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HEALTHCARE STRATEGIES: POSITIONING GHANA FOR THE NEW MILLENNIUM

March 31 and April 1, 2000

Howard University Hospital
Towers Auditorium
Washington, D.C.

TABLE OF CONTENTS

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Dear Colleagues and Friends:

We are pleased to welcome you to this first inaugural landmark conference of the Ghana Health Foundation (GHF) entitled **"Healthcare Strategies: Positioning Ghana for the New Millennium."** We are very happy that so many of you are here.

There are many who share concern for the health of those who live in Ghana and others who travel to the country on business, and want to contribute to finding solutions to improve the current health care in Ghana. As the Government of Ghana restructures and develops the health care system, the country continually seeks partnership with organizations with interests in and commitment to the national health care agenda. The purposes of this conference are to stimulate your thinking and provide you with the most current health care conditions in Ghana so that we begin a concerted and collaborative effort to find sustainable solutions to the problems facing Ghana's health care system.

The conference proceedings and summary recommendations will be available to the Ministry of Health in Ghana and international non-governmental agencies, organizations and foundations operating in Ghana. It is our sincere hope that the summary recommendations will also serve as a general guide for necessary policy review and cooperation among the various ongoing programs in Ghana for the purpose of improving health care resources and delivery in the country.

We extend our sincere thanks and appreciation to His Excellency Koby A. Koomson whose genuine concern to address "the brain drain dilemma" facing Ghana and Africa encouraged the formation of Ghana Health Foundation. We are also grateful for the support from the entire staff of the Ghana Embassy in Washington, DC throughout the planning of this landmark conference.

We thank Howard University Hospital for jointly sponsoring this conference. We recognize and appreciate the long history of Howard University and Howard University Hospital as partners in training Ghanaian and other African health professionals. We are also grateful to The Global Health Council, Howard University Hospital Women's Health Institute, and Ghana International Health Foundation (Canada) for cooperating with us for this effort.

We know that you will want to be part of this collaborative effort to make a difference in Ghana's healthcare system in the new millennium. Welcome again to our first annual conference. We appreciate your participation in this important event.

Sincerely,

Bertha Koomson, M.D.
Chair, GHF Board of Directors

Joseph Kurantsin-Mills, Ph.D.
Chair, Conference Committee

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ACCREDITATION

HEALTHCARE STRATEGIES:
POSITONING GHANA FOR THE NEW MILLENNIUM

March 31 and April 1, 2000
Howard University Hospital
Towers Auditorium

Accreditation: The Howard University College of Medicine, Center for Continuing Medical Education is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

Category 1 Credits: The Center for Continuing Medical Education designates this educational activity for a maximum of thirteen (13) hours in category 1 credit towards the NMA Physician's Achievement Award and the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

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ACKNOWLEDGEMENTS

Ghana Health Foundation gratefully acknowledges the support of

Howard University Hospital

Ghana Airways
Embassy of Ghana
Howard University Women's Health Institute
United States Agency for International Development
Academy for Educational Development
Phyto Riker Pharmaceuticals
Virgil Waggoner
V.W. Investment

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GHANA HEALTH FOUNDATION

Ghana Health Foundation (GHF) is an independent, nonprofit foundation dedicated to contributing to the improvement of health care in Ghana.

OUR MISSION

We are committed to:

- Contributing to the improvement of health care in Ghana through health delivery programs, research and development.
- Providing coordinated opportunities for in-country contribution of skills and technology.
- Establishing a resource for collecting and disseminating information on current health issues in Ghana.
- Sponsoring conferences, workshops, and public forums to address health issues and explore solutions.

OUR PROGRAMS

Funding Programs

Organize and solicit funding to support current and future health care programs in Ghana

Healthcare Delivery: Program Development

Develop cost-effective programs and work in partnership with existing programs to resolve specific health issues. Apply technological solutions that promote sustainable results.

Policy Analysis and Program Evaluation

Conduct health policy analysis and its impact on public health. Provide comprehensive data collection for evaluation of all aspects of health services.

Healthcare Delivery: Professional and Material Support

Seek healthcare professionals to contribute expertise to specific funded health programs in Ghana.

Provide technical support, training and workshops designed to meet mission-oriented health programs in Ghana, with sensitivities to the current healthcare constraints.

Provide medical equipment and supplies to meet mission-oriented health needs in Ghana.

Medical and Allied Health Education

Assist in the establishment of medical and allied health professional training to optimize health care delivery, and to facilitate the collection and transfer of medical books and journals to Ghana for educational purposes.

PURPOSE

This conference will provide a forum for physicians, healthcare professionals, biomedical scientists, corporate businesses, organizations and concerned individuals to discuss the state of the healthcare system in Ghana. The goal of the conference is to highlight the current challenges faced by the healthcare system and to seek sustainable solutions.

The conference will review the economic, scientific, and traditional problems that have plagued Ghana's healthcare system and the different approaches that have been tried in order to improve it in recent years. There will be critical analysis by professionals and other individuals experienced in Ghana's health affairs, as well as contributions from other international experts who will present relevant research and clinical findings. We will seek to develop sophisticated and effective prevention models that will be useful in addressing these health issues.

Participants will be exposed to a broad range of health issues presently affecting Ghana through presentations and interactive panel discussions. Participants will be invited to share their experiences in the exploration of sustainable solutions to present difficulties and challenges. Through the conference's presentations and discussions, a consensus statement will be developed and presented to policy makers who influence health care in Ghana. To this end the Ghana Health Foundation intends to cooperate and work with Ghana government agencies as well as non-governmental organizations in the areas of health programs, research and development.

OBJECTIVES

At the end of the conference, participants will be able to

- Discuss the human resources available to Ghana's health sector today
- Understand what public and private healthcare institutions are doing
- Identify Ghana's major health challenges, including their epidemiological and statistical components
- Describe current trends and issues in health care payment policy
- Summarize how governmental health policy issues impact healthcare services in various communities in Ghana
- Outline how various policies can potentially benefit the healthcare system and the wellness of Ghanaians in general
- Understand in a comprehensive manner women's health issues
- Compare the healthcare delivery systems and significant medical conditions related to African-Americans and Ghanaians

CONFERENCE COMMITTEE

Doreen Ackom

Gloria Addo-Ayensu, MD

Mike Aidoo, MD

John B.K. Allotey, MD

Vincent Anku, MD

Cynthia Cudjoe,MD

Stella Debra-Siriboe, MD

Horace Dei

Yetunde Famogun

Shelia M. Edwards

Jemima Kankam, MD

Bertha Koomson, MD, Co-Chair

Joe Kurantsin-Mills, PhD, Co-Chair

J. Kweku Laast, MD

Peter Lamptey, MD

Sewnet Mamo

Celia J. Maxwell MD

A.O. Mireku-Boateng, MD

Rita Wallace-Reed, MD

Virginia Webster

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Friday
March 31, 2000

PROGRAM

7:00 – 8:00	Continental Breakfast and Registration
8:00 – 9:00	**Welcome and Introductions** Floyd J. Malveaux, MD, PhD His Excellency Koby A. Koomson Nils Daulaire, MD, MPH Thomas E. Gaiter, MD FACP
	The Concept of A Health Foundation for Ghana Bertha Koomson, MD, FRCP(C)
	Future Prospects for U.S. Government for Health Programs in Africa Sandra Thurman Director, White House Office of National AIDS Policy
SESSION I	**HEALTHCARE IN GHANA TODAY** **Moderator** Brian O. Williams, MD
9:00 – 9:15	**Health, Economics & Development in Ghana** Professor K. Danso-Boafo, Minister of Health
9:15 – 9:45	**Major Health Challenges in Ghana: Epidemiology and Statistics** Sam Ofosu-Amaah, MD, MPH
9:45 – 10:00	Coffee Break
SESSION II	**HIV/AIDS IN GHANA** **Moderator** Francis Yemofio, MD
10:00 – 10:15	**Global Perspective on AIDS** Ron MacInnis
10:15 – 10:45	**The AIDS Epidemic: Challenges and Solutions in Ghana** Kwaku Yeboah, MD Peter Lamptey, MD, MPH Wilbert C. Jordan, MD

Friday
March 31, 2000

PROGRAM

10:45 – 11:15	**Healthcare Insurance: Experimental Models in Developing Countries** Gilbert C. Kombe, MD, MPH Kwaku Ohene-Frempong, MD
11:15 – 12:15	Panel Discussion and Q&A
SESSION III	**Moderator** Bertha Koomson, MD
12:30 – 2:00	LUNCHEON Keynote Address: ***The Role of NGOs in Healthcare*** Her Excellency Dr. Nana Konadu Agyeman-Rawlings, The First Lady of Ghana
SESSION IV	**HEALTH MANPOWER AND RESOURCES IN GHANA** **Moderators** Nii T. Quao, MD, CM and John K. Allotey, MD, PhD
2:15 – 2:45	**Health Manpower and Resources in Ghana Today** Awudu Issaka-Tinorga, MB, ChB
2:45 – 3:15	**Medical Education in Ghana: Training and Retention of Health Personnel** David Nii-Amon-Kotei, MD, PhD
3:15 – 3:30	Coffee Break
3:30 – 4:05	**Barriers and Solutions to Returning Home:** **The dilemma of the foreign-trained Ghanaian Physician** Rita Wallace-Reed, MD, MPH Yaw Twum-Barima, MB, ChB, MSc, FRCP(C) Ken Aryeetey, MB, ChB, BSc
4:05 – 4:40	**The Physician Exchange Program:** **Building Links with Healthcare Professionals in Ghana** A.O. Mireku-Boateng, MD Edem Agamah, MD Kwasi A. Debra, MD, MBA
4:40 – 5:30	Panel Discussion and Q&A

Saturday
April 1, 2000

PROGRAM

7:00 – 8:00	Continental Breakfast and Registration
SESSION V	**SPECIAL TOPICS** **Moderator** Fred A. Ofosu, PhD
8:00 – 8:30	**Women's Health Concerns: Challenges and Solutions** Celia J. Maxwell, MD, FACP Sam Ofosu-Amaah, MD
8:30 – 8:40	**Rehabilitation Medicine in Ghana** J. Kweku Laast, MD, MPH
8:40 – 9:00	**Cancer in Ghana** Vincent Anku, MD, FACP
9:00 – 9:30	**Cardiovascular Diseases: Comparison of Ghanaians and African-Americans** Janice G. Douglas, MD Awudu Issaka-Tinorga, MB, ChB
9:30 – 10:00	**Nutrition and Health** Victor Aguayo, PhD Joyce I. Boye, PhD
10:00 – 10:15	Coffee Break
10:15 – 11:00	**Mental Health Issues** Jemima Kankam, MD Thaddeus P.M. Ulzen, MD, FRCP(C) Sammy Ohene, MD
11:00 – 11:30	**Newborn Screening for Sickle Cell Disease in Ghana: A Success Story** Kwaku Ohene-Frempong, MD, FACP
11:30 – 12:30	Panel Discussion and Q&A

Saturday
April 1, 2000

PROGRAM

12:30 – 1:00	Lunch Break
SESSION VI	**HEALTHCARE FINANCING** **Moderator** J. Kweku Laast, MD, MPH
1:00 – 1:20	**Healthcare Financing Perspectives** Francois Decaillet
1:20 – 1:50	**A Medical Care System for the Future: Improving Quality Care And Physician Compensation at a Price We Can Afford** Joseph Boateng, MD, MPH Manny Tuffour, MD
1:50 – 2:20	**Promoting African and African-American Health in Today's Healthcare Environment:** **A Panel Discussion by Experts from the Healthcare Industry** Vincent Anku, MD, FACP Sheila L. Thorne
2:20 – 2:50	Panel Discussion and Q&A
2:50	**Closing Remarks: Summary and Conclusions** Joyce I. Boye, PhD Bertha Koomson, MD

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ABSTRACTS

Helping Villagers in Ghana: Short Term Medical Mission Projects

Edem S. Agamah, M.D., June C. Agamah, BA, Randy Sepenu, M.D and IHDN Medical Mission Team

Background Short-term overseas mission trips to the developing world are becoming very popular. Disaster relief, construction work and specialized surgeries are the main focus of most efforts. Few mission projects have focused entirely on assisting the most vulnerable populations in villages and small towns. The majority of people in Ghana, live in villages and small towns and produce the bulk of the nation's wealth. However, they lack basic amenities of life including adequate health care. The International Health and Development Network (IHDN), is a medical mission organization that seeks to assist small towns and villages, develop sustainable primary health care programs. IHDN's experience in Ghana from 1996 to 1999 is described in this paper.

