Notes for Press Briefing by Stephen Lewis, UN Secretary-General's Special Envoy for HIV/AIDS in Africa, on his recent trips to Malawi and Tanzania.
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Since this is my first press briefing of 2005, I feel compelled to begin with brief reference to the Tsunami, the Millennium Development Goals, the debt of African countries and "3 by 5", the WHO/UNAIDS initiative to put three million people with full-blown AIDS into treatment by the end of 2005. Collectively, they form a backdrop for what I wish to say about the country visits to Malawi and Tanzania.

The evolution of response to the Tsunami is exhilarating and fascinating in equal measure. The outpouring of international concern and generosity attests well to the truth (with apologies to the Bard) that the quality of decency is nowhere strained. But it has also raised predictable anxieties about support for other humanitarian crises.

It is hugely worthy of applause that the Governments of the world, overwhelmingly of the western world, have pledged, in a mere three weeks, some five and a half to six billion dollars. However, it is bracing to note that in more than three years, they have summoned, in pledges, almost exactly the same amount --- $5.9 billion --- for the Global Fund to fight the pandemic of HIV/AIDS.

Without the slightest invidious intent, it is important to recall that there are today, now, at this very moment, six million people dying of AIDS, four million, one hundred thousand of them in Africa. I don't begrudge a penny to South-East Asia. But what does it say about the world that we can tolerate the slow and unnecessary death of millions, whose lives would be rescued with treatment?

The Tsunami must be seen to be the turning-point. The publics of the world have shown their desperate concern for the human condition: how long will it take for Governments to do the same?

Yesterday, Professor Jeffrey Sachs tabled his remarkable blueprint to achieve the Millennium Development Goals. The targets for Official Development Assistance which he sets are entirely attainable … indeed, the industrial world has been toying with the ".7% of GNP" figure for thirty-six years, overlapping the centuries with hypocritical disdain. They must finally deliver, and the UK Government's quest for an International Financial Facility can be an important step on the road.

What is crucial to recognize, as Gordon Brown said in his speech in Dar es Salaam last week, is that the goals are being fiercely compromised in many African countries by the pandemic of HIV/AIDS. It is the ultimate self-delusion to believe that the MDGs will be reached while the pandemic roils unchecked.

But the signs are not auspicious. For whatever inexplicable reason, the western countries, so magnificently responsive to South-East Asia, bridle in the most unseemly way when it comes to Africa. Nowhere has this been more dramatically underscored than on the question of debt. It took but days for the Paris Club to espouse a debt moratorium for all of the countries affected by the Tsunami, but time and time again --- most recently just last fall --- the G8 refuses to cancel

African debts. Even when they agree that it must be done, they can't agree on a formula which would make it possible. There's something indefensible at work, because it's not just South-East Asia. Iraq gets debt reduction; Africa festers in frustration. The G8 Finance Ministers meet next month; surely there's not an excuse left in the armoury of rationalization to prevent the reduction and/or cancellation of African debt.

What makes it all so painful is the possibility that we're on the thresh-hold of a breakthrough against the pandemic. Against all odds, I sense that WHO's "3 by 5" is taking hold. Certainly that's true in every African country I visit including, most recently, Malawi and Tanzania. The professional doubters and detractors are losing ground … absolutely everywhere, countries are exercising superhuman efforts to implement treatment, helped appreciably by the UN family, WHO and UNAIDS providing the lead, plus the Global Fund, the Clinton Initiative, the World Bank, and several bilateral donors, the United States in particular.

I don't want for a second to depreciate the difficulties. And some of the countries are facing delays and bottlenecks that can drive you crazy. But every country is trying, is resolute, and even where governments are slow, the force of civil society sustains the battle. It would be the destructive irony of the century, were the wealthy nations to default on their commitments at precisely the point when 3 by 5 is within sight, and with it, a cornucopia of hope.

Which brings me to Malawi and Tanzania.

