

**Excerpt from a speech by Stephen Lewis, UN Special Envoy for HIV/AIDS in Africa,  
to a UNICEF conference on children orphaned by AIDS  
Barcelona, Monday, February 7, 2005 – For immediate release**

Just one week ago, I visited a project, in Lusaka, Zambia, where children orphaned by AIDS, all of them HIV positive, were being cared for during the day. The project had identified 130 such children, drawn from the surrounding neighbourhoods, children who returned home in the evening to stay with extended family, or grandmothers, or in some cases, just their siblings in child-headed households.

The children looked to be between the ages of three and five. They were, in fact, mostly between seven and ten ... little bodies wracked by a combination of disease and malnutrition.

On the occasion of the visit, there were sixteen children in a small, bleak room, gathered at little tables, over which several of them slumped, asleep. Others stared vacantly at the visitors or into the nether distance. There were, of course, a few staff members in the room, ranged around the walls. Several of the children were identifiably ill; the scene was sad, anxious, wrenching.

We asked: are any of these children in treatment? The answer was no, although nine of the overall group of 130 were being treated with anti-retroviral drugs, courtesy of relatives who could afford the cost.

We pressed: when might they be treated? A meeting to discuss treatment was to be held that very evening. Coincidence is a wondrous thing: apparently when the site was reconnoitred a week before in preparation for our visit, the same questions about treatment had been asked and, lo and behold, the prospect of treatment was now more firmly on the agenda.

But that's not the point. The point is that all over Africa, the same situations exist. All over Africa, children are dying needlessly in the absence of treatment. And as always, solely because they are children, they stand at the bottom of the list of priorities. Article 24 of the Convention on the Rights of the Child reads: "States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health, and to the facilities for the treatment of illness ... States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services".

When it comes to the treatment of children living with AIDS, the Convention is a virtual dead letter.

The Governments who ratified the Convention are on the ground everyday. They know the extent of the suffering and despair, and what is happening or not happening to children. And though it pains me to remind you, United Nations agencies are also on the ground and yet, collectively, we're only now, now when it's so staggeringly late in the day, coming to grips with the carnage to which children have been subject.

The situation is frankly appalling. We estimate that there are half a million children in the world under the age of 15 --- 90% of them in Africa --- who need treatment at this very moment, and for the overwhelming majority, as things now stand, there's not the slightest prospect of them receiving it. In 2003 and 2004, the same number of children --- half a million in each year ---

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died of AIDS. In both those years, somewhere between 650,000 and 750,000 children were newly infected. Overall around the world, as we enter 2005, there are two million, two hundred thousand children living with AIDS. It all leads to a cruel and continuous parade of death, mirroring the adult population, but even more difficult to address because, incredibly enough, we still don't have the so-called 'paediatric formulations' --- that is to say versions of the drugs appropriate for children --- which would allow us to engage in their widespread treatment.

But there's more. We don't even yet have the tools for diagnosis of children under the age of eighteen months. Compared to the development of inexpensive and reliable rapid HIV tests for adults, we are light years behind for children. Simply put, there is still no affordable way to ascertain whether HIV antibodies found in children under eighteen months of age are their own or their mothers'.

How has it come to this? How have we reached 2005 and we're only now seized of the need to formulate and package ARV pills or syrups in ways that make them safe and effective for children? Does that not speak volumes about the way in which children are witlessly consigned to the coffins of history?

Currently, in the great majority of cases, caregivers try to manage by cutting or breaking adult tablets or capsules into pieces, hoping that you can guess the right dosage for a particular child's age and weight. Still other problems are true of syrups, many of which are foul-tasting, or need to be refrigerated, or expire quickly and cost so much more than adult pills. It's tough enough for a doctor or a nurse or a trained clinician to manage; imagine the tablets being expertly apportioned and administered by a sick parent, or grandmother, or by the eldest sibling in a child-headed household.

The most important touch of solace on the horizon is that UNICEF and WHO have come together in an effort to address the most complex aspects of this predicament. It's estimated that if we started immediately, we could get certain paediatric formulations onto the market within 18 months. But for the kids infected now, it's a frenetic race against time, and it's a race which most of the children will lose.

Inevitably, there will be much discussion of how to provide 'incentives' to the drug companies to manufacture or package the new formulations. I would think that preventing pain and death in just one child should be incentive enough. Both 'big pharma' and the generic companies have an obligation to move on this as though there was not a second left, because there's not a second left. They should need no prompting from UNICEF and WHO. They should spend whatever's necessary to spend (and it will be far far less than many other research and development initiatives) and get the drugs for children onto the market at prices which every Government and every NGO can afford.

What's needed, in brief, are diagnostic tools to identify HIV status under the age of eighteen months, and paediatric formulations that will make drug regimens safe for all ages, and easy to administer. There are, of course, many arcane details as well: but that's the core of the scientific

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pursuit. As I noted earlier, it is estimated that developing the formulations could take up to eighteen months from the start date, but it can't be allowed to take 18 months. We have counted too many bodies.

Let me take you back to those morsels of children sitting and sleeping and unsuspectingly awaiting their fate. The scene is repeated time and time again in other countries. This is not a matter of blame, although you will agree that a sense of anguish and anger inevitably roil just beneath the surface. This is a matter of simple human emergency to which all of us must respond.

The rhetoric about treatment, particularly prompted by the WHO "3 by 5" initiative is thrilling. But it's only thrilling for those who get it. And children are getting it last, if at all, if ever.

I cannot end this part of my remarks without adding a crucial context. Far and away the most effective method to stop infection in children --- the method successfully employed in almost every developed country --- is to reduce transmission from mother to child. But as we know, years after the scientific breakthrough that made such prevention possible, only ten per cent of all pregnant HIV-infected women in Africa have access to clinics providing PMTCT (prevention of mother to child transmission). How could this have come to pass?

UNICEF and WHO estimate that the spread of these clinics to 80% of the pregnant women who need them could, using the most common present intervention (single dose nevirapine) reduce child infection annually by half (that is to say, 300,000 children free of HIV). On the other hand, in the west, using a full anti-retroviral intervention, what we call triple dose therapy, the numbers of infected children have been cut virtually to zero. Just a few days ago, that astonishing achievement was front-page headlines in the New York Times. How long will this double standard be tolerated? How long will the lives of African children be considered of lesser worth?

It is said that we need a Marshall Plan for Africa. I agree. But we also need, immediately, an Herculean commitment from African Governments, from the United Nations family, from the pharmaceutical industry, brand-name and generic, from NGOs, external and indigenous, and from the international community ... a commitment not just to the target of putting millions into treatment, but to the certainty that amongst those millions we will find, as equals, every infected child.