Methods Agbozume is a small rural town of about 18,000 in Southeastern Ghana. Most of the citizens are farmers, traders and weavers. They lack ready access to medical care. A multidisciplinary, Christian Community Health & Development Program was initiated at Agbozume in 1996. Community Mobilization was done through Health Fairs modeled after Ghanaian funeral celebrations. Medical and Non-medical volunteers were recruited from the US and Ghana. Several Churches at Agbozume participated in the celebration of health. Ongoing training programs were also established in Community Health & Development work, Medical Laboratory, Computer Science and Christian Family life. An outpatient Family Medical Center was established to provide primary care. Medical supplies valued at over $18,000 were donated to hospitals including Korle Bu Teaching, 37 Military, Police Hospital, Ho Government, Aflao and Dzodze Hospitals.

Results Twenty-four US volunteers, including doctors, nurses, paramedics, educators and computer scientists were recruited and 245 Ghanaian volunteers, collaborated during the three Health Fairs held at Agbozume. The direct cost to the US team over the period was $72,600, despite donation of services and supplies. Health Fairs were held over a total of 10 days during which 2,690 subjects were either screened or treated for common diseases. Dental extractions were also done on 70 patients. Computer Science training was received by 45 students leading to a prestigious job with a multi-national company for one of the students. Thirty-six students were trained as Community Health and Development Workers (CHDW). Currently 16 CHDW are receiving practical training at the Family Medical Center. The Family Medical Center is the only physician-managed clinical facility at Agbozume. During a twelve-month period, ending in October 1999, over 4,469 patients received care and over 5,222 diagnoses were made. Most of the patients are women (55%) and 73% were less than 50 years. Malaria is the commonest (36%) diagnosis at the Center with musculo-skeletal disorder and hypertension each accounting for 10% of the illnesses.

Conclusion Village-based short-term medical mission projects are expensive, but several lives are saved. A community is energized. Comprehensive health care programs, focusing on training of local people produces reliable, skilled, personnel, needed to sustain such a program. Recruiting Ghanaian volunteers in urban areas may enhance the community mobilization process during Health Fairs and save lives.

Nutrition in Ghana. Issues and Challenges for the New Millenium

Victor Aguayo, PhD

Ghana has the vision of becoming a middle-income country by the year 2020. This vision will only be realized if the children being conceived and born today are given the opportunity to live to their full potential. Sadly, however, this opportunity is outside their reach because of malnutrition. Current estimates indicate that in Ghana, 28% of children are underweight, 39% of two-year-olds are moderately or severely stunted, 26% of children are vitamin A deficient, and 60-70% of pregnant women are anemic. This is very high by any standards. To estimate the consequences of maternal and child malnutrition in Ghana, we have used *Profiles,* a nutrition policy analysis methodology that uses a series of computer-based analytical models based on the most recent epidemiological research relating malnutrition to functional consequences. Our analysis shows that in Ghana:

- 45 % of all child deaths are due to protein-energy malnutrition
- 5,000 Ghanaian infants die each year because they were not adequately breastfed
- 9,800 children die annually because they are vitamin A deficient
- 44.000 new-borns suffer some level of mental deficit because their mothers were iodine deficient during pregnancy, and that
- 18 million dollars are lost every year in agricultural productivity as a consequence of iron deficiency anaemia in the female labor force.

These are only some of the social and economic losses in Ghana as a consequence of the high malnutrition levels. This situation will only change if there is a strong commitment at all decision making levels to a new and bold investment strategy in nutriion. This investment strategy needs to strengthen four priority actions :

- Promote better infant growth through optimal infant feeding practices
- Address the deficient micronutrient status of infants and school-age children
- Strengthen the micronutrient programs aiming at pregnant and lactating women, and
- Promote the consumption of iodated salt for the whole population.

This strategy will only be successful and sustainable if it is coordinated with programs designed to improve maternal and child health and food security. This investment strategy will reap benefits far outweighing the cost; benefits to survival, health, education, agriculture, industry, and the economic future of the country. Attainment of these social and economic benefits is our only hope of making Ghana's economic vision for the year 2020 a reality.

Medical Education In Ghana: Training And Retention Of Health Personnel

David Nii Amon-Kotei, MD, PhD

Formal medical education in Ghana has gone through a remarkable evolution within the last three decades of the twentieth century. This development was initialized during the colonial period by training of Ghanaians abroad. The next phase saw the establishment of three local medical schools in the three geographical regions of the country, which reminds of the influence of the colonial era. The premier medical school established in 1960 on the coast running a traditional approach to medical education, while the second with a three-tier modified traditional/orthodox system is located in the forest region. Finally, the third and youngest school in the northern and transitional savanna ecosystem is mandated to run an innovative approach to medical education.

The justification for the transition from a traditional/orthodox to the innovative system derives from the incapability of the two older schools to satisfy the expected health services needs of the country. Inadequate numbers and inappropriate variety of health personnel have been complicated further by a substantial loss of health manpower from the country. The perpetrators of this seemingly continuous and dynamic evolution of medical education in Ghana have been revolutionary politicians rather than academicians who seem to be very conservative, resisting changes and preferring the traditional/orthodox to the innovative approach. The vision and philosophy of the SMHS targets a participatory training process aimed at producing different cadres of health professionals. The approach to the education is student-centered, Integrated Problem- Based Learning and Community-Oriented.

Staggering during this process of this innovative educational approach should be a human right. The additional contribution to the health system of the country is a team of health workers who know about each other's individual abilities and capabilities, and despite all cooperate smoothly with each other to maintain a healthy society and nation. Furthermore, each type of health professional produced by the SMHS should have the freedom of choice of the end-station of his training, at which stage he should be adequately and appropriately equipped to serve his community, society and nation. This approach does not only minimize inter health-worker cadre exploitation, but can also curtail the exodus of locally trained professionals, which has been associated with an exodus of about 70% of the products from the two older schools to more affluent countries. Though a good and promising approach to medical education, the growth and development of the SMHS has been associated with problems. The initial impediments attributable to poor funding, lack of facilities inadequate staffing have been common to all three Ghanaian Medical Schools but particularly to the SMHS. The most threatening of all impediments in the way of the SMHS philosophy however, is the fear of the unknown that is shared by both professional and lay circles of the Ghanaian society.

Confusion about curricular issue, which have arisen firstly because of lack of commitment to the recommended innovation, and secondly because some responsibilities were not given timely attendance. This is avoidable if outside help is timely sought. The alleviation of this curricular aspect is right now on course through the involvement of much older institutions and organizations committed to promoting innovative tracks in medical education. It is advocated here that faculty members of Ghanaian medical schools should be required to have had training and knowledge in pedagogy. There is also the need of educating the general public on the different approaches to medical education to avoid, or at least minimize unnecessary disruptions of educational programs. It is also very vital that academicians, professional and accrediting bodies get more and actively involved in educational reforms than has been the case hitherto. This involvement has to begin with the conception of the idea, and should be upheld with commitment through maturation phase to implementation and review towards amendment for sustenance. Without these and others, and especially financial commitment, the termination of the test case at the SMHS is eminent. The efforts of government and all stake holders would have been naught. These problems are certainly surmountable through education of both the general as well as the professional public on the suitability and advantages of the innovative approach for development in general, but particularly for the improvement of the delivery of primary and general health care to deprived as well as other areas of the country.

Barriers And Solutions To Returning Home: The Dilemma Of The Foreign-trained Ghanaian Physician

Ken Aryeetey, MD

SUMMARY

BACK GROUND

The poor migration rate of foreign-trained Ghanaian Physicians back to Ghana has stimulated a lot of interest in national and international circles. A new attempt to address this problem is the challenge Ghana Health Foundation has set itself

METHOD

Using - his modest experience as a widely traveled foreign-trained Physician practicing at home, the author tries to capture the magnitude of the problem by interviews, views, data from local as well as international sources, opinions and discussions with return-physicians, retired colleagues, foreign-trained physicians in North America and a few on vacation. Officials and fellow physicians at the Ministry of Health and District Directors, GMA President also provided in-depth analysis of the problem associated with our inability to attract back home the brain glut in Europe, North America, South Africa etc,

FINDING

Two main barriers exist THE ANIT-PULL AND THE PRO-PUSH PHENOMENA. The poor Physician to patient ratio has also been aggravated by economic, social and cultural parameters. With a constantly decreasing Per Capita Income now at $350 ($20,000 in UK.) our country's healthcare system has entered a vicious cycle of LESS DOCTORS - MORE DISEASES -->-MORE POVERTY - LESS PAY--LESS DOCTORS: a situation which directly, indirectly and adversely affect relationships between the three main stakeholders; the populace, the government, and the medic. A poor health delivery system to a large extent drives away investment.

INTERPRETATION

Although the government is making strenuous efforts to address the dilemma of Foreign -trained Physicians very little can be achieved without seriously addressing what our priorities are as a nation, what principles should guide us towards the healthcare plan of our vision 2020 aspirations and the policies which should be clearly defined to break the viscous cycle.

A Food-health Link: Plant Proteins a Solution to Protein Malnutrition in Developing Countries

Joyce I. Boye, PhD

The problem of protein malnutrition in our world today, is second only to the overall food problem. Protein malnutrition continues to be responsible for a variety of diseases in humans. In children, particularly, lack of adequate protein in the diet results in failure to thrive and poor, sometimes, abnormal developmental growth. In developing countries, such as Ghana, the problem is further complicated by the fact that most traditional sources of protein, i.e., animal protein such as meat and milk, are very expensive and difficult to come by. Plant proteins offer an alternative solution to the problem of protein scarcity and protein malnutrition in developing countries. Proteins from plants such as soy, have been found to have the same protein efficiency ratio as milk, eggs, and meat. Most plant proteins contain the essential amino acids necessary for growth and when combined in the right proportions with other foods in the diet can serve to provide a well balanced source of adequate nutrition. Thus, eliminating the potential development of a number of diseases. Research continues to show, that other phytochemicals present in plants may also have significant health benefits. For example, the isoflavones found in soybeans have been reported to inhibit the growth of cancer cells, lower cholesterol, and inhibit bone resorption. Evidently, a direct relationship exists between the consumption of these foods and the health benefits derived from them. The FDA in October of 1999, approved a health claim which will allow food manufacturers to put on their labels that a consumption of 25g of soy protein a day as part of a diet low in saturated fat and cholesterol may reduce the risk of heart disease. This health claim comes in the wake of a rising body of evidence linking the consumption of plant proteins with a variety of positive health benefits. The presentation will highlight specific problems of protein malnutrition, the prospects for increased production and utilization of plant proteins in developing countries, current techniques for their processing and the potential risks and health benefits associated with their consumption.

Hypertension Prevalence In African-Americans and Africans

Janice G. Douglas, MD

LEARNING OBJECTIVES

- Review prevalence demographics of hypertension in African-Americans
- Review morbidity and mortality in US African Americans secondary to HBP
- Compare hypertension prevalence in African Americans and Africans

Hypertension associated target organ damage, with excess morbidity and mortality in the African American population continues to represent a substantial public health problem in the United States. According to the US Census Bureau, people of African descent currently constitute 13% of the American population. However, the rate at which hypertension occurs is significantly higher than In other racial/ ethnic groups. The third National Health and Nutrition Examination Survey (NHANES III, 1988-1991) estimated, the age-adjusted prevalence of high blood pressure (defined as systolic blood pressure $\geq$140 mm hg; or diastolic blood pressure -$\geq$90 mm. Hg. current prescription therapy for hypertension in adults (aged 20 years and older) to be 32% for African-Americans (34% for males and 31 % for females) compared with 23% for non-Hispanic Whites and 23% for Mexican Americans, Even more alarming is the observation that beyond 60 years of age 71% of African-Americans are hypertensive contrasted with 60% for other US populations.

