Notes for Press Briefing by Stephen Lewis, UN Secretary-General's Special Envoy for HIV/AIDS in Africa, on his recent trips to Uganda and Lesotho.
United Nations, New York: 12:30 PM, Thursday, September 16, 2004

This press statement is prompted by recent trips to Uganda and Lesotho. I want to highlight certain developments which are, I believe, symptomatic of current trends in Africa. The two countries are of course very different --- most notably, the HIV prevalence rate in Uganda hovers around 4%, while that of Lesotho approximates 30% --- but they nonetheless display strong features in common.

The most vivid of those features, and what I want to address, is the single-minded focus on treatment. Almost everywhere in Africa, where the prevalence rates are high, the momentum around treatment is irreversible. The WHO "3 by 5" target has become the centrepiece of the response to the pandemic. It's extraordinary the way country after country in East and Southern Africa has embraced the 3 by 5 formula as the benchmark for everything they do. This powerful goal --- to put three million people into treatment by the year 2005 --- may have its detractors, but there's no question that it has unleashed a torrent of purpose and hope.

To be sure, it's tough slogging. And everyone agrees that treatment cannot be allowed to eclipse the difficult issues around prevention, testing and care, but treatment is now the sine qua non of the AIDS response.

In the case of Uganda, the target is 60,000 people in treatment by the end of 2005; it's estimated that about 23,000, in the public and private sectors are now in treatment. The Government is absolutely determined to reach its goal; the Ministry of Health, in the best sense, is positively obsessed.

A telling combination of factors is going to make it possible. The Ministry of Health is in the process of using its hospitals across the country to initiate treatment free of charge which, it must be said, is the only way to ensure equitable access for women, who carry such a disproportionate burden of infection. The government is still a long way from getting there: lack of resources and diminished human capacity compromises every move. Many of the hospitals could, even now, treat far greater numbers than they are treating … the dollars and the drugs are not yet there. But they're coming. And the dogged determination to achieve the target of 60,000 is driving the process. Then, too, Uganda has TASO, one of the most sophisticated and effective AIDS Service Organizations in the world. And TASO, benefiting from PEPFAR (the US President's initiative), is also engaged in treatment.

What's more, Uganda shows what can be done in even the most remote and impoverished settings. In the far North-west corner of the country, in the rural community of Arua, I attended, along with UN country colleagues, the second anniversary celebrations of the introduction of treatment by Médecins Sans Frontières, through the local hospital, in conjunction with the Ministry of Health. There are eleven hundred people receiving antiretroviral drugs, generic fixed dose combinations in one tablet, taken twice a day. The adherence rate is well over 90%, the success rate is close to 90%, the simple regimen has shown few side effects … the community, especially the several vibrant groups of People Living with AIDS, is intoxicated with excitement and accomplishment. It's one of those rare instances where even stigma feels as though it has evaporated in the ether of success.

Admittedly, I'm carried away. Anyone would be carried away to see such large numbers of people surviving when death was at the door. But it's important for the world to understand that treatment transforms everything, and that there was a certain genius in the establishment of the 3 by 5 formula, because it has ignited so powerful a response.

In Uganda, as elsewhere, there have of course been tensions in the process of implementation. The Government and the Global Fund on AIDS, Tuberculosis and Malaria, have had shared moments of inexpressible frustration as money, so desperately needed, is tied up in regulatory complications. But the Global Fund is clearly making a tremendous effort to clear the bottlenecks, and they are indeed being cleared. Why? Because everyone recognizes that with treatment, survival is not an abstraction, and it would be a crime to stand in the way. Indeed, so strong is the acceleration of treatment in Uganda, that I'm of the view that the target for 2005 should be raised to 100,000.

In the case of Lesotho, dollars, capacity and infrastructure form tremendous barriers to treatment. But again, the determination to break through is almost fevered in intensity.

