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By Invitation

BOTSWANA BEGINS TO BENEFIT

By Donald de Korte and Ernest Darkoh

Countries should not wait until all the components are fully in place before starting to provide antiretroviral therapy

Botswana, with its relatively small population of 1,7m, was in the unenviable situation of having the highest prevalence of HIV/Aids in the world in 2001 - 38% of the group aged 15-49 was HIV-positive (300 000 people). An epidemic of such magnitude was resulting in devastating and unacceptable human and economic losses.

The African Comprehensive HIV/Aids Partnerships (Achap), a collaborative effort between Botswana's government, pharmaceutical company Merck and the Bill & Melinda Gates Foundation, decided to introduce antiretroviral drugs (ARV therapy), as a matter of policy, to address this emergency. The goal was to achieve no new infections by 2016.

Treatment began in January 2001. To date 8 000 eligible patients have been identified, of whom over 5 000 are on ARV therapy. The initial cost of US\$1 200-1 500/patient, already low by international standards, is expected to fall because of economies of scale arising from the extension of the programme and further decreases in the prices of ARV drugs.

With more than 5 000 patients on ARV therapy, we are beginning to see some of the benefits associated with providing a public therapy programme. People who would otherwise have died are getting better. Patients have regained levels of health that allow them to work, care for their children and continue being productive members of society.

An additional benefit is that the availability of ARV therapy has broken the cycle of denial and infection by providing people with a reason to find out their HIV status.

This has allowed us to acknowledge the extent of the crisis, and to link people to numerous beneficial targeted services. Services such as prevention of mother-to-child transmission and nutritional, psychosocial and prevention services may help postpone the need for ARV drugs.

Providing treatment to individuals will ultimately relieve the burden on other support and care systems. Thus, an investment in treatment now probably represents a saving in health-care costs in the long run.

Though the case for providing treatment is compelling, there are numerous challenges to overcome. Costs are still quite high despite dramatic decreases in drug prices, and the logistics of providing lifetime therapy for large numbers is daunting.

Countries launching therapy programmes will face the continuous challenge of unreasonably high expectations from the public. Furthermore, it is largely the very sick who come forward for care. Since they require five to 10 times more resources and time than patients who are less ill, this can set up a cycle of insatiable demand.

There is also a school of thought that ARV therapy should not be provided unless there is an incentive-based continuum of care and services in place. These criteria set the bar extremely high for countries contemplating therapy programmes, and can delay decisions to launch therapy.

In Botswana we have learnt that an important issue is capacity (human resources, physical infrastructure, equipment and systems), not just money. We have found that strong political will from the highest level of government, in conjunction with public-private partnerships such as Achap, is essential. There are also numerous interwoven systems, such as leaner community-based models, that need to be developed for successful and sustainable service delivery.

Despite these complexities, it can be done. Countries should not wait until all the components are fully in place before starting.

For instance, we agreed upfront that we would "learn as we go" because the goal was to save lives. Our primary aim was to keep people alive and, alongside this, we would try to establish the continuum of care. Our approach seems to be working.

Though ARV therapy is important to save lives, we have realised that the benefits go well beyond this. Offering therapy encourages prevention by giving people a personal reason to be involved in either protecting their negative status or managing their positive status. After all, the ultimate goal is to enhance prevention efforts and ensure that future generations are HIV-free.

As horrible as a 30% HIV prevalence may be, the good news is that 70% of the population is negative. Countries have to ask themselves what they are doing to keep that 70% negative. In Botswana we remain optimistic that individuals, government and the private sector, working together, can ultimately curb this deadly epidemic.

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