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Comments by Sandra L. Thurman
Director, Office of National AIDS Policy
AIDS/Malaria African Health Ministers Conference

Thank you Adam.

It has been said that when we look into the eyes of a child, we can see the whole of the universe. My friends, today the eyes of our children reveal a world devastated by AIDS.

The sad truth is - our battle against AIDS is far from over. In fact, it is just beginning. And now more than ever, we must be vigilant against the growing misperception in the United States that AIDS is no longer a lethal threat – a misperception that too many are only too eager to embrace.

As I look around this room, I am encouraged to see many of the key players who have played a vitally important role in shaping our shared response to the AIDS crisis, here at home, in Africa, and around the world.

Together, we can and we must use our small successes and recent signs of hope – not as an invitation to rest, but as a foundation for facing the future – and for fighting on.

AIDS is a plague of Biblical proportion, and it is claiming more lives in Africa than in all armed conflicts on the continent combined.

As you know, nearly 14 million men, women and children in Africa have already died of AIDS. Today and everyday, AIDS buries more than 5,500 Africans – and that number will more than double in the next few years. AIDS is now the leading cause of death among all people of all ages in Africa – as it is for young adult African-American men here in the United States.

And the epidemic rages on. Each day, 11,000 people in Africa become HIV infected - one every 8 seconds. Most of these new infections are among young people under the age of 25, and more than half are young women. By 2005, more than 100 million people worldwide will have been infected with HIV.

In just a few short years, AIDS has wiped out decades of hard work and steady progress in development – and will soon double infant mortality, triple child mortality, and slash life expectancy by 20 years or more.

In a host of different ways and from a variety of different vantage points, it is increasingly children and women who are caught in the crossfire of this relentless epidemic.

AIDS has not only had a devastating impact on individuals, families and communities, but is also threatening the economic and political stability of entire nations. We must move beyond thinking of AIDS just as a health crisis – AIDS is a human rights crisis, a development crisis, a trade and investment crisis, and a security and civil stability crisis.

Yet my message to you today is not one of hopelessness and desolation. On the contrary, I hope to share with you a sense of optimism. For amidst all of this tragedy, there is hope. Amidst this terrible crisis, there is opportunity: the opportunity for us – working together – to empower women, to protect children, and to support families and communities both at home and abroad in our shared struggle against AIDS.

In the United States, we have dramatically increased our efforts to fight AIDS on several fronts. In the last year alone, funding levels for minority programs increased to \$250 million – and the President's FY 2001 budget pushes HIV &

AIDS funding to an all time high, bringing our spending on AIDS, research, prevention and treatment to over 10 billion per year. As we seek to keep pace with AIDS in our communities of color, increases in prevention, new programs to prevent substance abuse, and enhanced treatment efforts begin to address the unique issues faced by the African American AIDS community.

I am also very proud that our commitment has now reached beyond our own borders. Many of our colleagues in this room have been deeply engaged in the effort to address AIDS in Africa. It is a testament to our growing spirit and energy that we can unite our efforts to address the AIDS epidemic here in the United States with the millions around the world who share our commitment to stopping this pandemic.

This past July, the Administration requested and the Congress approved a new Global AIDS Initiative that increased the US commitment to the global fight against AIDS by \$100 million for fiscal year 2000. That more than doubles our investment in the fight against AIDS in Africa. And just last January, at the UN Security Council, the Vice President announced that the President has requested an additional \$100 million to further expand our global AIDS response.

Luckily, painful experience has taught us some valuable lessons, and we should take them to heart.

First, in reality, we are much more alike than we are different. And while we must celebrate our diversity – there is much we can learn from each other. As President Clinton said recently at the National Summit on Africa, “We must make it clear to our African partners that we consider AIDS not just their burden but ours as well.”

Second, leadership matters.

Leadership from the very top – all the way to the community level.

Uganda is a great example. President Museveni has been a strong and effective leader in the fight against AIDS. In partnership with communities and donor nations, Uganda has cut the rate of HIV by more than half – and has organized model programs for HIV counseling and testing, and AIDS care and support. In Senegal as well, early leadership and mobilization has kept their AIDS prevalence low. In the final analysis – there is simply no substitute for real and committed leadership – in all sectors.

Third, this fight requires an investment – of time, energy and resources. Money, while desperately needed, is not enough.

Fourth, we pay a heavy price for the stigma that surrounds AIDS. We must lift the shroud of secrecy that surrounds AIDS, so that individuals and families living with AIDS will no longer be forced to suffer in silence. For years in America, AIDS remained underground, and people living with AIDS lost their jobs, their homes, their health insurance, and their dignity to the fear mongering and finger pointing of others. Leadership, education, and expansion of civil rights laws can help to bring AIDS into the light, where it can be seen and combated. We must learn to fight AIDS – not people with AIDS.

And finally, partnerships among all sectors are essential.

AIDS is everyone's problem – and everyone must be part of the solution.

Much has been said and written about each of these lessons.

The fact is *we know what works*. It is now time for us to move from paper to practice – and from words to deeds.

Together, we must join our voices and pool our skills and our resources to begin to keep pace with an epidemic that is out of control.

Together, we must continue to find ways to affirm that we are a global community where crisis and opportunity have no borders – that our battle against AIDS in America, in Africa, and around the world is a shared responsibility.

And together, we must push past denial and blame and inevitability – and toward a sense of real solidarity symbolized by shared commitment, collaboration, and constructive action.

This is a time of great challenge. The destiny of millions of people hang in the balance. Your experience, perseverance and hard work on this issue are desperately needed. I pray that each of us can leave this Conference more confident in our commitment, more invigorated by an expanding partnership, and more energized by our determination to doing everything that we can do to win the battle against AIDS.

As we stand at the beginning of the new millennium, let us commit together to build from this tragedy, a foundation for hope, a legacy of compassion, and a real partnership forged by real solidarity in this shared struggle.

Let us join together in what Archbishop Desmond Tutu has called our 'holy war'
and do as we have promised to those who have passed before us. Remember those
old words of our nation's struggle for civil rights:

Sing a song full of the faith that the dark past has taught us;
Sing a song full of the hope that the present has brought us;
Facing the rising sun of our new day begun,
Let us march on, till victory is won.



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National Center for HIV, STD, & TB Prevention

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Facsimile Transmittal

Date: May 4, 2000

**To: Sandy Thurman
White House
National AIDS Policy**

**Telephone Number: 202-456-2437
Fax Number: 202-456-2438
Number of pages: 5**

**Subject: The Atlanta Georgia Declaration on HIV/AIDS and Malaria in Africa
American Medical Team for Africa, Inc., Conference on HIV/AIDS and Malaria in
Africa, April 15, 2000, Atlanta, Georgia**



**CENTERS FOR DISEASE CONTROL
AND PREVENTION**

THE
ATLANTA, GEORGIA DECLARATION

ON

HIV/AIDS AND MALARIA IN AFRICA

AMERICAN MEDICAL TEAM FOR AFRICA, INC.
CONFERENCE ON HIV/AIDS AND MALARIA IN
AFRICA
APRIL 15, 2000
ATLANTA, GEORGIA, USA

THE ATLANTA DECLARATION

WHEREAS, we, the participants at the American Medical Team for Africa Conference in Atlanta, April 13-15, 2000, representing a collaborative effort of more than twenty four (24) Ministers of Health of Africa, of bilateral and multilateral agencies, private sector academia and NGOs; and

WHEREAS, because we are greatly concerned about the grave and deepening socio-economic impact in Africa of HIV/AIDS and Malaria; and

WHEREAS, because we recognize that the disease and economic burden that HIV and Malaria place on millions of Africans and the barriers that these diseases constitute to development and alleviation of poverty; and

WHEREAS, because we take note to the following:

- there is estimated more than 10.4 million African AIDS orphans;
- there is estimated more than 13.7 million AIDS-related deaths in Sub-Saharan Africa;
- there is a drastic drop in life expectancy from 59 years of age to below 45 years of age; and

● more people have died from HIV/AIDS in Africa than World War II, the Korean War, the Gulf War, and the Kosovo Wars combined; and

WHEREAS, because we appreciate that Malaria kills 3,000 children under the age of five (5) per day in Africa; that the mortality rate due to Malaria is estimated to be over one (1) million deaths each year; and that Malaria costs Africa close to three (3) billion U.S. dollars to control and treat in one (1) year; and

WHEREAS, because we are committed to ensuring that the provision of funds to implement national intervention programs, a “united voice of appeal” to the American public, policy makers, scientific, private, and religion sectors and other friends of Africa for concrete support to African initiatives aimed at addressing these two major problems, along with alliances between African Health Ministers, the American public, private sector and other friends of Africa to fight against these threats will be essential; and

WHEREAS, because we acknowledge the urgent need for (1) mobilizing financial, technical, and in kind resources in support of community based interventions for HIV/AIDS and Malaria prevention and control and supporting (2) supporting and strengthening of health/medical research institutions in Africa, including research into traditional medicine; and

WHEREAS, because we unanimously endorse this action-oriented Atlanta Declaration to confront the problems of millions of orphans and adults dealing with these threats; and

WHEREAS, because we are encouraged by the commitments from the African Governments and partners at the highest levels.

THEREFORE, BE IT RESOLVED, that we collectively and with undivided unity reinforce basic infrastructure, plans, and strategies to fight HIV/AIDS and Malaria by focusing at every community levels.

RESOLVED, that we emphasize the urgency of implementation using the existing systems, plans and strategies for the purpose of reducing the disease burden.

RESOLVED, that we recognize the most vulnerable groups, namely, women and children, as needing specific recognition and assistance.

RESOLVED, that we stress our concern about the impact of the deteriorating socio-economic well being of current and future generations by imploring that there should be (1) increased support from partners to fight the scourge of HIV/AIDS and Malaria, (2) support coming from partners be coordinated through the existing national structures to benefit communities, (3) made more accessible drugs through subsidization of generic manufacturing, introduction of pricing, and distribution of structures and other appropriate measures; (4) technical assistance provided to Africa; and (5) relevant joint research urgently undertaken to accelerate treatment, management, prevention, and control of these threats.

RESOLVED, that the U.S. Government allocate ten (10) Billion U.S. dollars over the next five (5) years to fight HIV/AIDS and Malaria in Africa and, in like manner, encourage the European Union, Japanese Government, and other similar non-governmental and private sector donors to provide matching funds.

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As I look around this room, I am encouraged to see many of the key players who have played a vitally important role in ^{shaping} our shared response to the AIDS crisis, ~~both~~ here at home, in Africa, and around the world.

Together, we can and we must use our small successes and recent signs of hope – not as an invitation to rest, but as a foundation for facing the future -- and for fighting on. ~~Most of us can still remember back to the~~ days, when ignorance and

indifference were the rule and not the exception, when treatments were desperate and unproved.

We have indeed come a long way in the battle against AIDS, building new bridges across old boundaries and translating words into deeds.

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orphan

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the UN Security Council, the Vice President announced that the President ^{was} requested an additional \$100 million to further expand our ^{global} ~~international~~ response.

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And finally, partnerships among all sectors are essential. ~~As I said earlier, AIDS is not just a health problem – it is a development problem, a trade problem, and a security problem.~~ *As health people, we must respect the*

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**REMARKS BY
MS. VIVIAN LOWERY-DERRYCK
ASSISTANT ADMINISTRATOR FOR AFRICA, USAID
*AFRICAN MINISTERIAL MEETING ON HIV/AIDS AND
MALARIA***

Good morning. Honorable ministers and guests, I am particularly delighted and honored to have this rare opportunity to welcome you all to the United States. Your being here represents your commitment to addressing two of the greatest challenges that Africa faces today: HIV/AIDS and malaria. These two issues not only gravely affect the health sector but the political, economic and social security of your entire nations.

HIV/AIDS and malaria in Africa and globally are two very high priorities of the US Government—both for our Administration and Congress. Last year, the Administration proposed, and Congress approved, the *Leadership and Investment in Fighting an Epidemic* Initiative, known as LIFE, that included a landmark increase of \$100 million for HIV/AIDS, almost all for Africa. Of USAID's \$200 million HIV/AIDS annual budget,

approximately \$130 million is devoted to Africa, providing assistance in 22 countries and several more through regional programs. These funds will help strengthen HIV/AIDS programs in countries to reduce transmission of the virus and to care for those affected. The initiative includes several components: 1) Primary prevention, including cutting edge interventions such as voluntary counseling and testing and prevention of mother to child transmission. 2) LIFE provided resources for a new area for USAID-- providing basic medical care and home based care for people living with HIV/AIDS. 3) The third component focuses on community programs to care for children affected by AIDS. 4) Finally, LIFE supports capacity and infrastructure development, including HIV/AIDS surveillance. In recognition that HIV/AIDS is not just a health issue, USAID is now integrating HIV/AIDS into our entire development portfolio.

USAID has been a world leader in fighting the HIV/AIDS epidemic for close to 15 years. This year, the Centers for Disease Control and Prevention joined us under the LIFE initiative to

provide expanded assistance to a number of African countries.

The President and Vice President's commitment have led to a new request this year for another \$100 million for HIV/AIDS internationally. In addition to USAID and CDC, we hope to gain the assistance from our Department of Defense and Department of Labor this coming year. USAID has been designated the lead agency for this initiative and we look forward to working with you in expanding the US government's combined assistance. USAID's commitment to controlling malaria is also substantial. This year, USAID will allocate \$17 million to malaria control efforts in Africa.

We are working very closely with all of you, as well as with our bilateral donor partners, UNAIDS, and multilateral agencies.

We have been actively helping to develop the International Partnership Against AIDS in Africa, which puts forward a framework for all of us—countries, donors, the private sector, NGOs—to work together. Similarly, USAID and the US

Government have been working closely with the WHO Rollback Malaria program.

CONTEXT

You are all familiar with the statistics. I wish to emphasize four points.

1. **These are global problems.** Whereas HIV/AIDS and malaria are global problems, Africa is still the hardest hit. 70% of all HIV/AIDS cases are in Africa, home to only 10% of the world's population.
2. **HIV/AIDS is not just a health problem, but also a development problem.**

Education – in Swaziland and Malawi, teachers are dying at more than twice the annual capacity for replacing them.

Schools are also challenged by the exploding numbers of orphans who, if able to attend at all, lack home support, other resources to be successful students

Economy - will reduce GDP in several sub-Saharan countries by 20% by 2010; in many industries, 3 workers trained for

every one because two will die. Add to this, reductions of up to 8% of GDP for malaria and we see the enormity of the burden.

Degrades infrastructure – AIDS is so widespread that top civil servants, the judiciary, parliaments all losing members. As leaders of civil society fall, often no immediate successors in sight.

3. **These are long-term problems**

No vaccine in sight; estimate at least 8 to 10 years away and may not be appropriate for strains prevalent in Africa

Meanwhile number of those infected continues to grow

40 million children affected by AIDS by 2010

450 million Africans at risk for malaria infection; 1.5 million deaths/year.

4. **HIV/AIDS and malaria disproportionately affect women.**

The burden is enormous. Consider:

Botswana and South Africa – in 1990, women outlived men by 7 to 10 years. By 2010, “advantage” will have disappeared and women will be dying younger than men. Botswana’s women

will have suffered 60% decrease in life expectancy – from 68 to 28 years!

This year, twice as many South African women as men will die from AIDS

55% of adult cases in Africa among women and the margin growing daily (Compare to 30% Southeast Asia, 20% in US/Europe.)

Mother-to-child transmission of HIV has been all but eliminated in the United States, but nearly 90% of the 570,000 infants and children infected in 1999 are in Africa.

Malaria affects women and infants particularly hard. 10% of low birthweight deaths and upwards of 20% of maternal mortality are associated with malaria.

These are global, development problems that disproportionately affect women and are long-term.

THERE IS GOOD NEWS

There is much greater worldwide acknowledgement of severity of these pandemics.

Increased support from private philanthropy – Gates Foundation, Ted Turner, others. Increased awareness on part of pharmaceutical manufacturers that products are too expensive and too difficult to administer in developing countries.

New interventions and drugs, such as the promising nevirapine
Uganda and Senegal have stemmed the rate of increase

WHAT NEEDS TO BE DONE

There is much to be done. I would like to emphasize eight key overarching points:

- 1. Improve health care system infrastructure and assessing the impact of HIV/AIDS on the health care system.** As the education sector example I gave earlier, HIV/AIDS in particular is having a heavy impact on the health care system: high

hospital occupancy rates due to HIV/AIDS and malaria; losing health care workers to these diseases; and insufficient health system infrastructure. Yet, we do not know enough of the full extent of the impact. USAID can assist with tools to help assess this impact, as well as to plan for new and innovative HIV/AIDS and malaria interventions. With international assistance, we need to continue to build strong health systems. We must also address the determinants of health such as the education of girls in general and health education in particular. Empowering people to take care of their own health by providing them with at least the necessary information is a basic human right.

2. **Reinforce leaders and increasing political commitment.** We have seen that without political commitment, little progress is made. Ministries of health are critical to providing the technical information and cost effective arguments to leaders. In the last year, major increases in political commitment have occurred in Malawi, Kenya, Zimbabwe, Botswana, Swaziland, Namibia, as

well as the continued efforts in Uganda and Senegal. Similarly, your actions are necessary help to lift stigma and discuss HIV/AIDS openly. USAID has developed advocacy materials that can assist your efforts.

3. **Mobilize resources.** You are vital to helping ensure that HIV/AIDS and malaria are included in poverty reduction strategies to ensure that you reap the benefits of debt relief in HIPC countries. Continue to work with the Ministry of Finance to increase resources for HIV/AIDS and malaria. USAID also looks forward to increased government-led donor coordination efforts.
4. **Emphasize HIV/AIDS and malaria in your programs and in the ministry's efforts.** This is particularly relevant in an era of increased decentralization. Human resources must be mobilized within the health sector to address these issues as priorities.
5. **Emphasize communities.** Work with communities to build local capacities. Stress involvement of religious leaders.

6. **Embrace partnerships.** Governments cannot provide all the services to the population particularly with shortages of budgets on the one hand and an imperative of increasing access to basic services at a rapid pace on the other. Therefore, partnership with the private sector and non-governmental organizations is not a matter of choice but an inescapable necessity. Governments, of course, have to play an important regulatory role. The building of systems and partnership take time. This meeting is also about partnerships—between the US and Africa, between governments and the private sector. Enabling policy environments are necessary. Ministries of Health can also emphasize partnerships whereby American and African researchers and implementers can work jointly to solve problems.

7. **Think globally and regionally.** We are living in an era of mobility and the health problems of one country or one region do not remain isolated events. What happens in Africa affects us and vice versa. Enhanced sub-regional and regional approaches

and collaboration to solving problems, particularly for infectious diseases, need to be expanded. In a continent where borders have little or no meaning for the ordinary citizens, "nations cannot and should not exclusively act within their geographic maps".

8. **Special attention to women.** Given the tremendous burdens that women experience, please give special attention to developing and implementing prevention methods that are cheap, safe, and under women's control. Develop support systems that empower caregiving without further compromising women's physical, financial, social well-being. USAID will continue to assist in these areas.

Our joint efforts to eliminate HIV/AIDS and malaria will take time, yet success will reestablish previous successes in furthering African development and improving the quality of life. We must seek synergies among all of our efforts, create better partnership and forge mutual trust. Unless these partnerships are realized,

African problems will continue to rise, the programs will consume more resources, and despite all of our efforts and huge resource inputs, the problems will claim more lives with a net result of aggravating poverty.

On behalf of USAID and the US Government, I would like to offer our services and cooperation in addressing HIV/AIDS and malaria that are our mutual concern and interest.

Thank you for your concern, your attention, and your commitment.

***What is the international
Conference on HIV/AIDS & Malaria?***

It is a collaborative grass-roots effort of local Atlanta-based health-related and non-profit organizations in partnership with Africa's Ministries of Health and the co-sponsorships of World Health Organization (WHO), Centers for Disease Control and Prevention (CDC) and local businesses.

It is designed to offer a platform for the Ministers of Health to present an "African Response" to pandemic diseases of HIV/AIDS and malaria and to create alliances between African health ministries and the American public, private sector and other friends of Africa to fight against these diseases.

It is a partnership of ordinary people, grass-roots organizations, local and international businesses, health agencies, governments and faith/religious communities that have concluded that the impacts of these diseases *have exceeded the boundaries of health concerns; that the absence of a known cure for AIDS is no excuse* for its widespread devastation; and that malaria is a curable disease which has been controlled in most parts of the world: *Why not in Africa?*

With millions of lives lost yearly, a growing number of orphans, a generation slowly disappearing, economic loss due to a lack of productive hours, a decrease in life expectancy of adults and many other related damages, an unprecedented, multi-level and multi-national plan is immediately required. **It is an "opportunity to make a difference!"**

Organizer

American Medical Team for Africa (AMTA)

Partners

African Ministries of Health

Collaborators

Zenzele Service Corporation
Premier International Healthcare, Inc.

