

“2 in 5”

By Geoff Dyer
Financial Times Weekend; Oct 10, 2003

Although most of Botswana is a sand-filled basin of scrubland savannah, in the south-eastern corner granite and sandstone hills slope down towards the Limpopo river. It is here that a large part of the population lives, many in towns such as Palapye, which is on the highway to South Africa and the rail route to Zimbabwe.

If it were not for the 24-hour funeral parlour on the edge of town, there would be no obvious clues that Palapye is one of the epicentres of the global Aids pandemic. In this southern African country nearly two in five adults are infected with the virus. Without the drugs that have made Aids a treatable disease in the west, most will die within a decade.

With its population of 1.7 million, Botswana has been one of the African continent's few success stories. Since the 1960s, its per capita income has grown as fast as Singapore's or South Korea's. It is a popular tourist destination for upmarket safaris, but its real wealth is the huge diamond deposits that have turned it from the poorest country in Africa at independence in 1967 into the second-richest. Now, President Festus Mogae regularly warns that Botswana faces "extinction".

In Palapye, when the winter sun sets quickly behind the acacia trees, the lorries that criss-cross the country leave the highways and many spend the night there. Outside the town's busy supermarket, local women have set up tables where they sell time on mobile phones to drivers who come to eat at Nando's fast food restaurant. The overnight truck stop, which includes vehicles from neighbouring South Africa, Zimbabwe, Zambia and Namibia, also attracts a large number of local prostitutes.

Near the town there is a mining area that employs many migrant workers. Away from their families for long periods, they are also a magnet for prostitution. Just down the road is the copper mining town of Selebi-Phikwe where Aids has become so rampant that the government estimates more than half the population is infected. In the country as a whole life expectancy is 44 and, according to some estimates, it could eventually fall to 27.

Botswana may be suffering more than most from Aids, but it is also the country that has come up with the most ambitious response. The administration of President George W. Bush has focused much attention on Uganda, which has shown that Aids prevention campaigns can reduce the number of new infections. But, so far, treatments for Aids

patients in Africa have been largely for the rich. However, with the help of the Bill and Melinda Gates Foundation and US drugs company Merck, Botswana has become the first African country to try to offer Aids treatment to its population through the public health service. The organisation they have founded to assist the government is called African Comprehensive HIV/Aids Partnerships - or Achap, for short.

It is hard to overstate the importance of the Botswana experiment. In sub-Saharan Africa, there are 30 million people with HIV and the UN predicts more than 50 million Africans could die from the disease over the next two decades.

Whether Aids can be tamed in Africa has become one of the great moral challenges of our time. Western donors are watching closely before deciding whether to set aside more funds. If Botswana, with its track record of political stability and rising prosperity, cannot make its Aids treatment programme work, then the outlook for the rest of Africa is not encouraging.

The early signs from Botswana are that many of the problems can be overcome. There are 10,000 people already on Aids therapy. Yet the biggest difficulty for the government is not the delivery of the drugs, it is waking up the population to the crisis they are caught up in. After 15 years of hearing about Aids, Botswana's people now treat the disease as normal. The lesson appears to be that Aids drugs are not a solution. They are only a first step, an opportunity to begin peeling back the thick layers of denial and superstition, awkwardness and fear that surround the disease.

The paralysis runs deep. Donald de Korte, the Dutchman who runs Achap, says his father summed up the atmosphere well in a recent visit to Botswana. "It reminded him of Amsterdam in the early years of the war, in 1941 and 1942, before the Resistance really got going," he says. "Everyone knew that there were these horrific camps in Germany and further east and that people were disappearing and being taken to these camps. But no one did or said anything."

Holding the white pills tightly to his chest like a kid with his first pocket money, Thongsbotho Goepomang has the smile of a young man who knows that he is lucky. His girlfriend died three years ago of Aids and he thought he would die last year, before he enrolled in the government's treatment programme. "I was so thin that my family had given up on me," says Goepomang, who comes from near Palapye.

A look at the numbers shows just how fortunate he is. Of the nearly 30 million people in Africa who are HIV-positive, fewer than 100,000, that's one in 300, are on anti-retroviral therapy (ARVs), the drugs that since the mid-90s have kept many Aids patients in the west alive. Commenting on the situation, Nelson Mandela has said, "It is a travesty of human rights on a global scale."

These statistics have provoked a passionate debate over who is to blame. Activists have pointed the finger at the drugs industry, accusing the companies of charging excessive prices for Aids treatments, which are protected by patents. Some industry executives and

western government officials have countered that the reason so few people in Africa are receiving treatment is because of the poor quality of healthcare infrastructure in many countries. What does it matter if the drugs cost \$1,000 or \$10,000 a patient per year, they ask, if a government's annual per capita spending on health is only \$10?

