

## **Africa on the rise**

Prof. dr. Joep Lange

My first trip to Africa took place in August 1992. For 10 years, I had been treating and doing research on men who have sex with men (MSM; then usually called homosexuals or gay men) with HIV at the UvA's Academic Medical Center (AMC-UvA). I now, however, wanted to see the epicentre of the HIV/AIDS epidemic, which is why I joined the World Health Organization's Global Programme on AIDS (WHO/GPA) as chief of Clinical Research and Drug Development. My official starting date was 1 September, but I was asked to already make a visit to Kampala, Uganda, in August because GPA was in a hurry to initiate a study to demonstrate the uselessness of Kemron, a fake and expensive AIDS remedy promoted by former Kenyan President Daniel Arap Moi.

That visit turned out to be a life-changing event. Driving from Entebbe airport to Kampala, I immediately fell in love with the country: the red earth, the lushness of the vegetation, the way people walked (many barefoot) along the roadside. Nevertheless, even on that road the presence of AIDS could not be ignored – people were selling coffins everywhere. Although I was aware that Uganda at that stage had an adult HIV prevalence rate of 30+ per cent, even this knowledge didn't prepare me for what I was about to see at Makerere University's Mulago hospital. Accompanying Elly Katabira – the principal investigator of the Kemron study and the leading academic HIV physician in Uganda – on his rounds, I was shocked to see the internal medicine wards almost entirely occupied by people with AIDS, two in each bed and many lying on mattresses on the floor. At regular intervals, I saw how people who had just died were being carried away. Besides a lack of running water, there were virtually no diagnostic tools and little to no medicines. I still remember seeing a woman with a baby on her back and an enormous, painful anogenital herpes ulcer, visiting the hospital and being sent home without acyclovir or painkillers. After seeing all of this, I was unable to take care of people who complained about having to take too many pills when I returned to the AMC in 1995 – I literally told several of them to find another doctor.

That morning at Mulago hooked me on Africa. It also became my mission to do something about the terrible global inequality in access to life-saving medicines. When effective triple drug therapy for HIV became available in high-income countries in 1996, it vexed me to see how little could still be done for Africa. Drug regimens were very expensive, assumed too complex, and many policymakers felt that prevention was more cost-effective than treatment (we now know that treatment is the most effective prevention). Then, suddenly, in May 2000, on the eve of the 13th International AIDS Conference in Durban, South Africa, an agreement between five major pharmaceutical companies and UNAIDS was announced. In the agreement, the companies pledged to start providing antiretrovirals at greatly reduced prices for poor countries with a large HIV burden. This was the first International AIDS Conference to be held in Africa, which certainly prompted this agreement. Now that the drugs were 'affordable' and the regimens less complex, we could finally take action. I started PharmAccess Foundation and approached companies that are active in Africa, such as Heineken, to convince them to start providing HIV treatment to their local employees, which Heineken did in 2001. Since then, many companies have followed suit. It took another two years before big funding mechanisms for a massive HIV treatment roll-out were established. Today, more than 10 million people in low and middle-income countries are receiving antiretrovirals – an unprecedented success story of global health.

Throughout the years, our group has always remained active in Africa, doing clinical research, building research capacity, offering educational programmes and exploring novel ways of financing health care and improving the quality of care. We are active in many

countries (Ghana, Kenya, Mozambique, Namibia, Nigeria, Rwanda, Tanzania, Uganda, South Africa), but Uganda holds a special place in my heart. Elly Katabira has been a close friend and steady collaborator since our first encounter. Thanks to him, the AMC has been able to build a spiritual and physical presence at Mulago.

Since my first visit more than twenty years ago, I have seen Africa transform, especially urban Africa, which now boasts a rapidly growing middle class. The change has been impressive. Where roads once stood empty, they are now congested with traffic. Where virtually no proper restaurants once existed, visitors now have a pick of many excellent and exotic ones. Informal settlements are making way for splashy new buildings, nobody goes barefoot any longer, almost everybody has a cell phone, and a number of African cities, such as Nairobi, are hotspots of innovation. After years of one pessimistic story after the other ('the lost continent'), the Economist in December 2011 had 'Africa rising' on its cover, copied by Time magazine a year later. To those who regularly visit Sub-Saharan Africa, the pace of change is indeed astonishing, and there are many reasons to be optimistic about the region. We should, however, also realise that many countries suffer from bad leadership (not unique to Africa) and poor institutions, that many places have stayed behind and/or are conflict-ridden, that very little has changed for the poor in rural settings, and that the lives of those who left for urban slums are extremely difficult. To include the latter two groups in the 'great escape' from poverty is the big challenge ahead.

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