoring hope by combating this devastating pandemic. You recognized that HIV/AIDS was and is a global health emergency requiring emergency action. But to respond in an effective way, it has been necessary to build systems and sustainable programs as care is rapidly provided, creating the foundation for further expansion of care to those in need. The success of PEPFAR is firmly rooted in these partnerships, in the American people supporting the people of the countries in which we are privileged to serve -- including governments, non-governmental organizations including faith- and community-based organizations and the private sector -- to build their systems and to empower individuals, communities and nations to tackle HIV/AIDS. And in just three and one-half years, it is working.

Results

In rolling out the largest international public health initiative in history, we have acted quickly. We have obligated 94 percent of the funds appropriated to PEPFAR so far, and outlayed or expended 67 percent of them. But success in not measured in dollars spent: it is measured in services provided and lives saved.

PEPFAR is well on the way to achieving its ambitious five-year targets of supporting treatment for two million people, prevention of seven million new infections, and care for 10 million people infected and affected by HIV/AIDS, including orphans and vulnerable children.

Through September 2006, PEPFAR-supported programs reached 61 million people with prevention messages, and the U.S. Government has supplied 1.67 billion condoms through this August – as Dr. Piot of UNAIDS has said, more than all other developed countries combined. PEPFAR has supported antiretroviral prophylaxis during over half a million pregnancies, preventing an estimated 101,000 infant HIV infections. In fact, five of the focus countries have greater than 50 percent coverage of

pregnant women – the goal of the President's International Mother and Child Prevention Initiative (which preceded the Emergency Plan) – and Botswana has achieved a 4 percent national transmission rate, which approximates that of the U.S. and Europe. With Emergency Plan support, focus countries have scaled up their safe blood programs, and 13 of them can now meet two-thirds of their collective demand for safe blood – up from just 45 percent when PEPFAR started. PEPFAR has supported HIV testing and counseling for 18.6 million people, and supported care for 2.4 million adults and 2 million orphans and vulnerable children infected and affected by HIV. And through March 2007, PEPFAR supported antiretroviral treatment for over 1.1 million men, women, and children – more than 1 million in Sub-Saharan Africa.

Country teams will submit their annual program results data to us shortly, and we expect that the data will demonstrate impressive continued progress.

Success requires a comprehensive strategy

When the history of public health is written, the global HIV/AIDS action of the American people will be remembered for its size, but also for its scope: the insistence that prevention, treatment and care -- all three components, with goals for each -- are all required to turn the tide against HIV/AIDS.

Within the past decade, the pendulum of preferred interventions has swung from prevention to treatment and back to prevention. By the way, care always, and tragically, seems to get lost. Using these pendulum swings to determine policy and programs can be dangerous – and even deadly.

The President and a bipartisan Congress got it right the first time, because a comprehensive program that includes prevention, treatment and care reflects basic public health realities:

Without treatment, people are not motivated to be tested and learn their HIV status.

Without testing, we cannot identify HIV-positive persons and so we cannot teach them safe behavior, and they cannot protect others.

Without care and treatment programs, we do not have regular access to HIV-positive persons to constantly reinforce safe behaviors – a key component of prevention.

Without testing and treatment, we cannot "medicalize" the disease, which is essential to reducing stigma and discrimination—which, in turn, is essential for effective prevention and compassionate care for those infected and affected by HIV.

Without testing and treatment, we have no hope of identifying discordant couples, and women have no possibility of getting their partners tested so that they can protect themselves.

And, of course, without prevention, we cannot keep up with the ever-growing pool of people who need care and treatment.

Currently, we're spending 46 percent of our programmatic funds on treatment. When you include counseling and testing as a prevention intervention, as most of our international partners do, we're spending 29 percent of our funds on prevention. The rest is going to care.

Will that be the right mix going forward? It's impossible to know, because there is no way to know what the HIV/AIDS landscape will look like in three to seven years. This is why, as we've discussed reauthorization with many of you and your staff, we've supported an approach to reauthorization that doesn't include specific directives for the allocation among those three broad categories.