Co-Sponsors

Centers for Disease Control and Prevention (CDC)
The World Health Organization (WHO)
AID Atlanta
Coca Cola
Atlanta Hotels Council

Chair of Conference

Hon. Andrew Young, Former US Ambassador (UN)

Co-Chair (Francophone Countries)

Hon. Assane Diop, Ministre de la Santé
Republic of Senegal

Co-Chair (Anglophone Countries)

Hon. Dr. Peter Coleman, Minister of Health
Republic of Liberia

Conference Coordinators

Demian A. Rageh, Founder
American Medical Team for Africa

L. Wellington VanPelt, President
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The American Medical Team for Africa

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*"The only thing necessary for
the triumph of evil is for good
men to do nothing!"*

-Edmund Burke

**International
Conference**

***Forging
Partnerships to
Fight HIV/AIDS and
Malaria in Africa***



April 13—15, 2000

The Atlanta Apparel Mart

Downtown

Atlanta, Georgia USA

Why an International Conference on HIV/AIDS and Malaria?

AIDS! "The warnings were as clear as the terror in those three-year-old eyes." A UNICEF-sponsored study in the early nineties predicted that in 10 hard-hit countries of sub-Saharan Africa, up to 5.5 million children under 15 years of age would lose their mothers to AIDS. Millions would perish in a plague of medieval proportions. Now that the decade is over, it seems the warnings were somewhat underestimated. A full-blown crisis is upon us, and it is worse than expected.

Although AIDS is often viewed as a tragedy that people bring on themselves, many victims of the pandemic have done nothing more than enter the world.

In the absence of a known cure for HIV/AIDS but armed with evidence that lives can be saved; that individuals affected with HIV/AIDS can lead normal lives within the general population; that changes in behavior do prevent the spread of AIDS; that a few African countries have "broken the silence" and reduced the number of AIDS-related deaths; and that sup-

port for local stakeholders may provide alternative or complementary solutions, we present this **opportunity** to the world and to the American public, in particular, **to make a difference.**

Source: Newsweek, January 2000

"Each case of AIDS passes along, on average, two to ten additional cases of AIDS. A case of malaria can result in as many as hundred more cases of malaria. So the multiplier effect is quite substantial."

— Dyann Wirth Professor of Tropical Medicine,
Harvard School of Public Health

Malaria may be foreign to most people, but it is well known to all Africans. It is by far the world's most important tropical parasitic disease, and kills more people than any other communicable disease with the exception of tuberculosis. In many developing countries and in most African countries, malaria exacts an enormous toll on lives, in medical costs and in days of labor lost.

Malaria is epidemic to 101 countries and territories: 45 countries in Africa; 21 in Central and South Americas; 14 in the Eastern Mediterranean Region; 9 in the Western Pacific Region; 8 in Southeast Asia; and 4 in Europe.

These statistics represent the lost of millions of human lives and enormous suffering from a disease that is curable, if promptly diagnosed and ade-

quately treated. Thus, the rationale for this conference on malaria, is an **"opportunity to make a difference!"**

Source: "The Resurgence of a Deadly Disease" The Atlantic Monthly, August 1997
WHO Information: Fact Sheet No. 94/ Revised, October 1998.

Schedule of Events

(Draft schedule of events as of March 15, 2000)

Thursday—April 13

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Statements on Vision/Strategy

Opening Plenary: World Health Leaders from WHO;
World Bank; UNAIDS; ILO, CDC; and others

Plenary Sessions

Program Sessions

Opening Night Reception

Dinner/Cultural Interlude

Friday—April 14

Deliberative Process I

Program Sessions

Deliberative Process II

GALA Reception

Conference GALA (Attire: Black Tie/African)

Friday—April 15

The WALK on HIV/AIDS & MALARIA

Thank-you Atlanta

Free Afternoon

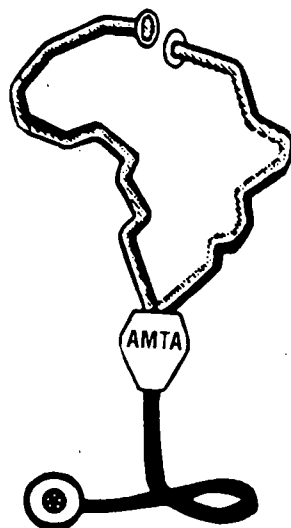
Ministers Appreciation Reception

Dinner

The American Medical Team for Africa
110 E. Andrews Drive Suite 309
Atlanta, Georgia 30345
Tel: 404-231-9030 Fax: 404-231-0920

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AMERICAN MEDICAL TEAM FOR AFRICA



REPORT

**“Forging Partnerships
To Fight HIV/AIDS & Malaria
In Africa”**

**AFRICAN HEALTH MINISTERIAL
CONFERENCE**

**13-15 April 2000
Atlanta, Georgia, USA**

ORGANIZER

American Medical Team for Africa (AMTA)

PARTNERS

African Ministries of Health

COLLABORATORS

Zenzele Service Corp.

Premier International Health Care, Inc.

CO-SPONSORS

Centers for Disease Control and Prevention (CDC)

AID Atlanta

The World Health Organization (WHO)

Atlanta Hotels Council

United States Agency for International Development (USAID)

Co-Chair of Conference

Hon. Andrew Young Former US Ambassador (UN)

Co-Chair (Francophone Countries)

Hon. Assane Diop

Ministre de la Santé (Former)

Republique du Senegal

Co-Chair (Anglophone Countries)

Hon. Dr. Peter Coleman

Minister of Health

Republic of Liberia

Conference Coordinator

Deman A. Rageh, Founder

American Medical Team for Africa

Conference Coordinator

L. Wellington VanPelt, President

Associate Internationale, LLC

Conference Advisors

Dr. Helene Gayle, Director, AIDS & STD

Centers for Disease Control

Conference Advisors

Al Anderson, CEO

Anderson Communications, Inc.

Conference Organizing Committee

Atty. Adam Smith, Steering Chair

Atty. Aasia Mustakeem, Steering Co-Chair

Selma Morris, Program Chair

Betsy Harris, Fundraising Chair

Andrick Anderson, Hospitality Chair

Connie Anan, "The WALK" Chair

Matt Roberts, Secretary

Program Committee

Selma Morris, Chairwoman

Fitz Harper, M.D., Member

W. Lynn Weaver, M.D., Member

Alawode Oladele, M.D., Member

Paula Berry, Ph.D., Member

N. Nhiwatiwa, Ph.D., Member (WHO)

Tony Braswell, Member (AID Atlanta)

Sponsorship Coordinator

Stephen Seda

Volunteers

Atlanta Black Nurses Assn., Inc

Chi Eta Phi Sorority

AMTA is an Atlanta-based 501C (3) organization that is dedicated to reducing poverty and improving the quality of life in Africa by assisting the healthcare sector with medical related supplies, medical training and facilitating partnerships with American healthcare institutions. **AMTA** has worked in 22 African countries since 1991 donating more than \$12 million dollars worth of medical equipment, sponsoring seven medical teams to Africa and facilitating partnership agreements with American medical institutions.

FORGING PARTNERSHIPS TO FIGHT HIV/AIDS IN AFRICA
MINISTERIAL CONFERENCE REPORT
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CONFERENCE OPENING: 13 APRIL 2000

WELCOME:

**HONORABLE ANDREW YOUNG, CONFERENCE CHAIRMAN;
CHAIRMAN OF THE BOARD, AMERICAN MEDICAL TEAM FOR AFRICA**

It is a wonderful morning to start off thinking about the problems of the world. Last night, we got a sense of flavor about this Conference. This is a gathering much in the African tradition. It just happened! I happened to be ill when Minister Diop came by my house for a visit. It was during his visit that we discussed the problems of the world. At this time, Minister Diop expressed his concern and frustration about AIDS in Africa and the cost involved. It is unfortunate that we do not have enough handles on this issue.

Deman Rageh, American Medical Team for Africa, and Dr. Alawode Oladele, GIANT (Global Initiative for AIDS Nutrition Therapy) were also there. We all agreed that maybe if we could get African-Americans and physicians of African descent in our churches and non-governmental agencies together, we could look at this epidemic from the African perspective. We might be able to find a way to address some of our specific needs.

I have been traveling back and forth to Africa almost every month. I have run from the topic of AIDS like the plague. It is a part of my psyche...just like Dr. Martin Luther King, Jr. He said he was not a very good Samaritan because a good Samaritan would help people on the side of the road, and he did not like to do that. He saw his calling as changing the Jerico Road. So that people would not get beat up, there would be streetlights and police on Jerico Road.

I found myself feeling as if I could not solve all the little problems of Africa, but if we could once get African development going---African development---African education---African scientists will take care of these problems themselves. So, I steered away from the tragedy of AIDS until I got caught by some wonderful little children in Soweto. When I looked into their faces and found their parents had already died of AIDS, they were only four and six years old: the same ages as my grandchildren. They are as bright and lively and intelligent as my own grandchildren. Then I had to look them in the face and say, "there is no hope for you." No, we cannot do that!

So for me, AIDS has a new face. It is not the massive face of people in hospitals or those who are too slim and left rejected and isolated on the side of the road. AIDS is really about the children. If we cannot do something to offer hope to the children of Africa---in the face of AIDS and the face of Malaria---in the face of all the political, economic, and nutritional crises that they face---then we would not have done our jobs.

We do not know what the job is. But, it is very much like what we said in Selma during the Civil Rights Movement. Let's send out a call for the people of goodwill from around the world to come together with us to think this through. Let's see if their thinking together might not create, if not a breakthrough, a sense of direction so we can move forward together under our own initiative. This way we would not be waiting on somebody else to bring us a cure. We would be doing something ourselves to help ourselves.

I have watched Alcoholics Anonymous turn alcoholism away from a plague--that everybody denied and where people were rejected and lived and died in isolation--to a group of people who come together in support groups, not only supporting themselves but who are,

perhaps, more aggressive opponents of alcoholism than the rest of the community. Dr. Helene Gayle calls this a kind of secondary prevention, when we can mobilize the people who are themselves the victims and take on the challenge of fighting the disease.

I think what we are looking at is a mobilization--a mobilization of medical ideas, nutrition, political will, religious faith---mobilization of all of the strength that we as a human family can muster.

We were determined that we were not going to come together to discuss how bad the disease is. We did not want to come together to curse the darkness. We wanted to come together to light a few candles and give some hope to the children of Africa, to the people of Africa, to the governments of Africa, also to the world.

Perhaps the solution to this problem will not be in the United States or Asia. Perhaps, the solution will be found in Africa from the people of Africa who have suffered the most and are at the greatest risk...who, with the strength of God, and the power of their own intelligence, their own governments, their own research facilities and support from friends around the world, will begin to offer the kind of leadership in this area that the world now requires.

WELCOMING REMARKS

HONORABLE ASSANE DIOP,

**CO-CHAIRMAN OF CONFERENCE & FORMER MINISTER OF HEALTH,
REPUBLIC OF SENEGAL; EXECUTIVE DIRECTOR, SOCIAL SERVICES,
INTERNATIONAL LABOR ORGANIZATION**

VIVIAN LOWERY-DERRYCK,

**ASSISTANT ADMINISTRATOR FOR AFRICA,
UNITED STATES AGENCY INTERNATIONAL DEVELOPMENT**

HERSCHELLE CHALLENGER, PHD,

CHAIRPERSON, NATIONAL SUMMIT ON AFRICA

HONORABLE ASSANE DIOP, ILO

This Conference is an initiative with which I can personally identify, having worked closely with the organizers in my previous capacity as Minister of Health, Republic of Senegal. I wish to commend and congratulate AMTA, and in particular, its Founder and Executive Director, Ms. Deman Rageh, for planning and organizing this event.

Deman founded American Medical Team for Africa in 1992 with the objective of building partnerships in the medical sector in Africa and America. Since then, she has built several collaborative partnerships between American institutions and professional/philanthropic organizations providing direct assistance for healthcare in Africa. Under her visionary leadership, AMTA has made contributions in excess of \$12 million in equipment to medical centers in 10 African countries. It is a collaborative venture designed to provide African Ministers a platform for exchanging views with American and international partners.

I wish to acknowledge the presence of the African Ministers visiting us here in Atlanta: my friends and colleagues with whom I have exchanged ideas and experiences over several years on how to improve the overall health situation in Africa.

I also want to recognize the presence of Ambassador Andrew Young and the important role played by him in making this event a reality and serving as the Chair of this Conference. Ambassador Young's long-standing commitment to Africa is well known and is demonstrated by his involvement with AMTA where he serves as Chairman of the Board. On behalf of the African Ministers of Health, I wish to express our appreciation and gratitude to Andrew Young for being such a good and trusted friend to Africa. Thank you.

This Conference is a result of collaborative efforts between the organizers and a number of co-sponsors including the Office of the World Health Organization. I wish to say thank you, again, to Dr. Ebrahim Samba, the Centers for Disease Control and Prevention, Joint United Nations Program on HIV/AIDS and the World Bank for support of the Conference in various forms.

I am participating in this Conference in my new capacity as Executive Director responsible for social protection in the International Labor Office (ILO) in Geneva, Switzerland. Fortunately, my new office includes, among other things, the organization's actions against HIV/AIDS in the context of the workplace. I will, therefore, be in a position to continue to work with committed organizations like AMTA.

I would like to reiterate the point made before. More than ever, partnerships are essential in order to create a solution towards HIV/AIDS in Africa. Partnerships must be organized and coordinated at the local and community levels, which is necessary to avoid duplication of efforts. There have been many meetings and conferences for action regarding HIV/AIDS and Malaria. This particular conference is different. It is organized around the concept of partnership between African and American policymakers and civil society. The purpose is to take concrete and immediate action to Africans worldwide. The ILO is committed to taking action to conquer HIV/AIDS and Malaria in Africa. We look forward to its conclusion and future collaboration with partners.

VIVIAN LOWERY-DERRYCK, USAID

On behalf of the Agency for International Development, I am pleased that we are a co-sponsor for this activity, and I welcome you. I, too, want to thank AMTA, Deman Rageh and Andrew Young, for having the vision to plan a Conference like this. Many times, we have met to discuss HIV/AIDS and Malaria, but this is an opportunity to get a different flavor of people to discuss and find resolution to this disease.

Of course, we at USAID applaud the emphasis on HIV and Malaria. These two diseases are not only interrelated, but they are impeding development. We are most concerned about the development of the African continent. Both of them are high priorities for USAID, the Congress and Administration. I am here as a symbol and to express how committed we are to help attack this disease. Ambassador Young discussed how we are going to be able to think together so let me start by addressing USAID's views of the scourge of HIV/AIDS and Malaria.

First of all, I always remind people that HIV/AIDS and Malaria are global problems even although Africa is most effected. 70% of all HIV/AIDS cases are in Africa, which constitutes only 10% of the world's population. The majority of Malaria cases are also in Africa.

Secondly, HIV/AIDS and Malaria are not just health problems. They are development problems. It is essential that Ministers of Education, Finance, and Agriculture work with you, the Ministers of Health, to deal with this issue. Think about education and the impact that HIV/AIDS and Malaria are having on education. In Swaziland, teachers are dying at twice the normal rate. There is no annual capacity for replacing them. School systems are challenged because if children who have been infected with AIDS come to school, they do not have the necessary home support and other resources to help them be successful students.

HIV/AIDS and Malaria are impacting the economies. The GDP in several Sub-Saharan African countries is going to be reduced by 20% by the year 2010. That's 20% in simply ten years! Many industry workers are being trained 3 to 1 for a job because, sadly, 2 of 3 workers will die. And when you add to this up to 8% GDP for Malaria, you can recognize the economic impact these diseases are having. It is also impacting Agriculture.

Last night, we heard an extraordinary presentation on how Vitamin A can be infused into crops, particularly grain. We need the impact of our research to do this because HIV/AIDS is impacting the economy, agriculture as well as education. More than that, it is also degrading infrastructure and putting a strain on new democracies in Africa. Who is going to replace the people in parliaments, judiciaries, and civil service when they die? We know the population that AIDS attacks.

And so, as these leaders of civil society fall, there is no immediate succession in the wings. When you think about HIV/AIDS, think about it as a development problem. This is a long-term problem, a long-term development problem. There is no vaccine in site for at least eight to ten years. If that does occur, it may not be relevant for the strains in Africa and, meanwhile, those that have the disease continue to grow in numbers. In the year 2010, there will be 40 million children infected with HIV/AIDS. There will be 450 million Africans at risk for Malaria infection. Malaria is causing 1.5 million deaths per year.

Lastly, I always remind people that HIV/AIDS and Malaria disproportionately affect women. We are the ones carrying the biggest burden. Consider what's happening in Botswana and South Africa. In 1990, women outlived men by seven to ten years. But by 2010, this advantage will disappear and women will be dying younger than men. Botswanan women will experience a 60% decrease in life expectancy. That's 60% from 68 years to 28 years. This year, twice as many women than men will die from HIV/AIDS in South Africa.

Malaria also disproportionately affects women and children. In particular, 10% of low birth rate deaths and upward to 20% of maternal mortality are associated with Malaria. So, at USAID we realize this a development problem, this is a global problem, this is a long-term problem, and one that disproportionately affects women and children. Now, the United States Government is committed to working in Africa for sustainable development, and we know that we have been one of the key architects of globalization. We understand that globalization affects all of us. So, when USAID is beginning to expand its efforts to deal with HIV/AIDS, it is in recognition of the fact that we really are one world.

Last year, the Administration proposed and Congress approved an HIV/AIDS initiative called, LIFE Initiative (Leadership and Investment in Fighting an Epidemic). This is a landmark for the United States and has given us an increase of funds: \$100 million for HIV/AIDS and almost all of it is going to Africa. USAID spends about \$200 million in its annual budget, and about \$130 million is devoted to Africa. We provide assistance to 22 African countries and to other countries through our regional programs.

This LIFE Initiative enables us to expand from our traditional programs, particularly to prevention for our home-based and community-based treatment. This program has four major components:

- Prevention: Volunteering, Counseling, and Testing
- Basic Medical Home Care and Treatment
- Community Programs
- Capacity and Infrastructure Development

Centers for Disease Control (CDC) will partner with USAID for the LIFE Initiative. USAID has been designated the lead agency for the LIFE Initiative. We look forward to working with the CDC and you, as partners in this initiative. The President and Vice President are committed to combating this problem and have asked for another \$100 million to be allocated. This year USAID will allocate \$170 million towards Malaria efforts in Africa.

There are several things that need to be addressed. Hopefully, this group will come together and think about these eight areas for action:

- Improve Healthcare System Infrastructure
- Provide Access for HIV/AIDS and Malaria Patients in Healthcare Systems
- Reinforce leaders and increase their political commitment
- View poverty reduction
- Emphasize HIV/AIDS and Malaria in your health programs and Ministries
- Embrace partnerships
- Think globally
- Pay special attention to women

I conclude with both an invitation and a pledge to continue to work with USAID. I invite you to have frank dialogue. We need effective ways to work with you. We pledge to continue partnerships and cooperation on our part in tackling these two scourges. And that is a commitment from our Agency, the Government, the President and Vice President of the United States because we envision an Africa that is filled with democratic nation-states and free from these two diseases. When that Africa becomes a reality, we can all relax.

HERSCHELLE CHALLENGER, PHD, NATIONAL SUMMIT ON AFRICA

It is a singular honor to have been invited to this groundbreaking Conference on HIV/AIDS and Malaria. For this purpose, I bring you greetings from the National Summit on Africa, in my capacity as Chair of its Board of Directors.

Health in Africa is one of several priorities accorded significant attention by the 2,300 delegates and more than 5,000 participants for the historic National Summit on Africa held in Washington, DC, 16-20 February 2000. And, I hope this will be only the first of a series of several Ministerial meetings on the critical multi-sector issues.

I particularly would like to commend Deman Rageh for her presence and perseverance in establishing AMTA and organizing this Conference following a suggestion from the former Minister of Health, Republic of Senegal. I would also like to pay tribute to CDC, World Health Organization, and the United Nations system at large for the priority they have given HIV/AIDS and Malaria.

I recall very vividly the great contributions made by the first United Nations AID Coordinator, the late Jonathan Mann. He and I, in my capacity with the United Nations Decade of Cultural Development, in the late 80s had to make our presentations in ECOSOC.

My first and most intensive experience in healthcare in Africa was lived vicariously through my late husband, Dr. Bernard Challenor who directed the Smallpox Eradication and Measles Control Program in Togo, Ghana and Benin in the late 60s. I would have never imagined then, as we ended the dreaded disease of Smallpox, that we would face a bigger challenge of HIV/AIDS and the problematic issues of Malaria as the drugs become resistant to the new strains. Just recently, HIV/AIDS has surpassed the epidemic of Malaria as the leading cause of death on the continent.

Oscar Wilde once described the British popular notion of the idea of health as, "The English gentleman galloping after a fox, that is the inspeakable in search of the inedible." This definition seems frivolous indeed in light of the scourge of HIV/AIDS, which by the end of 1999, reportedly, had killed 12 million Africans. It is estimated that 22.5 million Africans are infected by HIV/AIDS and that represents 11,000 infections a day. As previously mentioned by the distinguished Assistant Administrator of USAID, over 50 million children will be orphaned in Africa by the year 2010.

