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SUCCESS OF PEPFAR

PEPFAR has saved millions of lives in Africa. PEPFAR started at a time when the AIDS crisis in Sub-Saharan Africa had reached a catastrophic stage because timely action was not taken, and the African countries were too overwhelmed by the sheer magnitude of the disaster. Before PEPFAR, less than 100,000 thousand in Africa had access to life saving antiretroviral drugs, and millions were dying what had become preventable deaths in rich countries. Today, there are four million people on ARV treatment in low- and middle-income countries who would not be alive without the treatment scale-up only possible with donor support. More than half of them have benefited from the U.S. government's contributions to PEPFAR and the Global Fund. These people – and their mothers, husbands, wives and children – got a chance to live. This is a chance they simply would not have had without the humanitarian global AIDS program, backed strongly by the American people.

During the first 7 years of PEPFAR, the carnage that I and my fellow health care providers used to witness on a daily basis faded as the situation changed from that of despair and misery to hope. PEPFAR did more than treat people—nearly 4 million AIDS orphans and vulnerable children have been assisted because of it. By keeping parents alive, PEPFAR has prevented millions of others from becoming orphans. It has also allowed more than 300,000 babies of HIV-positive mothers to be born HIV-free. In the area of prevention, millions have been tested for HIV, and preventive initiatives based on the Abstinence, Be faithful, and Condoms--otherwise known as ABC strategy for AIDS prevention—have been supported.

OPPORTUNITIES TO END THE EPIDEMIC & AFFECT OTHER HEALTH AREAS

Recently, excitement has built around the potential to both reverse the pandemic and to have a major impact on overall health through effective AIDS programming.

Evidence has shown significant strengthening of health systems by AIDS programming. For instance, PEPFAR assisted my Institution, the JCRC, to establish diagnostic and clinical facilities. It has also helped us improve our standards of care by supporting our training programme, which has so far trained thousands of health care providers who are now providing crucial services to both the public and private sectors in Uganda.

There is also significant evidence that AIDS programming, where it has reached community-wide coverage, has been among the most successful interventions for broader health. Studies in Uganda have shown the increase in services for HIV/AIDS was accompanied by a reduction in

non-HIV infant mortality of 83% as parents not only lived but thrived.[1] The DART study, which I co-chaired, found that of 300 HIV-positive pregnant women with very low CD4 counts, ARVs prevented their children from being infected 100% of the time. Essentially, it also found a 75% reduction in Malaria associated with anti-retroviral therapy.

Most recently, there has been considerable excitement coming out of the CROI conference—held a few weeks ago in San Francisco. Evidence there showed that reaching all those in need with anti-retroviral therapy could have a major impact on preventing new infections. A study of HIV transmission between heterosexual couples in Africa found that the chance of transmission is reduced by at least 90% if the HIV-positive partner is on antiretroviral therapy. This gives credence to recent modelling by the World Health Organization and experts in South Africa that shows some of the first good news on prevention in several years: that we could truly end the AIDS crisis within a generation if we can reach all those in need with testing and treatment, combined with rolling out new, important prevention technologies.

FUNDING CRISIS UNDERMINING PROGRESS

Today, however, the twin realities of the economic crisis and flat-lining of funding for PEPFAR threaten to reverse these highly positive changes and miss opportunities to defeat the epidemic.

PEPFAR responded to a crisis of immense magnitude that is still devastating. AIDS in much of Africa is still an emergency. In Uganda, only 170,000 adults out of estimated 350,000 in immediate need of life-saving ART, and 12,000 children out of estimated 60,000 who also need treatment, are receiving it now.

And every year, the number of patients who need treatment but who have no access will increase—in fact, the numbers in need of treatment are projected to increase to over 14 million worldwide in the next 10-15 years.

Over the last few years, data from research made it clear that the CD4 level of 200 cells used in Africa to determine when to start therapy was late and was predisposing patients to poor treatment outcome and increased mortality. Accordingly, WHO has revised the when-to-start recommendation to a CD4 of 350, as already established in developed countries. The possibility of starting treatment at even higher CD4 level for better treatment outcomes and as a preventive strategy is currently being researched. However, Africa is currently unable to implement the new recommendation for the simple reason that a majority of countries are not able to treat even half of the patients in need at the old CD4 level. It has been estimated that, by using this criteria, the numbers in immediate need of ART in Africa would double, further compounding the already dire situation.