A rare combination of factors is at work. Lesotho has a truly impressive political leadership, and that leadership has, as an opening act of good faith, given the Ministry of Health some five million dollars with which to purchase the first tranche of drugs. Treatment guidelines are already drafted. The Clinton Initiative has signed a memorandum of understanding with the Ministry of Health, through which drugs can be purchased at vastly reduced cost, and technical assistance can be provided. Boston University has a ten-year commitment in place, focused initially on the provision of treatment, but also providing management skills to assist in the drafting of the elaborate procurement and logistical plans. The World Health Organization has provided experts to help the government design the rollout of treatment. The Global Fund is being as flexible as possible in the interpretation of the proposal Lesotho submitted, and which has been approved. The World Bank has provided several million dollars to ensure the implementation of the Global Fund monies. And how's this for commitment: early last March, the Prime Minister of Lesotho, in concert with the Archbishop of the Catholic Church, went together to be tested with the results to be public. It spawned a culture of testing throughout the country.

Interestingly, the Ontario Hospital Association in Canada is twinning with Lesotho so that some specific professional assistance --- doctors, nurses, pharmacists, community health specialists --- can be provided on a continuing basis to secure the treatment imperative. The first group will arrive on World AIDS Day, December 1st. Columbia University's School of Public Health is, as soon as next week, sending people in to assess the establishment of a "Prevention of Mother To Child Transmission **Plus**", programme in one of the hospitals, where the "**Plus**" represents treatment of the mother and any other members of the family, children included, who need it. It's known colloquially as MTCT Plus. Doctors Without Borders have been approached to consider involvement in the treatment process if that seems possible. The UNDP initiative on capacity building (SACI: Southern Africa Capacity Initiative) is taking a hard look at Lesotho as one of the early recipients of assistance. And the entire UN team has established a close and

indispensable liaison with the government in the pursuit of every aspect of what's happening on the ground.

In other words, in a panoply of artful ways, the Government, led by a revamped and indomitable Minister and Ministry of Health, is mobilizing external support to re-enforce its internal determination to break the back of the pandemic. Will it succeed? I believe it will. I think it will exceed the 3 by 5 target of 28,000 by the end of 2005. And as it does so, it will become a microcosm, a model, of the art of the possible.

That's what has to be understood. Even where Governments are slow to embrace the treatment rationale as in the case of South Africa; even where Governments feel overwhelmed by putting everything in place, as seems to be the case in Tanzania, there is an almost universal Pavlovian reflex --- for example, Botswana, Rwanda, Zambia, Malawi, Kenya, Namibia --- to demolish the obstacles and get pervasive treatment underway.

It is inconsolably painful that it has to happen so slowly, as we lose, unnecessarily, through this protracted, incremental process, so many lives. What is happening now should have happened and could have happened several years ago. History will be entirely unforgiving, particularly of those who could have freed the resources but locked them away in impenetrable vaults.

Finally, however, we have "3 by 5", we have something to rally round, we have momentum building.

That doesn't suggest for a moment, that countries like Lesotho and Uganda aren't swamped by other aspects of the pandemic. They both face an horrendous orphan crisis, for which answers are yet elusive. They both still wrestle with school fees, keeping orphan children out of school when, ostensibly, fees have been abolished for all or most of the primary grades. Everywhere I travel in Africa, the spectre of school fees haunts the lives of children. Both Governments face acute food shortages in parts of the country; for Lesotho it's an ongoing catastrophe, and if it wasn't for the remarkable work of the World Food Programme, large parts of Lesotho's population would not be fed. Both governments face the plague of gender inequality … the dreadfully high rates of prevalence amongst women, for which a legislative response is still negligible. They both struggle with testing and counselling: questions of sufficiency, of universality, of accessibility. And they both still reel from the limitations on resources.

And as is always the case, there is at least one particular situation which throws up seemingly insuperable problems.

