

# **Successes and Challenges of Public/Private Partnerships in Scaling-up Treatment for HIV/AIDS in Sub-Saharan Africa**

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**On the occasion of the 2003 Conference of African Ministers of Finance, Planning and Economic Development followed by the joint Symposium with the African Development Bank.**

Sunday, 1 June 2003  
Time: 7:30 PM  
Sheraton Addis

English/French-French/English interpretation provided

**Global Alliance for Women's Health (GAWH)**  
and

- **Association for the Rehabilitation of Girls Addis Ababa**
- **The Permanent Mission of the Republic of Angola with the African Union, the ECA, and the Embassy of the Republic of Angola in Ethiopia**
- **The Permanent Mission of Niger to the United Nations**
- **The Permanent Mission of the Republic of Angola to the UN**

in partnership with the corporate members of the

**Accelerating Access Initiative (AAI)**

Abbott Laboratories Inc., Boehringer Ingelheim GmbH, Bristol-Myers Squibb,  
GlaxoSmithKline, F. Hoffmann-LaRoche, Ltd., Merck & Co., Inc

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Accelerating Access Initiative (AAI)

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## SPEAKERS

- Dr. Yodit Abraham, Internist, Medical Director, Armed Forces Hospital, Addis Ababa, Ethiopia
  - Dr. Tesfanesh Belay, Ministry of Health, Addis Ababa, Ethiopia
  - Mr. Alex de Waal, Director, UN Commission on HIV/AIDS and Governance in Africa
  - Mr. Robert Dintruff, Director, Global Care Initiatives, Abbott Laboratories Inc.
  - Mr. Niraj Doshi, Business Manager (HIV Products), Merck Sharp & Dohme
  - Prof. Alan Whiteside, Director, Health Economics & HIV/AIDS Research Division, University of Natal, South Africa
  - Elaine M. Wolfson, Ph.D., President, Global Alliance for Women's Health
  - Fantaye Mekbebe, Ph.D., Vice-President, Global Alliance for Women's Health (GAWH); Manager, Association for the Rehabilitation of Girls, Addis Ababa
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## AGENDA

- I. Welcome and Introduction
- II. The Context of HIV/AIDS: is it an emergency requiring urgent action?
- III. The role of public-private partnerships in scaling-up treatment for HIV/AIDS.
- IV. Successes and Challenges: short term and long term
- V. Summation

## PROCEEDINGS

Edited by Alice Shiller

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Addis Ababa, Ethiopia, 1 June 2003



**Elaine Wolfson, President, Global Alliance for Women's Health:** Welcome. My name is Elaine Wolfson, and I am the President of the Global Alliance for Women's Health. This event is meant to be a roundtable where we discuss some very important issues. And, we are going to do it with some informality. Before we begin, I want to acknowledge and thank people here, because we would not have been able to hold our meeting without their support. They are our partners and co-sponsors.

You will notice that we are co-sponsoring this event with the Association for the Rehabilitation of Girls in Addis Ababa. We are delighted that they are doing such fine work, and you will hear about them shortly. We are grateful to the Permanent Mission of the Republic of Angola to the United Nations, the African Union, the ECA, and the Embassy of the Republic of Angola in Ethiopia. All have been so very helpful in our work here, and we are very delighted that they have come and are well represented at this meeting. Thank you so much for your support and also for the support your missions have given us in Geneva and New York. We are looking forward to having additional good relations with more government missions in Geneva and New York, Addis and other places, because we believe that the partnership of NGOs and governments is very important.

We are extremely pleased that the Accelerating Access Initiative has partnered with us on this event here in Addis and, last week, on a similar meeting that we held at the World Health Assembly in Geneva. The corporate members of the Accelerating Access Initiative (AAI) consist of six major pharmaceutical companies: Abbott Laboratories, Boehringer-Ingelheim, Bristol-Myers Squibb, GlaxoSmithKline, Hoffmann La Roche, and Merck & Co., Inc. We have worked with many of them before on an individual basis, and now we could not be more pleased that we have the opportunity to work with all six.

Our ability to partner with the private sector has meant a great deal to the Global Alliance and to our initiatives. As we continue the proceedings this evening, we will look at and discuss the successes and achievements of partnerships as well as the reasons for entering into partnerships.

Having said that, I now want to thank all of you for coming because it would not be enough to have an array of co-sponsors and partners if we could not have a dialogue with the people who are interested in these issues. And the very fact that there are so many of you in this room, when it is a very, very busy time for all of you, reflects how deep your concerns are. We are especially proud that our Ethiopian partners and the Ethiopian government are so well represented here. And we would like especially to acknowledge many of the honorable people who are in attendance.

Now, the Welcoming Address by Dr. Fantaye Mekbeb.



**Fantaye Mekbeb, Ph.D., Vice-President, GAWH, Manager, Association for the Rehabilitation of Girls (ARG), Addis Ababa:** Thank you, Dr. Wolfson, Your Excellencies, invited guests, ladies and gentlemen. On behalf of the Global Alliance for Women's Health and the Association for the Rehabilitation of Girls, I welcome you all to this night's roundtable discussion.

Thank you, Dr. Wolfson, for giving me this opportunity and honor to welcome the excellencies, honorable guests, and other distinguished participants who have come to this roundtable discussion.

The theme of tonight's discussion is to examine successes and challenges of public and private partnerships in scaling-up treatment for HIV/AIDS in Sub-Saharan Africa. We all know that HIV/AIDS has established itself as one of the major social and developmental problems of Africa. We also know that there are different multi-sectoral initiatives that are also underway through the concerted efforts of governments, NGOs, civil societies, and the private sector. We also know that the number of HIV/AIDS-infected and affected cases is increasing day by day. As a component of the care and support service package, the treatment of HIV/AIDS has now become a central issue in the fight against HIV/AIDS. And in this intervention, the role of governments, civil societies, and the private sector is also crucial. This meeting will focus on the joint partnership of these sectors in scaling-up the treatment of HIV/AIDS in Sub-Saharan Africa, including Ethiopia.

I am the vice-president of the Global Alliance for Women's Health, actively when I was in the United States, not actively since my return to my country. I am currently the manager of the Association for the Rehabilitation of Girls, which is a local NGO. The Global Alliance for Women's Health and the Association for the Rehabilitation of Girls and other co-sponsors arranged this discussion.