Even when the drugs are available, Aids is a complicated disease to treat, requiring counselling, expensive testing, constant follow-up consultations and a good diet. Some experts have questioned whether poor and illiterate Africans would be able to follow such a regime.

It was to help answer some of these questions that Achap was set up. With \$100m to spend over five years, the idea was to see what could be done if money was taken out of the equation. Achap has been designed to work in tandem with the government, which is supposed to take over its functions at the end of the programme when much of the infrastructure, such as clinics and staff, will already be in place.

Founded in 2001, the programme had a slow start. Parts of the government resented the interference of outsiders and winning approval for some projects required painful consensus. There was not enough space at hospitals, computers to track prescriptions or people who knew how to use computers. There was also a huge lack of doctors, nurses and counsellors. Botswana does not have a fully fledged medical school and most of the doctors are foreigners.

Thongsbotho Goepomang's experience shows, however, that many of those obstacles can be overcome. Now 24, he had several sexual partners before he met his girlfriend. They started out using condoms but, after a while, he says, "I didn't want to have to eat sweets with the wrappers on." When his girlfriend died of Aids in 2000, he realised he should find out if he was HIV-positive. But when he had his test, there was no counselling and he did not go back for the results because he was afraid of finding out the truth.

Two years later, when he started to feel swelling in his lymph nodes he consulted a traditional healer over his symptoms. When that did not work, he went again to be tested and this time was given advice. He started taking ARVs last October, but suffered side effects, including dizziness and vomiting. In February he changed to a different drug combination, which has worked much better. He still looks thin, but says he has put on weight. He is unemployed and doubts anyone will give him a job because of his status. But he adds: "I am very happy with the treatment. Before, I really felt I was almost dead."

Goepomang is also completely engaged in his treatment. One of the ways of checking a patient's health is to measure the so-called CD4 count, the level of immune system cells in the blood. If the level falls below 200, patients are supposed to begin taking ARVs. Goepomang knows exactly his CD4 level, which was 174 before he began treatment and is now 254.

Sceptics say that providing the drugs is the easy part. The real hard work is making sure the patients continue to take them. Aids drugs are for life. If patients do not follow the

treatment properly, resistance to the drugs can start to grow. Doctors who have worked on TB treatment schemes in Africa say it is common for patients to stop taking the drugs when they feel better. There is the added difficulty of the high mobility of many people in Botswana, which makes monitoring and compliance difficult. It is not uncommon for farmers to have three homes, albeit modest - one in a village, one on a farm and another at a cattle station.

So far the results have been surprisingly good, however, with compliance rates of around 80 per cent, which is higher than for Aids patients in western countries. "They are prepared to take the treatment religiously," says Philip Fredrick Mwala, the chief medical officer at Sekgoma Memorial Hospital.

Donald de Korte feels that most of the discussions about Aids treatment in the west miss the reality. He is scathing about the people in industry and governments who feel that treating Aids is too difficult and that money should be focused on prevention. On drug prices, he says recent cuts by GlaxoSmithKline have helped, but this is also far from the main challenge. "The people who say that it is all about drug prices do not really know what they are talking about," he says. "Treating Aids here is difficult, but it is do-able."

For all its ambition, however, the government is only starting to deal with Botswana's Aids crisis. Over the next year, it hopes to have 20,000 patients on ARVs through the public sector. However one survey indicated there were 100,000 people who were at the stage of the disease where they needed treatment. After a decade and a half of the epidemic, the scale of the problem is staggering.

It is first thing in the morning at the Princess Marina hospital in the capital Gaborone, the country's main public hospital, and the queue of new patients at the Aids clinic stretches the length of the long corridor. Several had to be brought in on stretchers. Many of the others are so thin you can see the bones of their legs pressing against their skin.

It is like this every morning. The earlier a person is diagnosed as HIV-positive, the easier and cheaper it is to treat them. However most are already extremely ill before they enrol in the government's programme and require substantial medical attention, often including a hospital bed. The average CD4 count of the patients asking for treatment is 50, an advanced state of the disease. While Botswana is providing evidence that Aids treatment in African countries is technically feasible, what it is beginning to confront is the extent of the stigma attached to Aids.

"With the time we spend on one patient who is in intensive care, we could treat 5-10 patients who were not so ill," says Ernest Darkoh, a qualified doctor and former McKinsey consultant who runs the government's treatment programme. "Our already short staff are burning out. It is not sustainable like this."

To begin unpicking the accumulated problems of Aids, doctors need to know who is actually infected. Yet fewer than 10 per cent of the population has taken a test. The majority of people in Botswana who are HIV positive have no idea. "The people who do not know their status, they are the real time bomb," says Donald de Korte. "Only if we can do more testing can we start to radically change attitudes."