I traveled to Malawi at the very end of October. The trip comprised the usual elements: political encounters, civil society, groups of People Living with HIV/AIDS, the diplomatic corps, the UN family and several trips to projects in and around Lilongwe. This is now a tried and tested pattern, with a debriefing for UN colleagues and a press conference as the finale.

Malawi, like every other country is preoccupied with treatment and meeting the goals of '3 by 5'. The adult prevalence rate is estimated to be 14.2%, and some 170,000 people require treatment now. Originally, the government had set a target of 44,000 in treatment by the end of 2005, but they moved the date up to June of 2005, and then revised their target upwards to 80,000 by the end of this year.

It has to be understood what a remarkable commitment this target constitutes, and how many potential obstacles the government must navigate. There are many in the country in high places, diplomats included, who think the 80,000 target to be "delusional" (the word was actually used), and the government faces all the classic problems of drug procurement, adequate financing, astonishingly limited capacity, and weary, crumbling infrastructure.

But nothing will stop them. They are as a nation obsessed. They have trained three specialized health professionals --- doctor, nurse and counselor --- for 54 treatment sites across the country, and undoubtedly, given the level of commitment, that number has grown since my visit. They have worked out a drug procurement arrangement involving a tripartite coalition of the National AIDS Council, the Ministry of Health and UNICEF. They have resolved, with goodwill on both sides, outstanding funding differences with the Global Fund, and resources are now flowing. They have decided that treatment will be free in all public health facilities, fully recognizing that

this makes all the difference in the world to the principle of access, especially access for women. They have accepted the routine testing approach, and are focusing in particular on patients with TB, working from the logical premise that co-infection rates of TB and HIV are very high. My meeting with the National AIDS Council and Ministry of Health officials on treatment roll-out was one of the most thorough and impressive discussions that I have yet attended.

The demand for treatment is overwhelming. In every facility, there are waiting-lists. It is estimated that there are now approximately 9,000 people in treatment, and the additional numbers to reach the target of 44,000 by June this year can be found in the ragged lines of the desperately ill that fill the hospital waiting rooms.

The biggest challenge is unquestionably capacity. In the health care sector alone, there is an annual attrition rate within the Ministry of Health of 15 per cent, and a vacancy rate of 67 per cent. There are five government pharmacists in the country. The Ministry of Health has a total of 103 physicians in all facilities. There are ten districts in Malawi without a Ministry of Health doctor, and four districts without a doctor, period.

Based on the rough norm for Africa, Malawi should have 12,000 nurses; there are just over 4,000. In 2003, 500 hundred nurses graduated; 70 of them ended up with the Ministry of Health; 108 left the country, 90 for the United Kingdom. Of the 126 obstetricians/gynecologists who are required, there are 11, leaving a 91% vacancy. There is an 85% vacancy rate amongst surgeons and a 100% vacancy for pathologists. All of the figures were given to us by departmental officials, and though they may be out by small factors here and there, the overall picture is inescapable: no, the overall picture is dreadful.

It was recently said --- so we were authoritatively told --- by a senior DfID official, that Malawi's capacity problems were second only to those of Afghanistan!

Nonetheless the government perseveres and will not be daunted. And in one of the most innovative initiatives in Southern Africa, Malawi, funded chiefly by DfID, is undertaking a six-year $283 million capacity building plan in the Health sector that is extraordinary in its design and intended implementation.

Will they make it? I think they will. And I have taken this time to emphasize why it is that '3 by 5' has become the sine qua non of treatment in Africa. It is driving the agenda.

As in all other visits, a number of predictable patterns emerged: the situation of women is truly desperate, and although there are plans afoot to address the issues, little has changed on the ground; the situation of orphans is, as everywhere, numbing in sadness and complexity, and although there is a Plan of Action to address the needs of the estimated 900,000 orphan and vulnerable children, it has yet to be funded and implemented; there continues to be widespread food insecurity and malnutrition, some 1.3 million to 1.6 million people forever experiencing hunger. In fact, highly reminiscent of a trip I made to Malawi with James Morris, Executive Director of the World Food Program, exactly two years ago, the repeated pleas for food were amongst the most depressing experiences of the visit.