In contrast to the United States, the prevalence of hypertension in rural African communities has been reported previously to be relatively low, ranging between 2.5% and 10.9%.

In a survey of hypertension prevalence conducted on >3,000 adult residents of the Liberian Agricultural Company rubber plantation located in rural Liberia, West Africa, we observed significantly higher prevalence than previously reported (12.5%). Hypertension was most common in older women (50% in women older than 55). In some ethnic groups, the prevalence was as high as 25%. In a more recent survey of hypertension prevalence in the Kampala District of Uganda, we found a prevalence of 30.5% in a survey of 500 adults. The recent observations suggest that the prevalence of hypertension in rural and more urban African communities is higher than previously reported suggesting that most attention should be focused on this important public health problem.

The excess prevalence and early onset of hypertension is causally related to end organ diseases including cerebrovascular accidents, left ventricular hypertrophy, coronary heart disease, end-stage disease (ESRD) and premature mortality when compared to other racial-ethnic groups,

HealthCare Insurance: Experimental Models in Developing Countries

Gilbert Kombe, MD, MPH

The concept of healthcare insurance is increasingly receiving attention in sub-Saharan Africa. Previous efforts to implement insurance in the public sector received enormous resistance from both politicians as well as health policy-makers. However, recent changes in the health sector particularly reform initiatives, have challenged the traditional methods of paying for care. Because of the shrinking health budget due to economic crises in the developing countries, this has precluded the provision of free health care and introduced new methods of payments including insurance. It is very well established that a lot of illness is unpredictable for a person or community and individuals can not plan their health care consumption in the same they can plan for food consumption. In the presence of such uncertainty, governments are exploring innovative approaches of insuring individuals or communities who are at risk of illness based on need as well as the ability to pay.

The objective of this presentation is to generate debate on health care insurance issues in developing countries. The speaker will attempt to do three things. The first part will consider feasibility of implementing health care insurance in sub-Saharan Africa. The second part will center on major implications for shifting the focus from government funded free care to health care insurance coverage. As observed in many countries, sub-Saharan Africa still faces many health care challenges including poor health information systems, lack of insurance markets and regulations, and inappropriate distribution of primary care services. Finally, experimental models from different parts of the world will be reviewed including the structures, services covered, co-payment arrangements, provider payments and premiums charged.

The Mind-Body "Divide" - Bridging The Gap

Jemima A. Kankam, MD

Despite the explosion in information about the neurobiological basis of mental illnesses, there is still a major lag in accessing treatment. This is largely due to the biases towards people with mental illnesses for centuries. Today, even in the most advanced country like the United States, the battle for the recognition of mental illness as an illness like the other "medical illness" is still being waged sometimes with not so encouraging pace.

However, it is becoming clearer that the consequences of untreated mental illnesses are sometimes tragic, not just to the individual whose quality of life is compromised the individual whose life is prematurely terminated by suicide or homicide, the families who are left to live with the emotional consequences, but also to society as a whole. Celebrities who graciously share their pain and suffering and that of loved ones and family members help to bring public attention that socioeconomic status does not protect against mental illness or its dire consequences. Their going public also goes a long way in educating the public that mental illness does not always necessarily doom us never living a meaningful life.

Unfortunately there is still a long way to go. We in the medical profession, in our own offices, in our interactions with patients, family members or in our influence of policy makers an make a difference. However , we cannot unless we examine our own subtle and sometimes not so subtle biases, broaden our knowledge base in this field with regards the interplay between psychiatric and other symptoms. We also have to program our clinical thinking to view the patient before us as a whole - mind and body, and not components.

It has taken the Unites States 200 years for a surgeon general to pronounce a Psychiatric illness, a mental illness, a major heath problem - Suicide.

At the end of this session it is the hope that attendees will, to a greater extent, work in whatever way an opportunity exists to better coordinate the treatment of patients, and encourage access to mental health treatments. It is also hoped that as we embark on contributing to the improvement of the Ghanaian public health and medical infrastructure as our mission statements clearly outlines, that we can utilize the experiences here in the United States and other more technologically advanced countries, to avoid waiting decades before recognizing the major impact of mental illnesses and their lack of treatment on the Ghanaian society.

Medical Rehabilitation in Ghana: An Abstract

J. Kweku Laast, MD, MPH

The need for medical rehabilitation in Ghana and the Continent as a whole is indisputable. Rehabilitation services in Ghana is practically non-existent, however the people disabled from acquired injuries such as motor vehicle accidents and other trauma including workplace injury, strokes, "heart attacks" etc or congenital diseases, continue to increase everyday.

Low cost medical rehabilitation models are now available and proven to be effective in improving the quality of life of many individuals and making them less of a burden to their families and to society as a whole. A public/private effort to invest in medical rehabilitation would not only be cost-effective, but would change the social stigma usually associated with this target population who could potentially still contribute to the economy of the country.

Training programs for needed staff could lead to the meaningful employment for many currently educated people looking for work e.g. Physical, Occupational, Speech and Respiratory therapists, Orthotists and Prosthetists, not to mention Physiatrists.

HIV/AIDS epidemic in Africa: How Serious is it?

Peter R. Lamptey, MD, DrPH

OBJECTIVE: To discuss the status, trends and impact of the HIV/AIDS epidemics in Sub-Sahara Africa.

DESCRIPTION: A description and discussion of the HIV/AIDS epidemics in Sub-Sahara of Africa.

This will include:

1. The evolution of the epidemic over time, the current status as well as the future trends.
2. The social, health demographic and economic impact of the HIV/AIDS epidemics in various African countries.
3. The response: preventing and mitigating the impact of the epidemics.
4. Success stories in prevention and care Africa.
5. Comparison with the Ghana epidemic.

CONCLUSION: Recommendation for further action.

Women's Health Concern: Challenges and Solutions HIV, STD's and other issues

Celia J. Maxwell, MD, FACP

Women are increasingly at risk for a number of health concerns, including infectious diseases such as HIV and other STD's, domestic violence, female genital mutilation in some settings and depression. Between 1991 and 1995 we have seen the number of women diagnosed with AIDS to increase by more than 60%. Additionally, this epidemic is the major cause of morbidity and mortality in women between 25 and 44 years of age. Of growing concern is the way the epidemic disproportionately affects women of color in the United States. In developing countries like Sub-Saharan and other areas of Africa AIDS is the number one killer of young adults. In 1999, this disease claimed 22 million lives which is ten times the death roll from all of Africa's civil wars. In addition, it has created a generation of about 10 million orphans and this goes unabated.

In the US, the percentage of AIDS cases in women attributed to heterosexual exposure has risen steadily. Currently, it is estimated that 70% of the 40 to 80, 000 new cases annually is due to this mode of transmission. It is also known that the risk of infection per contact is significantly higher from male to female than vice verse. Globally, 42% of all adults with HIV?AIDS are now women. Other STD's (such human papilloma virus (HPV), syphills or herpetic infections) can be more difficult to diagnose and treat in the face of concurrent HIV infection. It is also important to note that vaginal candidiasis, trichomoniasis and HPV infections appear to increase the rate of sexual transmission of HIV. While the reasons for the increased incidence of HIV infections in women are many, we will focus on heterosexual transmission and the impact that co-existing STD's have on the progression of this disease as well as other concerns that compromise the general health and well being of women.

Major Health Challenges in Ghana : Epidemiology and Statistics

S. Ofosu-Amaah, MD, PhD and P. Antwi

Compared to other regions of the world, Sub-Saharan Africa has the greatest Burden of Disease (BOD), as expressed in Disability Adjusted Life Years Lost (DALYs) per 1000 population. The Ghanaian disease burden would be similar to the Sub-Saharan indices. The contribution to the BOD is due preponderantly to infections and parasitic disease, followed by the health problems of mothers and young children. Unfortunately the burden due to non-infectious disease and injury is also marked.

Half of all mortality in Ghana is due to infective and parasitic disease; in children under 5 years of age the proportion is more than 70%. Poverty and lack of infrastructural development impinge most directly on the home and living conditions. The main health problems are due to malaria, respiratory infections, diarrhoeal disorders, helminthic infections, skin infections and nutritional deficiencies. They are generally water-borne, faecal-related, food-borne and vector-borne.

The so-called tropical diseases, malaria, guinea worm, yaws hookworm and other geohelminthic infection, onchocerciasis, schistosomiasis, filariasis, buruli ulcer are still prevalent. Epidemics such as yellow fever, cholera and cerebrospinal meningitis require effective surveillance and prompt attention. The emergent communicable diseases of the greatest concern are HIV/AIDS, tuberculosis, and drug resistant malaria. Ghana is at the stage in the development of HIV/AIDS with a prevalence of about 5%, where the most vigorous public and private action is urgently needed. Although efforts have been made to tackle disease specific conditions, and significant advances have been made, e.g. in vaccine-preventable diseases, guinea worm and schistosomiasis, the burden are still a major challenge.

The second set of challenges are the consequences of inadequate maternal and child care, malnutrition and high fertility. The level of modern contraceptive use is still only 13%, and only 44% of women are delivered in or by trained health workers in hospitals and clinics. The next in importance is the increasing prevalence of chronic diseases, accidents and injury. A major challenge is the collection, analysis and use of vital events and health information. Ghana has to urgently improve its system of disease surveillance.

To deal with these challenges the tendency has been for programmes that deal with specific diseases mainly because there is usually donor funding for them. But these can only be additional to the main efforts in reduction of the burden of disease. Ultimately Ghana has to pursue a much more broad-based policy in health action for the lightening the communicable disease burden. This clearly implies a major and sustained national intersectoral effort to deal effectively with communicable disease problems, mainly through the improvement of the living conditions of Ghanaians. The home is where most of Ghanaian ill-health is produced. This is what all other countries have had to do to reduce their health burden. The education of Ghanaians, especially of girls, empowering them to taking charge in improving their living conditions, to lowering their fertility levels and to using the social and health services effectively for their families. Secondly, the cost effectiveness of immunization requires Ghana to take advantage of this strategy and similar strategies "buying time" to improve our living conditions. There is need for the training of health workers in maternal and child care, sanitarians as well as specific disease controllers, who work in houses, communities, supporting the efforts of households and local government. Increasing local autonomy through the strengthening of local government, and encouraging intersectoral collaboration to improve the infrastructure for water and sanitation, and for improving health knowledge and practices will ultimately be the breakthrough to significantly improve the health of Ghanaians.

Mental Health Issues in Ghana

Sammy Ohene, MB, ChB

BACKGROUND

Despite the introduction of formal psychiatric services into the Gold Coast over 100 years ago, availability of mental health facilities in Ghana remains limited. Mental illness is still believed by many to be of supernatural origin and most patients are sent to traditional healers. Modern services are restricted by few facilities and lack of trained mental health professionals. Stigmatization in both public and official domains persists. These have led to a number of serious issues, which are examined in this paper

METHODOLOGY

The issues are discussed under various topics:

- Policies and Perceptions
- Facilities and Human resources
- Range of Mental Problems
- Alternative Therapies
- Human Rights issues
- The Future and way Forward

RESULTS

Both public perception and official attitudes do not encourage the development of mental health in Ghana. A large proportion of patients seek alternative care exclusively or in addition to 'western' type care. Modern mental health care facilities are few and poorly spread over Ghana. Twelve (12) Psychiatrists, 4 Clinical Psychologists and less than 300 trained psychiatric Nurses serve the entire population of about 18 million. The whole range of recognized mental health problems are seen among Ghanaians but there is a severe lack of trained professionals. Human rights abuses are rife in the mental health field.

CONCLUSION

The need for epidemiological research, public education and a change in official attitude to Mental Health is stressed. Training staff and retaining them, provision of more facilities and integrating mental health into general care services are emphasized as ways of improving mental health services in Ghana.