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[1] Mermin J, Were W, Ekwaru JP, et al. The Lancet, 2008; Ndirangu J, Bland R, Newell M-J. IAS 2009, abstract WEAD105; Stoneburner R, Montagu D, Pervilhac C, et al. *16th International AIDS Conference*, Toronto, abstract THLB0507

There are other unmet needs that are vital for successful control of the raging HIV epidemic in Africa. Many rural areas, where the majority of people live, remain without services. Most laboratories are in a miserable state, and the available few are not accessible to the majority of patients. The epidemic is still spreading at an alarming rate, calling for robust preventive interventions. Data from UNAIDS has indicated that for every 2 patients who started therapy, 5 new ones—mainly females—were infected. The epidemic in Africa is increasingly becoming feminized because of gender inequity. There were 1.9 million new infections in Sub-Saharan Africa in 2007, and since then there has been no significant decline in rates. This situation underscores the urgent need for strengthening of preventive initiatives incorporating new strategies, like male circumcision, and targeting emerging vulnerable groups who are most at risk for HIV/AIDS, including men who have sex with men, drug users, sex workers, and women.

Unfortunately, over the last two years, PEPFAR funding has flat-lined. A decrease in budget neglects the clinical and economic analyses that survival, overall cost of care, and even new infections are linked to getting people into care as soon as possible. Decreased spending now will increase costs in the future; that is the essence of responding to infectious diseases with a growing infected population and increasing burdens over time. It will also increase mortality: patients in need of treatment cannot wait for the international AIDS treatment budgets to increase.

SENDING PATIENTS HOME TO DIE AGAIN

This brief glimpse of a grim and still deteriorating AIDS situation in Africa is not commensurate with a frozen budget. On the contrary, it clearly calls for urgent intervention by increasing funds for treatment and prevention of HIV. The effects of the current flat-lined budget have already demonstrated some worrying trends. Currently, my institution, which pioneered antiretroviral therapy in Africa and treats a big proportion of AIDS patients in Uganda, is not taking on any new patients. We are forced to turn away desperate patients daily. Most of those who come to us will have been turned away from a number of other clinics. A majority of these patients are already receiving care and have been waiting years to receive drugs. Those that still have a few slots have a long waiting list of very sick patients—some of them staring death in the face—jostling to jump the queues.

A survey by UNAIDS found that many adult AIDS patients in Africa are still using the highly toxic Stavudine (d4T) based combinations, which WHO removed from the list of recommended first-line treatment because of serious toxicity. The reason why they still use this drug to-date is because it is the cheapest—they have no other choice. Meanwhile, the lack of new funds means clinics are now being forced to stop enrolling patients. All new PEPFAR contract awards emphasize treatment for only those already on it and only very limited slots for new patients—yet the new patients are the majority.

Hundreds of thousands in Uganda, and millions in Africa, responded to PEPFAR's highly successful testing program, but its success was largely due to the promise that treatment would be provided to those found to be in need. Those found positive but not yet at a stage to require therapy were put in PEPFAR-supported care programs where they were provided with Bactrim, a drug that protects against some opportunistic infections. Those in care had regular CD4 checks

and whenever they reached a stage to need therapy, they received it. Nowadays, when new ones reach a stage when they require therapy, which they were promised, they are disowned and abandoned to their fate.

Let me tell you what I have seen: I have witnessed desperate patients unable to access therapy, including pregnant women, resorting to desperate and dangerous measures including sharing drugs with their family members, ignoring the good counselling they receive advising against this dangerous practice. Recently, an HIV-infected poor woman who was breastfeeding her HIV-negative child because she could not afford formula milk came to our clinic, having been turned away from three other clinics in Kampala because they had no slots. She knew that every day she breast fed her baby without being on treatment greatly increased the chances of her child getting infected, but she had no alternative. As we were trying to find her a treatment center that still had a slot, we were repeatedly told that they were turning away similar cases. We have a situation where some people in need of therapy get it, yet their family members in similar need don't. Through our long experience, we learned that it is virtually impossible to have successful public sector AIDS treatment program where some people get therapy and others in dire need don't.