Part of the reasoning behind this is that we are one piece--albeit a very large piece—of a complex puzzle of partners engaged in combating HIV/AIDS. The other pieces include: the contributions of the countries themselves, including remarkable efforts by people living with HIV, families, communities, and national leaders, and which can include substantial financial contributions in countries such as South Africa, Botswana, Namibia and others; the Global Fund to Fight AIDS, Tuberculosis and Malaria – for which the American people provide 30 percent of its budget and which is an important piece of our overall global strategy -- and other multilateral organizations; other nations' bilateral programs; private foundations; and many others. We constantly adapt the shape of our bilateral programming piece to fill its place in this puzzle, so flexibility is needed.

Prevention is the bedrock of PEPFAR

That being said, prevention is the bedrock of an effective global response to HIV/AIDS. In PEPFAR's Five-Year Strategy, in each Annual Report, in nearly every public document or statement, including those before Congress, we have been clear that we cannot treat our way out of this pandemic, and that prevention is the most important piece for success.

Prevention is also the greatest challenge in the fight against HIV/AIDS. Globally, and certainly in the hardest-hit countries, which are in Africa, the vast majority of HIV is transmitted through sexual contact. Changing human behavior is very difficult -- far more difficult than determining the right prescription of antiretroviral drugs, building a health system or creating a better life for orphans and vulnerable children.

Not only is effective behavior change and, therefore, prevention, more difficult than care and treatment, measuring success is also far more complicated. While it is possible to rapidly and regularly report on numbers of people receiving care and treatment, prevention is evaluated every few years, with metrics and mathematical methods that are constantly being refined. We must currently rely on estimating prevalence – or the percent of HIV positive persons in a population -- rather than evaluating directly the rate of *new* infections, which would be a far better indicator of success of interventions. In addition, as treatment programs are scaled up, fewer people die and prevalence may actually go up despite successful prevention efforts. Therefore, we cannot provide updates on success in prevention in the same way we do for care and treatment

But that does not mean that prevention has failed – as some seem to want to say. In addition to earlier dramatic declines in HIV prevalence in Uganda, there is growing evidence of similar trends in other African nations, including Botswana, Ethiopia, Kenya, Tanzania, Zambia, and Zimbabwe. There is also evidence for stabilization or declines in the Caribbean, including Haiti.

I do not mean to minimize the seriousness of disturbing increases that we're seeing in certain places, nor the fact that there is an urgent need for greater progress in every country and region. But I highlight these successes because the data make something very clear. Our best hope for generalized epidemics – the most common type of epidemic in Africa, which is home to more than 60 percent of the global epidemic and where our efforts are highly concentrated - is ABC behavior change: Abstain, Be faithful, and correct and consistent use of Condoms. Of course, bringing about these behaviors, as

Uganda did during the 1990s, is a far more complex task than the simple letters suggest, because the roots of human behavior are so complex.

ABC requires significant cultural changes. We have to reach children at an early age if they are to delay sexual debut and limit their number of partners. We must partner with children's parents and caregivers, supporting their efforts to teach children to respect themselves and each other – the only way to truly change unhealthy gender dynamics. We are rapidly expanding life skills programs for kids because of the generational impact they can have – changing a 10 year old's behavior is far easier than changing a 25 year old's. Behavior changes due to programs for children may not immediately be apparent, because you're working to change their future behavior rather than their immediate behavior. Yet we must be patient and persistent – we are only three and a half years into PEPFAR's generational approach to prevention.

For older adolescents and adults who are sexually active, ABC includes reducing casual and multiple concurrent partnerships, which can rapidly spread HIV infection through broad networks of people. We must also identify discordant couples, in which one partner is HIV-positive and the other is HIV-negative – especially in countries like Uganda where they represent a significant contribution to the epidemic – and focus prevention efforts on them.

We also need to teach correct and consistent condom use for those who are sexually active, and ensure a supply of condoms -- and we are doing just that.

ABC also includes changing gender norms. As young people are taught to respect themselves and respect others, they learn about gender equality. Through teaching delayed sexual debut, secondary abstinence, fidelity to a single partner, partner reduction and correct and consistent condom use to boys and men, ABC contributes to changing unhealthy cultural gender norms.

And, of course, we need to reduce stigma against people with HIV – and ***also*** reduce stigma against those who choose healthy lifestyles. On the other hand, we must identify and stigmatize transgenerational sex and the phenomenon of older men preying on young girls, and we must also prevent sexual violence. Again, life skills education – a part of ABC -- is key.

