



Keynote by Stephen Lewis to open the annual conference of the Consortium of Universities for Global Health (CUGH), New York City, March 16, 2018

When I talked to Dr. Keith Martin about this speech, he told me that he wanted some sort of clarion call to action. If, at this hour of the morning, that seems a little strenuous, I fully agree. Nonetheless, keeping the theme of the conference firmly in mind, I shall do my best. If my best falls short, you have only Dr. Martin to blame.

However, this I can say at the outset. I intend this speech to be entirely unorthodox in terms of the likely expectations. I ask only that you bear with me to the end, when threads of coherence may emerge.

This is not, for me, an exercise in calibrating the obvious. The Occupy Movement, the annual Oxfam reports detailing the obscene concentrations of wealth, the huge disparities in human health between struggling nations in Africa and the Western world, the grotesque indignity of poverty in the United States chronicled by Philip Alston, UN Special Rapporteur on Extreme Poverty and Human Rights, the hegemony of the 1% who parade their self-impressed beneficence at the World Economic Forum ... these are all too well-known by anyone who follows the quest for social justice in global public health.

I don't want to drive the nail through the wall with a litany of examples of inequality with which this audience is familiar. I want instead to attempt to make an argument about what to do about it.

Let me start briefly with the temper of the times because that's the necessary context. This is not an philosophical riff on my part; this is, I think, accurately descriptive, and by no means novel.

We're in a wildly volatile period of right-wing populism. From Chile to Italy to Poland to India to Zimbabwe to the United States, the winds of change are, for the most part, hostile, reactionary, suffocating, and at times, misogynist, racist, and malevolent. When it comes to global health, we struggle with everything from disabling financial shortfalls to eviscerating gag rules. The terrible toll that's taken on the uprooted and disinherited of the earth seems to cause barely a ripple of concern. If Dickens were still alive he would say it was the worst of times and the worst of times.

If, as in the Sustainable Development Goals, health is one of the most important measures of the human condition, then we are notably failing. It's 2018, and UNICEF reports last week that there are 650 million children in 52 countries who are unlikely to reach even two-thirds of the Goals. We still have nearly 6 million children dying of preventable diseases before the age of five. It's 2018, and UN Women reports last week that 122 women live in extreme poverty for every 100 men, and 303,000 women and girls still die from pregnancy-related illnesses every year. And those who struggle and those who die are not in the rich countries of the North. This is not to deny the significant gains that have been made; this is simply to say that there remains far too much pain in this world, in the poorest countries of this world.

The drama of disparities, as they pertain to health, can be viewed through a three-part lens.

The first is climate change. That same UN Women's report states that 14 times the number of women as compared to men die in climatic disasters, from tsunamis to hurricanes induced by global warming. I don't wish to be unduly apocalyptic, but my own view is that climate change presents the single greatest threat to humankind.

Will you permit me a personal aside? In June of 1988, I chaired the first International Conference on Climate Change; it was held in my home city of Toronto, Canada. There were assembled 300 scientists, politicians, and activists from around the world for a week of intense, sometimes splenetic debate, and at the end, a conference statement was issued whose opening paragraph read, in part: "Humanity is conducting an unintended, uncontrolled, globally pervasive experiment whose ultimate consequences could be second only to a global nuclear war ... The best predictions available indicate potentially severe economic and social dislocation for present and future generations ... It is imperative to act now."

At the time, those words were considered extravagantly hyperbolic. Today, no longer. It's 30 years later, and the imperative to act now was never heeded.

Why do I make much of this? Two reasons. First, the pulverizing consequences of sea-level rise, small island states disappearing beneath the waves, massive droughts, concomitant famine, agricultural dislocation, the ice evaporating in the Arctic and the Antarctic, inundation of coastal regions, heat waves leading to asphyxiating deaths, plus the huge and proliferating range of climate-induced catastrophes is, collectively, a recipe for illness, death, and despair. And that doesn't begin to touch on the tens of millions of environmental refugees who are about to be unleashed on the world.

I needn't drive home the obvious: the consequences for human health fall far more heavily on the poorest parts of the planet. And when the richest parts of the planet are, so far, assailed by climate change, it hurts momentarily, but they can cope.

What is so galling is the profound intellectual hypocrisy that pretends that progress is being made. The world went into hyperactive overdrive at the Paris Climate Conference when, in December 2015, 196 countries agreed to the Paris Climate Accord by consensus. You will recall that the centrepiece of that Accord was the commitment that temperature rise would not exceed 2° Celsius over pre-industrial levels. Indeed, the second half of the Accord set the target at 1.5°Celsius.