In the instance of Lesotho, it's the industrial zone, with 54,000 workers (overwhelmingly women) in garment factories, labouring at minimum wage in a classic sweat shop environment. The pay is so low that the prospect of transactional sex looms large, and with it, the spread of the virus. It's a crucible for viral contagion. But as always, the moral questions are virtually unanswerable: if the Government imposes improved working conditions, the employers threaten to leave (and in this world of cheap labour, the threats may not be idle), and for the women,

however inadequate is the minimum wage, it is a wage. Where else would income be found if the sites closed down? It requires the skills of Solomon to find the balance.

In the instance of Uganda, it's a much more terrible reality. At the request of the UN team, I traveled to Northern Uganda, specifically the District of Gulu, to observe the consequences of the ongoing conflict with the Lords Resistance Army.

It was not my first trip. I had been there three times before in the 1990's, on behalf of UNICEF. I was totally unprepared for the staggering change.

Ten years ago, even five years ago, the skirmishes and abductions of children by the LRA, were awful but not yet monumental. One lived with the hope that the Government of Sudan, which sustained the LRA, would recognize the inhuman abuse and murder of children, and withdraw its support. Alas, it never did. The sub-regional politics were apparently more important than the lives of children, thousands of children. I can vividly remember, on two separate occasions, at OAU Summits, meeting personally with the President and Foreign Minister of Sudan, and begging them to stop the carnage. I was totally unsuccessful.

Today, astonishingly, Northern Uganda is a war zone. At minimum, ninety percent of the population is crowded into internally displaced camps, living in appalling conditions. Ugandan troops patrol the periphery. The world has not yet grasped that there 1.8 million displaced people in Northern Uganda --- numbers that stun the mind. Fear is everywhere palpable. The LRA attacks are less frequent, but when they come, as in the camp of Pagak with more than twenty thousand 'residents' just a few months ago, they are deadly. Thirty-one killed, five hundred huts razed to the ground, and now laced throughout the camp the untidy mounds of earth and rock signifying the graves of the slaughtered.

But of even greater sadness is the parental conviction that their children are not safe, no matter what the assurances of the Ugandan troops, or of the Government of Uganda whose role, in the minds of the parents, is clearly suspect. So every night, in a ritual that smacks of science fiction, forty thousand children, walk up to several kilometres to make-shift shelters of safety in Gulu town. Little kids, children of four, five, six, seven and eight, straggling in single file at dusk along the side of the road, ghost-like apparitions emerging from the darkness. Family life is dismembered: camp, shelter, school; camp, shelter, school …what is this madness the war hath wrought?

And from my particular vantage point, the entire environment is a breeding-ground for AIDS. Antenatal clinic surveys suggest that the prevalence rate in Northern Uganda is at least twice the rate in the rest of the country. People in the camps talk cautiously but openly of sexual violence. The situation is so desperate, the soldiers are so omnipresent, it's a miracle that prevalence rates aren't even higher (though perhaps they are and we just don't know). Certainly, the two local hospitals are overwhelmed with cases of AIDS for admission to the medical wards, and equally overwhelmed by so many people seeking treatment where there's little treatment to be found.

At the Reception Centre for abducted children who have escaped the LRA, it is widely perceived that rates of infection amongst the girls are high. How has all of this been allowed to escalate so grotesquely out of control?

In every way, there needs to be a crisis intervention in Northern Uganda, not least because the pandemic is now threatening the entire human landscape.

Still, despite such difficult circumstances in each country, I come away with the sense that the pandemic can be defeated. There are several obvious imperatives for the domestic and international communities.

The 3 by 5 initiative has barely more than fifteen months left. It must succeed; it's the best thing we have going for us. The Global Fund must be supported, in the billions of dollars, annually, so it has the resources which will make 3 by 5 possible. And the vital work around capacity must be given the highest priority.

All the other items, from prevention to women to orphans, we have talked about forever. They are in no way diminished by what I've set out above. The pandemic must be confronted on every front simultaneously.

-30-