Taking prevention to the next level

While PEPFAR is aggressively pursuing prevention as the bedrock of our efforts, it is also true that we need to improve what we are doing – in every area of our work. We need to take prevention to the next level. I'd like to share with you some of our lessons learned in prevention and give a glimpse of some new directions.

Know your epidemic

First, you must know your epidemic and tailor your prevention strategy accordingly. While ABC behavior change must undeniably be at the core of prevention programs, we also recognize that one size does *not* fit all.

This is why we take different approaches depending on whether a country has a generalized and/or a concentrated epidemic. It's surprising how little this is understood. The existing Congressional directive that 33 percent of prevention funding be spent on abstinence and faithfulness programs is

applied across the focus countries collectively, not on a country-by-country basis – and certainly not to countries with concentrated epidemics.

Even speaking of the epidemic at a country level can be misleading, in fact, because a country can have both a concentrated epidemic and a generalized one. Even in generalized epidemics, we must identify vulnerable groups with especially high prevalence rates, such as people engaged in prostitution, and tailor prevention approaches to reach them. On recent trips, I've seen great examples of this sort of program in Haiti, Cote d'Ivoire and Ghana.

Moreover, epidemics can shift over time. In Uganda, for example, ABC behavior change had such a significant impact that we now see the highest infection risk in discordant couples.

Combination prevention

While much progress has been made in effective prevention, often we are still using prevention techniques developed 20 years ago. It is important for prevention activities to enter the 21st Century, to use techniques and modalities that have been developed to change human behavior, especially those developed in the private sector for commercial marketing.

We also need a focused and concentrated effort that mirrors progress in treatment. As we need combination therapy for treatment, we need combination prevention. Combination prevention includes using many different modalities to affect behavior change, but it also includes geographic concentration of those different modalities and adding existing and new clinical interventions as they become available. PEPFAR is supporting many extraordinary prevention programs, but they are not always concentrated in the same geographic area. We need to make sure that, wherever people are, we are there to meet them at every turn with appropriate knowledge and skills. For example, many youth listen to faith leaders, while others don't. Many youth hear prevention messages in church or in school, but then hang out with their friends and hear conflicting messages. Many have no access to either school or church. We need to make sure that we blanket geographic areas with varied prevention modalities, so that all the youth hear the messages and can change their behavior accordingly.

We also need to create effective approaches to older populations, including discordant couples, and have them in the same geographic concentration as the youth programs. Effectively reaching these populations demands work that is outside the traditional realm of public health, such as gender, education and income-generation programs, for example.

We have made great strides to provide both linkages and direct interventions in these areas under the expansive existing authorities of the Leadership Act. But we also need to evaluate these combination programs with real science to know how best to do them. Some things might be good for general development, but if they don't prevent infections in a significant way, they are the purview of USAID and Millennium Challenge Corporation (MCC) development programs, not those of PEPFAR.

As part of the effort to implement innovative prevention programs, while evaluating their impact, we are developing several exciting and future-leaning public-private partnerships for combination prevention. Part of this effort includes "modularizing" successful prevention programs so that the components found to be most effective and easy to transfer to other geographic areas can be rapidly scaled up.

Integrating scientific advances

Part of combination prevention is to rapidly incorporate the latest scientific, clinical advances to expand the effectiveness of behavior change programs. As you know, recent studies have shown that medical male circumcision can significantly reduce the risk of HIV transmission for men. PEPFAR, working closely with the Gates Foundation, has been the most aggressive of any international partner in pursuing implementation. We have to be clear that this is not a silver bullet, but rather one part of a broad prevention arsenal that must and will be used. We also need to ensure that programs demonstrate cultural sensitivity and incorporate ABC behavior change education.

We need to manage rollout carefully, beginning in areas of high HIV prevalence and with those at greatest risk of becoming infected. For example, male circumcision could be very important in discordant couples in which the woman is HIV-positive.

As for other promising biomedical prevention approaches, we are also hoping for more scientific evidence on the effectiveness of pre-exposure prophylaxis to prevent infection, which could be another valuable tool for most-at-risk populations. Microbicides and vaccines still appear to be a long way off. Yet thanks to our wide network of care and treatment sites, we will be able to implement these methods rapidly whenever they become available – demonstrating again the value of integrated programs.