Slowing down infections and eventually eradicating this disease is without question a millennial challenge. The National Plan for Africa adopted by the National Summit on Africa held in Washington, DC, February 2000, following six regional meetings across our nation, contains 15 (50 if you count all the subsections) resolutions related to health in these areas:

- | | |
|--|---------------------------------------|
| *Health Policies in US-Africa Partnerships | *Education, Training, and Health |
| *Structural Adjustment Programs in Health | *HIV/AIDS |
| *Donors in Health | *USAID in Health |
| *Community Health Policy | *Developing/Improving Health Capacity |
| *Smoking and Health | *Drugs and Health |
| *Traditional Medicine | *Disability |
| *Business and Health | |
| *Women's Reproductive Health/Family Planning | |

Mr. Chairman, it is said that a lot of good behavior is due to poor health. Yet, it is often the ill-advised and the ill-informed behaviors, many of which are culture bound or accidents of fate that have caused this dreaded disease to threaten the development and indeed the security of Africa and very soon all of the nations of Asia. HIV/AIDS regrettably is an equal opportunity infection.

In closing, allow me to quote Hypocrites, "Extreme remedies are very appropriate for extreme diseases." HIV/AIDS prevention and treatment, not family planning and reproductive health, must become the singular top priority for USAID programs in Africa. Although we applaud the government for its contribution of over \$100 million, it is however, not enough. I do want to commend the Turner Foundation for their generous contribution to HIV/AIDS treatment in Africa. We, here in Atlanta, like to paraphrase Dr. Martin Luther King, Jr. In that connection, I would like to say, "as long as someone is infected with HIV/AIDS and Malaria anywhere, we are all in danger everywhere." Mr. Chairman, the National Summit on Africa gives our unreserved support to this Conference and the work of the American Medical Team for Africa.

OPENING PLENARY: 13 APRIL 2000

PRESENTERS:

HONORABLE EBRAHIM SAMBA, MD,

DIRECTOR OF AFRICA REGION, WORLD HEALTH ORGANIZATION

HELENE GAYLE, MD,

DIRECTOR, HIV, STD, AND TB PREVENTION,

CENTERS FOR DISEASE CONTROL & PREVENTION

RON MACINNIS,

DIRECTOR, GLOBAL HEALTH COUNCIL

HONORABLE PHESTILE DLAMINI,

MINISTER OF HEALTH, KINGDOM OF SWAZILAND

HONORABLE EBRAHIM SAMBA, MD, WORLD HEALTH ORGANIZATION

We have come a long way. Some have flown 14 hours non-stop to take part in this meeting. I would like to explain to you, distinguished partners, why. As Andrew Young said, I am privileged to be Regional Director to 46 countries, but more significantly, I have been elected by the governments of Africa...all of them.

I, therefore, organize meetings of Ministries of Health all the time. Every year, all the Ministers gather in September. We have several meetings planned after this Conference in many African countries. I have never seen as many Ministers of Health gather together outside of Africa as I have seen this morning. This is very significant because what is going to be discussed is extremely important to the Ministers. As I said, we have traveled for hours, and for a Minister to be away from his office for days, it must be to discuss a very, very important issue.

We are also grateful to you, starting with Deman Rageh whose name has been mentioned so many times with Andrew Young and with the support of His Excellency, the Honorable Assane Diop. Ms. Rageh and I first met in New York in 1993-1994. Soon after my election to this position, she spoke with me about her support to Africa, and we have been working together providing equipment and training to so many countries in Africa. She has done a wonderful job. This Conference is an example of her tirelessness and devotion. I am not going to take your time discussing the effects of HIV/AIDS and Malaria. You already know. I just want to cover a few points.

Approximately eighty percent of HIV/AIDS in the world come from Africa. Some are not registered. Those that are registered cover 34-35 million. 24 million are in Africa. Over 300 million Malaria cases are in Africa. Africa covers 10% of the world's population. The economic effect runs in \$6-\$8 billion. The resources are limited. In America, the HIV/AIDS resources run in billions, but Africa receives \$100-\$200 million. Though we are grateful for the offers, I must underline, our resources are very small indeed.

Since we have to do something, I came here. I am underlining that which has been said earlier about partnerships. I have been coming here since 1968 working with the CDC on Smallpox. For Polio, we will eradicate it within a matter of a few years. I had visits and meetings in my office regarding LIFE. We have the technicians' plans and strategies for this epidemic, but the resources are short. We are doing something on prevention, promotion,

rehabilitation, and care for the orphans. There is a lot of goodwill and political commitment. I repeat---the resources are short. You in the United States are fortunate to have resources, please come and let us do it together. There are some things you have that we do not have. There are many things we have that you do not have. You do not know Africa as we do.

It is no longer valid to say we cannot account for the funds. We can account for every penny. The world is suffering from an epidemic of meetings. I am hoping this Conference is different because any disease that kills 80% of Africans will kill 100% of Americans. Ladies and gentlemen, please, let us follow-up this Conference with concrete solid action. We guarantee you our full commitment.

HELENE GAYLE, MD, CENTERS FOR DISEASE CONTROL

I want to echo what everyone else has said about AMTA and the vision behind their mission. I congratulate Deman Rageh and her team for the organization of this Conference.

(SLIDE PRESENTATION)

- Forging Partnerships
- Adults and children estimated to be living with HIV/AIDS at the end of 1999:

North America: 920,000	Australia / New Zealand: 12,000
Caribbean: 360,000	East Asia / Pacific: 530,000
Latin America: 1.3 million	Sub-Saharan Africa: 23.3 million
Western Europe: 20,000	
- Zimbabwe and South Africa will have a rapid orphan rate due to AIDS, 1990-2010
- Sub-Saharan Africa
 - ❑ Worst affected area of the world
 - ❑ Up to 50% of pregnant women infected in some southern African districts
 - ❑ Only 10% of the world's population, but 70% HIV/AIDS infections
 - ❑ 90% of mother-to-infant transmission in 1999
 - ❑ Worsening child survival
 - ❑ Decreasing life expectancy
 - ❑ Over-burdened health care systems
 - ❑ Increasing orphan-hood
 - ❑ Economic losses
- Social and Economic Impact
 - Household Level
Personal grief, family breakdown, diversion from schooling to care (especially girls), reduced reproduction, lost income, increased healthcare expenditures
 - Institutional Level
Strain on the healthcare system, absenteeism, increased recruitment, training and staff replacement costs, healthcare expenditures, losses of skilled staff, weakened controls
- Macro Level Impact
1-3 point decrement in GDP / year predicted in high prevalence African countries

Intervention that Works

- Mathare Youth Sports Association, Kenya
- Tateni Home Care Services, South Africa
- Chirumhanzu Home-Based Care Project, Zimbabwe
- Family AIDS Education and Prevention through Imams, Uganda

Acting Early to Prevent AIDS

- Political Leadership
- Religious Leadership
- First African country to implement a national STD control program
- One of the lowest rates for HIV infection in Sub-Saharan Africa

Uganda's Response to AIDS

- Political commitment and stigma reduction
- Early establishment of safe blood supply
- Involvement of person's living with AIDS (The AIDS Support Organization)
- Community Mobilization

The Prevention & Care Continuum (Examples of Interventions)

- Home-Based Care System
- Improve TB Management
- Support Referrals and Support Systems
- Voluntary Counseling and Testing
- Efforts to Reduce Stigma and Discrimination
- Behavior Change Interventions

Aim of HIV/AIDS Care in Resource-Poor Countries

- Maximally prolong life
- Reduce suffering
- Promote prevention
- Enhance impact limitation

Reducing Mother-to-Child Transmission

Nevirapine

- Inexpensive
- Effective for perinatal transmission
- Limited access
- Long-term follow-up

Preventing Infections and Death

Bacterium Treatment in Africa

- Cost-effective treatment
- Proven to be safe
- Reduces opportunistic infection rates, 43% reduction in hospitalization
- Promotes reduction in mortality, 46% reduction in TB/HIV patients

Preventing Disease

TB Treatment and Prevention

- DOTS, Directly Observed Treatment Short Course
 - Cost-Effective
 - Reduces infection rates
 - 95% Cure Rate
- Prevention therapy in conjunction with treatment reduces incidence and saves money

New Developments

Progress in vaccine development

- Uganda's pioneering efforts in Africa clinical trials
- 14 million pounds granted to Senegal
- Kenya's work with United Kingdom scientists
- Nairobi's new human-being clinical trials
- Critical to match vaccine strain to circulating strain in population

United States LIFE Initiative Partner Countries

India	Nigeria	Zimbabwe
Botswana	Rwanda	Regional Programs
Cote d'Ivoire	Senegal	
Ethiopia	South Africa	
Kenya	Tanzania	
Malawi	Uganda	
Mozambique	Zambia	

"The man who removes a mountain begins by carrying away small stones."
- Chinese Proverb

RON MACINNIS, GLOBAL HEALTH COUNCIL

Global Health Council is the United States Alliance for International Health. We have several hundred organizations and several thousand individuals who are members around the world. Many you may know work particularly in Africa:

- CARE
- World Vision
- Christian Children Fund
- Family Health International
- Save the Children

We implement the ABC's of Global Health through lobbying and education, particularly in Washington, DC.

A: Advocacy

B: Building Alliances

C: Communications

We try to support community networks and promote their work. We encourage political leaders to put laws and policies in place to benefit those affected by this epidemic. Our best ally has been Internet and e-mail because of the global reach, seeing that time is of the essence. Fortunately, the media is now paying attention to the epidemic in Africa, which should help when acquiring funds. Many elected officials in Washington, DC, have been writing legislation that will have specific programmatic funding for AIDS (e.g. vaccines, trust funds for orphans, general increases in global health, etc.)

In addition to CDC and USAID, we also have global agencies such as the United States Peace Corps and the Department of Defense, which are active in this engagement. Getting access to drugs for the effects of HIV/AIDS is an uphill battle. As someone living with the virus, I speak from first-hand experience. When I meet with pharmaceutical companies, governmental, and non-governmental agencies, the importance is not only access, but also the price for medication.

We believe that support of HIV/AIDS and Malaria in Africa is simply the right thing to do and the moral thing to do. It is great to look at this from a political strategy, but the most important thing to remember is that these are human beings, and compassion should be the first thing that comes to mind. Also, people's lives in Africa are important to people in America.

HONORABLE PHESTILE DLAMINI, MD, MINISTER OF HEALTH, SWAZILAND

I am neither an expert on Malaria nor a scientist---just a humble clinician with deep concern and compassion for this cause. So I promise, I will be brief. A lot has been said about HIV/AIDS. Malaria still poses a big problem. Dr. Samba said it best, over a million people are dying from Malaria. A large number happen to be children.

Those who are not dead are living with the risk and the parasites that affect their productivity as a community. They are living with paranoia and headaches from the parasites and the nagging mosquitoes that keep biting them certainly are not welcome friends.

The impact of floods did destroy the breeding nests, but now is the worst problem. We are also faced with an unstable climate that can activate the breeding of mosquitoes. It goes without saying the effect and impact on the crops. More resources have been directed to the floods and not the diseases.

Mosquitoes need no passports and very little space to get into houses. So the issue of houses and nutrition is a challenge. It is urgent to find resources in assistance mobilization. At the end of the day, it is human lives that we are trying to save.

I want to emphasize that we are looking for solutions: relevant research, traditional and alternative therapies. I hope this new relationship will foster action because we have a need for the infrastructure to gain strength. Malaria research is not reaching its full potential.

PANEL ON HIV/AIDS & MALARIA: 13 APRIL 2000

MODERATOR: **STEVE BLOUNT, MD, MPH,**
 ASSOCIATE DIRECTOR, GLOBAL HEALTH, CDC

PRESENTERS:

HONORABLE LIBERTINE AMATHILA,
 MINISTER OF HEALTH, REPUBLIC OF NAMIBIA
HONORABLE SAM ONGERI, PHD,
 MINISTER OF HEALTH, REPUBLIC OF KENYA
HONORABLE MORIFERE BAMBA, PHD,
 MINISTER OF HEALTH, REPUBLIC OF COTE D'IVOIRE

HONORABLE LIBERTINE AMATHILA, MD, MINISTER OF HEALTH, NAMIBIA

Namibia is one of the hardest hit countries with the HIV/AIDS epidemic in sub-Saharan Africa. For the past year, we have worked closely with HIV infected and affected people to come up with a policy, particularly to get a grasp of our civilian records.

Initially, we had difficulties due to misunderstanding of the principle of confidentiality between doctor and patient, the Hippocratic oath. We misunderstood it, and even the mother of the AIDS patient who was responsible for caring for the person was not even informed about the cause of suffering. Likewise, it had a huge impact on the orphans left behind because that person did not even prepare for the future care of the children who were left destitute. This was compounded by the fact that families kept quiet because they were ashamed of HIV infection.

Nevertheless, I am happy to announce that all of these attitudes are changing in Namibia. Initially, we the policymakers talked about this problem all the time without results. Then in March 1999, we launched the "expanded response" via the National AIDS Council which set up AIDS policy units in every Ministry. I have personally been involved in visiting 50 schools, which is quite a lot for a country of only 1.7 million citizens.

We have also trained police officers as counselors, as well as nurses and other health personnel. Counselors are very useful. For example, a young woman from the northern region, where AIDS is rampant, discovered that she was HIV positive and kept quiet initially, but afterwards she met with AIDS counselors in the remote village and then spoke freely to the news reporters about her condition. This means a lot to us because we made the mistake of talking to people in incomprehensible terms: for example, when is it HIV and when is it AIDS? We must help the people understand that they may carry the disease for six or seven years and spread it to others before it becomes noticeable as AIDS.

We have tried every effort imaginable to combat this disease. We even passed a law in parliament two years ago regarding discrimination against AIDS patients. Nothing helped. The disease continued to spread. Therefore, we decided last year to do an anthropological study through the university in the villages to understand how the villagers viewed the disease.

The study finds that gender is a serious issue, and women have no choice with their husbands in the bedroom. In fact, even if she suspects her husband's infidelity and fears HIV infection, she has no way to force use of a condom because she may be beaten or divorced for this demand. Violence against women in my country must be solved, or HIV will be decided by one

side of the relationship. Last month, young men created a group which is against violence against women, and in order to encourage them, we will set up a counseling center for men who perpetrate violence. Secondly, poverty causes women to enter into prostitution and other high-risk relationships.

People do not understand the difference between HIV and AIDS and how a person can look so healthy for a long time. In my part of the world, there is not necessarily alcoholism, but one drinks a lot of alcohol, and this contributes to lack of condom use. The Roman Catholic Church has established AIDS groups in Namibia. Other churches must take unequivocal decisions to engage in the campaign against HIV/AIDS. Similarly, condom distribution in prisons should be initiated despite religious and cultural taboos. Men have created beliefs about condoms by saying that the spermicidal fluid was the HIV virus itself. These types of taboos and misconceptions must be addressed as well.

In Namibia, every child has heard about AIDS, but hearing and being told what to do and then actually doing it are very different issues. As for the drugs like AZT, scientists are still quarreling among themselves. In the mean time, we are going to take care of STDs and opportunistic infections, and I hope Pfizer will not only give medication to South Africa but also to us because we are suffering from the same thing. This donation must be for all Southern African Development Community member countries because we work in partnership.

In regards to care for AIDS victims and orphans, we have set up a fund for pensioners who are left with grandchildren, as well as for foster care parents. We are ascertaining that children indeed have assistance to attend school even if they are orphans. Counselors have played a very important role in our efforts because initial lack of understanding about AIDS led to high rates of suicide, but this has now decreased thanks to their role in communities.

Finally, in regards to Malaria, it is not endemic in Namibia because we are the driest country in Southern Africa, with the Namib and Kalahari deserts. Nevertheless, it is common in the northern part where we have rivers. Malaria is seasonal, and people have not developed immunity and therefore they die easily from the disease. This year, it will be in the southern region as well as the north due to the floods. The principal causes of death in Namibia are #1 HIV/AIDS, #2 Malaria, & #3 Tuberculosis.

In the fight against malaria, we are still using the insecticide DDT because we have no other, and due to lack of resistance we still use chloroquine. We are concentrating predominantly on women who make mosquito bed nets impregnated with insecticide.

Politically, I believe that Malaria will receive a great deal of attention, like AIDS in the past, at the Abuja Heads of State Meeting on 25 April 2000. Indeed, Malaria accounts for 10% of Africa's disease burden, 9 out of 10 cases worldwide occur in Sub-Saharan Africa, and it costs more than 2 billion US Dollars to control each year. Poor families spend more than 25% of their annual income on treatment and workdays lost due to malaria illness.

In conclusion, we know the statistics on HIV/AIDS, and I never again want to hear the accusation that African leaders are not committed to the struggle against AIDS. Even our president, who won the last elections resoundingly, spoke at length about the epidemic in his campaign and inaugural speech. When we launched the new ministers, President Nujoma declared that this would be the decade for elimination of HIV/AIDS. Indeed, there is no lack of political commitment in the campaign against this epidemic across Africa.

HONORABLE SAM ONGERI, PHD, MINISTER OF HEALTH, KENYA
(SLIDE PRESENTATION)

I. Africa's Top Killers

- HIV/AIDS
 - Leading killer of adults, 13.7 million dead
 - Poverty, poor health, and lack of resources to scale up implementation of what works fuel the epidemic
- Malaria
 - Leading killer of children, close to 2 million each year
- Armed Conflicts
 - Devastated health and well-being of humanity

II. Malaria in Kenya

- Malaria controls are a high national priority
- Accounts for 30% of out-patient attendance, 19% of in-patient admissions of which 5% die
- Close to 3,000 children die under the age of five years old
- High Chloroquine resistance-drug replaced by sulfa-primethamine
- Kenya, Uganda, and Tanzania formed East African Network for Monitoring Anti-Malarial Treatment (EANMAT).

III. Kenya's Strategies within the Framework of the Malaria Initiative

- Strengthen National Malaria Programs
- Enhance community participation in prevention and treatment
- Support Malaria case-management at facility and community level
- Conduct Malaria epidemic preparedness campaigns in epidemic-prone areas
- Promote research on affordable drugs and herbal medicine
- Quality assurance of Anti-Malaria drugs

IV. Public / Private Participation

- Reduce poverty, inequalities, and inequity
- Create incentives for private sector investment in research and development to produce affordable drugs, vaccines and diagnostics for HIV/AIDS and Malaria
- Increase resource allocations to scale up cost-effective interventions
- Prevent armed conflicts
- Enhance local participation for sustainability

V. HIV/AIDS in Kenya

- June 1999: 87,070 reported AIDS cases, 760,000 actual AIDS cases,
- 1,900,00 additional HIV infections
- Constant continual increase in HIV infection rate since 1984
- Infection rates highest in most economically productive population
- If the rates continue, then by 2010, there will be over 3 million Kenyans affected
- In 1992, only 15% of hospital beds occupied with AIDS patients; today, it's 51%.

- AIDS declared a National Disaster & National AIDS Control Council established by parliament; Kenyan politicians have agreed to join hands in the fight against AIDS irrespective of their differences
- Strategies: advocacy through educational curriculum for children & teens; encourage faithfulness to a single partner; the church is one of the biggest problems in the use of condoms
- Goal: to reduce HIV/AIDS by 20-30% among 15-24 years of age by 2005; strengthen the capacity/coordination of response to epidemic at all levels of the community; prevent sexual transmission and mother-to-child transmission by drugs; we must access these drugs at cost-effective levels
- Cost translates to 10 billion US Dollars in a country where 50% of the population lives beneath the poverty line

HONORABLE MORIFERE BAMBA, PHD, MINISTER OF HEALTH, COTE D'IVOIRE

(SLIDE PRESENTATION) (French-English translation)

I would like to seize this opportunity provided by AMTA and Ambassador Young for the Ministers of Health of Africa to meet and thus to share with you about the experiences of Cote d'Ivoire. The country is quite exemplary not only in the organization of the fight against AIDS, but also in the engagement of its political authorities at the highest level, without whose involvement we would not have expected such results. Cote d'Ivoire is exemplary because despite these aspects, there is much left to do, and despite the financial efforts made by the country, which represents a significant portion of the GNP, the means are not yet sufficient and this necessitates official development assistance and international solidarity.

Cote d'Ivoire is a west African country with a population of more than 15 million inhabitants (49% female and 20% less than 5 years of age). It is bordered by Burkina Faso and Mali to the North, the Gulf of Guinea to the South, Ghana to the East, and Liberia and Guinea-Conakry to the West.

CAMPAIGN AGAINST MALARIA

Malaria is prevalent all year long with peaks during the rainy seasons. Malaria causes 20-30% of total morbidity and 10% of all causes of mortality in Cote d'Ivoire. The Ministry of Health and Social Welfare has identified Malaria as a priority and has initiated a Malaria Program, which is part of the National Plan for Health System Development. The management of the program is the responsibility of the National Committee, Regional Committees, and the Executive Director.