The Association for the Rehabilitation of Girls' vision is to see marginalized girls, children, and mothers live a sustainable and improved life. Its service package includes vocational training and rehabilitation of marginalized school dropout girls; provision of reproductive health services and training; and interventions against HIV/AIDS that include prevention, care and support, and voluntary testing and counseling services. ARG is ready to network and cooperate with all sectors that are engaged in the fight against HIV/AIDS.

Excellencies, ladies and gentlemen, I am sure that this meeting will facilitate the process of the scaling-up of treatment and other interventions in the fight against HIV/AIDS. Once again, I thank you all for coming to this meeting and wish you all a happy dinner and a fruitful discussion. Thank you.

**Dr. Elaine Wolfson:** Thank you very much, Dr. Mekbeb. I would like to draw attention to the program speakers who will be presenting on different aspects of this issue. They are seated at this table. Our program lists them alphabetically, not in order of presentation, and they will raise their hands as I call their names: Dr. Yodit Abraham, Dr. Tesfanesh Belay, Mr. Alex deWaal, Mr. Robert Dintruff, Mr. Niraj Doshi, Professor Alan Whiteside. Fantaye and I will be chiming in from time to time. I will be moderating this event. Our goal is to encourage discussion, so I have asked the speakers to keep their remarks to a relatively short period.

The agenda for the evening is rather broad. We have a number of issues we want to cover, but the main themes are in the context of HIV/AIDS: is it an emergency requiring urgent action; what is the role of public-private partnerships in scaling up treatment for HIV/AIDS, and successes and challenges, short term and long term. I hope we can get through all. First, Professor Alan Whiteside will talk on the context of HIV/AIDS. Professor.



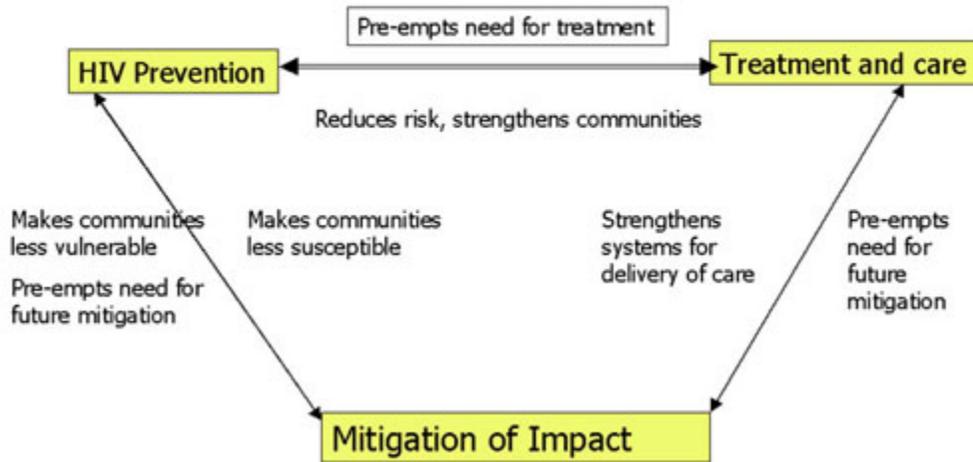
**Professor Alan Whiteside, Professor, University of Natal:**

Thank you very much indeed. I am an academic, and as an academic, I need some assistance. So, I will use the flip chart. What I am going to do is give you a presentation which will have one graph, one picture, and two stories in it. And I hope that at the end of it, you will be convinced, as I am, that this HIV epidemic is a crisis of unprecedented magnitude, and in fact it would not be wrong to call it a Darwinian event. It is something which is going to change the way the world operates.

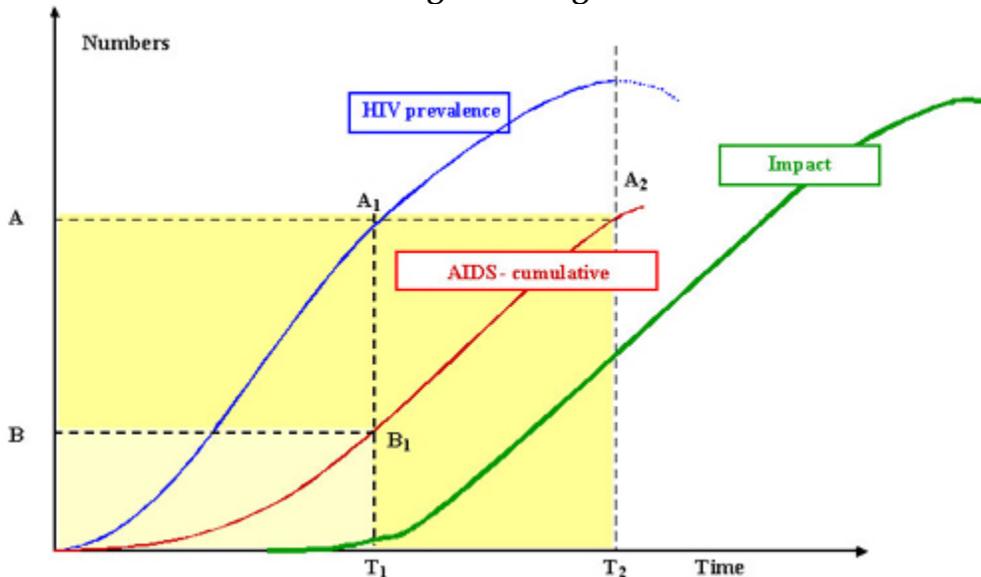
I am a professor at the University of Natal in South Africa, and as such, I have been working on HIV/AIDS now for 13 years. I have watched this epidemic take off in a way that we would never have believed possible. I want to show you what has happened.

## Epidemic Curves, HIV, AIDS, & Impact

# A Virtuous Circle



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If we compare the points 1990 and 2003 – you can see how rapidly the HIV epidemic took off. In my country, 25% of the women attending ante-natal clinics today are HIV infected. In 1990, it was less than 0.5%. In the country I grew up in, Swaziland, there is a 38% HIV prevalence rate among the women attending ante-natal clinics today. Thirteen years ago, it was less than 0.5%.

Now this HIV curve which I just drew in for you is a story of what we know. We know at what point this epidemic started, and we know where we are now. What we do not know is where this curve will go. We do not know if it will continue to go up, or if it will stabilize, or if it will decline. We do not know that. And that, ladies and gentlemen, is the first challenge that this epidemic faces us with: the challenge of prevention. We must stop those people who are not infected from becoming infected.