Health Manpower Resources In Ghana

Awudu Isaka-Tinorga, MB, ChB

The most important obstacle to health development in Ghana is the severe shortage of health manpower of all categories. In the past decade, the number of physicians practicing in Ghana has not changed in spite of the production of over 100 physicians a year. In addition, the number of nurses has almost halved during this same period. Physiotherapists are almost extinct! The average age of the lecturers are close to what would be considered retirement age.

Although the health status of Ghanaians has improved since Independence (as measured by mortality, fertility and nutritional indices), the improvement is considered slow and inadequate, especially when compared to the East and Southern African countries.

The health profile can be characterized as follows:

1. Slow improvement in health status of the average citizen since Independence
2. Little change in disease patterns over time
3. Inadequate availability and use of health services
4. Poor coordination of ancillary health services and public health measures

The preponderant pattern of illness falls among communicable diseases, under-nutrition and poor reproductive health. Emerging diseases of increasing magnitude include HIV/AIDS, TB, Buruli ulcer and Filiarisis. Trauma and other injuries also remain high. The HIV epidemic remains relatively low at about 5%, but there remains a likely potential for an explosion unless the public can be convinced to adopt a change in lifestyle and attitudes.

The four key human resource challenges are:

1. Severe manpower shortages and inadequate salary compensation
2. Inequitable staff distribution around the country.
3. Training and retention of staff, complicated by the "Brain drain" and aging Instructors
4. Maintenance of Industrial harmony in the general labor force.

The Future and Possible Solutions:

- Establish a collaborative effort between Ghanaian professionals in and out of Ghana around common goals, e.g. organizations such as the GHF.
- Explore a less laborious advancement process, and establishment of postgraduate programs in Ghana as part of a general improvement of conditions of service.
- Increase the pool of trained health personnel.
- Establish a user-friendly process/system for those outside Ghana to contribute resources or talents whether or not they plan to move back home.
- Encourage private sector involvement and establishment of business in the health sector e.g. medical supplies and equipment etc.
- Health care finance reform.

Health Care At A Price We Can Afford

Manny Tuffuor, MD

Health arguably is a fundamental human right and in observance of that, the World Health Organization had taken on the challenge to ensure that by year 2000, all people have access to basic health services.

While such an endeavor is laudable, the goal is far from being realized and the emerging countries or the "Third World Countries" are the most affected by lack of adequate health care.

It has been the general perception that provision of health care is solely the responsibility of the government. In the developing countries, the private sector's involvement in providing health to the people has been minimal at best.

I maintain that in the new millennium, making health care available to all citizens of Ghana should be a joint effort between the government and private sector. While profit margins in the health care industry are comparatively inadequate, certain incentives could be instituted to encourage the cooperative effort of the private sector.

Health Africa/GhanaCare has developed innovative and sustainable ways of health care financing. Healthcare financing represents a major challenge to bringing health to all.

Barriers and Solutions to Returning Home: The Dilemma of the Foreign-Trained Ghanaian Physician

Yaw Twum-Barima MB. Ch.B, M.Sc., FRCPC

The last two decades have witnessed an unprecedented emigration of highly qualified Ghanaian professionals into the western world. This group includes engineers, physicians, accountants, lawyers, career academics and many others. Some of the physicians received their basic medical degree from Ghana and subsequently came overseas for postgraduate training, others received all their professional training outside Ghana after their secondary school education .Irrespective of which category that they fall into, the average Ghanaian physician currently practicing outside has a dream of returning home at point during their active career. Unfortunately only very few have been able to make this transition. Major obstacles exist along the way and it is only with careful and long term planning can an individual aspire to overcome them. In this paper I will evaluate some of these problems and provide a systematic approach to some solutions.

The barriers can be classified broadly into "INTRINSIC" and EXTRINSIC" FACTORS.

A) Intrinsic factors refer to all those "barriers" that the individual must consider before making the jump and for which he/she has direct control. These include:

- Appropriate Financial Planning
- Market Survey and Analysis
- Family commitments e.g. children's education
- Type of practice envisaged etc, etc

B) Extrinsic factors are those that exist in Ghana and over which the individual has no or very little control. These include:

- The Political Climate
- Economic and business atmosphere
- Unstructured/ " Chaotic" Health Care System
- Support Systems e.g. laboratory and other diagnostics
- Transportation and other infra structural problems.

Each of these factors will be discussed in detail and some solutions will be proposed.

Psychiatry and Primary Healthcare

Thaddeus P. M. Ulzen MD., Dip Child Psy., FRCP(C)

An overview of the prevalence of psychiatric illnesses in primary healthcare settings is presented. Over 30% of primary care patients have diagnosable psychiatric illness. The Global Burden of Illness for psychiatric and other medical illnesses are compared and the implications are discussed. Collaborative models of care involving primary care physicians and psychiatrists are examined. A consultation model applied in underserviced areas in North America is described and its applicability to Lesser. Developed Countries (LDC) is discussed. Finally, a psychiatric screening tool designed for primary care physicians, PRIME-MD Is Introduced and its ease of use

Barriers and Solutions to Returning Home: The Dilemma of the Foreign-Trained Ghanaian Physician

Rita Wallace-Reed, MD, MPH

Ghanaian physicians who have trained, practiced and lived abroad may face transitional difficulties when they attempt to or actually move back home to practice medicine, particularly private practice.

When I completed the construction of my clinic in West Legon, Accra , my expectations of practicing in Ghana were very American. That has its limitations. I took a lot of resources to Ghana. They included building materials, medical equipment and supplies, office supplies, pharmaceuticals as well my years of experience as a staff physician and Medical Director of a PHP Health Care Corporation Clinic. But cooperation with a local physician in Accra made a difference. It is important to do work in conjunction with a respected local physician(s) for the practice to function effectively. After a careful search I was able to find the right person. A physician who was preparing to retire from a Medical Director's position in a Company Clinic, agreed with me that there would be mutual advantages in his coming to work in my clinic. I returned to practice in the U.S.A and continue to resource the clinic from here. Through the work of Dr. Kwadjo Owusu and my very competent nurse the clinic continues to grow, albeit slowly.

The affordability of care is a major concern. There is no insurance system- self pay being the major option left to most patients. Most have difficulty paying the rather low fees and usually cannot afford prescribed medications. I ended up providing charity care and giving free medicines in many instances. Lack of water and power outages sometimes made work a challenge!

It is not impossible to resettle at home. Still, it is necessary for us to have realistic expectations. Consider joint rather than solo ventures, work with local physicians who know the system well (before and after relocating), make time to re-learn the system and network. Plan for alternatives, which means working here and resourcing projects at home for a period of time before relocating.

Having lived away from home for decades, one gets molded into a different system and takes the availability and provision of services for granted. We assume the 'rapid results' will be served to us wherever we go but the pace of life is different and things are done a lot more slowly at home. Keeping this in mind, we can bring the best of our experiences to bear at home while being flexible enough to work with the realities there.

The AIDS Epidemic: Challenges and Solutions in Ghana

Kwaku Yeboah, M.D.

The first cases of AIDS were reported in Ghana in March 1986. By the end of that year a total of 42 cases had been reported to the health authorities. The number of reported cases has been increasing steadily over the years with a cumulative total of 33,919 as at the end of 1999. The estimated level of reporting is 30%. The female/male ratio which was 6:1 in 1987 has closed up to 2:1. The Ashanti region leads with about 27% of all reported cases. All age groups have reported cases. The peak age for males is 30-34 years while that for females is 25-29 years. Ninety percent of all reported cases are in the age range 15-49 years. The lowest numbers have been reported in the 5-14 year group which has been described as the "window of hope". The most predominant mode of transmission is heterosexual sex, accounting for about 80%. Vertical transmission and transmission through blood and blood products account for 15% and 5% respectively. The adult prevalence of HIV is currently estimated at 4.6%. using the twenty sites scattered all over the country. It is estimated that about 400,000 Ghanaians are currently living with HIV or AIDS.

The national response began in 1985 with the setting up of The National Technical Committee on AIDS (NTCA). This was replaced with The National AIDS/STD Control Programme (NACP) based in the Ministry of Health. NACP is the co-ordinating body of the national response. It has pursued one short term and two short term plans since its inception. The objectives of the plans have been to reduce further transmission of infection and to mitigate the effects of HIV/AIDS on the infected and affected. Priority interventions have focused on promotion of safe sex, condom promotion, improved management of STDs, safe blood, infection control, nursing/clinical care and counseling and home based care. The context of the response has been multisectoral multidisciplinary and expanded.

Stakeholders have included government sectors, private sector, NGOs, traditional healers, PLWAs and civil society. Advocacy and capacity building have been crucial in the response. A national policy is currently being finalised and is expected to provide among others policy direction and an enabling environment for the pursuit of the various interventions. Awareness levels are newly universal but this has yet to achieve the desirable behavior change. Blood is screened in all district and regional hospitals prior to transfusion. Counseling services are available at all district and regional hospitals with a few NGOs also complementing this. There is a surveillance system for both HIV and AIDS. Clinical management has mainly been for opportunistic infections but lately a few people have been on anti retroviral therapy The biggest challenge has been how to cover the high awareness levels to the desired behavior change. This will require adequate human, material and financial resources which continue to be inadequate. There is still a considerable amount of non personal risk perception. Yet another challenge are the false claims of cure and the relatively high levels of misconceptions about the disease. A lot of Ghanaians perceive the disease as remote from them. Stigmatization of the disease is phenomenal. Effective co-ordination of the expanded response remains another big challenge. Attempts at overcoming the challenges have focused on mobilizing high level political commitment through advocacy. There is an intensified action to provide more interpersonal communication to enable people relate more practically to the epidemic. Testimonials from PLWAs is also being actively pursued.

Capacity building among all partners with the view to expanding access and improving quality of service is being undertaken. Voluntary counseling initiatives are being advocated as well as intensified community mobilization. Discussions are on going regarding the establishment of a high powered multisectoral co-coordinating group. Increasing budgetary allocations are being made by all government sectors. Those efforts will hopefully lead to reduction of prevalence rates in the very near future if all hands get on dock.

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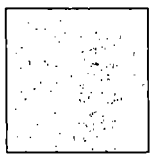

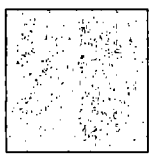

VICTOR M. AGUAYO, PhD, MPH

Dr. Víctor M. Aguayo holds a Ph.D in Nutritional Epidemiology and a Master's in Public Health from the University of Paris. He has ten years of experience in international nutrition, including five years of resident experience in Latin America conducting nutrition survey design and data analysis, developing monitoring and evaluation systems, and applying the use of research findings to guide the development of nutrition policies and programs with a particular focus on infant feeding, child survival, growth and development, maternal nutrition, and micronutrient deficiencies. A former post-doctoral research fellow at the University of California (UCR-UCLA), Dr. Aguayo is currently a senior Nutrition Policy Analyst at the Academy for Educational Development (AED) in Washington. His present work focuses on nutrition policy analysis and advocacy in Africa and aims to strengthen goverments' and donor agencies' capability to formulate improved nutrition policies and to implement cost-effective life-cycle nutrition programs. In his current work in Africa, Dr. Aguayo is involved with various international agencies, bilateral agencies, and nongovernmental organizations. Dr. Aguayo is a member of the World Alliance for Nutrition and Human Rights.

JOHN B. K. ALLOTEY, MD, PhD

Dr. John Allotey is the Medical Director of the Health First Medical Center in Rockville, MD. He is a Diplomate of the American Board of Internal Medicine. He received his medical education at the University of Ghana Medical School. His post-graduate education was at McGill University in Montreal, Canada where he was a Commonwealth Scholar and obtained a Ph.D. degree in Physiology in 1977. He did his residency in Internal Medicine at Howard University Hospital in Washington, D.C. He was an Assistant Professor in the Department of Physiology & Biophysics at Howard University College of Medicine until 1990. His research activities related to the mechanisms of hypertension, regional hemodynamics in hypertension, cerebral blood flow regulation and blood rheology. Among his major current interests are health issues affecting the Third World; and to this end, he is actively involved with several organizations such as the Ghana Health Foundation, Children's Health International and International Bioethics Organization.