But as always there are images of vivacity and pain co-mingled. In a community, just outside Lilongwe, we were taken to an orphan setting called Consul Homes. Sustained purely by volunteers, with projects around the country, encompassing nine thousand orphan children, it has managed to create an environment of fun and purpose and support and hope for orphans, widows and grandmothers. The concentration is very much on psycho-social support for the children, with everyone joining in, and a mere modicum of training. But it works because the emotional and psychological well-being becomes the prevailing rationale.

The children had created their own "OAU", standing for Orphans Affairs Unit, where the elected "President", and members of parliament, all between the ages of 8 and 16, regularly meet to debate the issues of the day. I had a glorious encounter with these youngsters, who raised everything from fees for secondary school as a bar to attendance, to sexual violence against young girls, to children with disabilities. It was all conducted in such a tenor of mixed solemnity and touches of hilarity as to make the ravaging ills of the world fade into the nether distance.

Before leaving Consul Homes however, I met with seventy-five widows and grandmothers, all of them beset by hunger and orphans. We talked for quite a while. It confirmed for me, yet again, that grandmothers are emerging as the heroes of the African continent: no one gives them their due; few acknowledge that society and its children could not exist without them; no special provision is made for their food or clothing or shelter or healthcare or emotional needs. Does no one recognize that the grandmothers of Africa are the ultimate and final expression of gender inequality? All that awaits them is death.

The trip to Tanzania was just last month. It encompassed all of the elements of the visit to Malawi, except that I traveled more widely --- to Zanzibar, Mwanza and Arusha, as well as Dar es Salaam --- and managed to have a lengthy and productive discussion with President Mkapa.

Tanzania is curious, in some ways inexplicable. As in all other countries, there is a profound yearning for treatment, but it seems to get confounded in all manner of ways, large and picayune.

The adult prevalence rate is 8.8 per cent. It is estimated that 450,000 people need antiretroviral treatment now, and consistent with '3 by 5' goals, the government is aiming for 220,000 by the end of 2005. The first tranche of intended treatment would reach 44,000 by June.

But there have been endless difficulties, and Tanzania is only now gathering itself together.

Originally, the roll-out was slated for March of 2004; it was delayed until October. There was, for a time, quite a dispute with and within the diplomatic community, about how realistic the treatment goals were. Could they possibly be achieved given the limits on human capacity? There was a running contretemps over Global Fund monies, now it would seem, largely resolved. Tanzania was even affected more than others by the delisting of certain generic drugs, that is, taking them off the WHO pre-qualification list … it happened at a most inopportune moment (I spent an inordinate amount of time explaining that delisting didn't mean the drug couldn't be used). And just when they were ready to proceed, the packs of 'starter drugs' (special dosages required in the first fifteen days) weren't available. And of course, as always, the limits on capacity undermined resolve.

But Tanzania has also done some strikingly intelligent things. The government has determined that treatment will be free. It has also determined that the treatment regimen will consist of generic fixed dose combinations (FDCs) which undoubtedly provides the greatest treatment potential because the cost to the government of generic drugs is so low. The treatment potential is further enhanced because the FDCs are but one tablet taken twice a day so that adherence rates are very high. Further, in a thoroughly reasoned move, Tanzania has resolved any potential competitive difficulties with the US AIDS Presidential initiative (PEPFAR), by arranging that the Government of Tanzania would provide the drugs for first-line interventions (the great mass of treatment), and PEPFAR would provide the drugs, free, for second-line interventions, as well as providing the paedeatric medications. This seems an excellent compromise (although the PEPFAR drugs are not yet in the country).

