Speech by Stephen Lewis, UN Special Envoy on HIV/AIDS in Africa, at the conference of the "Centre for the AIDS Programme of Research in South Africa",Durban, South Africa, August 3, 2003.

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I've been in this Envoy role for just over two years. The issues related to the pandemic ebb and flow, but remain much the same --- care, prevention, treatment, stigma, discrimination, gender, orphans, leadership --- they all continue to reverberate, unceasingly, as we struggle to overcome HIV/AIDS.

At this moment in time, however, no one would dispute that the centerpiece of the debate is the quest for treatment. I recognize that the debate has controversial edges --- witness the situation here in South Africa --- but there's simply no denying that everywhere one goes on the African continent, everyone affected or infected by the virus is talking about or demanding treatment. And I mean everywhere. And at every level, from groups of women at village health clinics to the Presidents of countries. The change, even in two years, is startling. Suddenly there is the recognition, especially amongst People Living with HIV/AIDS, that treatment is possible, that it should be affordable, that lives are prolonged, and that treatment brings hope.

It is not just an idea whose time has come; it is a reality whose time is now.

I want to address that reality in this speech. I want to emphasize that although treatment is a source of raging, and often bitter dispute in South Africa, that doesn't mean that I should be precluded from discussing it. On the contrary: not only does the issue of treatment consume the continent --- the continent to which my role is dedicated --- but it is an issue on which the United Nations has pronounced in clear and unequivocal fashion, and it is within that context, and from that foundation, that I make these remarks. Because I am speaking on the eve of the South African AIDS Conference, and because I am physically in Durban, I shall naturally make reference to South Africa itself where it seems appropriate, hoping that my remarks will then be relevant to the discussions of the next few days.

The Special Session of the General Assembly of the United Nations on HIV/AIDS was held in June of 2001. The session, as we all know, produced a Declaration of Commitment, supported by consensus of every nation present. One section is headed "Care, Support and Treatment", and says, amongst other things, "in an urgent manner make every effort to provide progressively and in a sustainable manner the highest attainable standard of treatment for HIV/AIDS, including the prevention and treatment of opportunistic infections, and effective use of quality-controlled anti-retroviral therapy."

In particular, I draw your attention to the words 'in an urgent manner' and 'the highest attainable standard of treatment'.

Last year in Barcelona, July 2002 to be specific, the then Director-General of the World Health Organization announced, as you know, the commitment of WHO to put three million people into treatment by the year 2005. By simple arithmetic extrapolation, that would mean over two million people in treatment in Africa. Let me remind you that the WHO is a specialized agency of the UN system. When WHO speaks, it speaks for the United Nations. The new Director-General has made it clear that he adheres to the solemn undertaking made in Barcelona.

But that's not all. There is as well, the wide panoply of United Nations human rights instruments. We tend to view the spectrum of universal human rights as theoretical abstractions, forgetting that international covenants, once ratified by a government, become instruments of binding international law, applicable to those self-same governments. Let me, therefore, briefly examine the relevant treaties.

First, the International Covenant on Economic, Social and Cultural Rights, adopted by the General Assembly of the UN, and entered into force in 1976. Article 12, section 1, reads as follows: "The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."

Section 2 reads "The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include…" and I turn here first to sub-section (c): "The ... treatment and control of epidemic diseases .", and then sub-section (d): "The creation of conditions which would ensure to all, medical service and medical attention in the event of sickness".

I note that there are no qualifiers. The statement is categorical. And as a matter of interest, I further note that the Covenant has been officially signed, connoting an intention to ratify, by the Government of South Africa. May I be so bold as to draw your attention to Article 28: "The provisions of the present Covenant shall extend to all parts of federal States without any limitations or exceptions".

Second, the International Covenant on Civil and Political Rights, which also entered into force in 1976. This is a much more contentious piece of jurisprudence, but it has two clauses which must be noted; any good legal counsel could make much of them in arguing the right to treatment in a court of law. Article 6, section 1 reads: "Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his (sic) life". Article 23, section 1 reads: "The family is the natural and fundamental group unit of society and is entitled to protection by society and the State". If I was given to rhetorical flourishes, I'd say that I rest my case. I note that the Covenant has been ratified by the Government of South Africa.

Third, there is the Convention on the Elimination of All Forms of Discrimination against Women, passed by the UN General Assembly, and entering into force in 1981. Article 12, section 1 reads in part: "States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to

ensure ... access to health care services... ". Please note the use of the mandatory word "shall". I further note that the Convention has been ratified by the Government of South Africa.

Finally, I invoke my favourite Convention which nearly every country on the face of the earth has ratified: The Convention on the Rights of the Child. The relevant clause is Article 24, section 1 states: “Parties recognize the right of the child … to the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services".