Along with these prevention interventions, we are also incorporating the latest scientific advances in evaluation. We hope to have markers for incidence – new infections -- available in the field soon: they have been validated, and we are now awaiting calibration. These will make evaluation of prevention programs and our overall impact much easier, leading to program improvement and perhaps cushioning against pendulum swings.

Confronting gender realities

Addressing the distinctive needs of women and girls is critical to effective prevention, as well as to treatment and care. Taken as a whole, the Leadership Act specifies five high-priority gender strategies: increasing gender equity in HIV/AIDS activities and services; reducing violence and coercion; addressing male norms and behaviors; increasing women's legal protection; and increasing women's access to income and productive resources.

PEPFAR has been a leader in addressing gender issues and has incorporated gender across its prevention, treatment and care programs. The Emergency Plan was the first international HIV/AIDS program to disaggregate results data by sex. Sex-disaggregated data is critical to understanding the extent to which women and men are reached by life-saving interventions, and helps implementers to better understand whether programs are achieving gender equity. For example, an estimated 61 percent of those receiving antiretroviral treatment through downstream U.S. Government support in Fiscal Year 2006 were women. Girls represent 51 percent of OVCs who receive care. Women represent 70 percent of all people who receive PEPFAR-supported counseling and testing services. In Fiscal Year 2006, across four key program areas, approximately 45% of the total prevention, treatment and care budget was directed towards reaching women and girls.

The Emergency Plan also annually monitors its progress on the five priority strategies specified in the Leadership Act. In Fiscal Year 2006, a total of $442 million supported more than 830 interventions that included one or more of these gender strategies.

Building health systems

While HIV/AIDS remains a global emergency, which we are responding to as such, we are also focused on building capacity for a sustainable response. As President Bush has said, the people of host nations are the leaders in this fight, and our role is to support them. Eighty-five percent of our partners are local organizations.

An important part of that effort is the construction and strengthening of health systems. Like the pendulum swing between prevention and treatment, discussions here sometimes reflect misconceptions and unsubstantiated opinions on the effect of HIV/AIDS programs on the capacity of health systems. Some wonder whether by putting money into HIV/AIDS, we're having a negative impact on other areas of health systems.

Yet all the data suggest just the opposite. A peer-reviewed paper from Haiti showed that HIV resources are building health systems, not siphoning resources from them. A study in Rwanda showed that the addition of basic HIV care into primary health centers contributed to an increase in utilization of maternal and reproductive health, prenatal, pediatric and general health care. It found statistically significant increases in delivery of non-HIV services in 17 out of 22 indicators. Effects included a 24 percent increase in outpatient consultations, and a rise in syphilis screenings of pregnant women from one test in the six months prior to the introduction of HIV care to 79 tests after HIV services began. Large jumps were also seen in utilization of non-HIV-related lab testing, antenatal care and family planning. In Botswana, infant mortality rose and life expectancy dropped by one-third because of HIV/AIDS despite significant increases in resources for child and basic health by the Government of Botswana. Now, because President Mogae has led an all-out battle against HIV/AIDS, infant mortality is declining and life expectancy is increasing.

The reasons for these improvements make sense. For one thing, PEPFAR works within the general health sector. When we improve a laboratory to provide more reliable HIV testing or train a nurse in clinical diagnosis of opportunistic infections of AIDS patients, that doesn't just benefit people with HIV – it benefits everyone else who comes in contact with that clinic or nurse, too.

A recent study of PEPFAR-supported treatment sites in four countries found that PEPFAR supported a median of 92% of the investments in health infrastructure to provide comprehensive HIV treatment and associated care, including building construction and renovation, lab and other equipment, and training – and the support was higher in the public sector than the non-governmental sector. In fact, many of our NGO partners are working in the public sector. In Namibia, the salaries of nearly all clinical staff doing treatment work and nearly all of those doing counseling and testing in the public sector are supported by PEPFAR. In Ethiopia, PEPFAR supports the Government's program to train 30,000 health extension workers in order to place two of these community health workers in every rural village; 16,000 have already been trained. So it is clear where those broader improvements are coming from. We estimate that nearly $640 million dollars of Fiscal Year 2007 funding were directed toward systems-strengthening activities, including pre-service and in-service training of health workers.

Another key fact is that in the hardest-hit countries, an estimated 50 percent of hospital admissions are due to HIV/AIDS. As effective HIV programs are implemented, hospital admissions plummet, easing the burden on health care staff throughout the system. In the Rwanda study I just mentioned, the

average number of new hospitalizations at 7 sites that had been offering antiretroviral treatment for more than two months dropped by 21 percent.