There are new cohorts of young people becoming sexually active all the time. And it is incumbent on us to stop HIV infections from spreading to them. There is a second curve though, and an equally concerning one. It is the subject of why we are here this evening. This is the curve of AIDS cases and AIDS deaths. We know that this follows on some distance behind the HIV statistics and represents a cumulative number of AIDS cases. Now the point about this is that if we are here in 2003, then the number of cases and deaths that we are seeing over here represents infections that took place over there. Understand this and understand this well: if we are here on this HIV curve, then in the absence of affordable, effective, and deliverable treatment, then these people here will fall ill and they will die. And that, ladies and gentlemen, is the second challenge that we face. It includes the challenge of care and treatment, the challenge of taking care of these people, the challenge of making sure that they do not fall ill, that if they do fall ill, then they have some chance of recovery, the challenge of ensuring that they live with HIV but live positively, that their opportunistic infections are treated, and that in the long term, there is antiretroviral treatment available.

I said the first challenge was the challenge of prevention, and the second challenge was the challenge of treatment and care. There is a third challenge, and this is the one so often neglected. It is the challenge, ladies and gentlemen, of impact mitigation. AIDS deaths here have already created tens of thousands of orphans across Africa and have left tens of thousands of elderly people without sons and daughters to care for them. We have a curve of impact coming up behind, and that, ladies and gentlemen, is our third challenge: the challenge of paying attention to and trying to deal with the impact.

I promised you two pictures, and I would say that if you were to understand this epidemic and what we need to do about it, then we have to look at a triangle composed of prevention, treatment and care, and impact mitigation. I would argue, ladies and gentlemen, that we cannot do one of them without doing the others. We have to do all three if we are going to deal with this catastrophe facing us. As I said, there are things we know. We know that in Swaziland 35% of the adult population is infected. We know that in Nigeria over 5% is infected. Now, I said I was going to show two pictures and tell you two stories. The first story I would like to tell you is the story of Mozambique. What does

that have to do with AIDS? Is there anyone here from Mozambique? Unfortunately not. In Mozambique, in 1999, in Maputo, they knew that the rivers were rising in the interior of southern Africa. They knew that a flood was coming. They knew it because it was raining in Malawi, in Zambia, in Zimbabwe, in South Africa, and as far away as Botswana and Angola, where the Zambezi rises. The rain had come, and the flood was coming.

Ladies and gentlemen, that is what we face. We face the flood of the AIDS epidemic in Sub-Saharan Africa. The flood is coming, and just like those people in Mozambique, I have the same frustrations when I stand up and present to groups. Because people in Mozambique, in Maputo, knew the flood was coming. They were telling them at Beit Bridge that the water was high. At Kariba they had opened the sluice gates. At Cohara Bassa they were opening the gates on the dam to let the water through. But how do you convince the people on the floodplains of Mozambique that there was a flood coming when they had no experience with anything like this ever. They had never seen anything like what was coming in living memory. The last time there was a flood of this magnitude, God gave them a warning; he told a man called Noah. That was the only time a flood like this occurred, as far as the Mozambiquans were concerned. In fact, where they were, it was not even raining. How do you tell these people on the floodplain that the flood is coming? Well, ladies and gentlemen, this evening I am telling you that the flood is coming, and we have to do something about it.

That brings me to the last thing I am going to say. It is a story which wrenched my heart, and I make no apologies for telling it to you this evening. I think it is important that we remember what this epidemic means for many millions of people out there in Africa, in my country South Africa, in Swaziland, in the country where I worked, Botswana. This story was told to me by the head of the National Emergency Response Committee in Swaziland.

He has a farm in Swaziland. He was down there in the fields one Saturday afternoon when he saw four children walking towards him. The eldest child was a girl, perhaps about eight years old; the rest were younger. The only child wearing anything was the oldest child, the girl, and she was just wearing a pair of pants, a pair of knickers. These children were in a desperate way. They were clearly exhausted, hungry, disheveled. Clearly not cared for. My friend who runs the National Emergency Response Committee on AIDS for the Swaziland government went to the oldest child and asked her, "What has happened to you? What is going on? Where are you from? Why are you walking on this road?"

The child said, "Our mother died this morning. And we heard that maybe, just maybe, our grandmother was living in this town. And so we set off to walk to find this grandmother that might be living in this town."

He said, "Where have you come from?"

"Moluma."

Those children had walked 20 kilometers on a "maybe." He fed them, cleaned them up, and took them back to the area where they had come from. True enough, there was a hut and there was a mother who was dead. Now, ladies and gentlemen, I tell you this story because I am living in a world where children are walking 20 kilometers on a "maybe" because there is no one to take care of them. And frankly, that is not a world that I want to live in. I do not think it is a world that you want to live in either. So let's really gear up to respond to this epidemic. The flood is coming, and we had better be ready for it, because it is coming sooner than we think. Thank you very much.

**Dr. Elaine Wolfson:** Thank you very much for that moving presentation. The issues that are facing us about women and HIV/AIDS, and families and HIV/AIDS, are tremendous. Next we will hear from Mr. Alex deWaal, who also has been very involved in studying the epidemic and has addressed many of the complex issues. Mr. deWaal.



**Alex de Waal, Program Director, UN Commission on**

**HIV/AIDS and Governance in Africa:** Thank you. Over the last year or so I have gotten quite used to following Alan Whiteside in various presentations, and it is always impossible actually to follow a presentation which is so moving. So, I will not even really try to match what he has conveyed. Alan, I am glad to say,

has recently been requested by UN Secretary General Kofi Annan to be one of the commissioners on the United Nations Commission on HIV/AIDS and Governance in Africa, which is located here at the Economic Commission for Africa and is chaired by K.Y. Amoako, the Executive Secretary. I am serving as the program director of this Commission, so at the end of the day I have to answer to Alan.

I would like to tell you a short story as well. It comes from my experience 19 years ago when I started doing my Ph.D. research on famine survival in Sudan. In the early days of that field research, I remember meeting a woman, whose name was Amina, in a very, very remote village in the far north of Sudan, on the desert edge. She was an extremely resourceful and impressive lady. What struck me about her was a particular story she told about how she had survived the last year, which was one of severe drought.

