Two statements on HIV/AIDS issues in Botswana

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A: STATEMENT BY H.E. PRESIDENT MOGAE ON THE FIGHT AGAINST HIV/AIDS IN AFRICA AT THE FOURTH ORDINARY SESSION OF THE ASSEMBLY OF THE AFRICAN UNION, Abuja, Federal Republic Nigeria (31/1/05)

I am pleased that HIV/AIDS continues to be one of the key issues on our agenda. The epidemic has so far claimed the lives of 15 million of our people. In 2004 alone, over 2 million Africans died of AIDS. Today, more than 25 million people in Africa are living with the virus. This is according to the United Nations AIDS (UNAIDS) Report!

As long as HIV is the leading cause of death in Africa, as long as large numbers of people are infected, over 3 million new infections in 2004, again according to UNAIDS we must continue to remind ourselves and one another that whilst HIV/AIDS is a global human tragedy, given the magnitude of AIDS related deaths on this continent, we must view the epidemic as an African disease. We must accept that we are sick, in need of help and ask for assistance!

The problem of HIV/AIDS is more severe in Sub-Saharan Africa. It is important to point out, however that some countries have more HIV infected people than others even if their prevalence rates are lower. This means that the large variations in prevalence rates that currently exist between individual countries and regions of Africa should not be a source of comfort for any one of us.

HIV/AIDS respects no geographical boundaries. Africa is a vast continent but given the supranational dimension of the epidemic particularly with regard to transmission, the inter-regional and inter-country linkages as well as the inter-dependence of our economies the epidemic has swept across all countries. Increasing numbers of people with HIV are ill. The social and economic consequences of the epidemic are felt widely in education, industry, agriculture, transport and human resources. In other words, the impact of HIV/AIDS on our economies and societies is pervasive and insidious.

Mr. Chairman, in discussing the problem of HIV/AIDS, we should not dissipate our energies on debating the validity or accuracy of the statistics. We must agree that whatever the percentages of HIV prevalence or the number of infections per annum, the problem is sufficiently serious to warrant our immediate response. We must focus on actions which we must take individually and collectively to respond effectively. We must also be direct and honest in stating that generally our response to HIV/AIDS has not matched the severity of the epidemic. This should be a source of grave concern to all of us because our people are dying.

Africa's response can be measured in terms of leadership and commitment of governments, the provision of financial and human resources as well as the mobilization and involvement of communities in the development of programmes to fight the epidemic.

In the absence of expanded prevention, treatment and care, the AIDS death toll in Africa is expected to continue rising before reaching its peak by the end of the next decade. This means that whilst the current situation is already severe, the worst impact of the epidemic is yet to come! We should not allow this to happen. The time to act is now!

Prevention of new infections is key to success if we are to avert this impending catastrophe. This means a number of things. Encouraging people to know their status so that appropriate support may be given, access to health care by all citizens, research on preventive measures such as vaccines, the use of medicines such as, tenofir and microbicides, as well as the prevention of mother-to-child transmission of HIV/AIDS.

Part of the struggle against HIV/AIDS should be the recognition that Africa cannot fight the epidemic alone. We are an integral part of humanity and must seek the assistance of others who have the capacity and resources. In this respect, we must be willing to establish partnerships which can strengthen our own capacity in dealing with preventive measures, in undertaking research on the development of vaccines and in the administration of anti-retroviral drugs (ARVs).

Whilst ARVs are not a cure, they must be seen as an essential component of care that can enable large numbers of people to live normal and productive lives. This would reduce the adverse social and economic consequences such as the loss of productivity and our educated and skilled personnel in the fields of education, industry, agriculture and transport.

It has been estimated that in 2004, over 5 million people in the developing world were in need of life-saving ARV medication but only 8% of them had access to it. In Africa, only 4% of those in need had access to ARV treatment.

This situation is in stark contrast to what obtains in the highly industrialized countries where treatment is available to almost everyone who needs it. There are many factors which are an obstacle to treatment, chief amongst them is the lack of resources.