The first major area of program strategies includes treatment of patients at home and in health care institutions. Secondly, strategies comprise prevention via chemoprophylaxis in high-risk groups such as pregnant women, incoming persons from non-endemic areas and via vector control through use of treated mosquito netting. Thirdly, the program is responsible for operational research, as well as support strategies that consist of training/education, supervision and evaluation processes.

The organization of the response is characterized by strong high-level political commitment by the government and participation of Cote d'Ivoire in different initiatives, including the Conference on Malaria for Ministers of Health in Amsterdam in 1992 where the international strategy was elaborated. Likewise, there was the development of the five- year

national plan (1996-2001). Similarly, in 1997, Cote d'Ivoire was among 21 countries selected by the World Health Organization for the implementation of an accelerated campaign against Malaria. We participated in the 1998 OAU Summit which constituted the first intergovernmental consensus meeting to push back Malaria in Africa. In April 1999, the Director of WHO launched the "Roll Back Malaria" in Abidjan.

Concerning treatment of Malaria, 2/3 of health care personnel in national hospitals have been trained, and there is ongoing training in the military and private sector. There is periodic supervision and monitoring at the district level to guarantee the quality of care. Concerning vector control, 125 centers have been created for impregnation of mosquito nets, and each public and military hospital has at least 20 beds with mosquito nets. There is an annual campaign to fight mosquitoes in high prevalence areas, and creation of centers for the impregnation of mosquito nets in the military is ongoing.

Concerning surveillance and social mobilization, community health care personnel and NGOs have been trained for the development of community programs to fight Malaria. For the improvement of the surveillance system, we established 12 sentinel sites for drug resistance testing and 4 centers to study mosquito susceptibility. Finally, in the domain of social mobilization, we have provided support for information, education and communication, and there are 8 billboards with Malaria information messages on the principal roads of Abidjan.

Moreover, the program consists of operational research on anti-malarial drugs, insecticides, human and vector behavior, and clinical characteristics. Likewise, the program reinforces collaboration with partners in other Ministry of Health sectors as well as external partners, such as other governmental and private actors, bilateral and multilateral institutions.

There are numerous obstacles in the implementation of these programs. There is a lack of resources at the government level, and there are socio-cultural constraints and lack of resources at the local level (ex: mosquito nets are underutilized). Likewise, there is insufficient realization of the government program because of lack of resources, and there is insufficient control of environmental determinants of Malaria.

Regarding the perspectives and challenges in this campaign, the efforts constitute a revival of the fight against Malaria via several initiatives including the WHO accelerated plan and the "Roll Back Malaria" campaign with the upcoming meeting in Abuja, etc. There is also the need for reinforcement of the national health care system through the diversification of health care services, the search for a new funding mechanism for the Malaria Program, and the reinforcement of institutional capacity.

In conclusion, Malaria is an enormous challenge for this new century. The fight against Malaria will require the mobilization of all the sectors responsible for the development of our countries, notably the support of the international community.

CAMPAIGN AGAINST HIV/AIDS

Cote d'Ivoire is one of the most affected countries by the HIV/AIDS epidemic in West Africa. The epidemic began in the early 1980s and both HIV1 and HIV2 are present. Cote d'Ivoire is one of the crossroads of West Africa with an important influx and transit of people and immigrants from neighboring countries.

In 1988, the prevalence of HIV among pregnant women spans from 8.1% to 13.6% according to the region, but it is relatively homogeneous across the country. We estimate that 10% of the sexually active population is HIV infected, and thus 1 million people are living with

HIV in Cote d'Ivoire. Tuberculosis has become the most frequent opportunistic illness among HIV/AIDS patients.

As of 1987, there were only 500 AIDS cases notified in Cote d'Ivoire. In 1993, there were 4,000 cases, and since 1994 there have been 5,000-6,000 cases every year. This number should be multiplied by seven in order to have a perspective on the amplitude of the epidemic.

Regarding organization of the response to the HIV/AIDS epidemic, in 1987, an advisory committee for HIV/AIDS was created to coordinate research, to implement a surveillance system and to serve as a liaison with the WHO. In 1989, we established a central bureau for coordination that was responsible for the implementation and supervision of HIV/AIDS activities. In 1995, the National Program Against AIDS was created and integrated the programs against STDs and Tuberculosis as well. The strategic plan of the national program included the establishment of a surveillance system, prevention of HIV and STD transmission, and care and support of persons living with HIV/AIDS.

The Ministry of Public Health and Social Welfare is responsible for the implementation of the government's HIV/AIDS policy, provides assistance to the National AIDS/STD/TB Control Program, and coordinates all HIV/AIDS related activities. However, the Ministry works with various partners, including international and local NGOs, as well as persons living with HIV/AIDS. The NGOs provide important support for the National AIDS/STD/TB Control Program, are involved in information, education and communication activities, and assist in clinical care and psychological support activities.

Multilateral partners include UNDP, WHO, UNPF, World Bank, UNESCO, UNICEF, UNHCR, UNAIDS, and the European Union. They provide financial support of the activities of the National Control Program and NGOs. Their priorities consist of prevention, sensibilization, and reduction of social and economic consequences of the disease. UNAIDS is responsible for the coordination of all UN agencies' activities.

Bilateral partners include France, Germany, Canada, Belgium and the US. They provide technical assistance, training and research. They work in the domains of safety of blood transfusion, STDs, sensibilization and prevention. They also provide financial support to the National Control Program.

In the domain of prevention, there is promotion of condom use that is conducted by the NGO Population Service International supported by the US and Germany. Likewise, initiatives for blood safety are effective via four blood banks across Cote d'Ivoire thanks to the important support of the European Union. Finally, efforts target prevention in high-risk groups, including commercial sex workers, and provide counseling and STD care. These efforts are supported by Canada, Belgium and the US.

Furthermore, in Abidjan, there are projects to limit mother-to-child transmission with support from France and UNICEF. With support of France and the US, NGOs are active in voluntary counseling and testing in three centers, but attendance is low. The Ministry of Public Health and Social Welfare, with the support of NGOs, pursues initiatives in the area of information, education and communication, but unfortunately there is a lack of resources to sustain these activities.

Care and support activities are extremely limited and expensive. There are three daycare centers for persons living with HIV/AIDS. However, the government has allocated 2 million US Dollars to a UNAIDS initiative in the domain of anti-retroviral therapy. Despite the fact that 50-55% of the cost is subsidized, the prices are still much too high. For tuberculosis, which is the

most prevalent opportunistic infection in Africa, diagnosis and treatment are available countrywide and impose a heavy burden on health care services. We have been successful in increasing the number of TB centers to more the 70 centers that provide cost-free care.

Certain activities undertaken have begun to give encouraging results. For example, there is a decreasing trend of HIV prevalence among commercial sex workers: from 80% in 1992 to 32% in 1999. Likewise, there is an increasing trend in condom sales, which shows that efficient actions can have important results.

Nevertheless, there are numerous obstacles to our efforts, including socio-cultural and economic factors. In particular, there is a high level of illiteracy (60% in population below 17 years of age), taboo on sexuality, stigmatization of persons living with HIV/AIDS, and difficulty to understand the risk of HIV infections. Furthermore, there is a generalized lack of resources, lack of personnel and health care infrastructures, and a majority of activities is supported by external partners.

Concerning challenges and perspectives, there is decentralization via expansion of activities to all regions of the country, creation of new voluntary counseling and training centers, prevention of mother-to-child transmission and opportunistic infections, and treatment of STDs. Furthermore, there is the reinforcement of health care and social welfare systems to respond to the increasing demand on health services, and the mobilization of all sectors of the government and society. Similarly, there is the reinforcement of advocacy targeting politicians and decision-makers, as well as of the collaboration with existing partners and the search for new partnerships and resources.

In conclusion, the HIV/AIDS epidemic is an enormous challenge for African countries due to the destruction of the work force and the impact on all development efforts. Despite constraints in resources, African governments are committed to fight the HIV/AIDS epidemic. Successes in stopping this epidemic are dependent on the reinforcement of social mobilization in African countries and the development of international cooperation. This struggle is not only an African one but rather a global campaign for the eradication of these scourges. This conference should be the departure point for a change of mentality and should produce concrete recommendations and solutions.

TRACK I: 13 APRIL 2000
PARTNERSHIPS IN PREVENTION, ADVOCACY & TRAINING

MODERATOR: FITZ HARPER, MD, ZENZELE, INC.

PRESENTERS:

HONORALBE FAUSTIN BOUKOUBI,

MINISTER OF HEALTH, REPUBLIC OF GABON

HONORABLE STANISLAS NTAHOBARI, MD,

MINISTER OF HEALTH, REPUBLIC OF BURUNDI

FRANKLYN LISK, PHD,

DIRECTOR AND REPRESENTATIVE TO THE UN, ILO

DEBORAH FONTAINE,

AFRICAN-AMERICAN COORDINATOR, AID ATLANTA

DERRECK KAYONGO,

DEPUTY REGIONAL DIRECTOR, AMNESTY INTERNATIONAL

RON MACINNIS,

DIRECTOR OF AIDS PROGRAM, GLOBAL HEALTH COUNCIL

HONORABLE FAUSTIN BOUKOUBI, MINISTER OF HEALTH, GABON

(French-English translation)

Until the present, prevention has been the most utilized means in the struggle against AIDS, although it has not been entirely successful. In this perspective, partnership is an absolute necessity for the following reasons: 1) the governments' resources (human, material, financial, research) are not sufficient to satisfy their needs; 2) these pandemics know no borders, so the solutions must be global, at the regional and international levels, in order to succeed.

However, if the necessity for partnership is recognized by all, the implementation of such partnerships should be designed according to the specificity of each country and context. Please allow me to expound upon the situation in Gabon, regarding public health in general and HIV/AIDS & Malaria in particular.

Gabon is a country in central Africa located along the equator. The population is very small: approximately 1.5 million people. The climate is hot and humid, and this favors the prevalence of Malaria. According to 1998 statistics, the mortality rate was 15/1000; the infant mortality rate was 99/1000 and the maternal death rate was 600-900/1000. Life expectancy was 52 years of age, and the population's access to clean water was 66% in urban areas and 30% in rural areas. Although public health coverage exists for about 78% of the population, this is truly theoretical because lack of financial and material resources mean that many of the clinics no longer function.

In 1998, Malaria ranked as #1 among principal causes of death, especially among children, up from #4 in 1996, which means that the situation has worsened in just two years. Furthermore, diarrhea-related illnesses, viruses from vaccination, respiratory and other infectious diseases were

the main causes of death. Likewise, in conjunction with the spread of AIDS, tuberculosis has reemerged to a level of 6.7% from 2.8% five years ago.

Since 1995, the evolution of the AIDS pandemic has been as follows: among adults, 2.9% in 1995, 5% in 1998, 6.6% in 2000. This unsettling progression of the epidemic, and thus the number of patients with full-blown AIDS, has increased hospital occupancy from 2.3% of AIDS patients in 1991 to 23% in 1997.

Since 1996, the campaign against AIDS in Gabon has been localized via the establishment of a National Committee Against AIDS & Sexually Transmitted Diseases. Under the first short-term plan developed, it created provincial committees. In the medium term, the plan deals with aspects of patient care and consolidation of prevention programs. The strategies are based on a national system founded in 1995 to integrate operations and services. So, our top priority entails prevention strategies to limit the number of infections. To build upon these advances, we work closely with educational institutions as well as members of civil society.

In 1999, President Omar Bongo established an inter-ministerial commission, which organized a multi-sector approach and a solidarity fund to provide health care services for HIV patients. The short-term studies show that if the infection rate of recent years continues until 2005, there will be serious socioeconomic consequences, from the demographic and economic points of view, among the population 24-44 years of age.

Concerning Malaria, there is a national program which organizes and coordinates a campaign against Malaria via the promotion of preventive means like treated mosquito netting, as well as the implementation of a "Roll Back Malaria" campaign by standardizing care services. The program is also responsible for monitoring of resistance against Malaria. In both the case of Malaria and AIDS, the Ministry of Health works not only with targeted populations but also other Ministries in order to coordinate effective healthcare initiatives.

Partnerships exist within the government and nationally, as well as internationally. NGOs are key partners because there are more and more such NGOs that campaign against AIDS & Malaria, but also against feminine cancers, alcohol, etc. These local NGOs have very little experience and financial resources, so they rely upon external assistance. Partners in the multilateral domain include the UN Agencies, European Union, African Development Bank and Islamic Development Bank, etc.

Bilateral assistance comes predominantly from France, US Peace Corps, China & Egypt. Furthermore, the International Red Cross and Rotary International are key non-governmental partners. Many initiatives have been launched with these partners to train human resources, to develop public health infrastructure, and to increase capacity in the domains of information, education and communications. This includes a surveillance system of healthcare.

However, there are a number of obstacles to these initiatives, including the insufficiency of national resources because most international aid must be matched by national contributions. If this national financial contribution is not available, then the project can not be realized. The high costs and difficult access to international expertise means that money, which is supposedly invested in a country for a healthcare project, is utilized largely to cover the salaries of the international experts engaged by the UN, etc. Therefore, the capacity is reduced to be able to implement intervention in these sectors.

Furthermore, there is a lack of national capacity to manage programs because the national and local experts are utilized by the international partners. Likewise, the rigidity of structures and procedures means that the offices of international agencies in-country do not have the power to

make decisions and allocate resources or change policies, but rather are dependent upon headquarters and have no authority nor autonomy to respond appropriately to the local context.

Each partner functions according to its own interests and resources, and thus comes with a specific project they want to achieve, but there is no coordination with local partners. These programs are often not appropriate nor adapted to the local circumstances, but rather only serve the interests of the partner. There is an absence of integrating social institutions and community involvement. Therefore, local mistrust exists due to lack of transparency of the financial and other management of these groups.

In conclusion, I would like to share a list of recommendations related to these obstacles:

- 1) Systematic adaptation of actions/services of partners with local populations as primary partners;
- 2) Elaboration of international action plans for Malaria and AIDS under the auspices of WHO in cooperation with all donors and national partners;
- 3) Reaffirmation of the role of WHO as global leader in health management and coordination of international partners for appropriate programs for each country;
- 4) Assurance of accountability and transparency in programs which are elaborated;
- 5) Avoidance of dispersion of financial resources to a plethora of programs, but rather focus on key areas like AIDS, Malaria, and vaccinations;
- 6) Encouragement of Bretton Woods institutions (IMF/World Bank) to augment the alleviation of poverty because health pandemics will exist as long as there is poverty.

HONORABLE STANISLAS NTAHOARI, MD, MINISTER OF HEALTH, BURUNDI

(French-English translation)

Since 1993, Burundi has experienced a period of political and socioeconomic crisis caused by the civil war, embargo and suspension of development aid. In Burundi, Malaria has become the #1 cause of death, and 40% of hospital patient needs are related to Malaria. As is normally the case, Malaria in Burundi is geographically located in the low plains, but there are also cases in the higher plains regions of the country.

The numbers are clearly increasing. In 1988, there were 230,000 cases of malaria; in 1993, there were 800,000 cases; and in 1997, there were 1.5 million. This past year, there were 2 million cases, which represents 1/3 the population of Burundi. Most of the patients are infants under 5 years and pregnant women. Unfortunately, this evolution coincides clearly with the political and socioeconomic crisis of the past seven years.

We are mobilizing the necessary means to address the situation through partnerships with multilateral and bilateral institutions. First, these initiatives focus upon the care of Malaria patients, but they also concentrate on preventive efforts such as the use of treated mosquito netting, the spraying of homes inside, and the improvement of sanitation services.

AIDS also represents a major problem for healthcare in Burundi. The first case of AIDS was diagnosed in 1983, and at the time, the infection rate in the urban zones was only 1%. Six years later, the infection rate was 15% in the urban areas and 7% in 15 of the 44 rural regions. Since 1996, the HIV infection rate of pregnant women was 16-20% in urban areas and 7.5% in rural areas.

The large displaced persons camps in the interior have the largest number of incidents. In 1997, UNAIDS estimated that in 1997 there were 200,000 deaths from AIDS. Therefore, AIDS has become the number one cause of death for adults in Burundi. As in other countries, this

epidemic has dramatically impacted the entire socioeconomic situation. In the capital of Bujumbura, 70% of hospital beds are occupied by AIDS patients, and therefore, there has been a noticeable drop in the hospitals' quality of services.

In response to this crisis, we must work towards prevention, particularly through the distribution and increased access to condoms. Likewise, we need projects to target vulnerable groups such as displaced persons from the war, prostitutes, military personnel, and prisoners. Our needs lie predominantly in the area of essential medications and access to AIDS drugs. In terms of social services, we need to take charge of orphans of AIDS victims, to organize home-based care visits, and to give support to local-based organizations that work in these domains.

In conclusion, this is the current situation in Burundi, which continues to suffer from an international embargo on development and humanitarian assistance. We should encourage the leaders and members of the international community to lift embargo restrictions on health provisions and reinstitute funding for victims of AIDS and Malaria, so that we can save innocent lives in the struggle against these epidemics.

FRANKLYN LISK, PHD, INTERNATIONAL LABOR ORGANIZATION

The ILO creates activities to promote social protection. They are operating under four strategic objectives:

- 1) Create opportunity for decent work and productive employees
- 2) To protect the fundamental rights of all at work
- 3) Forge social protection
- 4) Promote social dialogue between employers and workers

Specific Concerns About AIDS:

1. Economic growth and work productivity
2. Discrimination (workplace and housing)
3. Child labor elimination
4. Promote equality
5. Health and Social Protection

Human Rights:

1. Right to work
2. Right to Social Security
3. Right to confidentiality
4. Right to safe work environment

DEBORAH FONTAINE, AID ATLANTA

- African-Americans represent 13% of total population
- In 1998, 66.4% per 100,000 population were African-Americans who reported AIDS (two times as many in Hispanic / 8 eight times as many in Whites)
- 85% of the women infected in Georgia are African-American.
- Many of the same issues in Africa are the same issues we face in Atlanta, Georgia.
- We have people here who are educated with access to resources but still ignore the urgency.

- There are African-Americans in the United States who believe AIDS is a gay/white male disease.
- Great deal of bi-sexuality among African-American men
- Churches and schools refuse to discuss this problem. If we wait until children complete school, it would be too late.
- African-American women as a whole do not talk about AIDS amongst themselves or children.
- In the Atlanta area, we are victims of a "class" society. Those in the upper/middle class do not believe it exists in their community.
- Students should be trained to replicate the knowledge
- Lack of medical research-- research does not target African-Americans
- Lack of support in the community--legal and case management
- Lack of prevention measures--we must use the media to send the message
- We must educate each other
- African-American men do not want to listen to African-American women, especially in the church
- All prevention efforts are not effective

DERRECK KAYONGO, AMNESTY INTERNATIONAL

Amnesty International has not yet established an official position on HIV/AIDS because it is a long process to elaborate a policy, due to the sensitivity of local governments who are so critical of Amnesty's reports. We are investigating the relationship of AIDS and the debt crisis, which constitutes one of the principle impediments to effective campaigns to combat AIDS because these governments are taking money from health services to be able to make debt payments.

When US Ambassador to the UN Richard Holbrooke returned last fall from Africa, he began significant advocacy of campaigns against AIDS in Africa. We must follow up on this initiative. If you do not work within the Congress to influence policymakers like Senator Jesse Helms, you will not be able to break ground. One must cultivate long-term relationships and know this society's key actors in order to pursue effective advocacy. If you do not know the players in this country, you will not be able to get results.

You can not simply write a paper in Africa on an issue and expect there to be an impact. You must come in person and actively campaign with these key policymakers. You must educate the West about the issues. In particular, when we need funds to address critical issues, we must target the appropriate sources. Amnesty has been holding governments accountable, particularly in the allocation of funds to save lives. I would like to recommend the following areas of action:

- 1) Your African governmental representatives in Washington, DC, must be your voice and actively advocate these issues with the US policymakers.
- 2) Build partnerships with other governments, or you will not be effective.
- 3) For NGOs like Amnesty, we can work with you regarding AIDS as a human rights issue. For example, we can pressure pharmaceutical companies to make the treatment "cocktails" more affordable as a human rights issue.

RON MACINNIS, GLOBAL HEALTH COUNCIL

There is a divide between governmental leaders and community organizations because often Ministers are not willing to get their hands dirty. You must be partners with these groups or you may become obsolete. Politics is Perception, so if the community perceives their governments as unresponsive or not engaged, then these governmental institutions lose their credibility and legitimacy. An example in the US would be the Gates Foundation's donation to combat health crises in Africa, which rivals the US Government's bilateral programs. More and more private organizations are bypassing governments and working directly with one another...the Internet has facilitated this process.

People need to ask themselves why they are in a service position. Everyone has a right to be treated respectfully. Technology is a major asset for communication and building relationships. You have to be prepared to get your hands dirty. Politicians and community leaders need to go into the community and meet with groups.