Of this Convention on the Rights of the Child, I can speak with mild authority, as a former Deputy Executive Director of UNICEF. It is a matter of record that Governments everywhere attempt to fashion national legislation in a manner consistent with the provisions of the Convention. It goes without saying that the Government of South Africa has ratified the Convention.

But let me not stop with these international covenants to which the United Nations is wedded. Let me invoke, as well, the Global Fund to combat AIDS, Tuberculosis and Malaria.

To be sure, the Global Fund is an independent entity; an entirely new multilateral financial vehicle. But its genesis lies in the recommendation of the Secretary-General of the United Nations, who first proposed such a Fund at the Conference on AIDS, Tuberculosis and Malaria in Abuja, Nigeria, April, 2001. Since that time, the Secretary-General has been seen as the patron of the Fund, and all of the programmes, agencies and funds of the United Nations system support the Global Fund, and vigorously campaign to have the donor countries contribute the necessary financial resources.

Why do I make this point? Simple: of the money which the Global Fund has dispersed to countries in the fight against AIDS, over 50% is for treatment. Obviously, that is a policy of which the United Nations approves or the support for the Fund would not be so strongly forthcoming.

In other words, when discussing the provision of anti-retroviral treatment, the UN is definitively, categorically, irreversibly on record. My remarks are a straightforward expression of that record.

Happily, the imperative of treatment is spreading non-stop across the African continent. At a recent breakfast, during the AU Summit in Maputo, chaired by President Obasanjo of Nigeria, and attended by the Secretary-General of the United Nations, the head of the Global Fund, Dr. Richard Feachem used the phrase that we are "on the verge of an explosion of treatment" throughout Africa. My experience suggests that Dr. Feachem is exactly right.

During 2002/2003, I had the opportunity of visiting a number of countries, all of which give credence to the powerful drive for treatment. In Mozambique, where I was last month, the combination of monies from the Global Fund and the Clinton Foundation is about to initiate widespread treatment; already Medicins Sans Frontieres has laid the groundwork with successful treatment regimens at pilot

sites. In Malawi, an appraisal of the healthcare infrastructure by experts from WHO suggests the possibility of treating 50,000 people in the public sector in the relatively near future. In Namibia, in a meeting with the Prime Minister and his Cabinet colleagues, the Government indicated it had published an impressive set of guidelines for treatment, and has finished the training of a large number of health professionals to implement a treatment programme.

In Rwanda, the combination again of resources from the Global Fund and the Clinton Foundation suggests a large treatment programme about to be implemented. The numbers rise as high as 70,000 within 4 years. There are already model pilot programmes underway in the private sector. In Zambia, the goal is to put 10,000 people into treatment as speedily as possible --- indeed treatment has begun --- using a grant from the Global Fund. In Kenya, the Government will use the force of a new regime and a new Minister of Health, to introduce treatment at the earliest date, relying initially on Global Fund dollars. In Nigeria, according to President Obasanjo, the country already has one of the most extensive public sector treatment programmes on the continent, using --- as I can personally attest --- generic antiretroviral drugs, purchased from India, and of course on the approved list of WHO antiretrovirals. I need hardly remind you of Botswana: everyone is surely familiar with their successful and concerted treatment programme.

Finally, I just returned yesterday from a four-day trip to Uganda. Uganda, as everyone knows, is the country which has had the greatest success in countering the pandemic. If ever there were lessons to be learned, they are to be learned from Uganda. I want to say, without any fear of contradiction, that the country is obsessed with treatment and is pursuing it single-mindedly. The approach is orchestrated by the Joint Clinical Research Centre, which offers the following information: there are well over a million people living with HIV/AIDS in Uganda; it is projected that some two hundred thousand would today qualify for treatment. Seventeen thousand are currently being treated through the public sector, civil society sector and private sector combined --- and the target is to have sixty thousand in treatment by the end of next year, which would make it the largest public sector programme of its kind on the continent. They are not cowed by infrastructure. They are not cowed by human resource capacity. They are, quite simply, determined to keep their people alive.

Perhaps I can add an encouraging footnote: the Research Centre insists that the 17,000 people now in treatment has resulted in a significant increase in the numbers seeking voluntary counseling and testing. The Research Centre is persuaded that there is a direct cause and effect relationship between treatment and testing; that is, between treatment and prevention.

I could go on, but I trust the point is made. No matter how high the prevalence rate in individual countries; no matter how impoverished those countries may be; no matter how frayed the infrastructure, government after government across the continent is bent on treatment. They are answering the desperate call of the people living with AIDS; they are responding to the NGO activists; they are embracing the proposition that treatment prolongs life and treatment brings hope.