As the Chair of the Institute of Medicine panel that reviewed PEPFAR's implementation put it, "[O]verall, PEPFAR is contributing to make health systems stronger, not weakening them."

We know that building health systems and workforce is fundamental to our work, and PEPFAR will remain focused on it. We are working to improve our interagency coordination on construction, and we recently tripled the amount of resources available for pre-service training of health workers. We've already trained or retrained 1.7 million health care workers, and we need to continue to expand that number in order to keep scaling up our programs.

'Connecting the dots' of development

At this point, I want to step back and offer a look at a larger picture: the role of PEPFAR in 'connecting the dots' of development. PEPFAR is an important part of the President's expansive development agenda, with strong bipartisan support from Congress. Together, we have doubled support for development, quadrupled resources for Africa, supported innovative programs like the MCC, President's Malaria Initiative (PMI), Women's Empowerment and Justice Initiative (WEJI) and African Education Initiative (AEI), as well as more than doubling trade with Africa and providing one-hundred percent debt relief to the poorest countries.

In Haiti, for example, the Emergency Plan works with partner organizations to meet the food and nutrition needs of orphans and vulnerable children (OVCs) using a community-based approach. The kids participate in a school nutrition program using USAID-Title II resources. This program is also committed to developing sustainable sources of food, and so the staff has aggressively supported community gardens primarily for OVC consumption, and also to generate revenue through the marketing of vegetables.

In education, we have developed a strong partnership with the President's African Education Initiative, implemented through USAID. In Zambia, PEPFAR and AEI fund a scholarship program that helps to keep in school nearly 4,000 orphans in grades 10 to 12 who have lost one or both parents to AIDS or who are HIV-positive, in addition to pre-school programs and support for orphans in primary school. Similar partnerships exist in Uganda, where PEPFAR and AEI are working together to strengthen life-skills and prevention curricula in schools. This program, with $2 million in funding in FY 2007, targeted four million children and 5,000 teachers.

We are also working with the President's Malaria Initiative and the Millennium Challenge Corporation to coordinate our activities in countries where there are common programs. In Zambia, by using PEPFAR's distribution infrastructure, known as RAPIDS, PMI will deliver more than 500,000 bed nets before this malaria season at a 75 percent savings – and the U.S. Government saved half the remaining cost of nets through a public-private partnership led by the Global Business Coalition on HIV/AIDS, Tuberculosis and Malaria. In Lesotho, PEPFAR is co-locating our staff with that of MCC to ensure that we are jointly supporting the expansion of health and HIV/AIDS services.

Broadly speaking, PEPFAR is contributing to general development in the following ways: 1) leveraging an infrastructure developed for HIV/AIDS for general health and development, as demonstrated by the data from Rwanda, the Zambia malaria initiative and other examples; 2) supporting aspects of general development activities with a direct and significant impact on

HIV/AIDS, as demonstrated by OVC education programs, and in aspects of general prevention such as gender equality and income generation if scientific evaluations show that they impact significantly on HIV/AIDS; and 3) providing a piece of a larger approach, for example by supporting the HIV/AIDS component of Ethiopia's community health worker project.

When President Bush called for reauthorization of the Leadership Act, he emphasized the need to better connect the dots of development. The Leadership Act provides us with expansive authorities for such work, and we are constantly trying to improve our efforts.

But let me candidly make clear our view of the appropriate limits of PEPFAR's role. While we want to connect dots, PEPFAR cannot and should not become USAID, MCC, PMI, or any of its sister initiatives or agencies. Nearly every person affected by HIV/AIDS could certainly benefit from additional food support, greater access to education, economic opportunities and clean water, but so could the broader communities in which they live. We must integrate with other development programs, but we cannot, and should not, become them. PEPFAR is part of a larger whole. Congress got this right in the original legislation, and that is the right position going forward.

Improving indicators and reporting

As we improve the linkages between our programs and other related areas of development, we also need to do a better job of measuring the impact and outcomes of our programs. We need to know not just the number of people that we support on treatment, but also what impact that is having on morbidity and mortality. We need to know not only how many infections we're averting, but also how we're doing at changing societal norms such as the age at sexual debut, the number of multiple concurrent partnerships, or the status of women. To do this, we have instructed our technical working groups to develop a new series of impact indicators, in consultation with implementers and other interested groups. These new indicators should be completed by early next year, and we will then incorporate them into our planning and reporting systems.