- African Community Network Organizations
- Society for Women and AIDS in Africa Network (SWAN)
- International Community of Women Living with HIV/AIDS
- African Council of AIDS Service Organizations
- The Network of Africans Living with AIDS
- Network of Traditional Healers
- Civil Military Rights to Combat HIV/AIDS

TRACK II: 13 APRIL 2000
PARTNERSHIPS IN TREATMENT & NUTRITION

MODERATOR: PAULA K. BERRY, PhD, HELICAL SCIENCE LABORATORIES

PRESENTERS:

HONORABLE KANDJOURA DRAME, MD,
 MINISTER OF HEALTH, REPUBLIC OF GUINEA-CONAKRY
HONORABLE ALBERTINA JULIA NAHOUSSE H. HAMUKWAYA
 MINISTER OF HEALTH, REPUBLIC OF ANGOLA
ALAWODE OLADELE, MD,
 PREMIERE INTERNATIONAL HEALTH CARE, INC.
WILL TAYLOR, PhD,
 UNIVERSITY OF GEORGIA
OKEZIE ARUOMA, PhD,
 IMPERIAL COLLEGE OF SCIENCE, LONDON, U.K.

HONORABLE KANDJOURA DRAME, MD, MINISTER OF HEALTH,
GUINEA-CONAKRY

(French-English translation)

I appreciate the opportunity to exchange ideas with other Ministers of Health and representatives from Africa and the US. I would like to make two points regarding partnerships in the domain of treatment and nutrition. In terms of initiatives against HIV and STDs, Guinea has established a multi-sectorial program and four ministries are involved in the national efforts. The Ministry of Education has created ten committees in the communes nation-wide. The Ministry of Defense has established a program to train counselors for HIV/AIDS prevention. The Ministry of Agriculture has developed a program supported by the World Health Organization.

Assessment studies were conducted in two districts, and then there were training sessions for local elected officials, teachers, agricultural and other community officials. There are two types of partnerships established in Guinea. The first concerned HIV/AIDS prevention. The second partnership was established with Bristol-Myers for people living with HIV/AIDS in Guinea. Bristol-Myers helps educate and train medical teams for nutrition and treatment.

The gap that exists in Africa in terms of communication and information on this epidemic requires that we work together. In particular, President Clinton on November 29, 1999, said "there is a disparity between those who take advantage of our economic prosperity and those who have no benefits." Most of the millions of people suffering from HIV/AIDS live in poverty and have no access to new treatments or even basic health care services.

Therefore, in conclusion, we must establish active partnerships. If no partnerships are established, it will not be morally justifiable or acceptable. I hope that this conference will enable us to further bridge the gap and advance the struggle against HIV/AIDS.

HONORABLE ALBERTINA JULIA NAHOUSSE H. HAMUKWAYA,
MINISTER OF HEALTH, ANGOLA (Portuguese-English translation)

I would like to speak about the nutritional situation in Angola. Angola is a country that, due to the social and political situation, has a population that is displaced and suffers from severe malnutrition. These displaced persons have been forced to abandon their original homes and regional areas of residence, and they have lost all of their personal belongings. They have abandoned their farms that used to help them have minimum requirements for sustenance, and this is obviously creating a heavy burden on the country.

This nutritional problem is certainly affecting the children who are the most vulnerable. The government has mobilized efforts to assist these people in need, and it is forming partnerships with various international organizations that have also volunteered with foreign aid. We have areas that have just been liberated, and these people are suffering from severe Vitamin A and E deficiencies, and the government is taking supplies to them.

This nutritional situation has contributed to a large number of deaths in the population. This has also aggravated the spread of Tuberculosis and Malaria, and therefore it is a crisis situation that is affecting us all. This is a real struggle that we face against hunger and disease, together with the internal crisis with which we are dealing with today. This is a summary of the current situation.

ALAWODE OLADELE, MD, PREMIERE INTERNATIONAL HEALTH CARE, INC.

About one year ago, Ambassador Young was meeting with us to discuss nutrition and general health wellness. On 12 January, we formed an initiative called GIANT (Global Initiative AIDS Nutrition and Therapy). Ambassador Young called upon experts around the world for guidance and direction.

Mission

- Promote and produce nutrition-based therapy approaches to the HIV/AIDS population
- Support and encourage further research in the area of HIV/AIDS nutritional therapy
- Advocate and implement culturally acceptable intervention programs worldwide

How to Accomplish

- Ambassador Young will lead an intensive fundraising campaign
- Formulation with countries culturally appropriate recommendations of protocols
- Collaborate with governmental and non-governmental agencies
- Provide advice and education to patients
- Support further research toward HIV/AIDS nutrition therapy

Structure

- Corporate offices have been established
- Board of Directors
- International Advisory Board

WILL TAYLOR, PHD, UNIVERSITY OF GEORGIA

(SLIDE PRESENTATION) (abstract not submitted)

OKEZIE ARUOMA, PHD, IMPERIAL COLLEGE OF LONDON

(SLIDE PRESENTATION) (abstract not submitted)

TRACK III: 13 APRIL 2000
PARTNERSHIPS WITH GRASSROOTS (NGO) EFFORTS FOR YOUTH & ORPHANS

**MODERATOR: MELANIE DUCKWORTH, PHD, GLOBAL HEALTH DIVISION,
CENTERS FOR DISEASE CONTROL & PREVENTION**

PRESENTERS:

**HONORABLE MONTOMBAZANA TSHABALALA MSIMANG, MD,
MINISTER OF HEALTH, REPUBLIC OF SOUTH AFRICA**

**RHOI WANJILA,
EXECUTIVE DIRECTOR, THE ARK FOUNDATION OF AFRICA**

**CHARLES PORCH,
EXECUTIVE DIRECTOR, YOUTH PREVENTION SERVICES, INC.**

**EGONDU ROSEMARY ONYEJEKWE, PHD, DIRECTOR,
INTERNATIONAL MEDICINE & PUBLIC HEALTH, OHIO STATE UNIVERSITY**

HONORABLE MONTOMBAZANA TSHABALALA MSIMANG, MD,
MINISTER OF HEALTH, SOUTH AFRICA

I would like to acknowledge the overwhelming consensus that we have the responsibility to find solutions for the HIV epidemic within the socioeconomic and cultural context of the African continent. This must be a complement of the African Renaissance. During the last 15 years, the HIV epidemic has entered our consciousness as an incomprehensible calamity already laying claim to millions of human lives, inflicting grief and pain, causing uncertainty and fear, and threatening economic devastation. It poses serious problems for sustainable human development, especially for countries in the developing world.

For the case of South Africa, the epidemic is a particularly difficult challenge given the history of our country. Political liberation from a repressive apartheid regime was a central objective of the struggle for liberation in our country. Our political and social struggle was based on the principle that democratic change would lead to an overall improvement of the quality of life for the poorest people. Over the past few years, experience has shown that overcoming the consequences of apartheid, including the social factors contributing to HIV transmission, will be indeed a daunting task.

One of the challenges is to find ways to unify a country deeply fragmented by race, class, gender and language, while at the same time trying to integrate South Africa into the global community. A central element of this transition is to develop a unity of purpose to address poverty and other development, and at the same time to address the serious threat to development that is the insidious process of the HIV/AIDS epidemic. Evidence suggests that unless its effects can be mitigated, the current impact of HIV at the level of the poor household is catastrophic and its future impact on society is likely to be devastating.

South Africa is currently experiencing one of the most rapidly progressing epidemics in the world. It is estimated that more than 4 million South Africans will be infected by the end of this

year. The determinants of the infection can not be explained only by individual risk-taking behavior. The causal factors of HIV transmission are rather to be found in the poverty and socioeconomic alienation suffered by most South Africans, and indeed most Africans. The HIV epidemic in South Africa has the potential to prevent the achievement of sustained human development.

So far the impact of the epidemic has been largely hidden, reflecting the initial slow build-up of infection and the delay in progress to AIDS. HIV infection is concentrated in age groups critical to social and economic development, in the core of the labor supply, in rural and urban areas, and in both skilled and unskilled groups. Public industries and public servants will not be exempt from the spread of the epidemic. They will experience both the consequences of HIV infection and the change in demand for public goods and services. Government will be unable to make these services available to the whole population, and this in turn will lead to intensified frustration among disadvantaged communities. So whatever we do to fight HIV/AIDS, all of our efforts must be underpinned with a message of caring and hope.

I would like to briefly address the issue of non-governmental organizations. All countries in Sub-Saharan Africa face a heavy burden of care for AIDS patients. It is clear to us that the formal healthcare system will have difficulty in coping with the burden of AIDS, as well as other opportunistic and chronic diseases afflicting people in these countries. There is an urgent need to find creative and sustainable ways of preventing HIV infection and caring for those who are ill.

Presently, people discharged from health facilities go home to be looked after by their own families and friends. Therefore, effective existing community initiatives must be reinforced and new ones nurtured. This will require flexible partnerships. Communities become mobilized when they identify a common concern and decide to take action against it. However, the momentum for continued mobilization must come from within the communities, or they will not be sustained over time.

A few basic principles for successful partnerships are assuring that the community takes ownership of the initiative and securing long-term support. A true community-based initiative is one where local people can say at the end of the day, "we did it ourselves." It is important to leave communities with resources and to recognize that they have a limited ability to meet all their needs. Governments and other partners must work together to provide these means.

Secondly, there is the need to secure long-term support for HIV/AIDS related initiatives. Maintaining the momentum of community responses requires regular replenishment of energy, skills and resources. It is important to include a wide variety of stakeholders, including faith-based organizations, traditional leaders and healers, business, women's groups and youth organizations. There must be a social contract between community groups and government, which clearly delineates their respective strengths, rights and responsibilities and that provides a mechanism and means for communication to share experiences. This must be based on mutual respect and trust.

In 1998, the South African Government established an Inter-Ministerial Committee for HIV/AIDS, chaired by our current President Thabo Mbeki, to solidify partnerships with all major sectors of our society: youth, labor unions, religious leaders, women's organizations, business, and people living with AIDS. Likewise, the South African AIDS Council constitutes another partnership between government and civil society to address HIV/AIDS. A successful example of these partnerships includes the recent agreement by Pfizer to offer AIDS medicines to our citizens.

When we intensify our campaign to encourage abstinence and safer sex through use of condoms, an essential part of our campaign is to focus urgently on the elimination of poverty. In other words, the fight against AIDS must be located within a clear developmental strategy and perspective. We must also ensure that our society does not discriminate against those who suffer from AIDS.

As Chairperson of the Southern African Development Community's Health Committee, we have adopted a strategy to combat the combined threat of HIV/AIDS, Tuberculosis, and Malaria. These diseases are most prevalent among those who suffer from reduced immunity as well as malnutrition. Currently, there is a study underway in South Africa to document the relationship between HIV infection and Malaria. The challenge for Africa is underdevelopment, predominantly due to lack of resources. Therefore, we must strengthen our intergovernmental and regional cooperation efforts to stage a combined attack on these diseases.

Of the 33.4 million people alive with AIDS today, one third are young people aged 15-24. Every day, 7,000 young people worldwide are infected. The reasons for such vulnerability are linked to adolescence as a time of discovery, emerging feelings, and exploration of new behavior and relationships. Sexual behavior is an important element of this period...but they are confused by mixed messages calling for virginity in girls and any behavior in boys. They view images that portray sex, drinking and smoking as glamorous and risk-free. In the name of morality or religion, they are denied access to education or means of prevention for AIDS. Therefore, they are more vulnerable, especially those who live on the streets or are sexually abused. Development of youth-friendly services is essential and must involve youth themselves.

A special group of youth are those who are already living with HIV and find it difficult to reconcile themselves to being infected so early in life due to feelings of anger and confusion about HIV, sexual matters and risks of infecting others. Young people whose relatives have died of HIV/AIDS may be subjects of ridicule and even thrown out of school. Unless equipped with education, they may have no knowledge of their rights and means of recourse/treatment. Strategic partnerships are needed between youth and adults, between governmental and non-governmental organizations, to support the youth's own efforts. Any intervention *for* the youth must be *with* the youth. Encourage their participation, and be receptive to their ideas.

For orphans and youth in distress, the death of a caregiver brings a long and sustained fear from which there is often no escape. The HIV/AIDS epidemic decimates families, killing young parents and breadwinners and pushing survivors into destitution. Without help, extended families may collapse leaving the elderly and children without support. Children in distress is a term used to describe a child who has been orphaned, abandoned or displaced, or whose primary needs for physical, social, emotional and intellectual development are not being provided for. They may grow into dysfunctional adults unable to live peacefully and productively.

Communities in partnership with government must find ways to create safety nets for these children. In South Africa, these partnerships have identified the following solutions: care for children by family members, creation of community-based structures which allow them to remain in a familiar environment, economic empowerment of caregivers, and establishment of facilities for foster care. We must uphold and base all programs on the UN Convention on the Rights of the Child which guarantees that children have the right to be protected, provided for, and consulted about decisions that affect their own lives. Children have individual needs that need to be understood within the context of their families' culture, religion and community. A simple, inexpensive intervention--just being there to provide a constant trusted source of human contact--

may be the most valuable resource for children traumatized by the profound manifestations of the AIDS epidemic.

Great demands are made on the public health system to provide other anti-retroviral drugs, including the prevention of mother-to-child transmission of HIV. We continue to discuss these matters within the government, scientific and research communities and national licensing board for medicines. We are committed to investigating and implementing cost-effective approaches to provide for prevention, treatment and care.

There are no easy answers and solutions to the complex issues of this epidemic. We must therefore continue with the debate to try to find South African and African solutions to the epidemic. It is for this reason that we are not only working with other researchers through our Medical Research Council, but are putting together an international panel of scientists and experts to discuss all these issues in as transparent a setting as possible. We are convinced that all people of Good Will will join the people of Africa as they struggle to find African solutions to the HIV/AIDS epidemic.

In conclusion, the need for partnerships is essential to effectively address the HIV/AIDS epidemic and the problems of youth and orphans. Government cannot solve these problems alone, and it is only in partnership with communities, with other sectors, and with young people themselves that we as a society will be able to most effectively address the problems of HIV/AIDS.

RHOI WANJILA, THE ARK FOUNDATION

As a child, I was an orphan. Unfortunately, our government does not understand the crisis. Now, is the time to pull together our resources and put our egos aside. This can be done at a minimum expense. We need to help the children live productive lives.

Children are becoming parents at the age of ten to their siblings. They are forced to grow up quickly. 85% of Africans live in rural areas without access to television, radio, or public information. We must advocate for prevention of HIV/AIDS.

Ark Foundation trains students about everything regarding HIV/AIDS. In a class, we select two students--they take two students-- and so on to spread the information. They are eager to learn because they know parents are dying of HIV/AIDS. Youth are looking for role models. It is important to follow the new saying, "Do as I say, and Do as I do!"

Africa does not have adequate shelters. So Ark must create alternative housing. Youth just want the basic life needs--food, shelter, education, etc. We want them to grow up to be productive adults. They must have a voice. They must be able to openly speak about HIV/AIDS and sex. The Ark Foundation provides: Institutional Assistance, Counseling/Mentorship, and Academic Support.

We support those willing to become guardians. My experience living with missionaries taught me that I am smart, intelligent, and had a bright future ahead of myself. We have no reason not to support these children. Our job is to create a support system for children. For \$1.00 you can support a child in Uganda and this child will be able to attend a boarding school and become a productive citizen. They need to have scheduled activity to keep them from the street that can cause them to get into trouble.

CHARLES PORCH, YOUTH PREVENTION SERVICES, INC.

The United States must put our money where our mouth is. In one day, the country dropped \$60 billion worth of weapons on Kosovo. The problems we are discussing involve only a couple of \$100 million. My agency has been requested to put a team together to go to Africa to "train the trainers." Since June 1996, we have provided direct training services to over 47,000 teens and adolescents.

Services / Programs

- Peer Education Training Program (ages 11-17)
- The Rolls Royce Club (4 weeks of self-esteem training through puppetry arts)
- Peer Power (allow peer educators to support each other)
- Youth and Gang Violence Diversion Program
- Employment

As we look at developing programs for orphans and children on the continent of Africa, they must be comprehensive in scope! Some of the orphans are in the street. They have issues to be addressed:

- Self-worth / Self-esteem
- Gender Issues
- Violence
- Negative views of women

These programs can work with children anywhere. No matter what language a child speaks, they know if you are sincere. You can only make a difference if you are committed. Too many people have dropped the ball. Youth need to be aware that they can be virgins all over again. A spiritual guidance is important. We have trained 250 peer counselors. They counsel and reach youth better than I do.

EGONDU ROSEMARY ONJEJEKWE, PHD, OHIO STATE UNIVERSITY

(abstract not submitted)

TRACK IV: 13 APRIL 2000
PARTNERSHIPS IN RESEARCH

MODERATOR: GOODMAN ABBOT, MD

PRESENTERS:

ERIC BING, MD, MPH,

CHARLES DREW UNIVERSITY OF MEDICINE

RICK STEKETEE, MD, MPH,

**CHIEF OF MALARIA EPIDEMIOLOGIST BRANCH, DIVISION PARASITIC
DISEASES, NATIONAL CENTER FOR INFECTIOUS DISEASES**

MAMDOOH GHONEUM, PhD,

CHARLES DREW UNIVERSITY OF MEDICINE

ERIC BING, MD, MPH, CHARLES DREW UNIVERSITY OF MEDICINE

It is important for partnerships to be structured and brought together in a sound manner. It is very similar to a marriage, and without a cohesive vision it will end in divorce.

Drew University was founded in the late 60's after the Watts riot because care was not being provided to greater Los Angeles. As a result, people from various communities in South Central Los Angeles came to the University with their own agendas and chaos was created. So, as we branch out to acquire partnerships, there are four V's to consider:

- Shared Vision
- Shared Value
- Shared Valley/Community
- Shared Victory

I direct Drew CARES (Center for AIDS Research Education Services) which is a collaborative effort funded by the State of California. We focus on building partnerships focusing on academic, interdisciplinary and community-oriented institutional partnerships.

Research has found testosterone is associated with weight loss. The lower the testosterone, the lower the weight loss. If we can increase the testosterone, we can increase their weight mass and increase their quality of life. Energy level is associated with muscle mass. During an experimental study, we provided an exercise program two times for three months and/or 100 mg of testosterone.

There were four scenarios:

- Group I: No exercise / No testosterone
- Group II: Exercise / Testosterone
- Group III: Exercise Only
- Group IV: Testosterone Only

Result:

Those with testosterone made a significant difference over those with placebos.

The muscle mass and strength gave them more energy.

The challenge is creating a level playing field. Research done in the United States is not the same as in Africa. The research must be done there. The distance creates another challenge in terms of time and communication. This will effect the building of successful partnerships. We must determine how to use technology to move research forward. Partners must understand that everyone brings something to the table. One cannot give without learning. The purpose is to learn from each other and leverage your knowledge.

Ways to Reduce Challenges

- Create Infrastructure
- Tele-Medicine Units
- Link medical system, social service system, and mental health systems with community clinic via computer and cameras (ex: via satellite)

RICK STEKETEE, MD, MPH, NATIONAL CENTER FOR INFECTIOUS DISEASES

- CDC partners with WHO giving Malaria top priority
- Multilateral Initiative on Malaria to help expand training
- Support funding: Bill Gates Foundation (\$50 million towards Malaria vaccine research), USAID, and WHO
- More deaths are in the community than in the facilities
- This Conference is unique because most conferences focus on either AIDS or Malaria, not both
- HIV makes Malaria worse, especially during pregnancy
- Malaria and HIV may begin with some of the same symptoms, therefore, they are treated the same. However, the drugs are dramatically different which affects the progression
- Pregnant women are at greater risk because parasites congregate in the placenta causing low birth rates.

Strategy

- 1) Select a problem
- 2) Define the problem
- 3) Demonstrate that the interventions work
- 4) Deal with whether they are effective, affordable, and deliverable
- 5) Try to correlate a relationship with other diseases
- 6) Define interventions to address relationships
- 7) Work on national policy
- 8) Work with WHO to extend the policy

CDC will:

- 1) Address domestic and world travelers
- 2) Focus on pregnant women and children
- 3) Go through the steps (listed previously)
- 4) Expand collaborations

MAMDOOH GHONEUM, PHD, CHARLES DREW UNIVERSITY OF MEDICINE

(abstract not submitted)

TRACK V: 13 APRIL 2000

PARTNERSHIPS IN RESEARCH ON TRADITIONAL MEDICINES

**MODERATOR: CHARLES FINCH, MD, MOREHOUSE SCHOOL OF
MEDICINE**

PRESENTERS:

HONORABLE MARIA MASSOUGHBODJI,

MINISTER OF HEALTH, REPUBLIC OF BENIN

HONORABLE FRANCISCO FERREIRA SONGANE, MD,

MINISTER OF HEALTH, REPUBLIC OF MOZAMBIQUE

RHONNIE HEMPHILL, JD,

**DIRECTOR OF COMMUNITY EDUCATION AND FUNDRAISING, CHURCH
WORLD SERVICES**

WILLIS LOGAN,

DIRECTOR OF AFRICA, CHURCH WORLD SERVICES

LOWELL FUGLIE,

**REGIONAL REPRESENTATIVE, MORINGA PROJECT, CHURCH WORLD
SERVICES**

ANTHONY K. ANDOH, PhD,

TRADITIONAL MEDICINE SPECIALIST

HONORABLE MARIA MASSOUGHBODJI, MD, MINISTER OF HEALTH, BENIN

(French-English translation)

I was formerly a cardiac surgeon and studied medicine at University of Cotonou in the capital of Benin. I've been Minister of Health for the past five years and am particularly interested in traditional medicine and its promotion within the government.