Now here's the intellectual rub. The entire Accord is voluntary ... there is absolutely no mandatory requirement whatsoever to meet the agreed-upon objective. More, countries set their own targets and can change them at will or discard them at will. It is a grand illusory façade. It approximates a conspiratorial hoax on the planet. The most reputable climate scientists and experts have pointed out that the targets presently set and arithmetically computed will drive the temperature up by 4° Celsius or higher. That spells an incomparable calamity.

Why am I exercised? Because this is the ultimate definition of disparity that will haunt the rest of this century. And the greatest casualty of all, as everyone in this room can intuit, will be human health in the poorest regions and conditions of the globe.

It seems to me that in this room of scientists, experts, researchers, advocates, there lies a compendium of knowledge that should galvanize the world. I know you didn't achieve the celestial heights of excellence in order to mount the barricades. But surely voices must be heard. Whether it's a research study, or an article in a learned journal, or a press conference, or a media interview, or an op-ed in *The New York Times*, or a conference like this one, or an expert panel, or a *Lancet* Commission, or a review of academic materials, you must—I say this with great respect—you must shed your inhibitions and speak truth to the fossilized, antediluvian establishment.

There's too much at stake. There's too much hurt in prospect. Global health will be shredded ... and those who need health most will be abandoned to the gale force of climate change because those of us with a voice chose not to use it.

The second representative manifestation of disparity, of inequality, is more prosaic: tuberculosis. Forgive me for repeating what you already know. TB is now the greatest killer amongst infectious diseases; 1.8 million deaths a year, more than HIV and malaria put together. More, there were well over 10 million active cases of TB in 2016, and an accelerating web of Multi-Drug Resistant TB (MDR-TB) and Extensively-Drug Resistant TB (XDR-TB) in several countries, India and South Africa above all.

If ever there was evidence of disparity and inequality, TB is the exemplar.

Let me take you on a quick travelogue.

Last September, with Georgia White, a close colleague from AIDS-Free World, I travelled to the Territory of Nunavut, the Arctic home of the Indigenous Inuit people of Canada. They were experiencing a significant tuberculosis outbreak in 14 of the 25 remote communities. It was appalling. The incidence of TB was 260 times higher than any level of TB among the non-Indigenous people of Canada, and it became clear that a pattern of neglect had been government policy for decades. In fact, it was a pattern of ceaseless historical discrimination.

All the elements of transmission were there. Terrible overcrowding, dreadful shortage of housing, ubiquitous poverty, astronomic food prices, desperately poor nutrition; it was like a case study in the violation of the social determinants of health. We were there on a TB fact-finding mission, and believe me, there was a lot to find. The community struggled heroically; the Inuit people showed astonishing resilience, their Indigenous organizations were strong and tenacious, the Medical Officer of Health and her staff were extraordinarily impressive, but the lack of doctors and nurses and community health workers, particularly those who could speak Inuktitut and grasp the culture were sorely lacking.

There were no GeneXpert machines, the best diagnostic tool, in the outlying communities, or even digital X-ray machines, and at root, there was a fatal lack of funding. In Canada, the treatment of

Indigenous peoples, like almost everywhere else in the world, has been characterized by stigma, exploitation, indifference, and savage racism.

When the trip was over, we wrote a very strong and critical report. I can't pretend that it had undue influence, but the times, they are a-changing. The government of Justin Trudeau—by the way I am not of his political party—is working hard at reconciliation, and with the creation of a new Ministry of Indigenous Services and the appointment of a Minister to head it, Dr. Jane Philpott, one of the best Ministers in the government cabinet, the pendulum is swinging. As recently as one month ago, the Minister announced a \$400-million plan for housing and the pledge of an initial \$27 million to fight TB, which she promised to eliminate over the next five years. The Inuit people are 65,000 in number; it should be possible.

I dwell on this because it is ever thus. Indigenous communities, racialized communities, communities of diverse sexual orientation and gender identity, marginalized communities at the fragile cliff's edge of society are always beleaguered, mostly without voice, submerged in feelings of hopelessness. That's the meaning of inequality. That's how it poisons the anatomy and the soul.

In October, my colleague and I travelled to India, again on a TB fact-finding mission. I'm not sure we've yet recovered.

India has approximately 27% of the global TB caseload, some 2.8 million cases, and a quarter of the global multi-drug-resistant TB cases, some 147,000. It was MDR-TB on which we concentrated, primarily in Mumbai.