In addition, the existence of a health care delivery system with doctors, pharmacists, laboratory scientists and nurses is key to the provision of ARV therapy. This is why I strongly believe that we must be open about our lack of capacity and ask for help. And we can only do so if we know our situation and can clearly articulate our needs. In Botswana we have a saying that it is the child who cries that gets parental response.

In December 2003, the World Health Organisation (WHO) announced a strategy aimed at bringing ARV treatment to 3 million people living with HIV in developing countries by 2005. This strategy commonly known as the '3 by 5 Plan' does not translate into WHO actually purchasing and supplying the ARVs. It means working in partnership with global organisations, non governmental organisations and national governments to provide support and expertise. Part of the plan was to have half a million people in developing countries receiving ARV treatment by June 2004. But at that time only 440,000 people were in receipt of this treatment and not all of it was attributable to the plan.

Mr. Chairman, it was also planned that 25 countries will have implementation plans by June 2004, but only 3 countries had these plans. On the basis of the foregoing, it is clear that the

targets will not be met within the intended timeframe. But we must never lose hope. We must persist and persevere in the war against HIV/AIDS.

We cannot abandon the plan as a failure at this juncture. We should expect that once the required treatment structures are in place, the flow of drugs will accelerate. We must come up with implementation plans and then demand that our partners honour their commitments as the success of the plans would be largely dependent on timely availability of resources.

In April 2001, the UN Secretary General, Kofi Annan, estimated that an amount of US $7-10 billion was required annually to tackle the HIV/AIDS epidemic in the low and middle-income countries, worldwide. Given the prevalence rates currently experienced in Africa, the required amount has certainly increased. On the other hand, performance against the Secretary General's estimate has not been impressive, as demonstrated by the fact that by 2003, an estimated amount of only US$4.7 billion was available for the AIDS response, and this amount included funding coming from the affected country governments.

However, all is not lost, because since September 2001, a number of funding initiatives have been developed and implemented. These include the Global Fund to Fight AIDS, Tuberculosis and Malaria, President Bush's Emergency Plan for AIDS Relief (PEPFAR), the World Bank Multi-Country AIDS Programme, The Clinton Foundation, the Bill and Melinda Gates Foundation and the Merck Company Foundation.

PEPFAR is one of the main players in the provision of ARV medication to people around the world. This relief fund committed US$15 billion to fight AIDS in poor countries, over a 5-year period. Its goals are to prevent 7 million new AIDS infections, to treat at least 2 million people with life saving drugs, and to provide care for people suffering from AIDS and AIDS-orphaned children by 2008.

PEPFAR targeted 15 countries; 12 African and 3 Caribbean. By July 2004, PEPFAR was supporting ARV therapy for at least 24,000 HIV infected people in 9 countries. Although its exclusion of some of our countries is divisive and therefore unacceptable, it is nevertheless making a difference. The impact of AIDS on African economies and societies is comparable in magnitude to that of the Asian Tsunami. Assistance in connection with HIV and AIDS is therefore enlightened humanitarian relief which must not be conditional upon political considerations. I say enlightened because if the world thinks HIV & AIDS are peculiarly African, then they are in for a rude awakening, given the epidemics insidiousness.

PEPFAR currently supports the use of the expensive patent drugs from the big pharmaceutical companies. We can argue convincingly that even larger quantities could be procured if the prices were lower. A qualitative improvement to PEPFAR should therefore comprise greater inclusiveness and its use for the purchase of generic drugs.

I believe that if we put our case strongly to our development partners, they should recognise the magnitude of resource deficit in Africa and accept that cheaper generic drugs can go a long way in enhancing the effectiveness of existing funding initiatives. In this connection, just as in the case of the Asian Tsunami, comprehensive debt cancellation for all the affected African countries is called for.

In our fight against HIV/AIDS, we must consistently seek partnership and collaboration because there are many people of goodwill who are on our side. In recognition of this

problem of unaffordable prices the Clinton Foundation took the initiative to act as a mediator between some low-income countries and pharmaceutical companies.