Benin has a population of six million and reaches from the Atlantic Ocean northward to Niger and Burkina Faso. Our culture is very much attached to traditional medicines, and 70% of the population consults traditional healers. Therefore, the perception of AIDS and Malaria is quite different from in the Western World.

Malaria is considered to be a disease caused by the sun, thus called "the sun disease." On the contrary, HIV/AIDS--which is a relatively new disease in Benin--is not associated with death by the traditional healers. Therefore, they treat only the symptoms of AIDS: coughing, diarrhea, fever, etc. We take it with a grain of salt when traditional healers claim to have found a cure for AIDS.

Benin, like every country in Africa, has a reservoir of traditional medicines. 66% of all plants are still found in Africa. The presentation of these medicines is quite complex: powders, extracts, syrups, drugs, pills. Since fully 70% of our people consult these healers, it is in our interest to take these medicines seriously.

What is in our pathology? Traditional herbalists have knowledge of the rules of nature and are trained from childhood. They can distinguish between sorcerers, charlatans and true herbal experts. The language and communication that they use are quite different. Given all the differences that do exist, what are the possibilities for partnerships with traditional healers?

We find as doctors that they do not have organized methods. Since there is not even a minimum of organization, it is the duty of the Ministry of Health to work towards better organization. First, the Ministry undertook a survey that showed that there are over 7,000 traditional healers, which is 3 times the number of Western-trained doctors in Benin. To encourage the cooperation of these traditional healers, the Ministry of Health gave diplomas to recognize their skills as healers. We conducted forums and meetings in every state of the country, during which the traditional healers decided to distinguish among themselves according to who uses plants, who uses magical incantations, etc. and thus to separate their practices. It was our decision to work only with the healers who use plants.

Second, we established botanical gardens to grow herbs and traditional medicines in each village. Likewise, we set up a center for the study of traditional medicine at the University Hospital. Now we are in the process of determining eligibility, qualifications, etc. We know that some healers are very effective, especially in Malaria and also for opportunistic infections brought on by HIV/AIDS, at the village level.

What research and partnership can we solidify between traditional and modern medicine? We must have mutual trust and respect, because if we push the process too quickly, they will refuse to cooperate. Finally, Government has requested that these traditional healers identify the three-five medicines that they find most effective for further research.

HONORABLE FRANCISCO FERREIRA SONGANE, MINISTER OF HEALTH, MOZAMBIQUE

In fact, the issue of traditional medicine has been overlooked for many years, and worse than that, is that we ourselves who practice traditional medicine feel ashamed of using this powerful and valuable resource.

I would like to give you some statistical information about Mozambique. About 60% of our hospital beds is occupied by Malaria patients, and it represents the first cause of mortality in hospitals. If you take the case of HIV/AIDS, we estimate that at least 3 million people are infected with HIV, 1 million people have died of AIDS, and at least 800,000 children are left orphaned by AIDS.

We know by judging their own traditions that no matter how big the hospital, how skilled the doctor, or how ill the patient, they still believe in the traditional healer. Before the sickest child comes to the hospital, even if the mother knows that the fever is due to Malaria, she will not dare to come to the hospital without first visiting the traditional healer. That is the first law when the mother goes to seek help.

Therefore, we must discuss with the traditional healers to find out what type of medicines they use because we might be wrong when we prejudge them and say well "that's why these children are dying because they used the wrong treatment." It may be an overdose that killed the child. How are we contributing to worsening the situation...we keep playing with the traditional healers and never approach them to do research on their medicines.

The challenge that lies ahead for us is to set up proper institutions for research in traditional medicine. There seems to be a way out through traditional drugs against Malaria in light of this resistance problem. These drugs are in our backyard.

In regards to HIV/AIDS, we need to remove the stigma and shame, as well as the fear of using traditional medicines, because that is the main problem. In the case of HIV/AIDS, when one discovers that (s)he is infected, the first reaction and instinct is to commit suicide. People still have one source of hope and they go to the traditional healers. There is the belief in Africa that if you are not well, probably someone might have done wrong and wished bad things to you.

Either way, although we pretend not to believe that the traditional healers are doing a great job dealing with HIV/AIDS, we do not know if their claims are valid because we have not done research. This is the challenge that lies ahead. Therefore, we must identify the steps, in practical terms, which should be taken to do research and to put science into traditional practices and thus find solutions within our own traditions.

RHONNIE HEMPHILL, JD, CHURCH WORLD SERVICE

Read Spiritual Scripture (Matthew 25 and Isaiah 65: 21-22)

- Trained attorney
- Worked with the American Red Cross for 19 years prior to attending law school
- Struck by a case that caused the loss of my vocal cords. I was told I would not speak.
- Through my personal relationship with God, I know I am a walking miracle.

Church World Services

- Social and Economic Development
- Refugee Assistance
- Emergency Relief
- Education
- Financial Support (through collaborations)
- Material Assistance (through collaborations)
- Technical Expertise (through collaborations)

The church strongly believes in global partners (129). 29 are in Africa. The church has raised \$60 million towards partnerships and presently has \$20 million in planned gifts.

WILLIS LOGAN & LOWELL FUGLIE, CHURCH WORLD SERVICE

This project started in Senegal. A tree called Maranga was brought to us by the Senegalese community. We did not discover it, nor did we invent it. We are just trying to popularize it.

Maranga offers resistance to Malaria and HIV/AIDS. The tree grows in eight months starting with seeds. If the tree is cut down, it will re-grow. All parts of the tree are edible: fruit, leaves, limbs, roots, etc. This plant is used to treat everything from high blood pressure to diabetes. It has now become a part of the Senegalese daily diet. The Vitamin A in it boosts the immune system. The tests and research show that the leaves can cure malnutrition. Just three teaspoons will satisfy all Vitamin A / calcium requirements.

The problem is that most doctors have been trained in the Western civilization. So, they were not very open. After they have tested the plant (twice), it was found that the Maranga was four times more effective than their traditional way.

The edible tree is used to produce oil. The leaves provide the following:

- Three times the Iron in spinach
- Four times the Vitamin A in carrots
- Seven times the Vitamin C in oranges
- Three times the Potassium in bananas
- Four times the Calcium and two times the Protein found in milk

ANTHONY ANDOH, PHD, TRADITIONAL MEDICINE SPECIALIST

This afternoon should be the end of an era and the beginning of the future. *(He pauses to call upon the ancestors)* This is a day that all the African gods will shower me with their healing power. *(He says a loud passionate prayer and performs an herbal ritual.)* I have come to tell everyone to look to their parents for wisdom and knowledge. The first medicine was organized in Africa on the Nile 5,000 years ago. The forest and soil of Africa are full of medicine and miracles of which the Western medicine is not aware.

A plant that grows only in the Cameroon Island will combat HIV/AIDS and Malaria. The plant contains alkaloids allowing several medicines to be produced. Another plant is used to connect the galaxies of all ancestors. It will cure anyone addicted to crack cocaine, cigarettes, and street drugs after one dosage. As Africans, we must show pride in ourselves and not run to others on the outside. All of the answers are in our gardens. No one can save our people but ourselves.

PLENARY SESSION: 14 APRIL 2000

MODERATOR: HOPE SUKIN
CHIEF, AFRICA BUREAU HUMAN RESOURCE DIVISION,
OFFICE OF SUSTAINABLE DEVELOPMENT, USAID

PRESENTERS:

FRANKLYN LISK, PHD,
DIRECTOR AND REPRESENTATIVE TO THE UNITED NATIONS, ILO
JACOB GAYLE, PHD,
SENIOR TECHNICAL ADVISOR, JOINT UNITED NATIONS PROGRAMME ON
HIV/AIDS SECRETARIAT, UNAIDS
CHRISTOPHER WALKER, MD, AFRO MALARIA PROGRAM,
WORLD HEALTH ORGANIZATION

FRANKLYN LISK, PHD, ILO

For those of you who do not know, the ILO has been around since 1919. The organization was formed primarily to address social injustice. The ILO is prepared to help combat the horrible virus of HIV. Our interest in joining the battle against HIV/AIDS is great because we have with us the considerable knowledge and expertise of a team of directors. The membership of the ILO reaches over 174 states. I wish to impress upon you my appreciation for this Conference and its organizers.

The ILO promotes social conditions and employment. Our interest is to join in the battle of HIV/AIDS in the context of the work of the world. We have strategic objectives that have been defined by the newly elected Director-General.

It is a major responsibility for employers, governments, and agencies to take action against AIDS. It is obvious that the impact of the disease is impacting the economic growth. For employers, it affects productivity and profit margins. ILO provides an opportunity on an international level for the three parties, government, and social partners to come together to discuss common interests, in this case, how to eliminate HIV/AIDS and Malaria on a national level.

With respect to international labor, visa recommendations are adopted by the ILO on the basis of a consultation of the three parties, the government, and social parties. So any organization has a forum of support.

JACOB GAYLE, PHD, UNAIDS

Worldwide HIV/AIDS has exposed our collective vulnerabilities or own risks, fears, and bias. Though the actual picture may look different country-by-country, region-by-region, I think the underlying scenario is very common.

HIV/AIDS also demonstrates how vulnerable we are, hence, there is no such thing as your epidemic and my epidemic. As we live, breathe and move around this globe, the epidemic affects everyone. Accordingly, partnerships have a very special meaning.

Firstly, in the globalized social and economic world village, we are partners in this epidemic. What AIDS does in your community adversely affects what happens in my community.

Secondly, we are jointly responsible for responding to the HIV challenges in our countries. The impact of HIV in your response will have an impact globally. The Joint United Nations Programme is indeed a partnership. A partnership of the mandates, visions, and capacity of seven UN agencies and before 2001, hopefully, eight including the ILO.

More broadly, the Agency encourages forging a larger coalition--one that includes people who live with HIV as well as governments, non-governmental organizations, private sector, and other parts of civil society. The International Partnership Against AIDS in Africa was formed as a result of the leadership and vision of some of you present.

The vision is to support the intensifying efforts of countries living with HIV/AIDS by bringing multiple players together around a common table, and by expanding the capacity for HIV action and creating nationwide delivery to HIV care, prevention, treatment, and medication.

This cannot be perceived as a foreign epidemic attended to solely by ex-patriot benevolence. Since this is our epidemic, there are roles for us to play.

- 1) Recognition of national leadership which takes responsibility
- 2) Inclusion of non-governmental organizations and groups
- 3) Multi-sector / Multi-disciplinary response
- 4) Donor collaboration / Long-term commitment

Partnerships bring an added value. As we move forward, we have seen great progress. Hopefully, we will continue to move carefully and cautiously by sharing our resources and ideas. We seek your leadership, as we work together to conquer HIV/AIDS and Malaria.

CHRISTOPHER WALKER, WHO

(SLIDE PRESENTATION) (abstract not submitted)

TRACK I: 14 APRIL 2000
PARTNERSHIPS IN PREVENTION, ADVOCACY & TRAINING

MODERATOR: BETSY HARRIS, RN, MSN, ATLANTA VETERANS
ADMINISTRATION MEDICAL CENTER

PRESENTERS:

HONORABLE KONDI CHARLES AGBA, PHD
MINISTER OF HEALTH, REPUBLIC OF TOGO

DEBORAH FONTAINE,
AFRICAN-AMERICAN COORDINATOR, AID ATLANTA

HONORABLE TEFO MABOTE,
MINISTER OF HEALTH, REPUBLIC OF LESOTHO

CYNTHIA DAVIS, MD,
CHARLES R. DREW UNIVERSITY OF MEDICINE

HONORABLE KONDI CHARLES AGBA, PHD, MINISTER OF HEALTH, TOGO

Togo is a very small country of 56,000 square kilometers and has 4.5 million inhabitants in West Africa near Nigeria. Our country is very poor with an annual per capita GNP of \$340.

Our experience with AIDS dates back to 1982 when we sent one of our doctors to the US to learn about this disease. Perhaps at that time we made a big mistake. Due to the economic crisis, we did not speak about AIDS in our country so that the key sector of tourism would not be affected. Problems were "prioritized" in terms of economic development because in order to harmonize our relations with France our currency was devaluated by 50%.

In 1990, political instability ensued during the process of democratization because prior to that period there was a one-party system. In my country of 4.5 million people, we have 44 tribes and 65-70 political parties. In sum, the economic crisis and political disorder made us poorer than we were previously.

In 1987, we claimed to have only six cases of AIDS, but I am certain today that we did not count it very well. In 1998, we counted 1,623 cases among people who came from the inland to hospitals for treatment. Of course, the real number must be higher than this, indeed, we estimate that 3-6% of the population is infected with HIV. We are confronting the epidemic by implementation of similar programs as those in our neighboring countries. We have implemented prevention programs in the schools and maternity wards. We have used comic books to raise awareness among the young people.

However, we have financial problems to buy medicines that are too expensive. We have partnerships with the private sector and governments, but we need large companies to give money for AIDS medications. We have received help from international organizations like the World Health Organization and the UNDP. However, the World Bank has not provided any assistance because in order to receive loans for health programs, we must put money as a down payment before they start a program. We do not have even the smallest amount to pay because due to our economic and political crisis, we are even unable to pay the civil servants.

The European Union requires elections prior to the disbursement of assistance. Togo's former colonial powers--Germany and France--support us bilaterally in the domain of Malaria. Partners should not only look at the political situation and war in determining assistance for the campaign against AIDS because it is a GLOBAL problem, not just an African problem. Thus, partners should not look at the "color" of the government in power, but rather should address the humanitarian crises.

In conclusion, we no longer deny the reality of the AIDS epidemic, and we know how to address the issues, but we need partnerships to have the opportunity to effectively support our hospitals and diagnostic capabilities. Please come to Africa and speak with us, in order to better understand the situation before making decisions about how and when to establish partnerships.

HONORABLE TEFO MABOTE, MINISTER OF HEALTH, LESOTHO

Our country is small and surrounded by South Africa. We have a population of approximately 2 million people and an annual GNP of \$500 million annually.

Regarding the AIDS crisis, our first reaction was denial due to two major observations and misconceptions. Complacency made us believe that most cases of HIV/AIDS were in other countries, and thus not a problem in Lesotho. Likewise, our community did not associate AIDS with STDs. Our assessment of the knowledge of AIDS mobilized us to disseminate information and improve communication in order to raise awareness about the transmission modes and prevention methods by health care institutions.

The first attempts were not relevant or effective because we took a "universal" message, which had no context in which local communities could relate or understand. Moreover, family health programs associated with the use of condoms were less effective because they targeted women as the main objects. This boosted complacency among the men and made them believe that HIV/AIDS was a problem for women, not for everyone. In spite of the increasing level of awareness, complacency continues to impede preventive efforts to control the spread of HIV.

One reason for this indifference was the inappropriate application of the principle of confidentiality, an essential component of the practice of healthcare. However, when confronted with the HIV/AIDS epidemic, the duty to provide care for the individual came to a crossroads with the duty to protect the general public. Thus, we recognized that the epidemic clouded our minds with hopelessness, and "confidentiality" perpetuated the silence about the disease.

The most harrowing observation was that 60% of those infected by HIV were in the age group of 20-49. This had widespread socioeconomic and cultural implications that called for a broad-based approach. Analysis has revealed the urgent need for partnerships between the Ministry of Health and Social Welfare to spearhead the fight against AIDS. We established partnerships with private organizations, including NGOs, religious groups, and other people of good will.

We observed that there was an absence of strategic alliance to make such partnerships most effective. Therefore, we produced a national policy document on the control of HIV/AIDS elaborated by all the stakeholders with information, knowledge, and skills. They were expected to inform about appropriate lifestyles to reduce transmission of HIV and discrimination, to support those who live with HIV, and to improve the quality of hospital and home-based care for HIV/AIDS patients. In May 2000, we will hold a workshop to harmonize the strategic plan to address all policy issues.

The most prevalent political commitment, the homogeneous nature of our people, and the high level of awareness of HIV among our people contributes to successful partnerships. The trend is to forge these partnerships to address those who suffer from HIV/AIDS, as well as those orphaned by AIDS, and also to implement stronger home-based care to relieve pressure on overburdened formal infrastructure.

In conclusion, we must ensure sustainable partnerships and reform of the public health system. We continue to strive to gain more partners to share information and work toward the common goal of eradication of HIV/AIDS.

CYNTHIA DAVIS, MD, CHARLES DREW UNIVERSITY OF MEDICINE

In 1983, I created sex education programs for the African-American and Latino communities in Los Angeles. I was compelled to include HIV/AIDS as part of the programs. In 1987, collaboration began with the public and private sectors. Grants were received to build model programs. At that time, they received national media attention and created national programs. Many policymakers, educators, and community leaders were trained for counseling. The program targeted women and children. They collaborated with health departments with mobile testing vans for screening and evaluations. Many times they could get AIDS test results in 20-30 minutes. As a result, the health departments purchased six more vans and replicated the program. Outreach work in the community came to fruition. A \$1.2 million matching grant program and contributions were raised. These programs are networked nationally.

Goals

- Increase access to primary healthcare
- Provide useful healthcare services from a mobile van
- Evaluate in order to help the quality of life for young people

Needs Assessment Results from Homeless/Street Youth

- 90% of clients did not know where they would be at the end of the day
- They had been on the street for years
- Lack of transportation after hours
- They were the last to be treated when at health clinics

Therefore, the mobile vans would go out at night to treat youth and young adults (ages 12-24) and give them the trust and respect that they lacked in the agencies. No one was turned away. Medical students and residents worked on the van and would stay until the last person was serviced. Many children would sleep during the day and hang out at night. Accordingly, this service accommodated their schedule because the agencies were not open at night.

Injury Causes

Sexually Abused / Raped
Drug Abuse
Beaten by Pimp / Assault
Kidnapping
Suicide Attempts

Accomplishments

Trained clients for job interviews
Community Volunteer Programs
Provided Medication
Provided Hygiene Products

DEBORAH FONTAINE, AID ATLANTA

(Please refer to 13 April Session)

TRACK II: 14 APRIL 2000
PARTNERSHIPS IN TREATMENT & NUTRITION

MODERATOR: MARCIA WELLS, RN, ED D, GEORGIA BAPTIST
SCHOOL OF NURSING

PRESENTERS:

HONORABLE JOAO MEDINA, MD,
MINISTER OF HEALTH, REPUBLIC OF CAPE VERDE
HONORABLE PHESTILE DLAMINI, MD,
MINISTER OF HEALTH, KINGDOM OF SWAZILAND
ALAWODE OLADELE, MD,
PREMIERE INTERNATIONAL HEALTH CARE, INC.
WILL TAYLOR, PHD,
UNIVERSITY OF GEORGIA
OKEZIE ARUOMA, PHD,
IMPERIAL COLLEGE OF SCIENCE, LONDON

HONORABLE JOAO MEDINA, MD, MINISTER OF HEALTH, CAPE VERDE

(French-English translation)

Initially, I would like to recommend these fundamental elements for treatment and control:

- Guarantee safety of blood transfusions
- Shipments from industrialized nations of goods, equipment, and accessories for diagnosis and active tracking of those infected with HIV
- Training for healthcare professionals: doctors, nurses, psychologists, and trainers on HIV/AIDS
- Guarantee of confidentiality for HIV patients and their families
- Humanization of the services

At the level of civil society, we hope to stimulate multi-sectoral participation and proactive engagement of policy decision-makers, parents, teachers, students, youth groups, churches, NGOs, mass media, etc. We would like to train young activists and members of NGOs, churches, etc. Likewise, we want start a mass media campaign to disseminate information oriented toward the target groups, as well as to secure more adequate educational materials.

At the level of the international community, we must mobilize the necessary financial resources to support the strategies and actions in the campaign against this epidemic. We must solicit the technical support of the World Health Organization, UNAIDS, the European Union, Centers for Disease Control-Atlanta, UNICEF, etc.

Although this is necessary, it is not sufficient if we do not coordinate these actions within a framework to alleviate poverty. Similarly, we must also improve all conditions for sexual education and health, and we must work with urgency and efficiency to address all of these issues to improve public health in general and to fight against the epidemics of HIV/AIDS and Malaria in particular.

As a positive case study, Cape Verde has demonstrated the effects of a targeted campaign in the reduction of infant mortality rates down from 130/1,000 to 35/1,000. Likewise, life expectancy is at 67 years old. We have also been successful in family planning programs, and the birth rate has decreased from 6.38 to 3.5 in fifteen years. In conclusion, Cape Verde is a country without resources, but we have been successful in establishing this stability in the health sector.