Nor is there any naivete in any of this. The countries fully recognize the tremendous task they face in strengthening health infrastructures, in replenishing human capacity, in developing laboratory technology, in training thousands upon thousands of health care professionals and community health workers. But nothing daunts them. Even the question of sustainability in the face of acute financial distress --- put quite simply, unremitting poverty --- does not render them impotent. They are, in the words of President Mogae of Botswana, "fighting for survival", and survival does not brook delay. Happily, and this is true of almost every country, there is, either in the private sector or amongst NGOs like MSF, an increasing experience of antiretroviral treatment on a small scale, sufficient to make governments confident that they have the rudimentary knowledge required to move to the large scale.

It's truly inspiring to see how determined these Governments are in the face of the state of their domestic economies and the hurdles which must be leaped. Allow me to state the obvious: in comparison with South Africa, they are grossly disadvantaged and their economies are reeling.

Does that statement take liberties? I think not. Again, let me return to the work of the United Nations. I was interested to read the new Human Development Report, released by the United Nations Development Programme just last month. The comparative standings of various countries --- called the Human Development Index --- based on social and economic indicators, is fascinating. I'm a Canadian; my country hangs on every word of these reports because for several years running, we were in first place. You can only imagine the insufferable mortification we felt to be dropped to 8th place in 2003.

South Africa, as you probably know, ranks 111th, of 175 overall. Let me give you the ranking of the countries I earlier mentioned: Namibia is 124th; Botswana, 125th; Kenya, 146th; Uganda, 147th; Nigeria 152nd; Rwanda, 158th; Malawi, 162nd; Zambia, 163rd and Mozambique, 170th. You might legitimately ask: how can the others initiate treatment when South Africa has not yet been able to do so?

But there's another index, even more telling. It's called the Human Poverty Index for Developing Countries, or HPI. It's calculated, solely for the 94 developing countries, integrating three components: vulnerability to death at an early age, the adult illiteracy rate and standard of living, measured by access to clean water and the percentage of children under weight for age. On the HPI, South Africa ranks 49th. The others? Nigeria ranks 54th; Uganda is at 60th; Namibia 62nd; Kenya 63rd; Botswana 75th; Rwanda 77th; Malawi 82nd; Mozambique 87th and Zambia 89th. Again you might legitimately ask: how can the others contemplate extensive treatment when South Africa has not yet done so?

However, you may have caught an anomaly. The HPI, reliable in what it evaluates, does not appear to include figures for actual levels of income poverty as we normally measure such things. So I'm going to subject you to one more set of comparisons based, according to the report, on the most recent statistical year for which data is available, up to and including 2001. But this time, I'll present the figures in reverse order. In Kenya, the percentage of people living

on less than a dollar a day is 23%; the percentage living on less than two dollars a day is 59%. In Botswana, the percentage of people living on less than a dollar a day is 24%; the percentage living on less than two dollars a day is 50%. Then things start to escalate. In Namibia, it's 35% under one dollar and 56% under two dollars. In Rwanda, it's 36% and 87%. In Mozambique, it's 38% and 78%. In Malawi, it's 42% and 76%. In Zambia, it's 64% and 87%. In Nigeria, it's 70% and 91%. And in Uganda, it's an incredible 82% and 96% (although the Government would contest the figures the UN uses).

For South Africa, the figures are rather different. According to the HDR, fewer than 2% live on less than a dollar a day; some 15% live on less than two dollars a day. You might legitimately ask: how can the others begin to afford comprehensive treatment when South Africa is unable to do so?

Let me be clear. Ever since the days when I had the privilege of representing Canada at the United Nations, I've understood that the UN is composed of sovereign states, and I fully respect the rights and authority of sovereign democracies. But they're not sacrosanct. I didn't think back in the nineteen-eighties, and I don't think now, that the majesty of the nation state disenfranchises dissenting or alternative views from within the international community. I'm not so presumptuous as to tell South Africa what to do. But I do feel compelled at this moment in time, when the press for treatment is all-consuming across this, the most afflicted continent, to make clear the position of those of us who work within the United Nations, or at the very least, to make my own position evident.

In so doing, I seek no confrontation. I have read the news reports: I recognize that there are South African Government studies on coverage, cost and sustainability which will soon be assessed by cabinet; I recognize that there have been broad signals that the many private sector and private hospital treatment initiatives now in place may soon be joined by a roll-out in the public sector. My only caveat would be that when people are dying, a signal is seldom sufficient. Speed and action become the sine qua non. And when the action finally happens, there will be an outpouring of relief and exhilaration throughout Africa, akin, for many, to the emotional catharsis which accompanied the end of apartheid. South Africa is one of the leaders on this continent. If there is a breakthrough here, every country will feel similarly encouraged. And there's one other factor that must be taken into account: from the donor community --- World Bank, Global Fund, Clinton Foundation, international NGOs, United Nations agencies, bilateral development Ministries --- I genuinely believe that resources will flow to sustain whatever South Africa undertakes. The world, overwhelmingly, wants South Africa to defeat the pandemic.