The great hope among health officials is that by providing free Aids treatment, the fear of finding out your status will decline. People are more likely to get tested if they know they will not be sent away empty-handed. "Aids drugs are an entry point to engage a population that is used to the epidemic," says Darkoh.

However, they face a wall of denial. Elisha Chipandwe, a Zambian doctor who works at the Newtown Clinic in Serowe, near Palapye, says the reluctance starts at the hospital. "The greatest number of people in denial are the health workers," he says. "The nurses and pharmacists do not want to get themselves tested - it is one of the biggest reasons that the community does not get tested." These are the people, he says, who should understand better than anyone the importance of knowing your status and changing sexual behaviour. "There are times when I have refused to go to the funerals of staff members because it angered me so," he says.

Newspapers rarely report that someone has died of Aids, even when the victim is one of their own reporters, preferring instead to hide behind the euphemism of a "long illness". Some journalists say they are afraid of legal action if they name a person as a victim of Aids.

To help break the taboo, President Mogae took an Aids test in June. (He was negative.) Officials are talking about introducing routine testing whenever someone comes into contact with the health system.

Mmopane is a village about a half hour from Gaborone and once you leave the highway, the roads become dirt tracks. Most people live in modest stone houses with one room, but there is the occasional exception: a retired soldier has built a large white, modern house surrounded by lush plants and an iron fence.

I had come to Mmopane to visit a traditional healer, Kitso Mbenge, because of the huge influence healers like him have over medical practice across Africa. There are 50 times more traditional healers than medical doctors in Botswana. I had little idea of what to expect or even what language we would speak. Mbenge immediately caught me off guard by offering to speak in French before settling for English.

Mbenge is a curious mixture of the modern and the traditional. He also has a large, newly built house, of red bricks and tinted windows, but we sat on chairs in the dirt yard, with chickens and turkeys roaming around, under the fern-like leaves of a mosetlha tree. In the corner of the yard, there was a vegetable patch full of choumolia and rape plant and in the middle several women and children were cooking at an open fire.

Mbenge is tall and rangy with tightly cropped greying hair, as if he were topped by a sprinkling of talcum powder. He wears a lumberjack shirt, cream chinos and a pair of docksider shoes, blotched with paint. His story demonstrates the force of traditional medicine in society. He went to Catholic schools and his religious parents did not believe in traditional healers. It was only when he moved to the Netherlands to study graphic design that he says he felt his calling. "It came to me in a dream over four consecutive nights. It was a calling from the ancestors. I knew that I had to come back," he says.

Traditional healers offer a service that aims to be part medicine, part social work and part mystic. Mbenge spent two and a half years training with elders, learning about the use of herbs and other techniques such as bone-throwing, where healers give advice to patients based on the way that a bunch of bones falls on the ground.

To many doctors in Africa, the traditional healers are anathema, a direct challenge to the expertise they have painfully acquired. Some even believe they present a huge threat to public health. According to Dr Chipandwe at the Newtown Clinic, many indulge in dangerous and dubious practices. "I have heard of cases where to treat female infertility, some traditional healers put a medicine on the head of their penis and insert it into the vagina," he said.

Doctors say that just by improving the diet of an Aids patient, the healers might make that person's health improve temporarily, which could dissuade them from seeking help at a hospital or from continuing their treatment. And it is possible that some of the herbal remedies they use could react badly with powerful Aids drugs.

Yet traditional healers could have a crucial role to play in treating Aids. According to Oscar Motsumi, an anthropologist who works for Achap and who has studied traditional healers, they are critical to the government's plans. "If they say to people, do not use condoms and do not take anti-retrovirals, they can destroy everything the government is trying to establish," he says. Doctors say there have already been cases of patients not taking the drugs because the traditional healers told them not to.

Motsumi is encouraging the government to start training for traditional healers that would enlist them as partners in the Aids programme. They would be encouraged to refer Aids patients to doctors, to persuade people to get tested and to urge patients to take their drugs. "You have to operate in the cultural context. People believe in them. They are seen as guardians of society," he says. "The message has to come from them and not from a medical officer."

On the subject of Aids, Mbenge, the traditional healer, is evasive. He claims that none of the people who have come to see him in recent years has had the disease so he has not faced the task of trying to treat them. What healers like him really want, he says, is to be shown some respect by the medical establishment, to gain recognition that traditional methods are not irrelevant. "I do not use a stethoscope, I use visions from ancestors," he says. "But I can help people too."

Life-threatening diseases are usually discussed in hushed tones.

The mention that someone has cancer is often greeted with an awkward silence and a nervous in-take of breath. It is the natural human wariness of confronting our mortality. It is harder still to have an open discussion about a disease when the cause involves sex and promiscuity.

