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Dr. Wafaa El-Sadr, MD, MPH, MPA
Director of International Center for AIDS Care and Treatment Programs
Director of Center for Infectious Disease Epidemiologic Research
Professor Mailman School of Public Health, Columbia University

Testimony Concerning the President's Emergency Plan for AIDS Relief (PEPFAR)

Testimony of Wafaa El-Sadr, MD, MPH, MPA
U.S. House of Representatives Committee on Foreign Affairs Hearing
PEPFAR: From Emergency to Sustainability and Advances against HIV/AIDS
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Thank you for affording me the opportunity to testify about the transformative and life-saving PEPFAR program, its remarkable achievements, and the numerous opportunities it has created in our fight against the AIDS epidemic and other global health threats.

I have been working in the field of HIV medicine since the very beginning of the epidemic when the first cases were noted at the hospital I was working at in Harlem, New York. I have spent a great deal of my time over the last decade working on HIV research, training, and service delivery and related capacity building, program development and implementation in sub-Saharan Africa.

I currently serve as Director of the International Center for AIDS Care and Treatment Programs (ICAP), an interdisciplinary center which is situated at Columbia University's Mailman School of Public Health. ICAP has been a PEPFAR implementing partner since 2004, and now supports more than 1,200 health facilities in 15 countries in sub-Saharan Africa. To date, ICAP support has enabled the provision of HIV prevention, care and treatment services to more than a million HIV-infected adults and children, roughly half of whom have initiated antiretroviral treatment (ART). In partnership with local Ministries of Health and other stakeholders, ICAP provides nearly 10% of all antiretroviral therapy in sub-Saharan Africa. The ICAP model of multidisciplinary, family-focused HIV prevention, care, and treatment includes support for prevention of mother to child transmission (PMTCT) of HIV, and this effort has enabled more than a million pregnant HIV-infected women to receive care for their own HIV infection and interventions to prevent their babies from becoming HIV infected. ICAP-supported programs also provide HIV testing and counseling services to millions, as well as a wide range of prevention interventions, specialized services for infants and children with HIV, integrated tuberculosis (TB) and HIV services, laboratory support, training and mentorship, all in the context of health system strengthening.

The transformative impact of ICAP's work is made possible by PEPFAR, and by our partnerships with Ministries of Health, local universities, non-governmental organizations, faith-based organizations, civil society, and associations of people living with HIV (PLWH). My colleagues and I have been privileged to witness first-hand the unprecedented scale-up of life-saving services, the impact of PEPFAR on individuals, families, and communities, the rapid expansion of host country capacity, and the remarkable goodwill generated by PEPFAR towards the US government and its people.

PEPFAR's success is widely acknowledged. Millions of lives have been saved, communities have been restored, overburdened health systems have been buttressed, and while much remains to be done, significant progress against the scourge of HIV has been made. Despite these historic

achievements, however, some myths and misunderstandings regarding PEPFAR have gained surprising credibility. Some of these inaccurate ideas are the result of misinformation or genuine confusion, while others are harder to understand. I will highlight a few in my testimony today and address them through my own experience and observations.

First, some claim that PEPFAR works in isolation, disconnected from country ownership and country systems. My experience says otherwise. PEPFAR is demand driven, at the community *and* the host government levels. The work has not been done in isolation or in "silos," but rather in partnership with ministries of health, regional health bureaus, district health teams and non-governmental organizations. PEPFAR operates within the established health structures in the countries where we work, supporting national plans and protocols. All PEPFAR implementers, whether they be international organizations, indigenous governmental or local non-governmental organizations, faith-based organizations, community based organizations or academic institutions play complementary roles in the scale-up of prevention, care and treatment programs—all contributing to national AIDS control programs developed within the countries themselves.

Second, some claim that PEPFAR supported programs have been developed as separate and distinct services that are not integrated and linked to ongoing services within countries. Again, my experience differs from this perception. Those not familiar with HIV programs may envision stand-alone HIV clinics while in reality, the majority of sites that ICAP supports are rural or semi-urban. These health facilities deliver integrated HIV and primary care services right where other services are provided. In Nigeria, for example, ICAP supports PMTCT services for pregnant women within existing antenatal clinics. In Rwanda, ICAP has led efforts in collaboration with the Rwandan government to integrate HIV and TB services, and these innovations have now been taken to scale nationwide. In Ethiopia, in collaboration with regional health bureaus, ICAP supports scale-up of routine HIV screening for TB patients and to all patients and their families whether they are seen in a clinic or on an inpatient ward. In other countries, HIV testing for mothers and babies has been integrated into immunization clinics.

