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Speech by Aaron Motsoaledi at the 18th Annual International AIDS Conference

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Universal Access - Treatment and Prevention Scale-up: The South African experience
20 July 2010, Vienna
Introduction

Programme director, distinguished delegates, ladies and gentlemen

Let me start by thanking the organisers of the 18th International AIDS Conference for inviting me to address this plenary session. In the past South Africa has been the subject of much criticism at these conferences for being a heavily divided country on its approach to the HIV and AIDS pandemic. However, I can stand before you today and state categorically that in 2010 all of South Africa is united behind our work on HIV prevention and treatment. Through the South African National AIDS Council (SANAC) a structure chaired by the Deputy President of our country we have achieved a common purpose and approach to the challenge of HIV and AIDS.

In South Africa, we are proud of our Constitution that guarantees the rights to freedom of expression, to protest and to access to health services. Often times, the South African government has found itself losing court cases or being challenged because of not meeting or being perceived not to meet our Constitutional duties. But I want to assure my colleagues in government from across the world that this is a very good thing. It is democracy in action and it is helping to develop our country. Democracy and human rights are not a threat to government; they are the prerequisites for good governance.

Today we are guided by science, best practice, and recognition of our constitutional responsibilities to provide everyone in South Africa with access to health care services and to do our best to try and get control over the epidemic. I will say more about our efforts later.

During the past few weeks we hosted the first FIFA World Cup event ever held on African soil and most people, including our critics acknowledge that it was one of the best, perhaps even THE best! One of the most important lessons that South Africans have realised from this event is that, if we have the resources we have the skills, if we have the plan we have the commitment, and that if we are ambitious we can overcome even the greatest challenges.

Resources, planning and ambition are themes that I will dwell on in this speech.

During the opening session of this conference yesterday South Africa?s Deputy President Kgalema Motlanthe outlined the commitment that South Africa made to its people during the signing of our Constitution in 1995. The key aspects of the Constitution that are relevant for my address today are the socio-economic commitments, particularly those related to dignity, life and access to health services.

As I will explain, it is clear that we are falling short in this commitment and that in order for South Africa to meet the Millennium Development Goals (MDGs) and our commitment to "Improve the quality of life of all citizens and free the potential of each person" we need to take rapid and drastic action. Achieving universal access by meeting our targets on HIV prevention and treatment is critical to achieving both goals

However, we all acknowledge the scale of the challenge we face.

The State of the South Africa HIV and AIDS Epidemic

For the past 20 years South Africa has conducted a national prevalence survey among pregnant women who attended our public sector antenatal clinics. This survey constitutes the best record of our HIV prevalence levels and shows the speed with which the epidemic has taken hold.

In 1990 the prevalence amongst this group of women was a mere 0.9%. However in 15 years (2005) it had reached 30%. Over the past three years it seems to have stabilised around 29% - but is still extraordinarily high.

The effect of the HIV and TB epidemics can be seen in my country?s mortality statistics and in estimates of life-expectancy.

In South Africa 43% of maternal mortality is HIV related. Among pregnant HIV positive women maternal mortality has increased 10 fold as against those that are negative. A similar picture is seen with under 5 mortality whereby 57% of deaths of children under the age five during 2007 were as a result of HIV.

TB is the leading cause of death among people living with HIV in the South Africa - there is a 73% co-infection rate. Between 1997 and 2005, the number of people dying from TB each year rose by 334.8%. Of the estimated 5.5million people in South Africa infected with HIV, one third will develop TB during their lifetime.
So what is the plan to address this challenge?

Our Country Plan for Universal Access: the National Strategic Plan

In 2007, under the auspices of SANAC, both the government and civil society worked together to develop a 5-year National Strategic Plan for HIV and AIDS and STIs. We call this the NSP. The NSP is inspired by the principle of universal access. It has two main objectives to be achieved by the end of 2011:
to reduce the number of new HIV infections by half; and
to provide comprehensive treatment, care and support to 80% of those who need it.

In an effort to meet the targets of the NSP we have moved with great urgency to strengthen the comprehensive HIV and AIDS treatment response. I will briefly outline a number of innovations intended to assist this.

The HIV Counselling and Testing Campaign (HCT) and the expanded treatment programme: the road to universal access

In April this year we began a massive HIV counselling and Testing (HCT) campaign. We have set the ambitious target of testing 15 million people by June 2011. Leaders, starting with the President of the country, the Deputy President, myself and other Ministers as well as Premiers of our provinces and leaders of civil society took HIV tests to encourage testing and to destigmatise HIV testing . This has caught the imagination of South Africans with large numbers of people coming forward to be tested.