She had harvested very, very little grain--just two heads of millet. Rather than eating them, she had actually buried them in her compound, mixing the seed with sand and gravel to stop her little children from digging them up and eating them. Then she left. She spent the next nine or ten months traveling very widely over a huge area, gathering wild foods, preparing them for meals, visiting relatives and getting some food from them, working on farms, and husbanding her resources very carefully. Then when the rains came, she went back home, dug up her seeds, planted them, and a few months later had a crop. What this showed was a capacity to withstand hunger, also a resourcefulness, a capacity for hard work, and a capacity to undergo immense, short-term sacrifices for long-term gain. I found her story extremely impressive and moving. The key theme of my Ph.D. thesis became the resourcefulness and the ability of African rural people to withstand tremendous hardship and adversity. I think we should remember that today as 12 million people in this country face hunger.

What does this have to do with HIV/AIDS? The moral of this story is that those key qualities that allowed Amina and many others to get through extreme hardship during that drought year of 1984-1985 are all jeopardized by HIV/AIDS. This young woman went very hungry. Now, if she were HIV positive, going very hungry would almost certainly accelerate the progression to AIDS. If her mother had died young, Amina probably would not have learned the skills that she had picked up from her about what wild foods, what berries, what nuts, what grasses could be gathered and could be prepared. Perhaps she would simply have walked through those vast open spaces of western Sudan, past food that was quite edible but not knowing what to collect and what to eat. If she had had to care for orphans or sick relatives, she would also not have been able to do that. The amount of work she would have had to do simply to keep herself and her three young children alive would have been considerably more if she had had extra mouths to feed. And perhaps most important of all, if she were living in an AIDS-affected society and seeing the future beginning to erode before her eyes, would she have been ready to make those sacrifices in order to return to an acceptable way of life afterwards. If she had felt there was no future to look forward to, would she really have struggled in this way.

So, I think there is a tremendous lesson that we must learn. It is that the resilience of rural people in this continent we have relied upon is being destroyed by this terrible pandemic. And, in the context of our challenge today to provide treatment to HIV-infected people, two particular issues arise. The first is, when people are hungry--and millions are hungry in this continent--can we provide them with antiretrovirals? Can we sustain their lives in this way? Or rather, let's put it the other way around: What else other than antiretrovirals should we be providing? And secondly, if we look at what this means, this lack of resilience in rural societies means, what we may face is a terrible race between spreading

hunger--deepening hunger--and our efforts to actually provide treatment to those millions of people who need it. Let's hope we win that race. Thank you.

**Dr. Elaine Wolfson:** Thank you very much, Alex. Now, I would like to open the presentations in this section of the program to questions from the floor and comments from other speakers. Please identify yourself when you come to the microphone.

**Princess Oladummi, Director, Central Bank of Nigeria:** Thank you very much for the presentation. I am Princess Oladummi. I am from Nigeria. I am fascinated by the two stories that we have just been told. What I have to say is partly a question and partly an intervention. When you are hungry, and you have not enough food to eat, even a headache can be a big problem and you cannot use ordinary paracetamol. We are now talking about something to do with the immune system of the body. When you are hungry and do not have enough food to eat, even when drug is provided to you, you have to have food in your stomach for the drug to be effective and for you to be able to manage your sickness and do something.

That brings me to the question of why we are looking for medication for those who are infected and trying to prevent those who are not infected from being infected. Shouldn't we be looking at how we are going to have healthy human beings that will have immune systems that will not make them too vulnerable to AIDS? Everybody looks at AIDS as if it is something that is horrible because of the sex aspect that is attached to it. We all know that the source of infection can be more than just a relationship between the man and the woman. It can be passed from mother to child. You can go to your dentist and get infected, and that kind of thing. So I am thinking that the job at hand should include feeding those who are too poor to get enough food as well as getting drugs for those who are infected, and making sure that those who are not yet infected are safe from the pandemic. Thank you very much.

**Godfrey Sikipa, Deputy Associate Director, UNAIDS:** My name is Godfrey Sikipa. I work for UNAIDS. I would like to respond to the statement from Alan Whitehead that the flood is coming. This is something that we have been saying to people. "Yes, the flood is coming," we say to political leaders.

To understand the situation, let me tell you a story. I am from Zimbabwe and a couple of years ago, at the beginning of the epidemic, one woman was interviewed there. She was a prostitute, and her husband had died of HIV/AIDS. When she was asked, "Why are you doing this? Your husband has died," she said, "I am doing this because I have two daughters. I am doing this in order to earn some money so that I can send them to school, so that they do not end up doing what I am doing."

That is the choice that I think ordinary people out there, women, are being presented with. For the past two days, I have been attending a meeting of Finance Ministers looking at development prospects for Africa. When you hear the stories that are coming up, you wonder where we even begin to deal with the economic environment that pushes women into prostitution in order to save their daughters from what they are doing. I do not know if you have any comment on that.

**Meshack Shongwe, Analyst, Ministry of Finance, Swaziland:** My name is Meshack Shongwe. I am from Swaziland. That is where Alan Whiteside grew up and went to school. I am very happy that there is a forum like this. I think we should lock this door and talk until we have exhausted ourselves because it is so important that we talk about this scourge.

Let me start by saying that Alan talks about a flood that is forthcoming. And those who are able to run to the boat and are lucky to come onboard will survive. Those who do not come onboard will not survive. I understand this story to mean that you are sounding a bell that we should all respond to and come onboard to fight this scourge.

I just want to make a small appeal. I have worked for the African Development Bank for over a decade. And in its social sector, I was heading social policy. Some years ago, I was dispatched to go and help in Zaire, in Uganda and other places because AIDS was at their doorsteps. Nobody knew the etiology of the disease. I was going there to preach the gospel of awareness, the gospel of prevention. Now, I want you who are more enlightened to take a much more enlightened position, one that helps our people understand the disease. You would be surprised that, although we have many people dying from AIDS, there are still many who tell you all sorts of stories as if this is a joke. In the past, the incubation period was said to be ten years. And, if you remember, the Green Monkey theory was advanced as the cause of AIDS. I am just saying this so that you can formulate your strategies and programs in a much better way, so that our people could be saved, they could go into the boat and not be left behind.

The fellows who were 55, who were 60 at the time we began to tell them about HIV/AIDS said, "Ah. The incubation period is ten years, and I am an old man anyway. So let me die." No sooner had we tried to focus on disputing the Green Monkey theory, which was current in central Africa, than the thought was that the disease was predominantly a problem for homosexuals. No sooner had we learned that heterosexuals in the States, in Africa, everywhere, were infected, there were other stories (Here I am trying to lay the foundation for the one message I would like you to put together for all of us.) For example, we heard that a medical doctor in the United States of America wrote an article in one of the journals that said, "Who killed Africa." There was no question mark at the end of that statement. Actually, when you read the article, it said, "W.H.O. killed Africa."