Third, some claim that PEPFAR has had limited benefits to the countries' health systems. The evidence says otherwise. For example, in Tanzania, Ethiopia, Rwanda, Nigeria, Kenya, Mozambique and other countries, ICAP has supported the development of tiered laboratory systems; equipping national, regional and local laboratories; providing training and mentorship to staff; developing effective specimen tracking and transport system; introducing novel interventions, such as early infant diagnosis; and supporting quality assurance. This work strengthens lab systems overall, not HIV systems. At pharmacies across the continent, ICAP has provided infrastructure support, training, mentoring, and supervision, building capacity for stock management, patient counseling, and adherence support that reaches far beyond HIV treatments. Another major contribution has been in the realm of health workforce innovations. In addition to training tens of thousands of health care workers, ICAP and other PEPFAR partners have worked to build skills and morale, and to identify and treat HIV-infected health workers. ICAP programs have also supported new health worker cadres, from adherence counselors and outreach workers to advanced physician-assistant equivalents, such as the *technicos* in Mozambique—efforts aimed at addressing the severe shortage of health care

workers. These models, systems, and investments position the health system to respond to other threats.

A fourth misconception is that the evidence of PEPFAR's impact is lacking. In reality, a key attribute of PEPFAR is its focus on concrete measurable targets, updated quarterly, such as the number of individuals receiving HIV testing and counseling services, the number enrolled in care and the number on ART among other goals and objectives. This approach should serve as a model for other health and development programs. Without a doubt, PEPFAR has saved millions of lives, prevented tens of thousands of new infections, preserved families and communities, and enabled thousands to return to work, and unburdened health systems staggering under the weight of sick and dying populations. More than 7.3 million pregnant women have received counseling and treatment to prevent transmission of the virus to their babies, and we know that with ART we have a real chance to end the HIV/AIDS epidemic in children. Expansion of prevention counseling and campaigns for male circumcision are taking off in several countries. There is also encouraging new information from UNAIDS indicating that twenty-two of the most affected countries in sub-Saharan Africa have reduced new HIV infections by more than 25% between 2001 and 2009. Remarkably, we are now also witnessing a decrease in death rates in the most severely affected countries like South Africa and Botswana with the expansion of HIV treatment. Other evidence from South Africa showed a decrease in under 5 child mortality with expansion of HIV treatment to women in one community.

PEPFAR's contributions to other outcomes beyond strictly HIV targets, are a major achievement. As an example, ICAP-supported programs in Nigeria offer pregnant women insecticide-treated bed nets for malaria prevention, water purifying systems and "mama packs" to encourage safe pregnancy and facility-based delivery—thus impacting maternal and child health. Laboratories supported by PEPFAR serve all within a community, not just people living with HIV. Support and expansion of the healthcare workforce benefits all those needing services within a community. Renovation of antenatal care setting, labor and delivery wards and support of orphans and vulnerable children are just a few examples of the broad impact of PEPFAR. All of these achievements cause great apprehension that if we stall the expansion of PEPFAR, in the name of "greater balance" in global health spending, then we will also be stalling advances in maternal and child survival, as well as many other advances that go far beyond AIDS *per se*.

While so much has been accomplished, there is so much more that needs to be done. Scale up of HIV treatment in PEPFAR focus countries has been phenomenal, but it has only reached about a third of those in urgent need with many more in need of this lifeline today and many more will require treatment in the coming years. Desperately ill men, women and children living in communities near and far continue to line up at clinics with advanced HIV disease in need of urgent services, including HIV treatment. For these individuals with advanced AIDS, the emergency is far from over. In addition, the more we learn about HIV, the clearer it becomes that earlier diagnosis and treatment is more successful and more cost-effective. Reaching individuals at early stages of HIV and linking them to care and appropriate treatment is critical to the achievement of optimal treatment and prevention outcomes – and an entirely different

challenge than providing services to those with advanced or symptomatic illness. As new data have emerged, treatment guidelines have changed. New World Health Organization (WHO) guidelines support earlier treatment for adults, and it is now recommended that *all* children with HIV receive treatment. Similarly, a global consensus has emerged on the need to reach *all* pregnant HIV-infected women in a concerted effort towards the elimination of pediatric HIV. However, despite the evidence, national programs in some PEPFAR focus countries are reluctant to expand treatment eligibility due to resource constraints.