DAVID NII AMON-KOTEI, MD, PhD

Professor Amon-Kotei received his undergraduate education in physics from Fac. Medizin Charles University in Germany, and his medical training from Fr. Wilhelms University Bonn, and his doctorate in biophysics from the University of Bonn. He is a Fellow of the West African College of Surgeons. Since 1996 he has served as Dean, School of Medicine and Health Sciences, University for Development Studies, Tamale, Ghana. His previous appointments include Research Fellow, Department of Pediatric Surgery, University of Maikz, Germany, 1978-80; Consultant Surgeon, University of Mainz, 1978-80.

Dr. Amon-Kotei has held the following positions at the University of Science and Technology, Kumasi, Ghana: Lecturer in Surgery (1980); Head, Department of Physiology (1990-1993); Head, Department of Surgery (1993-1996); Vice Dean School of Medical Sciences, (1995) and Associate Professor (1996).

In 1994 Professor Amon-Kotei led a surgical and medical team to complete the first successful separation of siamese conjoint twins in Ghana at the School of Medical Sciences, University for Science and Technology, Kumasi. This successful surgical and medical effort in Ghana was commended by the world medical and surgical community. Prof. Amon-Kotei received a Commendation from the Minister of Health Ghana for his medical courage, initiative and ingenuity. Professor Amon-Kotei has received several international awards in biophysics and surgery including fellowship awards from the International Atomic Energy Commission for nuclear medicine and the International Centre for Theoretical Physics for Medical Physics. He serves on several national and international committees.

VINCENT ANKU, MD

A graduate of Cornell Medical School and London University School of Tropical Medicine and Hygiene, Vincent Anku, M.D. completed his internship and residency at Case Western University in Cleveland, Ohio. He is Board Certified in four specialties: Internal Medicine, Hematology, Oncology and Tropical Medicine. Dr Anku was Assistant Chief of Medicine for eight years and Chief of Medicine for four years at Southwest General Hospital as well as Section Chief of Oncology at St. John Westshore Hospital for four years and Assistant Professor of Medicine at Case Western Reserve University for two years.

Dr. Anku is the author of three books and has published and presented several papers at international conferences on extremely effective methods of treatment for various types of locally advanced cancer. His first book, *What to Know About the Treatment of Cancer,* was written to help cancer patients and their families understand their illness and its treatment. *Health of the Nation* presents an analysis of the U.S. health care system. The Foreword, written by Dr. Louis Sullivan, describes the book as "insightful and stimulating... a blue print that makes all of us winners." His third book *Hope at Last in Cancer Treatment* provides up to date information on the major types of cancer and describes a highly innovative cancer treatment technique. Endorsed by the Honorable Andrew Young, this book conveys a sense of realistic hope by using the stories and photos of many patients Dr. Anku has treated over the past 15 years.

In addition to being a successful physician and author, Dr. Anku is a well-connected entrepreneur in Ghana's business community and is actively involved in promoting and directing several development and investment projects in that nation. During the past five years, Dr. Anku has devoted a considerable amount of time to improving human conditions in Ghana with special emphasis on rural areas. He is President of The Vincent Anku Foundation which has worked closely with Africare and Self-Help International of Iowa on a number of projects in Ghana, principally in the areas of rural education, water supply and job creation. Dr. Anku is a strong believer in the bright future of Africa because of its vast human and natural resources and the gradual but steady return of many brilliant African brains scattered all over the globe. The increasingly favorable conditions in many parts of Africa give good reason for hope.

KEN ARYEETEY, MD

Dr. Ken Aryeetey was born on May 5, 1953 in Takoradi, and attended Ketan Catholic School in Sekondi. He is a graduate of St. Johns Secondary School (Sekondi) and University of Ghana, Legon, where he obtained his Bachelors of Science degree in chemistry and biochemistry.

Dr Aryeetey attended Rostov State Medical Institute and earned his medical degree in 1994. Since then, he has held several teaching posts at the University of Cape Coast and Korle Bu Teaching hospital. He has also served as Medical officer at Korle Bu Hospital and Mamprobi Polyclinic. He was the National coordinator for the Onchocerciasis (river blindness) Control Program from 1992 to 1993.

Dr Aryeetey currently serves as the Senior Medical Officer-in-Charge at the Ussher/James Town Polyclinic in Accra, Ghana.

JOSEPH A. BOATENG, MD, MPH

Dr Boateng qualified from the University of Ghana Medical School in 1979. He did internship rotations in Internal Medicine at the Korle Bu Teaching Hospital, and Obstetrics/Gynecology, Pediatrics, and Surgery at the Effia-Nkwanta Hospital. In 1981 he took an appointment as a staff physician at the St Thomas' Clinic, a 50-bed private hospital in Sapele, Nigeria. He was made the Deputy Medical Director of the Clinic in 1983. In April of 1985, he returned to Ghana and started his own private hospital in Takoradi, Ghana - the St Thomas' Hospital. After 2 years, the hospital had 51 beds and was the largest private hospital in the Western Region. In 1991 he proceeded to the USA for further clinical and administrative training. On arrival in the US, he first did a Masters in Public Health degree at the University of North Carolina, Chapel Hill, with concentration in Maternal and Child Health. He then entered a three-year Internal Medicine program at the Good Samaritan Hospital, affiliated with Johns Hopkins University School of Medicine, Baltimore. He completed a certification program in "The Business of Medicine" at the Johns Hopkins University in 1996/97. He took up appointment as a staff physician with Southwest Medical Associates/Sierra Health Services in 1997. He was appointed the Medical Director and Facility Chief of Integrated Health Services (IHS), a 118-bed hospital in Las Vegas, in December of 1997. In addition to day to day clinical administration of the hospital, he is also responsible for developing programs to control the cost of medical care and improve quality. He is the chairman of the Pharmaceutical and Therapeutics Committee and of the Infection Control Committee. He is a member of the Quality Council, the Utilization Committee and the Strategic Planning Committee. He has recently been appointed a member of the Medical Authorization Committee of Sierra Health Services, the largest Managed Care Corporation in the state of Nevada. He is a member of the Board of Directors of Ghana Health Foundation. He is currently doing a post-graduate Masters in Business Administration (MBA) degree course at the University of California at Irvine. He is the lead promoter of a group of Ghanaian physicians who are organizing the construction of an ultra modern private hospital in Accra, Ghana.

JOYCE I. BOYE, PhD

Dr. Joyce Boye is a Food Research Scientist at the Food Research and Development Center of Agriculture and Agri-Food Canada in St. Hyacinthe, Quebec. She obtained her Bachelor's degree in Chemical Engineering from the University of Science and Technology (UST) in Ghana. In 1990, after fulfilling her national service as a teaching/research assistant in the Department of Chemical Engineering of UST, Dr. Boye received a Rotary Foundation Freedom From Hunger Scholarship from Rotary International, under the sponsorship of the Rotary Club of Accra, to continue with graduate studies in Food Science and Technology. In 1995, after five years of study at McGill University (Montreal, Canada), Dr. Boye was placed on the Dean's Honour List and was awarded her Ph.D degree. She was subsequently employed by the Center for Food and Animal Research of Agriculture and Agri-Food in Ottawa, Canada where she worked as a Post-Doctoral Fellow. In 1997, Dr. Boye was hired permanently by the Department as a Food Research Scientist where she continues to work. She is project leader for a variety of government-industry collaborative projects totaling over $ 1.9 million in value. After several years of working on the structure-function properties of whey proteins from bovine milk, Dr. Boye's research is now mainly focused on studying the functional properties of plant proteins, particularly soybean proteins and the development of processes to increase their utilization in foods. Her research has great potential benefit for many developing countries where protein malnutrition continues to be a problem. She has over 30 refereed publications and technical presentations, including six book chapters. Dr. Boye is a member of the Institute of Food Technologists (US), the Canadian Institute of Food Science and Technology and the American Society of Quality. She served as President of the Ottawa section of the Canadian Institute of Food Science and Technology in 1996. She is a founding member of the Ghana International Health Foundation in Canada, and currently serves as President of the Foundation.

NILS DAULAIRE, MD, MPH

Dr. Nils Daulaire became president and CEO of the Global Health Council (formerly the National Council for International Health) Agust 1, 1998. The Global Health Council is a U.S-based non-profit organization founded in 1971 and committed to advancing policies and programs that improve health around the world. It is the world's largest membership organization dedicated to this cause.

Before assuming leadership of the Council, Dr. Daulaire was the U.S. government's leading authority on international health as Senior Health Advisor to the U.S. Agency for International Development (USAID). Appointed by President Clinton in 1993, Dr. Daulaire helped to develop and focus an integrated strategy for a health and family planning portfolio encompassing programs totaling over $1 billion annually. In 1992 he spearheaded the development of USAID's $50 million per year infectious disease initiative.

"Nils Daulaire has been one of our government's most effective advocates for international health programs," U.S. Senator Patrick Leahy has said, "there is no one more capable of providing the vision and energy to make health a key focus of an increasingly inter-dependent world. I look forward, as should all Americans, to the council giving these issues the heightened attention they deserve."

In his three decades of international health work, Dr. Daulaire, has developed close personal relationships with health and political leaders around the world. He was the lead U.S. negotiator on health at the Cairo International Conference on Population and Development in 1994, the Bejing World Conference on Women in 1995, and the Rome World Food Summit in 1996. He represented the U.S. at the last five World Health Organization (WHO) Annual Assemblies.

"Dr. Daulaire has had a tremendous impact on people's lives around the world," said J Brian Atwood, former Administrator of USAID. "Through his leadership in the federal government, the importance of global health as a critical element of sustainable development has been strengthened. I have no doubt he will continue to make health a priority in the 21st century's rush toward globalization."

A Phi Beta Kappa and summa cum laude graduate of Harvard College, Dr. Daulaire received his M.D. at Harvard medical School with residency training in family medicine at the University of Colorado. He received his Mater's in Public Health form John Hopkins University. He is board certified in preventive medicine and public health, and is a Fellow of the American College Of Preventive Medicine.

Dr. Daulaire's two decades of field work has included five years' residence in Nepal, where he served as the senior health advisor to the Ministry of Health and chief of party for USAID's Integrated Ruaral Health and Family Planning Services Project. He has also served in western Mali as resident technical advisor on a rural health project and has worked extensively in Haiti and other low-income countries. He has provided technical assistance in more than 20 countries in all the regions of the world, and speaks seven languages.

Just prior to his appointment to his senior government position, Dr. Dau;aire served as a professor at Dartmouth Medical School. He developed and directed a child health research project in the remote Jumla district of western Nepal, where he carried out a pioneering study on community-based management of childhood pneumonia that proved the feasibility and mortality impact of this approach (Lancet, 1991). He also carried out widely cited research on the child health and survival benefits of Vitamin A supplementation (BMJ, 1992) and has authored numerous papers. Dr. Daulaire has testified before Congress on numerous occasions and appeared widely in the press and on television and radio.

KWASI A. DEBRA, MD, MBA, FACOG

Dr. Debra is a board-certified Obstetrician/Gynecologist in a single specialty practice in Richmond, Virginia. At the Columbia Chippenham/Johnston-Willis hospitals, he holds the position of Chief of OB/GYN. He is also on faculty at the Medical College of Virginia as an Assistant Clinical Professor of Obstetrics and Gynecology.

For the past two years he has been a Health Care Management Consultant, working with major insurance providers such as Trigon Blue Cross Blue Shield of Virginia, and Cigna Health plan of Virginia.
His interests include Health Care Informatics, and identifying cost effective ways to introduce managed care principles into developing countries. He serves on the IT committee of the Richmond Chapter of the American Red Cross, and he is also a member of the Operations committee of the same volunteer organization.