If ever there was a disease of poverty and inequality, MDR-TB is it. But what's most discouraging is the behaviour of the Indian government. This is not a government that lacks for funds, but it has starved the response to MDR-TB and XDR-TB in a thoroughly callous way. It was perfectly prepared to watch patients die as they struggled to locate and be treated with life-saving drugs. And in the most recent famous case, it took the Lawyers Collective going to court on behalf of a 17-year-old girl to get the drugs released. Thanks to a remarkable physician, Dr. Zarir Udwadia, the young woman, with XDR-TB is still alive and TB-free.

But in our trip, the episode spoke volumes. The rhetoric we heard from virtually every government representative, right up to deputy-ministers, was a combination of dissembling vacuity and soothing fatuity. In fact, in one memorable encounter, at a very senior level of the Ministry of Health, we were told, and I quote, "Everything is perfect".

But of course, nothing was perfect. The struggles around TB between the public and private sectors was ongoing. The new drugs for MDR-TB, the first new drugs in 40 years, bedaquiline and delamanid, were just beginning to be rolled out, the community health workers, indispensable to patient recovery were catastrophically few in number, the patients with whom we met described a nightmare experience of treatment and continuing stigma with which they had to contend. If it hadn't been for the inspired work of MSF, we would have been thoroughly depressed.

It's necessary to ask: how does the Indian government get away with it for all these years, and no one, except for a courageous few, confronts them? Yes, India is still a developing country, seething with more than a billion people. It's a desperately poor country, where the human resources for health, and the laboratory components of health, and the infrastructure of health have been ignored for years. Do none of us have a responsibility for the toll on the human condition in another part of the world?

Let me take a cautious risk at this point. As we meet here today, the STOP-TB Partnership, the leading international force outside WHO, against TB, happens to be holding an executive meeting in India. That makes good sense: where TB is concerned, India is the fulcrum. And India's Prime Minister, Narendra Modi will be a guest of honour. He will undoubtedly be festooned with adoration and tributes lavishly paid for his unexpected commitment to ending TB by 2025 and doubling the budget for tuberculosis. You can be sure that not a critical word will be heard.

Now as it happens, I have a great admiration for the STOP-TB Partnership and what it does. But I respectfully disagree on the strategy employed. And in this instance, I can draw directly from my own experience. It is a mistake, I think, to cozy up to heads of state for the rhetoric they disgorge when past evidence suggests that the delivery is, or has been, negligible. It doesn't work.

I spent five and a half years as the UN Envoy for HIV/AIDS in Africa. I met with the president and cabinet of virtually every high-prevalence country, most of them more than once. I learned early on that ashes and sackcloth never led to policy change on AIDS. The only thing that worked, whether it was with an egomaniacal President Daniel Arap Moi of Kenya or a denialist like President Thabo Mbeki of South Africa, the only thing that worked was to lay the cards on the table with unequivocal candour. At times it was necessary to offend; it was never necessary to mollify. It was uncompromising but respectful. Lives were at stake.

Lives, many lives, are at stake in India. There's not a day to lose. Sure, the budget has been doubled, but it's laughably picayune compared to the way in which the health budgets have been starved for decades. As of our trip, the overall health budget was 1.2% of GDP, projected to rise to 2.5% of GDP by 2025. Frankly, that's pathetic compared to a majority of developing countries. Sure, the year 2025 has been trotted out as the end of TB. But everyone significantly ensconced in the TB world knows that's nonsense. Why can't it be said?

You see, that again is the message I want to convey. Wherever in the world there is oppression, on the basis of squalor or class or race, so that human health is imperilled, it's necessary to take a stand. It's necessary to find an opportunity to speak out about the indignity of increased morbidity and mortality where none need occur. Let impatience be your byword.

Just last month, my colleague and I made the final visit in our tuberculosis odyssey, this time to South Africa. South Africa has the highest number of TB cases in the world, and everyone in this audience will know that the co-infection rates with HIV are staggeringly high, and that TB is the greatest single killer of those with AIDS.

South Africa also has a very serious outbreak of MDR and XDR-TB, concentrated in the townships around Cape Town and KwaZulu-Natal. We went first to Cape Town and spent more than a day in the primary township of Khayelitsha, observing MDR-TB. What a difference from India!