Resources are also critically needed to scale up evidence-based prevention programs, as well as engaging marginalized groups like men who have sex with men (MSM), injection drug users and commercial sex workers. Ground-breaking new research suggests that HIV treatment itself may not only benefit the individual receiving ART, but may also prevent transmission of the virus to their partners. The promise of treatment as part of the prevention armamentarium is terribly exciting. In one recent study, providing treatment to an HIV-infected partner in a discordant couple lowered the chance of infecting the HIV-negative partner by 92 percent. Remarkably, UNAIDS estimates that treating everyone in need of treatment according to current treatment guidelines could result in a one third reduction in new infections globally. Let me emphasize this point – providing treatment to those patients already eligible and in need of ART *for their own health* could have a stunning secondary benefit on the global epidemic. If we continue to scale-up and decentralize access to HIV services, we may very well be able to "treat our way out of the epidemic." But, for now, results from research studies are needed to confirm the value of HIV treatment as a prevention strategy in populations. Encouragingly, recent studies offer promising microbicide and vaccine candidates and efforts are ongoing to study combination prevention strategies that include behavioral, biomedical and structural interventions. Recent guidance from OGAC in terms of an emphasis on addressing gender inequity and support for harm reduction including syringe exchange programs will go a long way to re-invigorating HIV prevention efforts.

Despite enormous progress in the form of lives saved, infections averted and the promise of major scientific breakthroughs, it is a sobering time. The worldwide economic recession has taken its toll on the global response to HIV/AIDS, both in donor nations and in developing countries. PEPFAR has been nearly flat-funded for several years now and the Global Fund will be greatly challenged to respond to continuing needs as it embarks on its replenishment conference this coming week.

This committee envisioned a scale up of resources when it reauthorized the PEPFAR program and set bold targets and new policies that would move us toward a world without an AIDS crisis and with an empowered and enabled health system in the most severely affected countries. We and other PEPFAR implementers are working hard towards this worthy goal. But the potential to truly turn the tide against the HIV/AIDS epidemic and to achieving the durable impact we all desire will be squandered if this funding crisis is not addressed.

While scaling up of treatment and prevention calls for a significant infusion of resources in the short run, there are remarkable benefits to be garnered. There is little doubt that PEPFAR can and does provide a platform for addressing some of the key priorities of President Obama's

Global Health Initiative, such as building health systems for the provision of critical health care services not only for those living with HIV but to others in their communities including women and children. PEPFAR supports tens of thousands of programs and sites embedded within antenatal care programs and primary care settings at health centers, district and referral hospitals. Rather than reinventing the wheel, or starting from zero, we can build on this platform, on the partnerships already established within the many communities, and on the lessons learned from the scale-up of HIV programs. Much can be achieved to advance the health of women and children through smart use of resources and by searching for synergies and economies of scale.

I have witnessed in my own career the worst of times and the best of times in relation to the HIV epidemic. In the early 1980s in Harlem, New York, we watched helplessly as our patients died and their families mourned. This was the worst of times. We then lived through the miracle of newly-discovered HIV treatments, reviving those close to death. In Africa, for years we watched helplessly as communities were decimated, despairing from the ravages of this epidemic. Here too, we witnessed a remarkable transformation, a transformation that you and every American citizen can take great pride in. So much has been accomplished through PEPFAR, so much remains to be done.

Time is of the essence. The sooner we scale up HIV treatment and prevention, the more lives we will save, the more deadly tuberculosis infections can be prevented, the more families, communities and livelihoods we will preserve. Aggressive investment in HIV prevention and treatment scale-up with universal access**,** combined with continued investment in research, in conjunction with a commitment to building capacity and the strengthening health systems, can change the trajectory of the HIV epidemic in sub-Saharan Africa. It can also contribute substantially to the overall welfare of women and children. Strong US leadership in partnership with affected countries and other donor nations can bring this goal within our reach.

Thank you