I am trying to say that the true message is so very important that we should go to the grassroots and tell the people exactly what is it that they are faced with. Some people talk to us and say, "You people are wasting your time." So, I am trying to say, Alan, go back to the countryside with your story of the three kids and make sure the people there hear it. And at least at that level, the real message must do away with the old stories. Thank you.

**Dr. Elaine Wolfson:** Thank you very much. Now that we have had that overview and perspective, I would like us to turn our attention to some more operational and some more action-oriented parts of this meeting. We at the Global Alliance believe that the epidemic is real, that the emergency is real, and that it requires urgent action. We have tried to learn over the past couple of years whether or not African governments who face this terrible pandemic have declared states of emergency. And if they have, what does it mean? What can be done?

Based on our experience treating HIV/AIDS in the United States, we know that there are some drugs available that can at least prolong lives. We know that there is no cure for HIV/AIDS. But we also know that over the past five to seven years, many people in the developed world who have HIV/AIDS have been treated with antiretrovirals. For several years, it has been said that these drugs are too expensive, that African countries cannot afford to make antiretrovirals available to their people who are HIV positive. Over the past few years, prices have begun to come down dramatically. Initiatives have been undertaken to address some care and treatment issues for people already infected. We know from statistical studies that more than 2 million Africans died of HIV/AIDS last year, more than half of them women. Last fall, before many of the initiatives of the last few months were announced, we at GAWH discussed doing a roundtable at an

African site, maybe one in conjunction with the World Health Assembly. It would give us an opportunity to engage with governments and other NGOs to talk about treatment and see whether these price reductions, these initiatives, could be applied successfully.

We knew that some of our corporate partners were already working in Africa. So, we approached those who were members of the Accelerating Access Initiative and asked them whether or not they would be interested in underwriting and working with us on a campaign that we could take to many places. The first program we did, we did without the involvement of the Accelerating Access Initiative. We did it at the UN in New York and relied on our own resources. We found the response at the UN to be great: eight African governments co-sponsored the event with us and 80 people attended our meeting which took place at a very busy time. This convinced us that we were doing the right thing. And we were delighted when the Accelerating Access Initiative agreed to work with us on the next events we were planning.

The issue of public-private partnership is a complex one, and it provokes many thoughts among people--some positive, some less positive. I, personally, have not had a problem working with the private sector. I had learned from my previous studies of women's health that in the United States we would not have many interventions affecting women without the private sector. We know that the oral contraceptive came from the initiative of Margaret Sanger and Katharine Dexter McCormick, a wealthy woman. They addressed the issue of family planning and went to researchers to get the solution. And when the researchers finally developed an oral contraceptive, they went to industry because they needed a producing arm and a distribution arm. So, way back in the 1950s, with the oral contraceptive model, it was clear that when addressing women's issues we had to have a multifaceted approach. Recently, we see that when the private sector, the pharmaceutical industry, private foundations, etc., join with government they have often produced some very remarkable results.

We would like to turn our attention now to the role of public-private partnerships, specifically with the idea that we are going to address the scaling-up of treatment for those with HIV/AIDS. And we are very pleased that two members of the Accelerating Access Initiative are going to do presentations. The first, Mr. Robert Dintruff.



**Robert Dintruff, Director, Global Care Initiatives, Abbott Laboratories:** Thank you, Elaine. We seem to have a story theme going tonight, and I am going to keep it going, though this time,

it is a different kind of story. It is a story about where hope begins for what will ultimately benefit many millions of people. And the story comes in the form of the efforts of the Accelerating Access Initiative, which was established some three years ago. Elaine mentioned the companies involved in AAI earlier, and I won't repeat the list. But I would like to state that I am here from Abbott Laboratories in my capacity as director for Abbott's Global Care Initiatives. Other partners involved in the AAI include UNAIDS, WHO, UNICEF, UNFPA, and the World Bank.

The Initiative has as its objectives to explore ways to accelerate and improve HIV/AIDS care and treatment, particularly in Sub-Saharan Africa. Industry partners are committed to working with governments, intergovernmental organizations, and other stakeholders to broaden access and do so responsibly. Six key principles that reflect a common vision for dealing with HIV/AIDS have been adopted by the AAI in a Joint Statement of Intent, and I will list them for you. First, political commitment by governments, an essential component; second, a strengthened national health-care capacity; third, engagement of all sectors of society in facilitating access; fourth, efficient, reliable, and secure distribution systems for these products; fifth, significant additional national and international funding from new sources--and we're starting to see much of that come forth now; and then finally, an environment for continued investment in research and development by the pharmaceutical industry, so that new antiretrovirals that are so desperately needed can continue to be made available.

As of 2003, 19 African nations have concluded supply agreements with companies and have begun to waive import duties and taxes on the importation of antiretroviral drugs. Significant strides have been made, and there are now tens of thousands of additional people receiving therapy. Today, we are faced with the challenge of making antiretroviral drugs available to millions of people so that they can realize the benefits that Elaine Wolfson described a few moments ago. Some of the fundamentals are already in place. Distribution systems and the ability to deal with some of the logistics of bringing products into Africa and into more remote regions of the continent are well underway. Certain others, such as product registrations in various countries, are not yet completed. This often takes some time and is a complex process across so many countries with so many different companies that are registering products. No doubt you have all heard at this point that there is some additional funding that is being made available to help us face this challenge.

The Accelerating Access Initiative is transforming the environment for antiretroviral treatment, but we are not doing it on our own. I am often asked, "How many people are you supplying Kaletra to in Africa?" Well, surprisingly, the answer to that is "zero." We supply Kaletra to programs. Programs supply

Kaletra to people. It is not happening through direct shipments from manufacturers to patients.

As a company in the pharmaceutical industry, we tend to stick to what it is that we do best: we research and develop products, we manufacture them, we take these products to market and distribute them. After that, the product is accessible, and at that point, individual countries, programs, intergovernmental organizations and other stakeholders can maximize these products as one resource for their programs.