If we reach our target we anticipate that 1.65 million more people will be diagnosed HIV positive. The campaign should provide them with the information and access to the interventions to enable them to manage their health and to prevent HIV transmission. Through rapid TB screening and CD4 counts the campaign also seeks to ensure that those patients requiring treatment are fast-tracked onto the treatment programme. In light of this we have planned for an enrolment of an additional 500,000 patients onto ART by March 2011.

Since the launch of the HCT campaign at the end of April about 1million people have tested voluntarily for HIV and 70,605 have been enrolled onto ART.

This extra burden on the health system has been accepted by health workers because of the rewards this campaign is likely to reap. I am confident it will increase the number of people on treatment and benefit our prevention efforts. It

will encourage openness and it will encourage people to use the health care system.

However, the HCT campaign is not without considerable challenges.
One challenge is that once people discover they are HIV-positive we must prevent them from being lost to the health system, especially people with high CD4 counts. We must ensure that people who are eligible for treatment start treatment on time. We must also strengthen our positive prevention programmes. Similarly those who test negative must be supported to remain negative for the rest of their lives.

Our HCT campaign will also place considerable pressure on the health budget, although I think in the long run it is possible this will be offset by reducing the number of opportunistic infections we have to treat and to reduced hospitalisation costs.

We are sending a clear message that this is the way to tackle HIV and that it can be done in a way that respects human rights, a way that is based on people choosing to be tested and not being forced to, a way that avoids criminalisation and combats stigma.

On World AIDS Day last year our President announced the government?s intention to introduce new treatment protocols in line with WHO recommendations. These were implemented with effect from 1 April this year and are as follows: pregnant women to be treated at CD4 of 350 or less; similarly for people co-infected with TB and HIV; children under the age of 1 to be treated regardless of their CD4 count; and PMTCT to start at 14 weeks.

Given our high levels of TB and HIV co-infection, we had agreed that all TB treatment sites must also test and treat for HIV and vice versa. Secondly, we have agreed to fully integrate all aspects of the HIV programme with maternal and child health programme at all levels of the system but especially at the coalface - where the patient meets the health care system.

We have also started to make treatment available at more health facilities. By December 2009 only 497 of more than 4000 public health facilities were enrolling patients onto treatment. These facilities have been placed under great pressure. To improve efficiency and to expand access we have moved to decentralise access to treatment. Through a process of training and preparing facilities to take on the role of initiating HIV treatment we have been able to add an additional 317 facilities to those already initiating patients on ART. By the end of 2011 all health facilities must be able to initiate patients on ART. Key to achieving this target is to train health workers and shift tasks from physicians to nurses, from pharmacists to pharmacy assistants and from nurses to lay counsellors. This represents scale up towards universal coverage!

Funding Treatment and care

Scaling up definitely needs additional resources, even as we improve the efficiency of the health system. From our own revenue we committed an additional R3 billion ($400million) to fund the ART expansion as from the 1st of April this year. We have also committed R5.4billion ($715million) to further expand the treatment programme over the next 3 years. At current drug prices this provides for 2.1million patients to be enrolled onto the programme by 2012/2013.

We recognise that South Africa is a middle-income county with developing country health performance and so we have committed to funding the majority of our health programme from within our own fiscus. As a measure of the extent to which we have scaled up programme funding, total HIV expenditure from government and development partners in 2009 alone was a combined R17.6billion ($2.33billion) - 83% of this provided by our government. This is up from just under R14billion ($1.84billion) in 2008.

We are doing all of this because we are committed to improving the lives of all people in South Africa. But it is not easy. We face many challenges. It is important to remember that apart from the challenges of HIV and AIDS we are having to transform our health system from one that, under the apartheid system, denied millions of people basic health care services because of their race. HIV and AIDS has made this more urgent and more difficult.

We face many problems. Some of these are systemic and structural. Others are financial. Jointly they are hampering the ability of the public health system to provide treatment, care and support to all those in need. For example, in 2009 one of our Provinces implemented a five month moratorium on new patients on treatment - that caused great unhappiness. We investigated the systemic causes of this and resolved not to allow it to happen again.

The lesson in South Africa is that universal access needs universal support and assistance.

The importance of sustainable financing for universal access

The issue of funding for HIV and AIDS has become a hot issue at this conference. I would like to say the following on this:

Over the last decade the world has seen an unprecedented mobilisation of resources for health to support poor countries, especially those in sub-Saharan Africa. We thank bilateral and multilateral organisations for heeding the call to provide additional funding as well as AIDS activists for the pressure that has helped bring this about. The Global Fund and PEPFAR have been crucial to scaling up treatment, so that today UNAIDS tells us there are 5 million people on antiretroviral treatment in low and middle-income countries.