He is a graduate of the School of Medical Sciences, Kwame Nkrumah University of Science & Technology, Kumasi, Ghana. At Howard University Hospital, Washington DC, he completed his residency training in Obstetrics and Gynecology. Dr. Debra received a Master of Business Administration degree at the College of William and Mary in Williamsburg, Virginia. He is a fellow of the American College of Obstetricians and Gynecologist and a member of the Richmond Academy of Medicine.

At the end of February, Dr. Debra led a team of physicians, pharmacists and nurses from the Pan African Foundation for Humanity International on a volunteer medical mission to Ghana. He is also the chairman of the board of directors of this organization.

JANICE E.G. DOUGLAS, MD

Dr Douglas is a graduate of Flsk University and Meharry Medical College. She began her formal training in biomedical research supported by the National Institutes of Health Endocrinology Training Fellowship Program at Vanderbilt University School of Medicine, where she also served as an Instructor in the Department of Medicine. She continued her research training in Bethesda, MD as a Senior Staff Fellow in the National Institute of Child Health and Human Development.

Dr. Douglas is currently a Professor of Medicine and Professor of Physiology and Biophysics at Case Western Reserve University School of Medicine. She is also the Director of the Hypertension Division and Vice Chairperson for Academic Affairs for the Department of Medicine. In addition, Dr. Douglas is past President for the Association for Academic Minority Physicians, Inc., (AAMP).

Dr. Douglas is internationally renowned as a physician scientist and conducts studies on cellular and molecular mechanisms of blood pressure regulation with a focus on the renin-angiotensin system and racial/ethnic diversity in the pathophysiology of essential hypertension. She has received in excess of 20 million dollars throughout her research career to support these important research endeavors. She has extensive authorship of medical publications and is (or has been) a member of Editorial or Publication Committee and/or Associate Editor (Guest Editor) for a number of prestigious medical journals including the Journal of Clinical Investigation, the American Journal of Physiology, Circulation, the Journal of Laboratory and Clinical Medicine, Ethnicity and Disease, and the Endocrine Society, to name a few.

Dr. Douglas has been elected to membership in the most prestigious organizations for physician-scientists which include the American Society for Clinical Investigation, the Association for American Physicians, Fellow of the High Blood Pressure Council of the American Health Association, the Association for Academic Minority Physicians, the Central Society for Clinical Research and the Institute of Medicine of the National Academy of Sciences. She also serves on the Board of Directors of the American Board of Internal Medicine (ABIM).

Dr. Douglas has served on numerous policy and review commentaries for the National Institute of Health and other organizations which include, the Advisory Council for the National Health Lung and Blood Institutes (NIH), the VA Merit Review Board for Cardiovascular Studies, the Cardiovascular Renal Study Section (NIH) and most recently, the Board of Scientific Council for the National Institute of Child Health and Human Development (NICHHD), and the American Health Association Research Committee. She has also played a leadership role in the American Heart Association and is a member of the Board of Trustees of the Diabetes Association of Greater Cleveland, and the Kidney Foundation.

GILBERT KOMBE, MD, MPH

Gilbert Kombe, MD, MPH, Assistant Professor of International Health at the George Washington School of Public Health and Health Services also holds a joint appointment at the GW Center for International Health as International Research Associate, where he is involved in many research projects.

Dr. Kombe is a public health physician with extensive international experience in primary health care and public health in Africa, Asia, Latin America, and the United States. His main areas of interest include primary health care program development and evaluation, quality assurance in health sector reform and evaluation of public health programs through epidemiological methods. In addition, he has developed programs and provided services to underserved populations in the areas of maternal and child health, infectious disease prevention and control. He is the director for the department's International Health Leadership Program. He is also an adjunct faculty at the Uniformed Services University of the Health Sciences in Bethesda, Maryland.

JEMIMA A. KANKAM, MD

Dr. Kankam is the current Chief of the Psychiatry Department, Laurel Regional Hospital. She is also the President and CEO of Kankam Psychiatry Associates, a private practice in Maryland. Since 1991, she has been in private practice and worked in several clinical settings including urban and suburban inpatient settings, partial hospital programs, substance abuse unit and geriatric long-term settings.

She has volunteered as a speaker in past Depression Screen Day as well as on the educational speaker list for some pharmaceutical companies.

She was born in Cape Coast, Ghana and received her medical education from University of Ghana medical School in 1975, after which she worked in various hospitals under the Ministry of Health of Ghana including Komfo Anokye Hospital, Kumasi, Ridge Hospital, Accra and Adabraka Psychiatric Hospital, Accra.

In the USA, she completed her residency at University of Maryland medical Systems, Baltimore, with additional training in geriatric psychiatry.

She is Board Certified in Psychiatry with added Certification in geriatric psychiatry. She is a member of the American Psychiatric Association.

BERTHA KOOMSON, MD, FRCP©

Dr. Bertha Koomson is chairperson of the Board of Directors of the Ghana Health Foundation, a nonprofit independent organization that seeks to assist with current healthcare concerns in Ghana. She is also a Pediatrician.

She graduated from the University of Ghana Medical School in 1981 and worked with the Ministry of Health in Ghana as a medical officer. She later joined the University of Toronto Pediatric residency program at the Hospital for Sick Children in Toronto, Canada. Following her training in pediatrics, she subsequently completed a Fellowship in Pediatric Emergency Medicine. She later moved to Los Angeles where she was appointed Assistant Professor of Clinical Medicine at the University of Southern California and Attending Emergency Room Physician at the Children's Hospital of Los Angeles. Her interest in General Pediatrics led to the formation of a private practice in Rosemead California. Since relocating to Washington, DC in 1997 she has worked part time as a General Pediatrician.

Dr. Koomson is Board certified in Pediatrics by the American Board of Pediatrics and is a Fellow of the Royal College of Physicians of Canada.

JOSEPH KURANTSIN-MILLS, PhD

Dr. Joseph Kurantsin-Mills is Associate Res. Professor of Medicine, and of Physiology and Experimental Medicine at the George Washington University, Washington, DC, where he develops and conducts basic biomedical research, and teaches medical, bioengineering, and health sciences students. He is also an adjunct faculty member in the Department of Biological Science where he teaches courses in human nutrition. His research areas of interest are blood rheology, microvascular biology of sickle cell diseases, and hemostasis in sickle cell diseases. He has also developed interest in Partnership in Higher Education for International Development. He has directed numerous projects, sponsored by the National Institutes of Health, Bethesda, and private corporations at the George Washington University Medical Center.

Dr. Kurantsin-Mills has served as a consultant to the National Institutes of Health, the National Science Foundation, Washington, DC, Howard University Women's Health Institute, and several businesses and corporations in the National Capital Area. From 1993 to 1996, he was program director and principal investigator at Hi-Tech International, Inc., a professional and technical service firm in Arlington, VA where directed the design, conduct and implementation of a nationwide statistical study entitled *"Assessment of current status of screening and treatment of sickle cell disease"*. The study, sponsored by the National Heart, Lung and Blood Institute, NIH included 700 major hospitals, health departments in all 50 States, and the Arm Forces medical centers. The goal of this nationwide study was to determine the extent of screening and treatment of newborn babies for sickle cell disease.

He is member of Microcirculatory Society, SIGMA Xi, The Scientific Research Society, and New York Academy of Sciences. He is chairman of the board of directors of the Sickle Cell Association of the National Capital Area, Inc., Washington, DC. He is also co-founder and a member of the board of directors of the Ghana Health Foundation.

Dr. Kurantsin-Mills received his undergraduate education in Chemistry and Biology at the University of Guelph, Canada, and graduate education and training in biochemistry and physiology at the University of Toronto, Toronto, and a Ph.D. in cell biophysics and physiology at George Washington University. He completed Post-doctoral research fellowship in biochemistry and immunology at the Hospital for Sick Children, University of Toronto. He has received several research awards including awards from the National Institutes of Health, the Chemical Manufacturer's Association. Washington DC, the Multiple Sclerosis Society of Canada, and the World Health Organization.

J. KWEKU LAAST, MD, MPH

Dr. Laast graduated from St. Augustine's Secondary School Cape Coast, Ghana in 1972 where he was active in the Voluntary Workcamps Association ("Volu") and the cadet corps. He obtained his Bachelors degree in Microbiology from the University of Notre Dame, South Bend, Indiana and a Masters in Public Health from the University of North Carolina, Chapel Hill. Subsequently, Dr. Laast worked with the North Carolina Public Health service as the Executive Director of the Governor's Council on Fitness and Health. He was the first black to serve as first year class president at the University of North Carolina. He also served as the first African-American Chair of the Medical Student Council (student body president) at East Carolina University Medical School, where he obtained his medical degree.

Dr. Kweku Laast completed his residency at the Johns Hopkins-Sinai Hospital Physical Medicine and Rehabilitation residency program. Dr. Laast now serves as the Executive Medical Director at the Centers for Neuro-rehabilitation, a five-center community based rehabilitation service that he hopes to replicate in Ghana. Dr. Laast has served as a captain in the U.S. Army Medical Corps. Dr. Laast is a frequent speaker and consultant to many professional and lay audiences, including HMO's and other health insurance companies and hospital staff. He is also a member of the board of the St. Martin de Porres Elementary School (Dansoman) Ghana.

Although he has been involved in a number of business ventures and civic organizations in the past, Dr. Laast is particularly interested in establishing a medical rehabilitation service in Ghana. He is also particularly interested in Health Care finance reform in Ghana. Although he supports the efforts of those who send donations of equipment and money to Ghana, he likens it to pouring water in a leaking bucket! Continually seeking international handouts will never solve our healthcare problems.

As President of the Middle Passage Memorial Foundation, he is leading an effort to have a worldwide recognition day to properly honor our ancestors lost during the "middle passage" and slavery, The African Holocaust! You are invited to participate in this effort.

Dr. Laast is a Founding member of the Ghana Health Foundation (USA).

PETER LAMPTEY, MD, DrPH

Dr. Peter Lamptey is the Director of the Implementing AIDS Prevention and Care (IMPACT) Project, based in Arlington, Virginia, which is funded by the United States Agency for International Development (USAID), and implemented by Family Health International (FHI). IMPACT manages HIV/AIDS prevention and care programs in Africa, Asia, Latin America and the Caribbean, and the Easter Europe. Dr. Lamptey is also the Senior Vice President of HIV/AIDS Programs for FHI, an international non-governmental organization (NGO) based in Research Triangle Park, North Carolina, with more than 12 years of HIV/AIDS programming experience in over 50 countries.

Prior to directing IMPACT, Dr. Lamptey directed the AIDS Control and Prevention (AIDSCAP) Project, funded by USAID (1991-1997) and the AIDS Technical Support (AIDSTECH) Project (1987-1992); both were implemented by FHI. The largest international HIV/AIDS prevention program ever undertaken, AIDSCAP comprised more than 800 projects in 45 countries.

Born in Ghana, Dr. Lamptey received his medical degree from the University of Ghana and holds a masters degree in public health from the University of California, Los Angeles (UCLA), and a doctorate in public health from the Harvard School of Public Health. He was a research fellow in nutrition at the Massachusetts Institute of Technology (MIT) and trained in epidemiology at the Centers for Disease Control and Prevention (CDC) in Atlanta, Georgia.

Peter Lamptey is a public health physician and an internationally recognized expert on HIV/AIDS/STI (sexually transmitted infections), with particular emphasis on infectious disease transmission in developing countries. He is the former chair of Monitoring the AIDS Pandemic (MAP) Network, a global network of more than 100 HIV/AIDS experts in 40 countries, formed in 1996 by AIDSCAP, the Francois-Xavier Bagnoud Center for Health and Human Rights at the Harvard School of Public Health, and the Joint United Nations Programme on HIV/AIDS (UNAIDS)

Dr. Lamptey has consulted worldwide on HIV/AIDS/STI, nutrition and family planning and was a lecturer on maternal and child health and family planning at the University of Ghana Medical School for ten years and at the University of North Carolina School of Public Health. For more than 15 years, Peter Lamptey has been instrumental in establishing FHI as a leader in family planning and as the world's largest international NGO involved in HIV/AIDS prevention and care. Prior to his international program management and teaching experience, Dr. Lamptey served as a district medical officer in Salaga, Ghana, responsible for health services to some 200,000 individuals and for the USAID funded Danfa Comprehensive Rural Health Family Planning Project.