Early resistance testing studies carried out at JCRC in Uganda found that treatment interruptions predispose the development of drug resistance. Inequitable access compromises the quality of ART programs and fuels resistance to ARV drugs because drug treatment interruptions will inevitably increase. This will result in big numbers of patients failing on the simpler and low-cost first-line drugs and needing more expensive and more sophisticated second-line therapy. It would not take long before an increasing number started requiring the ultra-modern, highly expensive third line drugs—which virtually do not exist in Africa.

Such a situation would make the current cost of ART therapy look small by comparison, especially if HIV-resistant strains start spreading within the community. This would make HIV management highly expensive and complicated. However, this unfortunate situation is not inevitable as long as timely action is taken. Therefore, there is urgent need for increased funding to address increased demand by supporting ART programs in order to prevent reversal of gains and a resurgence of mortality on a large scale. Action is needed now in order to minimize emergency resistance while at the same time expanding prevention services.

An AIDS epidemic of this magnitude calls for a long-term commitment to allow sufficient time for resource-limited countries to build capacity. Many nations in Africa realize that they need to play a bigger role in management of AIDS in their respective countries. A partnership between countries, which extends to civil society and faith-based organisations, needs to be strengthened. In building capacity, PEPFAR needs to help Africa address the main constraints of human resource deficiency by supporting training and salary top-ups for public sector workers, especially those in hard-to-reach and underserved rural areas.

However, almost all African governments and ministries of health systems are still too weak to undertake the enormous task alone. They need continued support and adequate time to build up the necessary capacity in the public sector to eventually take over the work established by

PEPFAR. Hurried hand-over, without allowing time for systematic capacity-building, will break the system instead.

And it is imperative that treatment and prevention together must remain a priority. Without tackling HIV/AIDS, which is the most devastating disease on the African continent, it is extremely difficult to successfully strengthen health systems to a level where they would function well and be sustainable.

The Global Health Initiative

The news of President Obama's new Global Health Initiative—which has added attention to Neglected Tropical Diseases, maternal health, and sexual and reproductive health—was received in Africa with great appreciation.

There are some innovative ways that can be incorporated for cost-effective integration of these diseases into the PEPFAR program. They include funding support for critical facilities like laboratories and clinics that can be shared for diagnosis, monitoring, logistics, and treatment of these and as many of the other diseases and conditions as possible. This envisions widening the scope of training syllabuses for health care providers and community support groups to cover the whole spectrum of diseases. In consideration of deficiently trained manpower in Africa, multi-tasking of staff is important, as the same staff would provide care and treatment for all diseases—especially in rural areas, where most of the people live.

However, the main requirement for successful integration of these serious health issues is to ensure sufficient funding, with new money. It should not be at the expense of HIV/AIDS, which needs increased support.

In this regard, Uganda's Minister of Health sent a letter to Secretary of State Hillary Clinton last September, in which he stated, and I quote, "concerns in growing across the African continent about a slowdown in U.S. assistance via PEPFAR and the Global Fund. I urge that you maintain the pace of assistance as envisioned in the Lantos-Hyde U.S. Leadership Act Against HIV/AIDS, Tuberculosis and Malaria of 2008 so that we do not lose crucial momentum."

Finally, I glance back to 1993 when the AIDS carnage was ravaging my country, Uganda. My institution, the JCRC, was facing a serious crisis. We were losing our staff members, and the rest were spending all their time attending burial ceremonies of their colleagues, siblings, parents, and close relatives. Our trained staff continued to dwindle. The turning point was brought about by PEPFAR. The sick staff members and their relatives who needed treatment got it. My institution gradually recovered and started working smoothly. We have not had any staff deaths due to AIDS in the last 3 years.

Nothing could have done more for health systems strengthening at that critical time than getting AIDS treatment. By treating AIDS, some of the critical elements of health systems strengthening were addressed. Treating AIDS does not contradict health systems strengthening, and it is not one or the other—they go together. What would be the use of training and building human resources only to lose them to AIDS if treatment is not provided when they need it?

In conclusion, allow me to refer to repeated commitments to universal access to AIDS services in UN declarations and G8 communiqués, which caused great excitement and expectation in Africa. But today, with such a dramatic slowdown in funding, we the United States risks jeopardizing the progress toward these goals, which would tarnish the current high esteem Africa has of the U.S. as a redeemer and the world's friend.