At this point I would like to give you just a couple of examples of what some companies are doing in this area, and I will start with Roche. The Roche-sponsored care program has been established in partnership with the not-for-profit organization PharmAccess International to develop local expertise, training, and provision of HIV health care and therapy across four African centers in Kenya, Uganda, Senegal, and Ivory Coast. Training of health-care professionals equips them with current knowledge of HIV management and how to deliver good clinical practice. Successful implementation of this pilot program, measured by sustainable benefits, demonstrated in line with international standards, will lead to the extension of this program to more people living with HIV. What we have learned from this initiative has been used to assist individual private organizations in the region pursue their desire to extend HIV care to their local employees. Also, the experience we gained will help us implement other access initiatives affecting more people in a sustainable way and could serve as a model for access to antiretrovirals and health care in a resource-poor setting.

In 1999, Bristol-Myers Squibb pledged an unprecedented \$100 million over five years to address the HIV/AIDS epidemic in the countries of South Africa, Namibia, Lesotho, Swaziland and Botswana through a program called *Secure the Future: Care and Support for Women and Children with HIV/AIDS*. In 2001, an additional \$15 million was pledged to the West African nations of Senegal, Cote d'Ivoire, Mali and Burkina Faso. The *Secure the Future* initiative seeks to develop local capacity that will allow local organizations and individuals to address the HIV/AIDS epidemic in a sustainable way.

The largest corporate commitment to date, *Secure the Future* has two components: (1) medical research grants which seek to support innovative, therapeutic research by local scientists and doctors to increase the capacity of the countries to manage the epidemic; (2) community outreach and education grants provided by the Bristol-Myers Squibb Foundation which help communities more effectively assist people living with HIV/AIDS by building on existing resources or by expanding or improving upon existing efforts to work against HIV/AIDS and its social consequences. To date, *Secure the Future* has approved more than 129 grants totaling over \$65 million in committed funds.

GlaxoSmithKline extended its offer of a 90% discount on HIV medicines to NGOs in developing countries and employers in Africa who offer care to their workers. It extended its offer to sell AIDS medicines at no-profit prices to 63% of the world's poorest countries and to all projects fully financed by the Global Fund to fight AIDS, TB and Malaria. Importantly, Boehringer- Ingleheim initiated the donation program in order to prevent mother-to-child HIV transmission.

Merck & Co., Inc has also made many significant commitments. That I will leave for Niraj Doshi to discuss.

Now, I will shift to some of the things we are doing at Abbott Laboratories. Recognizing that the problem of HIV/ AIDS in resource-limited settings is multifaceted, we have focused our efforts on a number of different areas, starting with a program known as Step Forward to assist children orphaned due to HIV/ AIDS.

We also are getting involved in infrastructure to better understand the requirements for providing our products. In this particular case, we have chosen the country of Tanzania to assist in that process. We are going through a rather extensive process to strengthen the infrastructure at Muhimbili Hospital in Dar es Salaam and also to improve laboratories across 20 regional centers throughout the country.

The third program that we have concerns access. It is a program that provides preferential pricing for three key products--two antiretroviral drugs in the protease inhibitor class, known as Norvir and Kaletra, and a third product known as Determine® HIV which is a rapid test for HIV antibodies that is critically important to dealing with issues of stigma and allowing people to know their HIV status.

Through our access program, we provide those products at the preferential pricing that I mentioned; however, where the Determine® HIV test is utilized for the prevention of mother-to-child transmission, we provide it free of charge throughout Africa and in all of the least developed countries as defined by the UN.

I understand we have a somewhat diverse audience here--a lot of people from a lot of different backgrounds. Whatever your role might be, we encourage you to take advantage of what we offer and do all that you can to streamline the process. It is about much more than antiretroviral therapy and delivering it to individuals. There are a large number of other things involved with that-- antibody testing, viral load monitoring, CD4 counts, management of

opportunistic infections, and so on. We find, for example, that if duties on many products essential for antiretroviral treatment, like diagnostics and related accessories, were removed, it would encourage wider and more appropriate use of those products.

To conclude: I look forward to our discussion today. I hope it will help define how we can progress even further in a public-private partnership. Working together, I think we can make a significant difference in the lives of many more people living with HIV/AIDS. Thank you.

**Dr. Elaine Wolfson:** Thank you very much. Before we move to the discussion, let's hear from our Merck Sharp & Dohme representative, Niraj Doshi.



**Niraj Doshi, Regional Manager for HIV Products, Merck Sharp & Dohme:** Thank you Elaine. My name is Niraj Doshi, and I represent Merck Sharp & Dohme. Merck, as Elaine mentioned, is one of the six pharmaceutical companies participating in the Accelerating Access Initiative. Merck has been providing and distributing our antiretroviral drugs, CRIXIVAN (indinavir sulfate) and STOCRIN (efavirenz) to the poorest countries and those hardest hit by the HIV epidemic. These drugs are being provided at not-for-profit prices.

I would like to augment two things said previously and so leave you with two points to go home with. Consider the question: What is Africa's biggest resource? It is our human resource. And this disease is actually breaking down the fabric of this human resource. If you look the situation in Kenya or in Uganda, you will find that one employed person supports at least ten people at home. Now, if that one person is affected by this disease, what is the magnitude of this problem? It involves not only the diseased person but also the family they have to support at home. That is what Alex deWaal mentioned in regard to support of the social fabric.

This brings me to a most important point. One of the ways to tackle this disease in a private or public-private partnership is to address the issue of HIV/AIDS at the workplace. Merck has been proactive in this sector. We try to encourage and bring together employers to look at the situation positively. These are your employees, we say to them, you need to really address the issue of how to support these employees in terms of managing the disease and developing prevention campaigns at the workplace. If African businesses are to be competitive, if Africa is to have a competitive advantage in a world that is

becoming globalized, we have to produce our goods and services at a more profitable level. Now, if companies address the issue of HIV/AIDS by choosing to manage employees' opportunistic infections and providing treatment with antiretrovirals instead of not managing them, they would actually be saving money. So, one of the things which is very important is to develop an HIV/AIDS workplace program that is one step forward in terms of augmenting a private-public sector partnership.

A unique public-private endeavor about which Merck is particularly proud is a \$100 million partnership with the Gates Foundation and the Government of Botswana, known as the African Comprehensive HIV/AIDS Partnership. Details are available at [www.achap.org](http://www.achap.org).