In South Africa, the government is onside. The Ministry of Health knows it has a crisis, and it's moving mountains to contain it. The Minister of Health is an eloquent advocate. GeneXpert has been rolled out more widely than in any country in the world; bedaquiline is commonplace; delamanid is only available on a compassionate-use basis, but the government and activists are placing great pressure on the manufacturer, Otsuka, to register in South Africa; community health workers are valued and have just received a major jump in pay; there are social grants for patients and families struggling with the disease; research is valued and supported; everyone with HIV takes a TB test and everyone with TB takes an HIV test; and above all, groups like MSF that lead the response in a township like Khayelitsha have the Minister on their side.

This is not to paint a romantic panacea. We encountered some heart-breaking realities. Too many patients recovering at home have no food; prevention has been neglected in the rush to treatment; short-term treatment runs for nine months with painful daily injections that can lead to deafness, plus 15 pills a day; children of two-, three- and four-months languish in paediatric wards with extra-pulmonary TB, some of them facing a life of disability. And several critics, from the Treatment Action Campaign to respected academic researchers, feel that the Minister of Health relies too readily on fanciful nostrums of success rather than hard-headed recognition of limited progress.

But that's the point. There is open public disputation. Unlike India, no one feels constrained, intimidated, or silenced. It's understood that breakthroughs occur when a spirit of unrestrained debate prevails. And that's the way you overcome disparity: it's identified and confronted.

Does that mean that South Africa is a crucible of equity? Far from it. Healthcare in the private sector still confers huge benefits on the 16% of the population that gets to use it. And the public sector, by comparison, though having some of the most talented clinicians in the country, is woefully run-down, overcrowded and struggling.

But again, I emphasize that even the Minister of Health himself is provocatively vocal rather than defensive about the state of health in South Africa.

Am I off-track here? Have I lost my way? I don't think so. Nunavut is in an opulently wealthy developed country, whose governments, through the decades, have chosen racism over equity. That changed with unbridled activism. India is a so-called developing country, with enormous wealth concentrated at the top, while the masses struggle for healthcare. How do you break that paradigm of inequality? I would argue that you achieve it through tenacious, indefatigable pressure on the government, driven by crescendos of activism until capitulation is the only alternative left. South Africa is the proof of the equation; it's also deemed a developing country, but a country where almost all the beneficial institutional change has come through the application of unrelenting advocacy ... in this case a combination of rousing public demonstrations combined with brilliant use of the courts. Do you remember how 330,000 people died of AIDS, who should never have died of AIDS, on Thabo

Mbeki's watch because of his refusal to roll-out antiretrovirals? He was forced to relent because the arsenal of protest wore him down.

That's what I'm asking of this audience.

And it leads me to the final issue I want to reconnoitre: conflict and sexual violence. I would posit that the health consequences of sexual violence surpass any communicable or non-communicable disease. That seems to me unarguable. I shall assume agreement.

Yesterday, March 15th, marked seven years of the war in Syria ... half a million killed, 12 million displaced, 13 million in need of humanitarian assistance. The carnage defies linguistic definition. War crimes and crimes against humanity seem inadequate approximations of the barbarism. Suffusing that barbarism, reported widely by human rights groups, is an explosion of rape that strangles credulity. You will note that the world has done virtually nothing.

Since August 25th of last year, 360 Rohingya villages have been burned to the ground in Myanmar. Six hundred and eighty-eight thousand have fled ... 900,000 in total are now refugees in Bangladesh. There has not been a single Security Council resolution on the Rohingya. Not one. It's incredible. We're witnessing a genocide against a Muslim ethnic minority and the world is utterly indifferent. But we're also witnessing a femicide, a war on women rooted in rape and finalized in slaughter. The stories and images out of Myanmar, women and children sacrificed to rapacious madmen in the Myanmar army, make you wonder wherein lies hope for this world?

Yemen is the ultimate killing ground; more than 1000 days of war. It's also the world's longest humanitarian crisis ... 75% of the population of 22 million require assistance and eight million face famine. Women and children are helpless collateral damage. The primary perpetrator, Saudi Arabia, sits on the United Nations' Human Rights Council, the very embodiment of mockery of the United Nations charter and all of its international human rights instruments. The social determinants of health have collapsed so dramatically that Yemen has had to face the largest cholera epidemic anywhere, Haiti included, since the turn of the century.

Burundi, the Democratic Republic of the Congo, South Sudan, Darfur, the Central African Republic, Mali, Zimbabwe, Afghanistan, Venezuela, Pakistan, Egypt, Ukraine, Turkey, Iraq ... Iraq: need I remind you of the Yazidis? Torn from their ancestral home by ISIL, a catalogue of massacres, abducted, tortured, beheaded, burned alive, agonizing death from dehydration, starvation, and for the Yazidi women and children the torment of sexual slavery, sold in the open market-place like some pre-feudal cattle-call, lives ruined forever. Is there a greater inequality?