The welter of predictions, from the views of Professor Alan Whiteside to the recent World Bank study, are not just sobering, they are terrifying. I have read the World Bank study, cover to cover. It's not an easy read, because much of the text is turned over to algebraic equations which are, for this layperson, indecipherable. But then you look at the narrative portion of the text, and what it says about the prospects for South Africa is nothing less than apocalyptic. I remind you that the Bank is given to sober appraisal, dispassionate analysis, econometric configurations, guarded

prophecies. For the Bank to predict the possibility of a failed state of South Africa within three generations, based on the socio-economic fall-out from HIV/AIDS, is astonishingly uncharacteristic. It must therefore be taken seriously. In truth, it doesn't surprise me. While it is pleasing and unusual to have the analysis of mortals confirmed by the World Bank, it was surely obvious, some time ago, that the methodical toll, year after year, exacted by AIDS would, cumulatively, cause the unraveling of whole societies. We've never given enough credence to that reality. It's good that the Bank has now done so.

But in a powerful way, it's the wrong reality. I, for one, am weary of hearing new justifications for intervention from the western world, or new reasons for declaring a state of emergency. It apparently isn't enough to have a human catastrophe; we have to couch it as a threat to international security; we have to imply potential destabilization so great as to spawn breeding grounds for terrorism; we have to wring our hands over the long-term economic consequences, damaging to investment, trade and growth, before we're moved to rescue the human condition.

What is wrong with the world? People are dying in numbers that are the stuff of science fiction. Millions of human beings are at risk. Communities, families, mothers, fathers, children are like shards of humanity caught in a maelstrom of destruction. They're flesh and blood human beings, for God's sake; is that not enough to ignite the conscience of the world? Why should we have to produce all these tortured rationales to drive home such an obvious point? This pandemic has done something dreadful to the instinct for compassion. I don't really understand what's happening; I don't really understand why the simple act of saving or prolonging a human life isn't sufficient anymore. It's irrational to need a balance sheet of geometric calculation and economic architecture. It's sick.

I was in Masaka District of Uganda just last Wednesday, where one lonely NGO is dealing with three thousand, six hundred people, men women and children, all of them HIV positive. Masaka was virtually ground zero of the pandemic in all of Africa. I was traveling with Ms Graca Machel, and when the people addressed us, right in the heartland of a rural community, they talked about hearing of drugs called anti-retrovirals, and they pleaded for the right to live. You really have to wonder what the world has wrought: there's something terribly degrading about people so ill, begging to stay alive. At least it can be said that the Government is desperately trying to respond to them. The day before, we were at the Mother-to-Child Plus clinic at Mulago Hospital in Kampala. That's the clinic where the mother and the infant are both on nevirapine to interrupt transmission of the virus, and where the mother, if her CD-4 count is below 200, can begin anti-retroviral treatment. We met a woman whose CD-4 count had dropped to 1 (yes, 'One'), and a month later, after ARVs, she was filled with buoyancy, energy and an inexhaustible lust for life. And her children aren't orphans because their mother is alive.

When Nelson Mandela spoke in Paris on July 15th, to the Conference on HIV Pathogenesis and Treatment, just in advance of the failed meeting in support of the Global Fund, he said, and I quote "The world must do more, much more on every front in the fight against AIDS. Of

course, it means dramatically expanding our prevention efforts, but the most striking inequity is our failure to provide the lifesaving treatment to the millions of people who need it most. The single most important step we must now take is to provide access to treatment throughout the developing world. There is no excuse for delay. We must start now. If we discard the people who are dying from AIDS, then we can no longer call ourselves decent people".

That seems to me to say it all. But I don't want to end these remarks without acknowledging three things. First, my emphasis on treatment is not meant, in the slightest, to diminish the need for prevention. I well recognize that the two work, irreplaceably and inseparably, hand in hand. Second, the question of access to drugs in the post-Doha world, and their cost, is obviously critical, and I shall be addressing that issue later this month in advance of the WTO meeting in Cancun. Third, the question of resources remains central to everything else, and I have no illusions that that struggle over money is yet joined.

All of that notwithstanding, treatment is the current agenda. It will remain the current agenda until the agenda is met. As Nelson Mandela said: it is an elemental matter of human decency, and history will judge where decency was wanting.