Some other questions which I want to also address are: As we move towards scaling up, how are these drugs going to be available? Through what means are they going to be available? Who is going to prescribe them? Are the doctors well-trained? Is there a basic curriculum used to train these doctors? Do you have the pharmacists involved in knowing how to give the patients the support they need when giving out the drugs? HIV drugs are very complicated, you know. It is not just like taking panadol, as was mentioned previously. It is not as easy as that. A lot of information and knowledge needs to be known if these drugs are going to be prescribed properly.

Other points to be considered: How are these drugs going to be distributed? Which are the accredited centers that are going to have these drugs? What are the guidelines that are available? What are the basic guidelines in terms of the standard regimens that need to be presented? These questions as food for thought, because scaling up is not just getting the drugs here; it is also involves knowing how to use them properly and ensuring that the people taking them learn that. Thank you.

**Dr. Elaine Wolfson:** Thank you very much. I realize that resolving the treatment and scaling-up treatment problems is daunting. But I think an opportunity exists for Africa because there is now a willingness to support treatment and scaling-up treatment. And while I know that past experience indicates the road ahead is a difficult one, the part of me that made me start an NGO and continue with it for nine years tells me that we are going to have to find a way--that we cannot lose this window of opportunity to keep people alive. This is one of the reasons that I wanted very much to do this campaign. I have spoken to people in Washington who are working on President Bush's HIV/AIDS initiative and found among them some like-minded people who said that they, too, were determined to stop

the epidemic but that they realize the history and the context of HIV/AIDS suggest that realizing that goal will be very, very difficult.

We know that some people are trying innovative approaches. We know that in Haiti certain initiatives are being used to reach rural areas without the trained personnel that we normally expect. I cannot give you a report on those initiatives, but I want you to consider them because I think that it would be a pity to allow ourselves just to throw up our hands and say, "It's too daunting. The complexity is too huge."

Are there any people in the audience who would like to comment about public-private partnerships or scaling-up treatment? Please introduce yourselves.

**Dr. Samuel Gayi, United Nations Conference on Trade and Development:** My name is Samuel Gayi, and I am with UNCTAD. Obviously we do not have anything to do with AIDS, our focus is on trade and development. So I am not quite sure when it comes to topics like AIDS. But I was quite intrigued listening to the last two speakers, particularly the last one, and my comment relates to the context of what we call a corporate social responsibility. I think that talking about public-private partnerships in prevention of AIDS probably could be examined within a context of the so-called corporate social responsibility. Of course, the speaker came quite close to saying this, but I just want to know if one model for handling AIDS could put public-private partnerships within the area of corporate social responsibility.

**Mr. Robert Dintruff:** I view what we do at Abbott Laboratories through the various initiatives that I described, as part of our corporate social responsibility. It is very difficult for any organization involved in an area like HIV/AIDS to provide products and just sit back and watch what is happening an ocean away and not do something about it. And the question is, "What can we do?" I go back to what I said earlier, which is, we can do those things that we do best.

We can also make sure that we do not profit from our efforts. Many of the companies that are involved in these areas today are very much in the same position. There is no intent to profit from the products that we are providing here. Instead, we want to make sure that these products are available, and we do that for the right reasons. Now, what are those reasons? Pretty simply, there is not any public relations motivation behind this. I doubt that anybody in this room has ever heard of our Step Forward program. Maybe you have, but not very much about it. It is a multimillion-dollar, multiyear, multifaceted program.

But we do not make a big deal out of it because that is not why we are doing it. Also, there is no hidden motivation to gain commercially by what we are doing through these programs. Plain and simple, we do this because it is the right thing for us to be doing.

**Neeru Singh, Analyst, International Fund for Agricultural Development:** My name is Neeru Singh, and I work for the International Fund for Agricultural Development, which is a specialized agency of the United Nations located in Rome. I have a couple of points to make. One is that we are constantly talking about the fact that HIV/AIDS is a problem. We know it is. I do not think we need to reemphasize that fact again and again.

We are sitting here, in this room, talking about this issue because it is such a major problem. Now that we are faced with this problem, what and how are we going to solve this problem? What do we need to solve this problem, and how are we going to do it? I think one of the biggest problems in handling the HIV/AIDS issue is a lack of coordination. There are 100,000, maybe more, NGOs, UN agencies, and people interested in this issue who are working on the ground, but there is no coordination of their efforts. It is a complete waste of resources. Everybody is doing a great job in their own little field, but there is no coordination. And because of that, there is duplication of effort. People are doing the same thing over and over again. We are not achieving what we could with the limited resources we have.

The other thing I would like to say is about public and private partnership. It is a great idea, and I really, really would like to see it happen. But in my mind--and please prove me wrong--there is an issue. The private sector, the way I know it, is motivated by profit. And in handling the situation of HIV/AIDS in Africa and in the developing world, there is no profit. I would like to know where good intentions and profit come together. In Asia, in Africa, where this problem is enormous, I would like to be convinced that we can work together. It is not a matter of just good intentions; it is not a matter of saying, "Yes, this is what we want to do."

I am sorry. I am sitting here. I have had this dinner. I have had a lovely evening. But I would like to say that the amount of money that has been spent on this evening could have been used to save many lives. Maybe what I am saying is unpopular, but I have to say it. Sorry. I would also like to say, like many other speakers have said, that just handing out antiretroviral drugs or handing out prophylactics is not a solution. It is not. We have to look at it. Other speakers have raised the point that antiretroviral drugs require very, very strict regimen.

How are we going to work towards supporting people on antiretroviral drugs in the villages, in the slums, in very difficult social circumstances? I would like to know.

And, finally, even if antiretroviral drugs are made available to the poor countries, I can see it becoming a very big moral issue. The amount of antiretroviral drugs that you can provide to a country free of charge or at subsidized rates is very limited. Who is going to benefit from them? Who is going to make the decision? This is a very, very important issue we need to look at. I will conclude what I have to say with that. Thank you.

**Mr. Robert Dintruff:** With regard to the problem itself, you are absolutely right, it is bigger than us, it is bigger than a company like Merck or Abbott Laboratories. It is bigger than the industry. It is bigger than the whole private sector from all I can see. But let's get right at your question of what do we do about it. Well, in its simplest form, this is a problem of knowledge and organization. But there is nothing simple about pulling together the knowledge and organization that have to be in place to do something about this, and we recognize that.