Where was I? Iraq? The list is never-ending of those countries and regions where conflict or deplorable governance leave women and girls—overwhelmingly, women and girls—at the mercy of sexual violence. And this doesn't begin to mirror the statistic in the UN Women's report that one out of five women and girls have experienced physical and/or sexual violence by an intimate partner in the last 12 months. Nor does it mirror the #MeToo movement, or the proliferation of sexual harassment, sexual exploitation and abuse, sexual misconduct, sexual assault that has been revealed in the international humanitarian NGO community and the United Nations system. I want to add with

some pride, that my co-Director of AIDS-Free World, Paula Donovan, launched our Code Blue Campaign designed, initially, to end impunity for sexual exploitation and abuse in UN peacekeeping operations. But Code Blue has now emerged as one of the strongest forces, with the most credible solution, against sexual harassment and abuse within the entire UN system. And believe me, it's a challenge, because the UN system is rife with sexual abuse.

The toll on women—physical, emotional, psychological—in all of these particulars is indescribable. It's an absolute assault on health. And, of course, the women who suffer the most, are the women who are most disadvantaged and vulnerable, or compromised and fearful, or desolate and alone.

I'm not asking that people in this room fashion world peace. But I would argue that what knits everything together is inequality on the one hand and health on the other. It's no accident that the World Health Organization is urgently considering a Framework Convention on Global Health. It's no accident that public health insurance plans—Medicare as it's known in countries like Canada—are now the rage in country after country. Health is the tie that binds. And if we can bring home the unconscionable damage to human health, to the health of women and children caused by these conflicts, caused by the use of rape as a strategy of war, caused by the use of rape as the ugliest excrescence of the patriarchy, then maybe, one day, we'll get world leaders to shift from the politics of self-aggrandizement to the politics of social justice and the human condition.

It would not have been difficult in this speech to parse specific indicators of disparity or inequality. I could have relied on HIV/AIDS alone. Just to examine the situation of the LGBT community, or sex workers, or injecting drug users and juxtapose their grievous predicament with the way in which we treat mainstream groups would make the case. Or take adolescent girls and young women. For how many years have we bemoaned our collective failure to persuade adolescents and young women of prevention, how many academic papers have been written in the hope of precipitating action? Yet, in a UNAIDS publication of 2016, it's established that there are 8,600 new HIV infections a week amongst adolescent girls and young women. A week! Talk of inequality! The HIV pandemic is the showcase for inequality, gender inequality.

So it would have been possible, using research papers published by many in this audience, to make the case for, and confront, the issue of disparity. But I chose otherwise. And as I close, let me explain why.

This is intensely personal, non-analytic, even faintly ideological, so if you want to leave the hall, please do: people have been walking out on me all my adult life.

I'm in my dotage. I'm 80 years old; I consort with geriatrics. And I'm frightened, not about issues of mortality, but about the life of the planet. I think things have gone haywire. Global warming was once an existential threat; now it's terrifyingly real. And on top of that, we appear to have the re-emergence of the cold war, with aggressive belligerence on both sides of the divide. But that's only the half of it: these intractable conflicts, in so many regions, threaten to engulf other geopolitical players with disastrous results. And in the hands of two of the most irresponsible of those players, there are nuclear weapons. It's no wonder that the Bulletin of the Atomic Scientists just moved the hands of the Doomsday clock to two minutes to midnight.

I think of my grandsons and the world they're about to inherit. So how do we fight back? How do we mobilize civil society to mount the greatest push for survival the world has ever known? What is the motivator? Striking the alarm of poverty doesn't seem to do it ... we can't even raise the funds to feed the starving on an emergency basis. The Sustainable Development Goals, writ large, sound good, but they're far too esoteric for both the noisy patricians and the lumpen proletariat. Water doesn't do it, sanitation doesn't do it, nutrition doesn't do it, education doesn't seem to do it ...

But the one unifying force that engages everyone's attention is health. And if you can make an argument, from any platform, any podium, for the preservation of health, then you have an instant audience. I beg you to believe it's worth doing. It has an elemental sanity of enormous appeal. The appeal is to decency, not malice. The appeal is to caring, not rejection. The appeal is to sympathy, not hostility.

When you concentrate on health, you touch the mind and you touch the heart. In biblical terms, please go forth and do exactly that. The world is actually worth saving.