As I have already explained, in South Africa we have over one million people on treatment. And while AIDS has taken tens of millions of lives, the global effort of the last decade has begun to reverse that. We are saving lives. Globally, we have a long way to go but I think we are on the right track.

Yet, this success will be under threat if funding dries up. The global economic recession has resulted in a situation where the Global Fund may fall far short of the $17 billion it needs over the next 3 years. The recent allocations to PEPFAR are keeping track with inflation but not much more. Certainly our government believes that there need to be greater donor investment in HIV if we are to ensure the millions of lives continue to be saved.

We also have to ensure that public and donor money is spent responsibly. We must not tolerate misappropriation of Global Fund, PEPFAR or our own tax funds. Corrupt officials must be prosecuted and in the long run Africa must become less dependent on international donors.

But we have to take the steps today to ensure this is possible in the future.

African civil society organisations have a key role to play in holding us accountable. Democracy is important to health-care and AIDS. With democracy, health ministers like myself, can be held accountable, and supported so that we can do our jobs more efficiently and effectively.

Should we put our money elsewhere?

Finally there are questions being asked all over the world, my own country included, even by people who are well meaning. The question is: are we not projecting HIV and AIDS as the only disease on this planet. Are there no other diseases that need more attention, perhaps even more than HIV and AIDS? Is our funding of HIV and AIDS not to the detriment of the whole health care system. These questions rage on and on. My answer to these questions is a big NO, NO!

The investment in HIV and AIDS has led to substantial increases in health-spending in Africa generally. HIV and AIDS has reversed life-expectancy gains in many sub-Saharan African countries. Only by combating HIV and AIDS can we ensure life-expectancy heads in the right direction.

HIV and AIDS is a relatively new disease that has had a terrible impact on sub-Saharan Africa. Because it primarily strikes young sexually active adults it has had evaporated much human capital and killed many bread winners with knock-on effects across society, throwing or keeping millions in poverty and producing a generation of orphans. In my country all the health related MDGs can never be achieved without a frontal attack on HIV and AIDS.

HIV and AIDS has brought our health system in the brink of collapse and there it is absolutely right to prioritise HIV and AIDS and we have to continue to do so. It has brought our health systems to the brink of collapse. It has therefore been absolutely right to prioritise HIV and AIDS and we have to continue doing so.

The focus on AIDS has also brought into sharp focus issues of women's rights, the rights of people with different sexual and gender orientations and the rights of patients generally.

The real question is how do we replicate what has been done for HIV and AIDS? How do we ensure that investment is mobilised against other diseases, many of which are easily treated, diseases that claim millions of lives across poor and middle-income countries and to rebuilding health systems.

This must be done, but not at the expense of treating and preventing HIV and AIDS because otherwise all our gains will be reversed. More money is needed for global health generally. A sustainable plan as to how health can be financed is needed. Better co-ordination across diseases and donors is needed. A globally endorsed plan to train and deploy more health workers is needed. These are things we should be getting to work on with a greater sense of urgency.

Conclusion

Investing in health is investing in development. Investing in HIV and AIDS programmes is investing in health.

A long time ago there was a big argument about whether money for HIV and AIDS should be invested primarily in prevention or treatment. We know the answer to that now. There is no conflict between treatment and prevention. An HIV-positive person adhering to treatment with an undetectable viral load is much less infectious. That is positive prevention.

Now that we have overcome that argument, we must not build other false dichotomies. We must tackle all the causes of maternal mortality and infant mortality, not just some. We must build decent health systems for all causes of ill health, not just some. Responding to AIDs with vigour and anger and commitment has started us on this road.

The bottom line is that to do this more resources are needed and existing resources must be used more efficiently. Developed countries have a responsibility to mobilise resources for this effort and we call on them to embrace this responsibility. The first test will be the full replenishment of the Global Fund to meet the needs that it has objectively calculated to exist. But once the money is found it must be spent honestly, equitably and accountably on medicines, health systems and health workers.

We should all know that because HIV and AIDS are going to be with us for a long time we must ensure that we are all in this partnership for the long haul. We cannot urge countries to make universal access a priority and provide assistance for one or two years! If high burden countries are not assisted for as long as assistance is needed we will all be violating human rights.
We cannot give up on universal access because that is giving up on life and human rights.

In conclusion let me quote the President of the Republic of South Africa: "At another moment in our history, in another context, the liberation movement observed that the time comes in the life of any nation when there remain only two choices: submit or fight".
I thank you for your attention.

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