HONORABLE PHESTILE DLAMINI, MD, MINISTER OF HEALTH, SWAZILAND

Swaziland is faced with many political issues and the climatic challenges of war, poverty, migration, and drought. We are currently fighting floods. With floods, the crops are not growing which affects nutrition. Scientists say that the nutrition has been drained from the soil. Maize is the standard staple for our food base. We rely on tilling the soil to produce a healthy crop. Women normally care for the fields while men look for a job.

In the fight against Malaria and HIV/AIDS, women and children are affected from a health standpoint and household. Traditionally, most countries in Africa encourage breastfeeding. Now with the medication of MCTC, the nutrition for children is at risk. Without breast feeding infants' lives are in danger, and with breastfeeding infants' lives are in danger. Healthy food is not accessible.

The other issue is when the community is infected with HIV/AIDS, their bodies are overcome with sores orally and externally. How can we provide proper nutrients under these conditions? The other challenge is the expense. Even if we had the resources, we could not afford it.

Likewise, accessibility to medication is problematic. We must communicate in laymen terms to the patients so they can understand their health issues / concerns. Medical terminology can be intimidating.

Finally, advertising is controversial in this struggle. The advertisers make television commercials to appeal to the children. The food that is advertised is not healthy. Children are eating junk food, and mothers are preparing food that is pre-packaged instead of cooking with fresh vegetables. So, we need to reach these companies and ask them to be responsible with their advertising campaigns.

ALAWODE OLADELE, MD, PREMIERE INTERNATIONAL HEALTH CARE, INC.

(Please refer to 13 April Session)

WILL TAYLOR, PHD, UNIVERSITY OF GEORGIA

(Please refer to 13 April Session)

OKEZIE ARUOMA, PHD, IMPERIAL COLLEGE OF SCIENCE, LONDON

(Please refer to 13 April Session)

TRACK III: 14 APRIL 2000

PARTNERSHIPS WITH GRASSROOTS (NGO) EFFORTS FOR YOUTH & ORPHANS

MODERATOR: JEROME LANDRY, MD, EMORY SCHOOL OF MEDICINE

PRESENTERS:

HONORABLE JOY PHUMAPHI,

MINISTER OF HEALTH, REPUBLIC OF BOTSWANA

HONORABLE ALAIN LUDOVIC TOU,

MINISTER OF HEALTH, REPUBLIC OF BURKINA FASO

RHOI WANJILA,

EXECUTIVE DIRECTOR, THE ARK FOUNDATION OF AFRICA

CHARLES PORCH,

EXECUTIVE DIRECTOR, YOUTH PREVENTION SERVICES, INC.

EGONDU ROSEMARY ONYEJEKWE, PHD, DIRECTOR,

INTERNATIONAL MEDICINE & PUBLIC HEALTH, OHIO STATE UNIVERSITY

HONORABLE JOY PHUMAPHI, MD, MINISTER OF HEALTH, BOTSWANA

Botswana is a country about the size of Texas, but with a population of about 1.5 million people who are sparsely distributed over a wide area of land. Currently, 29% of the sexually active population is infected with HIV, and we have extremely high infection rates among the youth. The majority of infected people are adults under the age of 40 years. Suicides have increased over the past ten years by 200% of which 80% are people who are HIV positive. Botswana has an estimated 65,000 orphans within the very small population of 1.5 million, and therefore the number is highly significant.

The essential elements of our program with grassroots efforts for youth are under the auspices of the National AIDS Coordinating Council, which is chaired by the President. The Counsel is multi-sectoral with representatives from government, business, NGOs and local communities. There are sectoral committees that are responsible for implementation of programs in their respective sectors.

For the HIV prevention and youth programs, our economy will not be able to sustain the amount of resources necessary to have an impact. Although we do have programs implemented in a few towns, it is not widespread enough to have the desired effects. We would like to develop and strengthen the HIV curricula in elementary and secondary institutions in order to educate and empower our children with the life skills necessary for them to remain HIV negative.

We have programs that allow youth to counsel other youth for which we have recently funding from the Bill Gates Foundation (7.9 million US DOLLARS over three years). We are also establishing youth prevention centers all over the country. They are designed to offer condoms and counseling services to the youth. They target life skills because many of the youth

engage in risky behavior as a means of income or to keep themselves busy because the unemployment rate has increased dramatically with rural migration to the urban areas.

Moreover, we are coordinating an information and documentation system so that people, who address the youth through advertisements, radio, plays, music videos, newspapers and magazines, operate through a coordinated framework and are commonly managed. With the funding from Bill Gates, we hope to make a real impact through this strategy.

The current blood donor program in the country relies primarily on the youth, which constitutes 80% of donors. This helps the youth to maintain their HIV negative status, so we are trying to find ways to prevent high exit rates and keep them in the program.

In regards to programs for orphans, we have introduced the foster care parenting program and one children's halfway house, which we would like to expand throughout the country. We also have a structure for orphans who are under the care of relatives with the support and monitoring by social workers for which we have a shortage. Unfortunately, many of these orphans are sexually abused, and most of them are HIV positive.

All of the programs for youth and orphans require remuneration of caregivers, training of counselors, purchasing of food, and establishment of infrastructure and a caring environment. Our future is under siege...the youth are the future of our countries. We must start with protection of the babies. In some parts of the country, 50-60% of expectant mothers who visit our family welfare clinics are HIV positive. Although we will not be able to sustain investment in these programs without outside support, we are trying to establish a program to prevent mother-to-child transmission of the virus.

We have a group of orphans who have come up with a motto for their home: "ALONE-- All Little Orphans Need Empathy" to encourage people to become foster care mothers and to care and contribute to the program. We have several NGOs like "Sponsor a Child" working in Botswana, but the country has recently been declassified as a Developing Country and practically all of the international NGOs have left the country. Therefore, many of the programs started for HIV prevention have collapsed because although government has taken over, we have other demands on our resources. The children's programs that we have in Botswana require 3.3 million US Dollars that we cannot afford. The equivalent amount in our currency would be about 50 million US Dollars and my budget is approximately 20 million US Dollars.

HONORABLE ALAIN LUDOVIC TOU, MINISTER OF HEALTH, BURKINO FASO

(French-English translation)

Burkina Faso is a country that is located in West Africa and surrounded by six countries. Burkina Faso is ranked #3 in terms of HIV/AIDS infection rates in the whole region, precisely 7.8% infection rate in the sexually active population. Malaria afflicts 28.7% of the population and represents the majority of patients treated in the hospitals. In particular, there are 15,000 cases per year of Malaria, and approximately 10,000 of these are treated at home. In the suburbs, 50% of the Malaria cases are very serious and require blood transfusions.

However, due to lack of equipment and trained personnel, the sources of blood are not safe, and thus the risks of transmission of HIV/AIDS and hepatitis infection by blood transfusion are very high. Finally, the AIDS epidemic has a huge economic impact on the country, and the number of children orphaned by AIDS is enormous.

In view of this situation, what types of initiatives can we launch in partnership with NGOs and other community organizations? We have been able to prevent the spread of Malaria via the

establishment of 51 centers that distribute treated mosquito netting and other insecticides, as well as education programs for the population.

We have been able to train more medical personnel to treat Malaria, and we have pursued medical studies on home management for malaria patients in four pilot districts. One of our major initiatives has been the adoption of a multisectoral National Plan of Action (2001-2005) on the methodology and operational strategies for prevention campaigns against Malaria and HIV/AIDS. This plan covers the public health areas of education, STD/AIDS transmission, blood transfusion, home management, and prevention of mother-to-child transmission.

In the area of Malaria, partnerships with NGOs have had an impact in the distribution of mosquito bed netting. Regarding AIDS, many initiatives have been launched in the area of home care. Furthermore, NGOs have participated in the elaboration of the National Plan of Action, and they are particularly involved in AIDS prevention efforts. There has been an explosion in the number of efforts in the area of arts, sports and social activities in raising awareness among the population. Moreover, through these organizations at the level of community work and via local public health infrastructure, there has been the development of Plans of Action in favor of orphans as well as AIDS victims.

Regarding the challenges to these partnerships, we must recognize the necessities of regular provisions in medication against STDs and opportunistic infections. Economically, we are working to overcome national insufficiencies and weaknesses in the system regarding intervention efforts. In the campaign against Malaria, we must provide insecticides and mosquito-netting, improved sanitation services, and training and protection of medical personnel. We would like to solicit the financial and material support of our American partners for reinforcement of the government-subsidized national center of blood transfusions, HIV testing, and prevention of transmitting opportunistic infections, as well as mother-to-child transmission.

In conclusion, we intend to contribute to the efforts to increase awareness and thus support among the American population for national and local initiatives against HIV/AIDS and Malaria in Burkina Faso.

RHOI WANJILA, THE ARK FOUNDATION

(Please refer to 13 April Session)

CHARLES PORCH, YOUTH PREVENTION SERVICES

(Please refer to 13 April Session)

EGONDU ROSEMARY ONJEJEKWE, OHIO STATE UNIVERSITY

(Please refer to 13 April Session)

TRACK IV: 14 APRIL 2000
PARTNERSHIPS IN RESEARCH

MODERATOR: JAMES BENNETT, MD, ZENZELE, INC.

PRESENTERS:

HONORABLE ANTONIO BAMBA,

MINISTER OF HEALTH, REPUBLIC OF GUINEA-BISSAU

KARIM SECK, MD,

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HONORABLE ANTONIO BAMBA, MINISTER OF GUINEA-BISSAU

(Portuguese-English translation)

Guinea-Bissau is a country that is economically dependent upon agriculture, and the main exports are the cashew nut and fish. In 1998, there was a military regime that lasted one year, and the infrastructure was severely neglected and thus is extremely inadequate, particularly in the domain of public health. Many of the health professionals, doctors, etc. left the country at that time. Medical doctors, nurses, and technicians experienced more obstacles than before the regime, and thus there are serious problems in terms of the population's access to health care.

With the support of the WHO, and other partners, Guinea-Bissau had elaborated a National Health Development Plan for 1998-2002, but implementation was disrupted in June 1998 with the arrival of the military regime. At this moment, the health sector with support from the World Bank is in the process of adapting a new National Health Development Plan according to the new circumstances. The new government elected in November 1999 has defined priorities in the area of education and health. The main public health programs in the country target Malaria, communicative diseases, AIDS & STDS, and leprosy. The infant mortality is also a major concern due to an estimated 140 deaths per 1,000 live births, and maternal mortality is very high at 900 per 100,000 births.

Concerning Malaria, there were 200,000 cases and these constituted 58% of hospital patients. In 1999, the overall mortality rate was 16/100 cases. There is a program of training for early diagnosis, and resistance against chloroquine used to treat malaria is at 20%. Likewise, there is a campaign to distribute treated mosquito netting, but conditions are very difficult and impede the campaign.

Concerning AIDS, the total number is severely underestimated. There were 120 cases reported in 1999, and in March 2000, there were 2,551 cases. Five years ago, the prevalence of HIV was estimated at 4.2%. However, there is great difficulty in measuring the rates of infection due to lack of information. There was a medical school, but the war had severe consequences on these institutions. Previously, there was a department of epidemiology that pursued research monthly in the regions. In sum, the entire health care system has been disrupted because much of the health staff has left the country. It will take time to bring these nationals back to Guinea-Bissau even though there have now been elections.

In conclusion, we would ask for technical and financial support for the health sectors from the international community, particularly from the World Health Organization, other UN Agencies like UNAIDS, bilateral and multilateral organizations like the World Bank, and North American institutions including the CDC-Atlanta and USAID. Partnerships should be created in an organized manner with well-defined parameters and objectives in order to improve the health system in Guinea-Bissau, in cooperation with the new government that is democratic, transparent, competent and well-managed.

KARIM SECK, MD, MINISTRY OF HEALTH, SENEGAL

As you know, Senegal has a low HIV prevalence rate at 1.6% of the general population. Research has been an important component in the national response to the epidemic, in order to have a better understanding of different elements that impact the spread of AIDS in the country. At the international and sub-regional level, we can cite the African Network on Research in HIV/AIDS that has been implemented since 1989 and has been a partner for all national AIDS programs in West Africa, indeed in Africa in general. Its national branch, in particular the Senegalese Network on Research in HIV/AIDS, attempts to promote research, particularly young researchers, through projects with the support of international donors.

Another initiative includes the West African Initiative on HIV/AIDS. This program is supported by UNAIDS and has been implemented since 1997. Its objectives entail the support of research at the rural level on common problems which are very important in the spread of epidemics between countries, particularly, the problem of migration and high-risk populations like truckers, commercial sex workers and refugees. Moreover, the Sanitary Initiative for Peace between the Gambia, Guinea-Bissau and Senegal has four components of interest: HIV, Malaria, National Immunization of Infants, Epidemiological Surveillance. Within its plan of action, this initiative plans to implement joint research on HIV/AIDS and Malaria.

At the international level, our country has particularly benefited from partnerships between our scientific teams and teams from the US, Belgium, Canada and France. There have been official visits to the University Hospital, the clinic of infectious and sexually transmitted diseases, which has implemented a large HIV project with the National Agency of France (INRS). On the biological level, we have a laboratory and professorial group which is the collaborative center of UNAIDS and has a very important and well-known role in Africa because of its strong partnerships with other schools of public health and hospitals.

The main fields of research are investigative, for example, at the laboratory of Professor Mbou which was very involved in the discovery of HIV2 in 1985. Most research in this laboratory is oriented towards the evolution of HIV1 and HIV2, the frequencies, transmissions and interactions. Now the introduction of molecular biology links has permitted implementation

of studies on genotypes and to show the predominance of the subtype A and the importance of the virus in the sub-region of West Africa.

At the clinical level, the goal is to improve the quality of life of people living with HIV and to delay the manifestation of opportunistic infections. Most of the studies are oriented towards associated pathology like lung disease, tuberculosis, and determining factors of infections in women. All of these studies have an impact on the quality of life if we refer to the mortality rate, which has decreased from 60% in 1986 to 30% in 1998.

In social science research, we can notice an evolution from the beginning of the epidemic that was dominated by cap surveys and now most research is focused on particular populations like orphans, women, etc. The introduction of anti-retroviral drugs in our country opened new doors for research, particularly concerning the compliance, practicability and acceptability of those new drugs. Despite all these initiatives, research in Africa faces many constraints. Particularly, the lack of financial resources has a negative impact on medical aspects because benefits from experiments in our country are not well defined. Likewise, the lack of training in methodology is problematic because medical university training does not provide enough skills and there is little visibility of the results.

In conclusion, Africa faces many challenges in the domain of development and all progress obtained in improvement of the health sector is impeded by the AIDS epidemic. In this context, due to its indirect impact, research has difficulty to emerge as an instrument of development in the communities. It is necessary to revise the specificity of research, which is important in evaluating all interventions so that they may be better adapted and more efficient for the populations. In sum, important issues include capacity-building for researchers, development of institutions, decentralization of research, and availability of financial funding of such initiatives.

ERIC BING, MD, MPH, CHARLES DREW UNIVERSITY OF MEDICINE

(Please refer to 13 April Session)

SUDHA SRINIVASAN, PHD, NATIONAL INSTITUTES OF HEALTH

(SLIDE PRESENTATION: abstract not submitted)

RICK STEKETEE, MD, MPH, NATIONAL CENTER FOR INFECTIOUS DISEASES

(Please refer to 13 April Session)

TRACK V: 14 APRIL 2000

PARTNERSHIPS IN RESEARCH ON TRADITIONAL MEDICINES

**MODERATOR: CHARLES FINCH, MD, MOREHOUSE SCHOOL OF
MEDICINE**

PRESENTERS:

HONORABLE ALEKE BANDA,

MINISTER OF HEALTH, REPUBLIC OF MALAWI

**RHONNIE HEMPHILL, JD, DIRECTOR OF COMMUNITY EDUCATION,
CHURCH WORLD SERVICE**

**WILLIS LOGAN, DIRECTOR OF AFRICA,
CHURCH WORLD SERVICE**

**LOWELL FUGLIE, REGIONAL REPRESENTATIVE, MORINGA PROJECT,
CHURCH WORLD SERVICE**

CHARLES FINCH, MD, MOREHOUSE SCHOOL OF MEDICINE

(SLIDE PRESENTATION)

What we think of as traditional medicine is truly the father and grandfather of modern medicine. Modern medicine flows out of traditional medicine, in every way that we mean that subject. We can start over 6,000 years ago in Northeast Africa, in the Nile Valley, the land we call Egypt, where medical science as we understand the term begins. This is a hieroglyphic sign that means "the tradition," and this is the ancient African god of medicine whose symbol of the staff and snake is found on modern hospitals and schools of medicine around the world. Themho Tep was the first "universal genius" of whom we have any knowledge. He was the true "father of medicine," but also prime minister, astronomer, designer, and most importantly a "physician of genius" who was in fact deified by the people in 600 BC. Indeed, he was even worshipped by the Greeks, and Hypocrites grew up in the temple built in his honor.

These are ancient papyrus scripts written 6,000 years ago that represent the founding documents of internal medicine (anatomy, etc.), as well as ancient surgical tools and methods of surgery dating from these times. This medicine jar shows the symbolic "moon" eye which became the prototype for the Rx symbol used today. As we have heard during our presentations by traditional healers, there are many plants used in traditional medicine that must be harvested only at certain hours of the night and certain days of the lunar cycle. Thus, in many ways, the moon symbolizes traditional medicine.

These are traditional medicines from around the world. For example, tetracycline has been found in plants of certain parts of Egypt and has been used for thousands of years. The periwinkle plant from Madagascar is one of the best medicines against blood-born diseases, leukemia, etc. The pygmies (Twa) use "Wabe" on their arrows to bring down elephants because it is a medicine, which is a stimulant and good for a failing heart, but too much of which will cause death.

In southeast Africa, a particular plant has been used traditionally to remove cataracts, and 75% of the time sight is restored. In Kenya, these are instruments and methodology used in “neurosurgery.” In western Uganda, cesarean sections have been practiced long before the arrival of “modern medicine” to save the lives of mother and children. These are obstetric methods utilizing the forces of gravity that were developed in Nigeria.

With this historical review of traditional medicine, may we begin our program on the uses of traditional medicine today.

HONORABLE ALEKE BANDA, MINISTER OF HEALTH, MALAWI

Malawi is a typical Sub-Saharan African country with poor social, economic, demographic and health indicators. The disease burden is high, and mortality from HIV/AIDS and Malaria is very high. Malaria is a major health problem in Malawi, especially among children under five years of age. Together with anemia also due to malaria, it accounts for more than 40% of all hospitalizations and 30% of hospital deaths.

Like most countries that are damaged from Malaria, the main strategies comprise prevention of mortality and reduction of severe morbidity through malaria-based management. Especially during pregnancy, we promote personal protective measures including use of insecticides. Unfortunately, our malaria control programs face scientific and material problems. Specifically, therapies are continuously threatened and undermined by drug-resistant parasites to the extent that there are limited, affordable and safe alternatives to anti-malarial drugs.

Widespread and often self-prescribed use of anti-malarials promotes the emergence of drug-resistant parasites. The most vulnerable populations, pregnant women and children, experience increased morbidity and mortality due to severe malaria. With regard to the promotion of prevention measures, there are obstacles related to costs and availability of the mosquito nets and insecticides.

On the other hand, HIV/AIDS is fast becoming the single most important underlying cause of premature death in young economically productive adults, with 8% of the general population and 14% of 15-49 year age group infected with HIV. Opportunistic infections, tuberculosis, diarrheal diseases and blood infections have increased and surpassed the capacity of the health and social systems to proceed. Drugs against HIV, which are commonly used and available in the developed countries, are essentially prohibitive to the majority of our people due to high cost and limited supportive technology.

Despair and hopelessness are the common reactions in most of our countries as infected persons wait for what is often a slow but certain death. HIV/AIDS has become a crisis in our sub-region and a fundamental threat to the future generation. However, one cannot help acknowledge the existence in our countries of age-old traditional remedies that are capable of preventing mosquito bites which can transmit malaria, curing malaria illness, alleviating symptoms of opportunistic infections related to HIV, etc.

Until now, the first-line drug for severe malaria illness in my country is known to come from herbs. Another important, modern anti-malarial is also documented originally from a traditional Chinese remedy. Many other potions and applications have been effective in people living with HIV infection. The list goes on, and the introduction to this section was certainly very enlightening.

Indeed, literature is full of evidence that traditional medicines can and have been useful for treatment, alleviation and other positive effects. It is therefore pertinent that, at an important

meeting like this one, we reflect on forming viable partnerships for research on traditional medicines in the need to seek readily available, affordable, acceptable, safe and effective alternative remedies for HIV/AIDS and Malaria and other diseases.