In Africa, there is an extra twist. One of the oldest prejudices in the world is white people criticising black sexual licentiousness. Especially in South Africa, some people have reacted aggressively to the implication that Aids has spread so rapidly in the region because of black promiscuity.

One example was an extraordinary 114-page document produced last year for a meeting on Aids of the national executive committee of the ANC, President Thabo Mbeki's governing party. It was full of sarcastic swipes at perceived stereotypes the Aids epidemic has encouraged.

"Yes, we are sex-crazy! Yes, we are diseased! Yes, we spread the deadly HI virus through our uncontrolled heterosexual sex! In this regard, yes, we are different from the United States and Western Europe! Yes, we, the men, abuse women and the girl-child with gay abandon! Yes, among us rape is endemic because of our culture! Yes, we do believe that sleeping with young virgins will cure us of Aids!" according to an extract published in South Africa's Mail & Guardian newspaper.

The document's main author is believed to be Peter Mokaba, a former ANC Youth leader. As a politician Mokaba denied the existence of Aids and described anti-retroviral drugs as "poison". He died last year of "acute pneumonia, linked to a respiratory problem" that he had denied was Aids. Yet Africans are also trying to understand how it is that in a country such as Botswana nearly 40 per cent of the adult population is infected with a virus that is largely transmitted by sexual contact.

Reverend Obed Kealotswe is one of growing number of people in the country who believe that sexual behaviour and the relationship between men and women is at the root of Botswana's Aids crisis. A minister at a church about an hour away from Gaborone, he did a doctorate in theology at Edinburgh University and there is a touch of the Kirk in the way he talks about personal morality. "Botswana is one of those countries where everything about the disease is advertised and understood, but still it spreads," he says. "You can only understand that if you look at culture."

He was motivated to talk publicly about Aids and sex when he found out his daughter Ingrid was HIV-positive. "It was a huge shock to me. You bring your children up a certain way with a certain moral code and give them all the information they need to protect themselves," he says.

Only by addressing the power exerted by men and attitudes to female sexuality, he believes, will the spread of the disease be halted. "It is a traditional culture where women

have no control over their bodies. They cannot say no for a good reason," says Reverend Kealotswe, who is a minister at the United Congregational Church of Southern Africa, David Livingstone's church, and also teaches at the university. "The man is always in control of the sexual life."

Banu Khan at the government's National Aids Coordinating Agency, says there is a high level of "inter-generational sex" between older men and younger women, which helps explain the rapid spread of the virus through society. "It is common for young women to have sex with older men before their peers," she says. As prosperity has spread, she says, so has the concept of the "sugar daddy", a middle-aged man who has a wife in his village but keeps a young mistress in the city during the week.

According to government statistics, around 80 per cent of children are born to unmarried mothers. Several research studies have shown a high level of sexual violence in South Africa and there is some evidence that the pattern is being repeated in Botswana.

David Ngele, the first man in the country to publicly admit that he was HIV positive back in the early 1990s and now an Aids activist, believes that men have to start changing the attitudes that dominate marriage in most of Africa. "If a woman says no, we think that she has met someone else who is doing this when we are out," he says. "If a woman does not want to have sex, we need to give her the chance to explain. If she has a good excuse, that is OK."

Sexual customs might help explain the relatively higher prevalence of the disease in southern Africa than the rest of the continent. According to some observers, the heavier industrialisation in the south, which spawned the armies of migrant labour, might have eroded some of the patterns of rural life and allowed a more permissive attitude to sex.

Patrice Kalenga, a doctor from the Democratic Republic of Congo now working in Botswana, says there is a different attitude to sex. "It is not that young unmarried women do not get pregnant where I come from, but my impression is that here there is less criticism or disapproval from elder members of the community when it happens," he says.

For those who are investing time and money in drugs programmes, the real prize might be in this area of sexual mores. A society that feels the disease is no longer an automatic life sentence might be more willing to analyse its causes. Donald de Korte of Achap says that if HIV-positive people are receiving treatment and counselling, they will be less reckless in their behaviour and more willing to take a responsible attitude to their sexual partners. Keeping people alive through treatment is hugely important in itself, he says, but it is only through substantial change in sexual behaviour that the epidemic will really be held in check.

"It is basically about sex and gender relations," he says. "The other factors, such as poverty and inequality, they all play a role in the spread of the disease, but it is really all about sex."

The hypothesis is untested, of course and the availability of treatment might encourage people to engage in more unsafe sex, not less, as seems to be happening in some western countries.

Reverend Kealotswe is upbeat, however. His daughter now runs a support group for other women and he believes people are becoming more comfortable discussing the disease and their experiences. "If we can make the drugs available all over the country, as easy to get as condoms, then attitudes will start to change," he says.

Geoff Dyer is the FT's pharmaceuticals correspondent