But seemingly inconsequential matters can turn best intentions on their head. When we visited the hospital in Zanzibar, there were 195 people on the list for immediate treatment, but they weren't receiving it because a) the hospital had no CD4 counter, and they felt they were obliged to do CD4 counts before they could proceed (a misconception as it turned out), and they didn't have the starter drugs. I raised these matters with the President of Zanzibar who was appropriately appalled, but to this day I suspect that treatment has not yet begun.

Why not? Because somehow the desperate sense of emergency has just begun to grip the bureaucracy. The President is fully engaged, but his appeals to urgency are only now penetrating the wider political establishment.

What is hopeful, however, is the feeling that the miasma is in methodical retreat. What is hopeful is the incontrovertible fact that the government has trained four to six health care professionals for each of the 60 facilities where treatment will be offered. What is hopeful is the sophistication and competence of the leadership and membership in both the Ministry of Health and the National AIDS Council. The change in priorities can't come soon enough. Everywhere we went, people were clamouring for treatment.

As in every visit, something arises which speaks to the broader issues. In the case of Tanzania, there were two such episodes.

First, in a large gathering of orphans in Zanzibar we were faced with a small number of children who needed treatment. But there was an insidious philosophic assumption that these children wouldn't get treatment, that it wasn't available for children, that they would simply live out their brief young lives.

It's a classic commentary on the human condition that children always come last. In the instance of antiretroviral therapy, the scenario for children is, quite simply, doomsday. Incredibly enough, we don't even have paedeatric formulations … when treatment takes place --- a rarity amongst rarities --- doctors and nurses fumble over breaking capsules into several pieces to estimate the dosage for a child, or scramble around to find a syrup solution. It's bizarre.

For some reason, beyond the capacity of the mind to identify, we've all blithely assembled the apparatus of treatment as though children don't exist. But the numbers are paralyzing: in 2004, 510,000 children under the age of 15 died worldwide of AIDS; 640,000 were newly-infected; two million, two hundred thousand were living with the virus, at least two-thirds in Africa.

How has it come to this?

Second, on both the mainland of Tanzania and in Zanzibar, I met with formal groups of People Living with HIV/AIDS ... the people with the courage to declare themselves and to take public stands on and against the pandemic. Their stories rang true: no one in authority listens to them, no one in authority consults with them, no one in authority offers treatment, no one in authority expresses concern except on public rhetorical occasions. There's a deep and abiding bitterness to all of this.

And it tends to be quintessential of Africa. It is a matter of continuing concern that lip-service almost everywhere characterizes the attitude and behaviour of government towards organized associations of People Living with HIV/AIDS. It's hurtful and it's painful. All the blather in the world about banishing stigma and discrimination can't mask the pall of rejection subtly conveyed by governments.

On the other hand, by way of vivid contrast, one of the strengths of Tanzania, is the phenomenal organization against the pandemic at district and village level. When I traveled into the hinterland, especially in and around Mwanza, I was stunned by the detailed planning for prevention and home-based care activities. There were endless community committees to deal with HIV/AIDS, working relentlessly to carry the message of prevention from household to household. And there was a culture of caring, not notably different from others, but made real by virtue of the support from the district officials. I talked to families, and local luminaries, and adolescents and elders and widows and grandmothers and orphan children, and they shared such a collective solidarity, and they got such pleasure out of supporting each other that I could scarce believe it. Of course it doesn't apply across the board; there are, I am certain, great reservoirs of alienation and isolation. But I very much had the sense that when the government gets its treatment rollout into gear, the entire country, district by district, will be galvanized.

A final word. In both Malawi and Tanzania, the UN country team was clearly valued and respected by Government … the relationships were first-rate. This isn't always the case. But in these two countries, there was the feeling that the UN had a decisive role in pricking the leadership into action, and then sustaining it. More, the expanded theme groups on HIV/AIDS were clearly working, with great potential for that coarse and vulgar word we know as "harmonization". I am more and more convinced that faced with the greatest calamity humankind has ever known, the UN family should be courageous, impatient, outspoken, bold, demanding, provocative, helpful and ineffably appealing.

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