In Malawi, government has been instrumental in organizing the various organizations of traditional healers into one body. As most of their medicines are derived from trees, they have now set up a center in one of the districts, which wishes to work with them constructively for health delivery as well as research. In pursuing partnerships for research between developed and developing countries, we must:

- 1) develop a shared vision, common goals and objectives to which all parties will subscribe;
- 2) base partnerships on mutually agreed principles and a set of key milestones accepted and respected by both partners;
- 3) build upon existing efforts in each country, and seek to enhance, expand and replicate successful initiatives to the extent possible within African countries; and
- 4) respect the sovereignty of each actor and the rights of each operating member within the partnership.

At the end of the day, Africa needs relevant research in traditional medicines, and readily available, affordable, and effective and safe remedies against HIV/AIDS and Malaria now and in the foreseeable future. We can no longer afford in the international community to bury our heads in the sand while millions of people are being needlessly exterminated by scourges which current research and technology would feasibly provide an end to.

We need to coordinate our research through a willingness to identify gaps and improve efficiency. We need to scale up our research initiatives through increasing resources available for national governments. This conference is very, very crucial. We need to link this research and response to sub-regional, regional and international resources and improve communication. We need to foster research on traditional medicines that is based on best practices in HIV/AIDS and Malaria prevention, care and support.

Just as the AIDS epidemic has necessitated changes in the practice of medicine, it has also necessitated therapeutic innovations. In some incidences, this shall mean new applications of age-old traditional remedies. Research into traditional medicines must be designed to protect the health and wellbeing of those afflicted by these diseases. Politicians, policymakers, researchers, physicians and other practitioners owe it to themselves and entire communities to be aware of opportunities that exist to prevent or alleviate suffering through the use of well-designed research on traditional medicines.

RHONNIE HEMPHILL, CHURCH WORLD SERVICE

(Please refer to 13 April Session)

WILLIS LOGAN, CHURCH WORLD SERVICE

(Please refer to 13 April Session)

LOWELL FUGLIE, CHURCH WORLD SERVICE

(Please refer to 13 April Session)

PRESENTERS:

OK PANNENBORG, DIRECTOR OF HEALTH,

AFRICA REGION OF WORLD BANK

SYLVESTER FLOWERS, PRESIDENT,

PROFESSIONAL MANAGEMENT DEVELOPMENT CORPORATION

OK PANNENBORG, DIRECTOR OF HEALTH, AFRICA REGION OF WORLD BANK

I am pleased to speak on the important topics of HIV/AIDS and Malaria in Africa. It is not a competitive advantage for the World Bank to provide technical advice. Although, sometimes, several of my colleagues and the institution as a whole may come across as if they are all knowledgeable, appropriate modesty is in order because they are just a development institution and development bank.

We do have financial resources and, sometimes, financial resources are very important, but at the same time, money itself will not solve the problem. The Bank is very dependent on the countries, and the resources that the Bank is able to leverage. Accordingly, these resources are only relevant if they can create partnerships with the countries in Africa, people in Africa, and our external partners: first and foremost, the World Health Organization, other UN agencies in Africa, and governmental organizations.

There is at least a billion favorable dollars to be allocated for Malaria programs, AIDS programs, and other infectious diseases in Africa. In certain areas, over \$500 million are available directly for investment in all of the African countries to combat Malaria and AIDS. However, those monies will only make sense if / when the governments feel they are useful to them, if governments feel they can use them, and if / when governments ask for the monies. As our rights to have access to these resources, we only want them in conjunction with the other partners, like WHO, to execute programs that make sense to address AIDS and Malaria.

There are formalities for direct financial transfer from the World Bank and other external partners in Africa to invest directly. Generally, that is in programs, etc. As you may know, as Ministers of Health, you realize most of your allocations to your sector come from your Ministry of Finance. The Minister of Finance would have the access, first and foremost, for the project's finances previously mentioned. They also support debt relief and budget support.

The World Bank feels that partnerships between Ministries of Health, WHO, UN agencies, the Bank, and some bilateral actors should work together with your Ministries of Finance to insure allocations at national levels to address HIV programs, AIDS programs, and Malaria programs. The relationship in most countries, currently, is less than ideal and has not grown to the extent that it needs to be effective.

It would be nice for all Ministers of Health and your partners in the NGO community and governmental community to highlight the importance. But ultimately, the only way to make a difference is to get all people together to discuss the nuts and bolts at the same time to get results and change the outcome of these diseases.

Finally, I strongly feel that my President and Vice President are committed to transfer resources, and these days they have relationships with African countries to insure the resources end up at a community level. It is very difficult to make that work. You know, as Ministers of

Health, it is difficult to insure your monies, for example, in the budget for Ministers of Health, they end up at multiple levels, at health clinic levels, for outreach workers, and women who treat children and mothers in terms of HIV/AIDS.

The first step is to recognize where those monies are most effective. All of us at the institution of the World Bank are increasingly convinced that the resources available to the international community are leveraged with our partners.

SYLVESTER FLOWERS, PROFESSIONAL MANAGEMENT DEVELOPMENT CORP.

We need to examine an entirely different approach to deal with this issue. What I offer is discussion. It may not be *the* idea and may not be the *best* idea, but I vowed when I left my staff in San Francisco that when I returned I would have a pretty good idea of what we plan to do next, instead of simply meeting!

The AIDS Drug Assistance Program in the United States is a federally funded program. Monies go to individual states. Typically each individual state would have "hounding" within the state to administer their own programs because it is believed that they can more efficiently reach and incorporate training, housing, shelter, and needs for the community.

I found that people are very mobile in this society. Technology gives the opportunity that allows people independence and flexibility in their lives, whether it is a job or commuting or relocating to the other part of the state. By centralizing under one administration, a patient would have the best chance to access it. To qualify, it was based on the patient's willingness to pay. If the patient had no money, the medication was free. If the patient had a certain income, they would contribute a certain portion.

It seems a bit redundant to imagine that someone who earns \$600.00 can afford the same as someone earning \$6,000.00. But yet, free enterprise, in which we are asked to pay for services that we receive, is primarily how the world's economy is driven. So, let's start talking about HIV treatment and start focusing on how we finance it. We all know how to finance cars, homes, farm equipment... but we haven't figured out how to finance healthcare.

The pharmaceutical manufacturing industry is under siege in America, Africa, and Europe because everyone says life is so precious, and the severity of your illness is translated into the need for you to spend more money. No one ever says, "what do you do if you do not have any money?" It is obvious you do not get treated and you die. Well let's consider---the manufacturers are big companies. They have shareholders. They are traded on the New York Stock Exchange. They have a Board of Directors. They have operating costs and need to make a profit. I want them to make money and succeed.

Listen to me carefully, and see if you can give pharmaceutical manufacturers an alternative to retreat from the siege and still accomplish our goal. I am advertising that pharmaceutical manufacturers themselves be urged to convene and form a coalition. They have in the United States a Pharmaceutical Manufacturer Association. This association among other things is responsible for the public relations, quality assurance, lobbying, etc. for this industry. Perhaps, it can be an instrument to coordinate the activity of the manufacturers. Allow them in confidence to form a coalition and work with the WHO, work with the International Monetary Fund, work with the World Bank and form a partnership that will allow every African nation to have access to the appropriate medication needed to treat HIV, Malaria, whatever the needs.

At the same time, in partnership with the World Bank, IMF, the pharmaceutical manufacturers, and the consultation and direction from the Ministers of Health, we should derive

a formula where individual nations will contribute to a fund based on their ability to pay. A country such as Malawi would not be asked to contribute the same amount as South Africa. But by all means, do not withhold treatment because one country based on their region, climate, resources, economy, and political issues cannot afford treatment.

So when the United States wants to attribute billions, Great Britain, Canada, or Germany can contribute to the fund that will be administered by World Bank in all other partnerships and not form competitors. Allow all to provide health services to their own communities. So when you see a manufacturer such as Pfizer make donations for the Council, it kind of puts the pressure on the rest of the Ministers. They should think, "I just met with the Pfizer representative, why didn't I make the speech to get them to come in and provide for Council." We do not want that kind of pressure on the Ministers. They have enough to do with the issues of nutrition, Malaria, clean water, etc. We want the pharmaceutical industry to make a profit. There is such a thing called "cost plus." What will it cost? Through this mechanism, let's finance the cost to give access to the pharmaceutical chemicals needed so that the individual members can be treated.

What is so troubling is that I have not heard specific strategies about treatment. A project I started three years ago in California comprised the ability to measure compliance to the drugs given to citizens. It was an adherence program that my company developed. Your scientists will say that it takes approximately 95% adherence to contain the disease for the combination drug therapy to be the appropriate one. If you are taking as many as 18 different pills, this means 95% of this quantity must be consumed day in and day out. What has not been stated that must be addressed is a deep political process that gets the funding institutions involved so that access can be made because absolute adherence is necessary or else you will "under treat" the disease.

Let's embrace the pharmaceutical manufacturers because this is a business. Research, development, and philanthropy we welcome, but do not create a position where they have to choose to whom they give or make some exceptional price for Ghana but not Kenya because all measures have their own way of persuasion and ways to get things done. Let's remove that piece from the equations. Let the manufacturer come up with a plan that they can present to the Ministers that they can live with. They can still profit, the World Bank can have funds for the progress, and when individual countries want to contribute---put it in this fund and they will be assured that it will be administered in an equitable businesslike manner. This way every country will have their Ministers responsible for identifying who is going to be treated, where, and devote their time toward prevention.

My company is also active in the free distribution of condoms. It does not make sense to charge patients for medication, tell them to practice safe sex, and then charge them \$2.50 for a condom. Give them away. It is the most preventative measure taken. Technology is used in California to get 3,800 pharmacists linked to my office computers using interactive web sites and modems. We can control and oversee the distribution of drugs and approve appropriate therapy. But they also administer the enrollment and accountability piece because information is invaluable. I am sure there is enough knowledge, relationships, and creativity in this room to come up with an effective strategic plan. Let's put all the cards on the table and start some dialogue. If there is anything I can do to help, I am offering my time, help, services, and imagination because I use technology to translate 41 years of a practicing pharmaceuticals company which I still own and operate. We cannot allow ourselves to sit on our hands and do nothing. We must start somewhere.

THE ATLANTA DECLARATION

ON

“FORGING PARTNERSHIPS TO FIGHT
HIV/AIDS & MALARIA IN AFRICA”

AFRICAN HEALTH MINISTERIAL CONFERENCE CONVENED BY:
THE AMERICAN MEDICAL TEAM FOR AFRICA, INC.
APRIL 13-15, 2000
ATLANTA, GEORGIA, USA

THE ATLANTA DECLARATION

WHEREAS, WE THE PARTICIPANTS OF THE CONFERENCE CONVENED BY AMERICAN MEDICAL TEAM FOR AFRICA (AMTA) IN ATLANTA, APRIL 13-15, 2000, REPRESENT A COLLABORATIVE EFFORT OF MORE THAN TWENTY-FOUR (24) MINISTERS OF HEALTH OF AFRICA, TWELVE (12) AFRICAN AMBASSADORS TO THE UNITED STATES, AND OF BILATERAL & MULTILATERAL AGENCIES, PRIVATE SECTOR, ACADEMIA AND NON-GOVERNMENTAL ORGANIZATIONS; AND

WHEREAS, WE ARE GREATLY CONCERNED ABOUT THE GRAVE AND CRITICAL SOCIOECONOMIC IMPACT OF HIV/AIDS & MALARIA; AND

WHEREAS, WE RECOGNIZE THE ECONOMIC BURDENS THAT HIV/AIDS AND MALARIA PLACE ON MILLIONS OF AFRICANS AND THE CHALLENGES THAT THESE DISEASES CONSTITUTE FOR DEVELOPMENT AND ALLEVIATION OF POVERTY; AND

WHEREAS, WE RECALL THE FOLLOWING FACTS:

- THERE ARE MORE THAN 10.4 MILLION AIDS ORPHANS ESTIMATED IN AFRICA;
- THERE ARE MORE THAN 13.7 MILLION AIDS-RELATED DEATHS ESTIMATED IN SUB-SAHARAN AFRICA;
- THERE IS A DRASTIC DROP IN AVERAGE LIFE EXPECTANCY OF ADULTS FROM AGE 59 TO AGE 45 AND BELOW;
- MORE PEOPLE HAVE DIED FROM HIV/AIDS IN AFRICA THAN WORLD WAR I, WORLD WAR II, THE KOREAN WAR, THE VIETNAM WAR, THE GULF WAR, AND THE BOSNIA & KOSOVO CONFLICTS COMBINED; AND

WHEREAS, WE RECOGNIZE THAT MALARIA KILLS 3,000 CHILDREN UNDER AGE 5 IN AFRICA EVERY DAY AND THE MORTALITY RATE DUE TO MALARIA IS ESTIMATED TO BE OVER 1 MILLION DEATHS

ANNUALLY, AND MALARIA COSTS AFRICA APPROXIMATELY 3 BILLION US DOLLARS TO CONTROL AND TREAT IN ONE YEAR; AND

WHEREAS, WE ARE COMMITTED TO MOBILIZING THE REQUISITE FUNDS TO IMPLEMENT NATIONAL INTERVENTION PROGRAMS, WE CALL FOR A “UNITED VOICE OF APPEAL” TO THE AMERICAN PUBLIC, POLICY-MAKERS, SCIENTIFIC, PRIVATE, AND FAITH-BASED SECTORS AND OTHER FRIENDS OF AFRICA TO DEMONSTRATE CONCRETE SUPPORT FOR AFRICAN INITIATIVES AIMED AT ADDRESSING THESE PARAMOUNT CHALLENGES, ALONG WITH ALLIANCES BETWEEN AFRICAN MINISTERS OF HEALTH, THE AMERICAN PUBLIC, PRIVATE SECTOR AND OTHER FRIENDS OF AFRICA TO COMBAT THESE THREATS; AND

WHEREAS, WE ACKNOWLEDGE THE URGENT NEED TO:

- 1) MOBILIZE FINANCIAL, TECHNICAL, AND IN-KIND RESOURCES IN SUPPORT OF COMMUNITY-BASED INTERVENTIONS FOR HIV/AIDS AND MALARIA PREVENTION AND CONTROL; AND
- 2) SUPPORT AND STRENGTHEN HEALTH/MEDICAL RESEARCH INSTITUTIONS IN AFRICA, INCLUDING RESEARCH IN TRADITIONAL MEDICINE; AND

WHEREAS, WE UNANIMOUSLY ENDORSE THIS ACTION-ORIENTED ATLANTA DECLARATION TO CONFRONT THE PROBLEMS OF MILLIONS OF ORPHANS AND ADULTS DEALING WITH THESE THREATS; AND

WHEREAS, WE ARE ENCOURAGED BY THE COMMITMENTS FROM THE AFRICAN GOVERNMENTS & PARTNERS AT THE HIGHEST LEVELS.

THEREFORE, BE IT RESOLVED, THAT WE COLLECTIVELY AND IN COMPLETE SOLIDARITY REINFORCE THE BASIC INFRASTRUCTURE, PLANS, AND STRATEGIES TO FIGHT HIV/AIDS AND MALARIA AT EVERY LEVEL OF THE AFFECTED COMMUNITIES; AND

BE IT RESOLVED, THAT WE EMPHASIZE THE URGENCY OF IMPLEMENTATION USING THE EXISTING SYSTEMS, PLANS AND STRATEGIES FOR THE PURPOSE OF ELIMINATING THESE DISEASES; AND

BE IT RESOLVED, THAT WE RECOGNIZE THAT THE MOST VULNERABLE GROUPS, NAMELY WOMEN AND CHILDREN, NEED SPECIFIC SUPPORT AND ASSISTANCE; AND

BE IT RESOLVED, THAT WE EMPHASIZE OUR CONCERN ABOUT THE IMPACT OF THE DETERIORATING SOCIOECONOMIC WELL-BEING OF CURRENT AND FUTURE GENERATIONS BY CALLING FOR:

- 1) INCREASED SUPPORT FROM ALL PARTNERS TO FIGHT THE SCOURGE OF HIV/AIDS AND MALARIA;
- 2) COORDINATION OF SUPPORT FROM PARTNERS THROUGH THE EXISTING NATIONAL STRUCTURES TO BENEFIT COMMUNITIES;
- 3) INCREASED ACCESSIBILITY OF DRUGS THROUGH SUBSIDIZATION, GENERIC MANUFACTURING, INTRODUCTION OF PRICING, AND DISTRIBUTION OF STRUCTURES AND OTHER APPROPRIATE MEASURES;
- 4) TECHNICAL ASSISTANCE TO BE PROVIDED TO AFRICA; AND RELEVANT JOINT RESEARCH TO BE URGENTLY UNDERTAKEN TO ACCELERATE TREATMENT, MANAGEMENT, PREVENTION, AND CONTROL OF THESE THREATS; AND

BE IT RESOLVED, THAT WE SOLICIT THE UNITED STATES GOVERNMENT TO ALLOCATE AT LEAST TEN (10) BILLION DOLLARS OVER THE NEXT FIVE (5) YEARS TO FIGHT HIV/AIDS AND MALARIA IN AFRICA, AND WE LIKEWISE ENCOURAGE THE GOVERNMENTS OF THE EUROPEAN UNION, JAPAN, AND OTHER NON-GOVERNMENTAL AND PRIVATE-SECTOR DONORS TO PROVIDE MATCHING FUNDS.

RESULTS OF THE HEALTH MINISTERIAL CONFERENCE **ON HIV/AIDS IN AFRICA**

The American Medical Team for Africa (AMTA), its co-sponsors, sponsors, contributors and volunteers, proudly submit “The Atlanta Declaration” of the recently concluded international health conference “**Forging Partnerships to Fight HIV/AIDS and Malaria in Africa,**” which was convened in Atlanta, Georgia, April 13-15, 2000.

We would like to express our profound sense of satisfaction with the tremendous feedback about the conference’s success, as indicated by numerous African Ministers of Health, Ambassadors and local grassroots organizations. Indeed, we have been informed of at least ten (10) possible working relationships that emanated from the conference thus far. Likewise, many people plan to attend the July 2000 “**Break The Silence**” (of AIDS) Conference in Durban, South Africa, as a result of their initial contacts with the ministers and policy-makers in Atlanta.

Our objective was to provide a platform for the Ministers of Health to articulate their collective position to the world as a whole and the American public in particular. This goal has clearly been achieved. Nevertheless, the goal of **Forging Partnerships** remains central to saving the millions of lives annually claimed by these diseases. For example, in many African countries, as many as one in four citizens are infected with HIV, and there are at least 10.4 million AIDS orphans across the continent. Hence, there is the urgent need to provide the requisite resources to ensure that health-care providers, including African researchers and local-care providers, have the essential medications, equipment, and supplies to educate, prevent and treat those affected by these epidemics.

Therefore, we respectfully ask all people of goodwill to assist AMTA, the African Ministries of Health, local African researchers, and health-care providers in the struggle against these diseases. In particular, we are seeking to:

1. Allocate resources for the training of local African NGOs;
2. Buy or secure reagents for testing purposes;
3. Identify financial or in-kind resources for AIDS orphans;
4. Provide access to affordable treatment, including safe blood;
5. Buy or secure condoms for both men and women;
6. Provide support to families caring for AIDS survivors and orphans; and
7. Assist with nutritional supplements and anti-retroviral therapies for those affected by HIV and other opportunistic diseases.

Along with the consensus resolution, “The Atlanta Declaration,” there are two very important and historic achievements. Most notably, these include:

1. **The offer** from *Mr. Noah Samara, Founder and CEO of WorldSpace Corporation* to work in collaboration with the African Ministries of Health, the World Health Organization, The United States Agency for International Development (Africa Region), the United Nations Joint Programme for HIV and AIDS Prevention, and the International Labor Organization, to broadcast via satellite all health-related information on education, prevention and treatment to the general population, including the rural sectors of Africa, at no cost; and
2. **The petition** for a special “**Called Meeting**” of the **United Nations General Assembly** to expeditiously and specifically address the issues, impact and consequences of HIV/AIDS and Malaria in Africa.

Finally, in the campaign to effectively eliminate these diseases, we believe that multi-national, multi-ethnic, and multi-level collaborations are required, both in the United States and in Africa. The government of each country must take an active role in addressing these issues. Likewise, communication is imperative in raising the required awareness and facilitating prevention, treatment, and care, especially in the rural communities. These diseases continue to ravage the globe. They have killed more people in Africa than the combined casualties of World War I, World War II, the Korean War, the Vietnam War, and the Gulf War, Bosnia and Kosovo conflicts. This issue constitutes more than a health challenge. Indeed, it has moral, economic, political, and security implications beyond health concerns in Africa, particularly, due to the interdependence of the international community in the 21st Century of increased globalization.

For more information on the **Conference, the Atlanta Declaration or the American Medical Team for Africa’s (AMTA’s) engagements over the last 10 years**, you may visit our website: www.amta2000.org. To make a tax-deductible contribution or become a supporter, you may forward your mail to:

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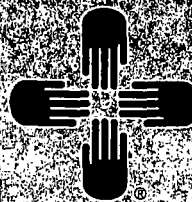
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