CELIA J. MAXWELL, MD, FACP

Dr Maxwell obtained a Bachelors Degree in Nursing from Hunter College and her medical degree from Columbia University College of Physicians and Surgeons, both in New York City. A move to Washington, D.C. afforded her the opportunity to complete internship and residency training in Internal Medicine at Howard University Hospital. She did her Fellowship in Parasitology at the National Institutes of Health, Laboratory of Parasitic Diseases in 1993. Her research interest involved the investigation of the immune response of humans to the hookworm parasite.

Dr. Maxwell returned to Howard University as an Infectious Diseases Fellow and was subsequently appointed an Assistant Professor of Medicine in the Department of Medicine Division of Infectious Diseases. She is bilingual, board certified in Internal Medicine and Infectious Diseases and is a Fellow of the American College of Physicians, as well as a member of several boards and scientific associations. She gives numerous talks to professional and lay audiences alike and is a frequent guest on radio and television. Additionally, she lectures to diverse groups, including physicians, educators, students, national service organizations. She has several publications in the areas of sexually transmitted diseases and parasitology to her credit. In 1990, Dr Maxwell was selected by Sharon Pratt-Kelly, Mayor of Washington, D.C. to co-chair the transitional Task Force on AIDS services. In 1993, she was appointed to the Healthcare Reform Task Force chaired by First Lady, Hillary Rodham Clinton, and, in May of 1995 was invited to serve on the Office of AIDS Research Advisory Council of the National Institutes of Health, by the Secretary of Health and Human Services, Dr. Donna Shalala.

From 1994 until September 1998, Dr. Maxwell was the Principal Investigator of the Mid-Atlantic AIDS Education and Training Center DC Local Performance Site at Howard University. Additionally, she served as Special Assistant to the Commissioner of Food and Drugs, Dr. David Kessler from 1994-1997. She is also the Director of HUMED Travel Medicine. In 1997, Dr. Maxwell was awarded a Robert Wood Johnson Health Policy Fellowship. As such she was one of six health professionals with a wide range of academic and Community based experience to share this honor. She served as a Legislative Assistant for Senator Tom Harkin (D. Iowa). Currently Dr. Maxwell is The Assistant Vice President For Health Affairs and Director of The Women's Health Institute at Howard University.

SAM OFOSU-AMAAH, MD, PhD

Dr. Ofosu-Amaah is currently the Director of the School of Public Health, University of Ghana, Legon. He is married with three children. He was born in Accra and was educated at Achimota School and at the Universities of Ghana, London, (Biological Science) Glasgow (Medicine and Pediatrics) and at the Harvard School of Public Health. He graduated in Medicine in 1959, specialized in Pediatrics and then was appointed Lecturer in Pediatrics at the Ghana Medical School, Korle Bu in 1966. In 1969 he went to the Harvard School of Public Health; in 1996 he was honored with the "Distinguished Alumnus" Award.

His main research interests are the epidemiology of childhood diseases, human growth and development, health policy and development and the history of medicine. In 1972 he was transferred from Pediatrics to the Department of Community Health and became Head of Department in 1974. In 1984 he was appointed as Senior Advisor in Primary Health Care at UNICEF's Headquarters in New York. He was involved in rural health research, maternal and child health and human growth, whilst teaching in Korle Bu. He was involved in the Danfa Rural Health and Family Planning Project and was Co-director from 1975 to the end of the project in1979.

He has served on several technical committees and commissions, both in Ghana and internationally. At home he served on the National Planning Commission, the National Family Planning Program, the Council for Industrial and Scientific Research, the National Children's Commission, and represented the medical profession on the 1969 Constituent Assembly.

Internationally he has served on several WHO committees, including the Global Advisory Committee on Health Research, the Expert Panel on Maternal and Child Health, the Onchocerciasis Expert Advisory Committee. He is a member of the International Advisory Panel of the United States Pharmacopoeial Convention, Washington, DC.

Dr. Ofosu-Amaah is a Fellow of the Royal College of Physicians, Glasgow, Fellow of the West African College of Physicians and a Fellow of the Ghana Academy of Arts and Sciences.

SAM OHENE, MB, ChB

Born April 14, 1956 at Ho in the Volta Region of Ghana, Dr. Ohene had his Secondary school education in Mawuli School between 1967 and 1972. He completed his Advanced Levels in Mfantsipim School, Cape Coast between 1972 and 1974.

He attended the University of Ghana Medical School from 1974 to 1980. Between 1981 and 1990 he did his residency training and worked in the Psychiatry department of the University of Benin Teaching Hospital, Nigeria,

He trained in Substance Abuse Prevention in Cleveland, Ohio in 1992. Since 1990 he has been on the Faculty of the University of Ghana Medical School teaching Psychiatry, and is Attending Psychiatrist at the Accra Psychiatric Hospital and Korle Bu Teaching Hospital.

He holds Fellowship of the West African College of Physicians and is Secretary to its Faculty of Psychiatry. He is a member of the American Psychiatric Association.

He is married to Sally-Ann M.D. who is in New York and they have two sons.

NII T. QUAO, MD, CM

After graduating from Adisadel College, Cape Cost, Dr. Quao completed the B.Sc. and the M.D. degrees at McGill University in Montreal. He returned to Ghana and worked briefly at the Accra Military Hospital and for two years at the Legon University Hospital.

He returned to Montreal in 1972. He is the Medical Director of the Westside Medical Clinic which he founded in 1974. He has been on staff at the Concordia University Student Health Services for twenty-five years. Over the past fourteen years he has been a member of the Committee organizing the McGill University Annual Refresher Course for Family Physicians. He is a member of various medical organizations in Canada and the United States.

Dr. Quao has been active outside medical practice and administration. He is the founder of the Ghana Family Council of Montreal and also the Black Legal Education and Support Foundation. He is a founding member and Vice-President of the Montreal-based Ghana International Health Foundation.

He is the past President of the Montreal Westward Rotary Club and a Paul Harris Fellow of Rotary International since 1988. His other community awards include:

1996 – Community leadership Award of the Ghana Business and Professionals of Canada
1977 – The Jackie Robinson Award of the Montreal Association of Black Business Persons and Professionals

Dr. Quao is married and has three sons who live and work in Toronto.

SANDRA L. THURMAN

Sandra L. Thurman was appointed by President Clinton on April 7, 1997 as the Director of the Office on National AIDS Policy at The White House.

For nearly two decades, Ms. Thurman has been a leader and advocate for people with AIDS at the local, state, and federal levels. Most recently, Ms. Thurman served as the Director of Citizen Exchange at the United States Information Agency. From 1993 to 1996, Ms. Thurman was the Director of Advocacy Programs at The Task Force for Child Survival and Development at The Carter Center in Atlanta, Georgia.

From 1988 to 1993, Ms. Thurman served as Executive Director of AID Atlanta, a community-based nonprofit organization that provides health and support services to people living with HIV/AIDS and offers an array of HIV prevention programs. Under her leadership, AID Atlanta, the largest and oldest AIDS service organization in the south, tripled in size, and became a multi-million dollar agency.

Ms. Thurman has been a tireless advocate on behalf of the disenfranchised and marginalized. After spending her college years as a volunteer in a Poverty Rights Program, she went on to work as a counselor in a maximum security facility for youthful offenders and a pretrial intervention program. She then turned her attention to health policy.

Ms. Thurman was a member of The Presidential Advisory Council on HIV/AIDS and a founding member of Cities Advocating Emergency AIDS Relief (CAEAR). She has served on the Board of Directors of numerous AIDS organizations and other health related organizations including the March of Dimes, and the National Kidney Foundation. She is one of the world's leading experts on AIDS issues and has provided testimony before the United States Congress, the White House Conference on HIV/AIDS, and the National Commission on AIDS.

YAW TWUM-BARIMA, MB, ChB, MSc, FRCPC

Dr. Twum-Barima received his medical education at the University of Ghana Medical School, Accra from 1969 to 1974, and graduated with the MB ChB (Medicine) degree. He continued his studies at the University of Western Ontario, London, Ontario, Canada from 1978 to 1980 where he studied Pharmacology and earned a M.Sc. degree. From 1980 to 1983 he pursued a specialty training in Internal Medicine at the University of Ottawa School of Medicine, Ottawa, Ontario, Canada. He continued his studies and completed a sub-specialty training in Endocrinology and Metabolism from 1983 to 1984 at the University of Ottawa School of Medicine. He is Fellow of The Royal College of Physicians and Surgeons of Canada. Currently, he is Chief of Medicine, Quinte Health Care Corporation, Trenton Division, Trenton, Ontario, Canada, Medical Director, Diabetic Education Clinics, Quinte Health Care Corporation and Consulting Physician, QHC, Belleville, Ontario. He is a member of the Eastern Ontario Diabetes Advisory Board to the Ministry of Health, Ontario, Canada. His previous academic positions include Lecturer, Faculty of Medicine, University of Manitoba, 1984 to 1989. He has published several abstracts, original articles and review papers in his specialty.

THADDEUS P. M. ULZEN, MD, FRCP(C)

Dr. Thaddeus Ulzen is currently Associate Professor and Vice Chairman Dept of Psychiatric Medicine, Brody School of Medicine at East Carolina University, Greenville, North Carolina (University of North Carolina System). He graduated with distinction from the University of Ghana Medical School in 1978 and joined the University of Toronto Residency Program in Psychiatry in 1980. He graduated from the program in both General and Child Psychiatry in 1984 and completed additional training in Clinical Psychopharmacology at the Clarke Institute of Psychiatry In 1985.

He Joined the faculty of the Department of Psychiatry at the University of Toronto In 1985 as Lecturer and later as Assistant Professor. He was appointed Psychiatrist - In - Chief of the George Hull Centre for Children and Families Toronto in 1995. He joined the faculty at The Brody School of Medicine at East Carolina University in 1997. Dr. Ulzen's academic interests include disruptive behaviour disorders, juvenile delinquency, paranoid spectrum disorders, mental retardation and mental health consultation to underserved domains and geographical areas. He has numerous publications, national and international presentations to his credit.

RITA WALLACE-REED, MD, MPH

Dr. Reed is a graduate of Achimota School and the University of Ghana Medical School. She completed an Internship in General Surgery and Internal Medicine at The Korle Bu Teaching Hospital, completed an Internship and Residency in Pediatrics at The Howard University Hospital, followed by a Master of Public Health Degree from George Washington University while working with PHP Healthcare Corporation's Clinics in Northen Virginia, first as a staff physician and later as Medical Director of The Fairfax facility.

Dr.Reed constantly felt a nagging sense of call to give something back to Ghana, the country which had made all her accomplishments possible.

With the help of family in Accra, she found land that had not been touched by development. Dr. Reed initially planned the layout of the clinic and drafted the architectural drawings. This project became a passion which was very close to her heart. She traveled to and from Ghana over a period of five years to supervise the construction of the medical center, arrange the shipment of building materials, equipment and supplies. After much effort and work the clinic was completed in 1998 and was indeed a beautiful piece of work - a spacious high ceiling foyer with a large nurses' station, two large pediatric examination rooms, separate male and female exam rooms and toilet facilities, one admission bed, an emergency room a laboratory, large waiting area , offices and two outdoor shops one for a pharmacy and the other for grocery and other petty potential patient needs, all of these to provide a one stop needs-met facility. It was a dream come true!

By the time the clinic opened in the summer of 1998, this new section of West Legon had become a thriving community with new houses coming up almost daily. With new people moving in, the vision of a need for this clinic was justified. However, despite the need, such a venture grows slowly.

Before returning to the U.S.A., Dr. Reed had the good fortune of finding a respected physician and competent nurse to take care of the patients. Since his retirement from The Cocoa clinic in January 1999, Dr.Kwadjo Owusu is now running Hope Medical Center fulltime.

While continuing to practice in Fairfax, Virginia, Dr. Reed is committed to providing resources for strengthening the clinic in Accra and to find ways to meet the medical needs of people in Ghana.