The mediation by the Clinton Foundation resulted in some companies reducing their drug prices, some handing over patents and others allowing cheap generic versions of the drugs to be manufactured. Due to this effort, the price for the most common antiretroviral medicine was reduced to about US $140 per person per year, and in April 2004, this deal to offer cut-price medication was extended to the 122 countries covered by the Global Fund.

It will also be recalled that the Global Fund was formally established in January 2003. Since its creation the Fund has approved proposals worth US$3 billion in 128 countries over the past two years. It has so far disbursed funding amounting to US$ 672 million and signed grants for US$ 1.8 billion.

There is no doubt that this money will enable Africa to, among others, procure the much needed medication for AIDS treatment and to build capacity. One of the main criticisms however, has been that the application process is too laborious and disbursements are painfully slow.

It is also a concern that the sustainability of the fund is dependent on the flow of donations and yet it has been found that the flow of money has been slower than pledges. This is a source of anxiety to the resource poor who see hope in the Global Fund.

Mr. Chairman, it is not my intention to either discuss all sources of funding or to discuss PEPFAR and the Global Fund exhaustively. I take this opportunity to emphasise the fact that whilst we need assistance and support, we must guard against falling into the trap of excessive dependence on external funding. Africa must work hard to ensure that we sustain what has been created through external assistance. In order to achieve this prevention and control of the spread of HIV must always be given priority in our interventions.

Apart from ARV treatment there are initiatives such as the development of HIV vaccines. The development of a safe, globally effective and affordable HIV vaccine represents the best long-term hope for the future control of the HIV epidemic. The development of such a vaccine requires the conduct of multiple clinical trials to assess protective efficacy of different vaccine concepts, and different HIV subtypes in diverse populations which may differ in the routes of virus transmission.

Additionally, populations may differ in genetic, nutritional or health backgrounds, hence the need for multiple trials conducted in both industrialized and developing countries. These require intense co-operation and collaboration.

Africa has an important role in the vaccine development process, given the burden of the epidemic on the continent. African countries, governments and communities must be involved in multiple trials, in all phases of the vaccine development so that the best vaccine candidates are identified on the basis of the most relevant data.

To this end, I am happy to note that the African AIDS Vaccine Program (AAVP), formed in September 2000, has been key in facilitating the collaboration of African countries in the process of HIV vaccine development. AAVP now comprises a network of African scientists, institutions and communities.

This network is promoting and facilitating HIV vaccine research and evaluation in Africa through capacity building, regional and international collaboration. It has facilitated the development of National HIV Vaccine Plans for several countries, and in collaboration with WHO has assisted these countries to hold vaccine workshops for national consensus-building on their role in HIV vaccine development. Such workshops have been held in Nigeria, Tanzania, Uganda, Zambia, Cote d'Ivoire, Ethiopia, Cameroon, Kenya, and Tanzania and most recently in Botswana.

The first HIV vaccine trial began in the US in 1987, while the first African country to conduct an HIV vaccine trial was Uganda. Since then, other African countries including Kenya, South Africa and Botswana have conducted Phase One and Two trials of experimental HIV vaccines. In June 2003, Botswana became the first country in Southern Africa to begin testing an experimental HIV vaccine. Follow up of volunteers in this trial is ongoing until later this year. We plan to move ahead with our vaccine effort and begin testing several other HIV vaccine candidates.

It must be recognised however that, prior to initiating vaccine trials substantial infrastructure needs to be developed. Community consultation and relevant epidemiological and socio-behavioural data is also required.

Mr. Chairman, in conclusion, I urge all African governments that even as we critically examine the assistance we get from others, we also need to pause and be introspective. Some of the questions we should ask ourselves are: Are we giving the fight against HIV/AIDS the attention and priority which it deserves? Are we providing the leadership in mobilizing the people to be part of the war against HIV/AIDS? Are we doing enough to raise domestic resources? Are we utilising the assistance we get efficiently and effectively? How are we contributing to an effective partnership regionally and globally?

Lastly, I take this opportunity to express our deep gratitude to our development partners for the assistance and support they have provided and continue to provide during these difficult times. I urge them to stay the course and strive to improve the terms of assistance provided to Africa. I also encourage African countries to unite in this fight against HIV/AIDS. It is a long fight. It is a war we cannot afford to lose because defeat can only mean ceasing to exist as Africans.