Of course, not all of the new indicators will be reported up to headquarters – we don't need all that information, and we don't want to burden our staff in the field with more reporting requirements. But we believe they will be useful to the country teams as they plan and evaluate their own programs, giving them a better idea of the impact they're having and where improvements can be made.

We believe that kind of information can improve the overall quality of programs and potentially reduce the demands on one of our most valuable assets – our U.S. Government staff in the field, both American citizens and Locally Employed Staff. Our *Staffing for Results* initiative also seeks to ensure that we have the right people in the right place in each country so that we can avoid unnecessary duplication of work and make the best use of our extraordinary human resources.

Reauthorization of PEPFAR

I think the understanding that PEPFAR is essentially in the position it needs to be in going forward is critical in the conversation about reauthorization. We could spend a lot of time debating new authorities and new earmarks on everything from the amount of money we spend on operations research to the number of community health workers we train. Yet the bottom line is that the Leadership Act already has the authorities we need, and provides the right amount of flexibility to put them into use. None of the issues being discussed truly require significant changes in the law. The

Institute of Medicine called PEPFAR a learning organization. We have used the flexibilities of the original legislation to learn, and to constantly change our approach based on the lessons learned.

Congress enacted a good law the first time. It's not perfect, but it's very good—that is clear from its results. While there are some modifications that are needed, rather than letting the perfect be the enemy of the good, it should be possible to take the time that is needed to develop a thoughtful, solid, bipartisan bill. And the President has made clear the Administration's desire to do just that. It is in no one's interest to be hasty – global HIV/AIDS is too important. But with a solid foundation in the first, good law, it is possible to move expeditiously.

And thoughtful but rapid action is important. In Haiti, a few weeks ago the Minister of Health expressed the same concern as every other country I have been to – 'Will this continue? Can we scale up now or should we wait to see what happens?' A recent letter from the Health Ministers of our focus countries conveyed this same urgency. While U.S.-based or local organizations experienced in the workings of the U.S. Government might have less concern, the policymakers who set standards and must decide the level of scale-up to allow in their countries are asking for rapid action. They need to be convinced that it is prudent to attempt the significant expansion in prevention, and especially care and treatment services, that is needed in 2008, to achieve our original goals and to save the maximum number of lives.

Because of this reality, President Bush has called for early, bipartisan, bicameral action. He has announced the Administration's commitment to double the initial commitment to $30 billion, along with setting new goals – increasing prevention from 7 to 12 million, treatment from 2 to 2.5 million and care from 10 to 12 million, including – for the first time -- an OVC goal of 5 million. These goals reflect the need for increased focus on prevention within our comprehensive program – that's why our prevention goal would nearly double while care and treatment would see smaller increases. President Bush challenged the G-8 leaders to respond to the U.S. commitment, and in June the G-8 committed $60 billion dollars to support HIV/AIDS, tuberculosis and malaria programs over the next few years. For the first time, the other leaders also agreed to join us in supporting country-owned, national programs to meet specific, numerical goals. President Bush has also called for enhanced effort on connecting the dots of development and strengthening partnerships for greater efficacy and increased sustainability.

A noble and ennobling work

Mr. Chairman, Senator Lugar and members of the Committee, through PEPFAR and our broader development agenda, the American people have engaged in one of the great humanitarian efforts in history. The foundation of that success has been true partnership, and the rejection of the donor/recipient mentality.

Our partnerships are founded in the profound sense of dignity and worth of every human life, and in trust and mutual respect between peoples. These partnerships are giving individuals, communities and nations great hope, and are transforming individuals, communities, nations, and -- in the case of Africa -- much of a sub-continent.

The people of those countries have a new window into the hearts of Americans; they know what we stand for and that we stand with them. This was made clear by Presidents Mogae of Botswana and President Kikwete of Tanzania in their powerful statements last month.

Beyond that, as President Bush has said, this effort is also good for our national character and who we are as a people. This noble and ennobling work has only begun. Working together to unlock the power of partnerships, we can and will achieve much more for others, and for ourselves.

Thank you very much.