KWEKU YEBOAH, MB, ChB, MPH

Dr. Yeboah is a graduate of Ghana Medical School in 1985, where he also earned a Masters degree in Pathology. He has a post-graduate diploma in Genitourinary Medicine and Venereology (1991) and also completed a Masters in Public Health (1997) from the School of Public Health at University of Ghana.

Dr Kwaku Yeboah has been involved as an attendee or presenter, Internationally and in Ghana, in several seminars, workshops and conferences on sexually transmitted diseases and AIDS. He currently serves as the Program manager of the National ATDS/STD Control Program of the Ministry of Health, Ghana.

Research interests include adolescent reproductive health, and has written a paper on "Treatment Seeking Behavior Among Adolescent Secondary Schools in Asuogyaman District " in the Eastern region of Ghana. Dr Yeboah also has an active research interest in sentinel surveillance of HIV among pregnant mothers.

FRANCIS L. YEMOFIO, MD, MPH

Francis L. Yemofio, is an HIV clinical specialist, with the Oasis Clinic and AIDS Program, at the Martin Luther King J. Hospital/Charles R. Drew University of Medicine and Science, Los Angeles, California. He is also an internist with Healthcare Partners Medical Group, a Multi-Specialty Managed Care group based in Los Angeles, California.

After earning his medical degree from the University of Ghana Medical School, Accra, Ghana, he worked as a Medical Officer with the Ministry of Health, in Koforidua, Ghana. Shortly thereafter, he came to the United States, and attended the School of Public Health at the University of California, Los Angeles, where he graduated with a Masters of Public Health degree (MPH), 1986.

While in the Preventive Medicine Residency program at the UCLA School of Public Health, he also conducted research with the Department of Neurological Sciences, at the Charles Drew University of Medicine & Science, Los Angeles.

Dr. Yemofio completed his internship and residency in Internal Medicine, at Howard University Hospital, Washington, D.C. and returned to Los Angeles, where he has since established his clinical practice.

He is a board certified internist, with the American Board of Internal Medicine, and a Diplomate of the American Board of Quality Assurance and Utilization Review Physicians (ABQUARP).

He is a member of the American College of Physicians, the American Public Health Association, and the International Association of Physicians in AIDS Care (IAPAC).

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Mercy Addo-Yobo	OB/GYN	Union, NJ
Sarah Addo-Yobo	Registered Dietitian	White Plains, NY
Teye Adusu	Pharmacology	New London, CT
Eyra Agudu	OB/GYN	Fairborn, OH
John Agwunobi	Pediatrics	Silver Spring, MD
Mike Aidoo	Public Health	Montgomery Co., MD
Samuel Akuoku	Internal Medicine	Freeport, NY
George Amoako	Internal Medicine	Chicago, IL
William Ankobea (Dr. B.)		
T. Arthur-Mensah.	Psychiatry	Amherst, OH
Robert Aryeetey	Internal Medicine	New York, NY
Barbara Ayew	Nurse Practitioner	New York, NY
Franklin Ayew	OB/GYN	New York, NY
Robert Blake	Pediatrics/Neonatology	Washington, DC
Rosemary Botchway	Healthcare Reimbursement	Laurel, MD
Monique V. Chireau	OB/GYN	Dorchester, MA
Cynthia Cudjoe	Family Practice/Com. Health	Washington, DC
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Harry Doty (Dr. Mills)		
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Charity Kankam Amba	Internal Med./Nephrology	Cleveland, OH
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Grace Laast-Adofo	OB/GYN	Dresher, PA
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Fred Ofosu	Professor	Hamilton, CN
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Osei-Tutu Owusu	Internal Medicine	Rahway, NJ
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Ruth Shaw-Taylor	Psychiatry	Baltimore, MD
Stephan Solat	Health Program Manager	Washington, DC
Alhaji-Adam Tahiru		Redlands, CA
Sharron Thompson	Physical Med & Rehab	Jackson, TN
Cassandra Wanzo	Psychiatry	Atlanta, GA
Dode Washington	OB/GYN	Jamaica, NY
Amanda a. Wiredu	Internal Medicine	Derry, NH
Degraft Yahkah	Urology/Gen. Surgery	Selma, AL

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Embassy of Ghana

Howard University Women's Health Institute

United States Agency for International Development

Academy for Educational Development

Phyto Riker Pharmaceuticals

Virgil Waggoner

V.W. Investment

Global Data Technology, Inc.

Nestle

Berlex Laboratories

Coca Cola Company

LKA Computer Consultants Inc.

Collins Kankam, MD

Oheneba Boachie-Adjei, MD

Cleveland Cancer Institute

International Travel Exchange

TeleCommunications Systems Inc.

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EXHIBITORS

United States Agency for International Development/AED

Phyto Riker Pharmaceuticals

Boston University School of Medicine

Howard University Women's Health Institute

Global Health Council

West African AIDS Foundation

Global Data Technology, Inc.

International Travel Exchange/Ghana Airways

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GENERAL INFORMATION

COURSE MATERIALS	The materials in the syllabus are arranged in the order of each speaker's presentation. Those not included in the binder may be available as a supplement at the registration each morning. Other materials include: 1. A Course Evaluation Form and Speaker Evaluation Form to be completed and returned to the Course Registrar before leaving. 2. A Record of Attendance Form to be completed, signed and returned on your last day.
ATTENDANCE AND DOOR CONTROL	Attendance will be monitored. For the maximum credit hours, please initial the registration list opposite your name each day between 7:00 a.m. and 8:00a.m. The evaluation sheets serve as a final check on attendance for full credit.
EVALUATION	Please rate each speaker as well as the overall program, daily while impressions are still fresh in your mind. DON'T FORGET TO LEAVE EVALUATIONS AT THE REGISTRATION DESK BEFORE LEAVING. WE APPRECIATE YOUR COMMENTS AND SUGGESTIONS.
RECORD OF ATTENDANCE	An official record of credits for participation will be mailed to physicians. This record will only be mailed to those who complete and sign a Record of Attendance Form (Item #2 above) certifying the number of hours attached.
NAME BADGES	Please wear your name badges to all course sessions and luncheons. This allows us to admit only registered participants to the sessions.
LUNCHEON	Lunch will be provided daily at no additional cost to registrants. The Friday Luncheon will be held at the Blackburn Center Ballroom. Buses will be available to transport registrants to the Blackburn Center.
PARKING	Registrants are responsible for their parking fees daily.

Sandra L. Thurman
Director
Office of National AIDS Policy
Ghana Health Foundation
March 31, 2000

Good Morning. I am delighted and honored to be with you today.

Nearly two years ago, President Clinton traveled to Africa to help Americans and Africans begin to see each other through new eyes. He went to reach out to our brothers and sisters in Africa, and to create together a bold new partnership for the new millennium.

Beyond the old stereotypes and policies of paternalism, our shared vision is one of hope and empowerment, of democracy and freedom. It is a vision born of more than just compassion. It is a vision born of the realization that we are a global community with a shared destiny. And in this global community, both crisis and opportunity have no borders.

As Africa stands on the brink of a new day, the threat of AIDS looms large.

If we are determined to hold fast to our new vision for the 21st century – we must commit today to join forces in an all-out war on a common enemy. That enemy is AIDS.

AIDS is a plague of biblical proportion – and it is killing more people than all of the armed conflict on the continent – combined.

AIDS is now the leading cause of death among all people of all ages in Africa. The progression of this pandemic has outpaced all of our projections. In 1991 the World Health Organization predicted that by 1999 there would be 9 million infected and nearly 5 million deaths in Africa due to AIDS. The resulting numbers are *two to three times* higher with nearly 24 million infected and 14 million deaths.

And yet the epidemic rages on. Each and every day Africa buries 5,500 men women and children as a result of AIDS – and by 2005, Africa will bury nearly 13,000 every day.

In a host of different ways and from a variety of different vantagepoints, it is the women and children who are caught in the crossfire of this relentless epidemic, and who are crying out for our help. The next generation is indeed in jeopardy.

In many communities throughout sub-Saharan Africa, AIDS has virtually wiped out parents and providers, leaving behind children and grandparents to care for each other.

In some countries, between one-fifth and one-third of all children have already been orphaned by AIDS. And the worst is yet come. Within the next decade more than 40 million children will be orphaned by AIDS – 95% of whom will live in sub-Saharan Africa – and this tragedy will continue to grow for at least another 30 years.

We must remember that AIDS is not just a health issue – it is a fundamental development issue, an economic issue, a trade issue, and a key security and stability issue.

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. And AIDS has had a devastating impact on economic growth – striking down skilled workers in their prime and forcing many companies to hire two employees for every one job – assuming that one will die of AIDS.

Not since the bubonic plague of the Middle Ages has the world witnessed such devastation from a single disease, and the worst is yet to come. The sad truth is that we are at the beginning of an epidemic – what we see in Africa is just the tip of the iceberg. A report recently released by the National Intelligence Council indicates that in the next 15 years the epicenter of the epidemic will be in India, and the Newly Independent States of the Former Soviet Union are not far behind.

AIDS is not an African or an American issue – it is truly a global issue.

Yet my message to you today is not one of hopelessness and desolation. For amidst this tragedy is hope. Amidst this crisis is opportunity; the opportunity to empower women, to protect children, and to support families and communities in our battle against AIDS.

The good news is we know what works – with our partners in Africa, we have designed model programs and proven that they work. And today, we know how to stem the rising tide of new infections, how to provide basic care to those who are sick, and how to mobilize communities to support the growing number of children orphaned by AIDS. But there is more, much more that needs to be done if we are to bring these successes to scale.

The United States has been engaged in the fight against AIDS here at home since the early 1980s. But increasingly we have come to realize that when it comes to AIDS – both the crisis and the opportunity have no borders. We have much to learn from the experiences of other countries, and the suffering of citizens in our global village touches us all.

We have done much, but there remains much more that the United States and other developed nations can and must do.

During the past year and a half, I have made four trips to eight African countries including Ghana at the request of President Clinton. Together with leaders from Congress and the private sector, we went to bear witness to the AIDS emergency and to search for ways to enhance our understanding and support for sustainable solutions springing up across Africa. In response to the findings of these trips, the Administration has launched a broad new initiative, the centerpiece of which is a $100 million investment in the FY2000 budget.

This is the largest ever increase in US support for fighting the global battle against AIDS.

It will more than double our investment in HIV prevention and AIDS care in Africa – finally a budget that begins to reflect the magnitude of this rapidly escalating pandemic. While this is just a first step, it is an essential foundation for progress. UNAIDS estimates that we need at least one billion a year to adequately address HIV prevention in Africa, and another one billion to start to address the care and support needs of those already infected.

In January, Vice President Gore opened the first-ever United Nations Security Council session on a health issue by addressing the AIDS crisis in Africa. He announced the Administration's request to Congress for an additional $100 million to further enhance our efforts against AIDS in Africa and around the globe.

But bilateral donors cannot - and should not - do this alone. This crisis will require engagement and contributions from all sectors of all societies working together. Every bilateral donor, every international lending agency, every corporation, every foundation, and every African government must do its part to provide the leadership and resources necessary to turn this tide.

Together we can do just that.

As we struggle to move forward together – the futures of the children and families devastated by AIDS compel us all to find ways to do better, to be smarter, to move faster, and to develop whatever capacity we lack, so we can gear up for the long haul.

Luckily, painful experience here at home 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.

Second, leadership matters. Leadership from the very top – all the way to the community level. And Ghana is a great example of leadership from President and Mrs. Rawlings and early mobilization at the community level. Ghana has managed to keep AIDS prevalence low. In the final analysis – there is simply no substitute for real and committed leadership.

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.

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.
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 find ways to affirm that we are a global community and our battle against AIDS in America, in Africa, and around the world is a shared responsibility.

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.

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 not to squander the lives of the 14 million people who have been lost to AIDS but 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.

In the words of Archbishop Desmond Tutu: "Let us wage this holy war together, and for the sake of our children, let us win."

Thank you.