B. NATIONAL AIDS COORDINATING AGENCY RESPONSE TO THE ARTICLE, "Government's comments on HIV prevalence misleading".

The National AIDS Coordinating Agency (NACA is tasked with the responsibility of coordinating the National HIV/AIDS Response at various levels and sectors. It coordinated and facilitated the conduct of BAIS II 2004, which was carried out by the Central Statistics Office under the Statistics Act.

Traditionally NACA does not respond to issues that are politically motivated. It is the responsibility of NACA to provide scientifically valid information as part of its endeavour to educate the nation. NACA has the obligation to set the record straight in a situation where

valid information on HIV/AIDS is distorted. As a result we are bound to respond to the article titled: "Government's comments on HIV prevalence misleading", written by Dr. Kesitegile Gobotswang, BCP Office of the Secretary for Health that appeared in the Botswana Guardian of Friday 21st January 2005.

The article states that Office of the President released BAIS II preliminary results a week before Christmas. As far as we know, Office of the President did not release any such results.

We are not aware of any statement from the Office of the President (OP) and the Ministry of Finance and Development Planning alluded to in the second paragraph of the article.

The statement that "a patently erroneous impression is created that National HIV prevalence in Botswana now stands at 17 percent compared to 37 percent allegedly used by the UN" is not clear to us. If such an erroneous impression was created, neither the Office of the President, or the Ministry of Finance and Development Planning nor any other organs of Government did it. It is a fact that the national HIV/AIDS prevalence rate is estimated at 17%, a population-based rate from the recent BAIS II results. The 2003 Sentinel Surveillance Report provided by the National AIDS Coordinating Agency clearly states 37.4% as the HIV/AIDS prevalence rate for pregnant women aged 15-49 years who visited antenatal clinics at the time of the survey. The 37.4% cannot therefore be interpreted to be the national HIV prevalence rate for Botswana; hence there is no comparison between this figure and the 17%. Production of the Sentinel Surveillance Reports was a collaborative effort between NACA, MOH, UN, BOTUSA, ACHAP and Botswana Harvard Partnership. This confirms the mutual respect, collaboration and cooperation that exist between all the concerned parties. It is therefore difficult to understand how the UN is allegedly using the 37.4% as the national prevalence rate. There has never been any inference on the part of Government that the UN fabricates data from outer space. We further disagree with the author's assertion that the Government seeks to celebrate the 17% prevalence rate. The rate is still very high and calls for continued and concerted efforts to combat the HIV/AIDS scourge.

Government has no intention to replace antenatal sentinel surveillance systems with population-based community surveys and has full confidence in the results and information generated from antenatal sentinel surveillance system. Both systems serve different purposes in a complementary manner. There has never been any insinuation by Government "that BAIS will from now on be the only official data source". The Ministry of Health will continue to conduct sentinel surveillance in line with its statutory mandate of disease surveillance. As far as we know, there has been no attempt by Office of the President and the Ministry of Finance and Development Planning to cast any doubt on the Ministry of Health's annual sentinel surveillance data.

The UNAIDS/WHO in their Global Summary of the AIDS epidemic report of December 2004 acknowledged the potential of national population based surveys on improving the accuracy of estimates of HIV. The report states that population based surveys provide countrywide data on HIV prevalence for both sexes including data from the remote rural areas rarely covered by sentinel surveillance systems. It provides information on HIV prevalence among men and non-pregnant women. The report from UNAIDS/WHO confirms the high standards the Government of Botswana employs to monitor HIV/AIDS trends in the country, and lends authenticity to the strategies put in place to tackle the epidemic.

The Government of Botswana has not tempered with any rate but only provided a prevalence rate from a population-based survey, the first of its kind in Botswana. Secondly, the ranking does not concern Botswana as much as the magnitude of the epidemic. The ranking is incidentally important, but more importantly informs us of how much resolve and efforts we need as a nation to combat the scourge.

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