It is an incredibly complex task that we have ahead of us, but we are going to do it one step at a time. We are going to do our best to see that monies are well utilized. I think that everybody has to play that role out there (whatever their role is) whether it is one of providing education, or one of providing antiretroviral drugs, or one of doing some counseling and testing. They have to be doing their best to utilize the resources that we have (which we know to be scarce) to their fullest.

Now, as for the private sector and its profit motivation. Sure, the private sector does have a profit motivation under most circumstances. I happen to be the only person that I know of at Abbott Laboratories who has the job of losing money. It is my job to lose several million dollars each year by doing what we are doing in providing these products for all of these programs. It is never going to be a perfect system; it is never going to have as strong a drive behind it as many other economic forces do. But we are headed in the right direction, and we have taken the right steps to ensure that we can contribute in this area where it makes most sense for us to do that.

The final thing that I'll say is in regard to some of the things at the local level that you have mentioned, about how difficult it will be to reach out in some of the areas of the world where people are most disadvantaged. These are the kinds of

things that have to be worked out within local programs. They will not be worked out through something like the Accelerating Access Initiative or through many of the intergovernmental agencies. The issue of who receives antiretroviral therapies is something that I think is getting worked out country by country and case by case. It will not be managed by those providing the products.

**Mr. Niraj Doshi:** I will just add one thing, and this concerns a different perspective of a private-public partnership. We have these pilot projects going on through the UNAIDS that the Accelerating Access Initiative is part of, and drug availability is a big problem. Once a patient starts on antiretrovirals, you must have an unlimited supply of these drugs and the logistics involved is tremendous. It is really complex. Now, if it were not for the public-private partnership having a secure distribution system, I am sure most of the countries that are having access to these drugs would not have these drugs at the regular intervals necessary. This is just one small example of public-private partnership. You need this partnership in order to secure some of the distributions and ensure the availability of these drugs.

**Benny K. Molosiwa, Secretary for Economic Affairs, Ministry of Finance, Botswana:** Thank you very much. I am from Botswana. We have been talking with the pharmaceutical companies and negotiating prices with them. The issue of profit-making has just been answered here. But we know how difficult it was when we were negotiating with these people. There was a point they could not go beyond. We could also understand that all of us are working together to try and get these drugs to the people. The problem that we are facing--I do not know whether this meeting can assist us with it--is the problem of the HIV/AIDS stigma. Even where the drugs are available and there are those who are struggling very hard to try and get them to the people free of charge, those with the disease do not just come to us for the medicine because of the problem of stigmatization. So, I do not know if making the drugs available over the counter somewhere or from the pharmacy will take away the stigma. But for those getting their medication in the public hospitals or public clinics, there is this problem of stigmatization. Maybe those of you at this meeting can assist us.

Another problem has to do with the complicated nature of the treatment. Because the treatment is so complicated, you realize that too many become defaulters. After they do it for two or three months, they get tired. Some of them are being treated without their families knowing about it. Without family

support, they are more likely to become tired. And once they get tired, you know better what happens.

Then, the issue of distribution also comes into question. You can sometimes go to our clinics just for a simple drug, and that drug is not available. You have to go to the next clinic. When that drug is not available there, you go home and sit. If you have that situation, where the distribution for some reason or other is not flowing regularly, it means a problem. I do not know how we can engage with the partnership to deal with what I am now talking about. Mainly we have to try and make sure that we work together to clear up some of these things.

So, first off, we need to try and eliminate the stigma. Secondly, we have to try and work together to improve the training the doctors for monitoring, for evaluation, for everything. Then there is the issue of assuring a regular flow of the drugs and all that is related with it. Also, the high cost of drugs. Much as we are trying to provide the drugs free to the people, the cost is crippling our economy because it is taking everything that was meant for any other development. Our economy is getting paralyzed because we are diverting all our resources to the fight against HIV/ AIDS. I think the private sector people could assist with the costs, much as I know that there is a point that they could not go beyond. Probably, they could still reconsider, to see whether they could assist further. Thank you.

**Prof. Sileshi Pulseged, University of Addis Ababa, Ethiopia:** Thank you, Madam Chair. First off, I would like to congratulate Elaine Wolfson and her group for organizing such an interesting forum. However, I have a problem with people saying that scaling up of antiretroviral treatment in Ethiopia is one of the initiatives. When we think strategically, scaling up starts from somewhere. As we know, we have very little experience with antiretroviral treatment in this country. So, I think we really will have to think of either changing the initiative or the name of the initiative. Instead of scaling up, probably we could call it an introductory track of ARV treatment in Ethiopia. I know that the Johns Hopkins University was telling our students that nevirapine was being introduced to treat HIV-positive pregnant women. However, this report has not yet come out. As yet, there is no documentation about the start of private sector or public sector programs here. Thank you.

**Mr. Robert Dintruff:** I will try to comment very quickly on a couple things that have been said. First, the issue of stigma. It is critically important. To resolve it

clearly takes political will. Also, testing. Encouraging people to know their status is a very important way of helping to reduce stigma. It is critical to avoid the whole issue of stopping drugs or their distribution because that might cause stigma. Once people have started therapy, they really need to continue that therapy. Failing to do that makes possible the emergence of antiretroviral resistance.

As my final comment I would like to say that there is an awful lot involved in everything that has to be done here, and you have mentioned many of those things: having a consistent supply of product, putting education in place, and doing all the other things that need to be done in order to run an antiretroviral program properly. My only word of advice, if I could offer it, would be a simple one: Please, do not wait until you are ready with all of the things that you need to do, because then you will never start. Get going with whatever you can, wherever you can.

**Mr. Niraj Doshi:** I would like to respond to something the gentleman said about Ethiopia. I think Ethiopia is moving in the right direction because, as we speak, they have already prepared their guidelines for antiretroviral therapy and are moving to implement them. Thank you.

**Dr. Elaine Wolfson:** Thank you very much. Dr. Yodit Abraham will begin the third part of our program.



**Dr. Yodit Abraham, Internist, Medical Director, Armed Forces Hospital, Addis Ababa:** Thank you, Madam Chairperson, and thank you all, excellencies and distinguished guests. I am sure that you would agree with me that all of us live with HIV/AIDS. Some of us have HIV, others have full-blown AIDS, and others are HIV negative. Whatever our status, all of us are members of our society and in the interconnected world we are living with the realities of HIV/AIDS, either directly or indirectly. This makes HIV an important agenda for all of us.

Understanding the magnitude of the problem is important to understanding the challenge. Globally, by the end of 2002, an estimated 42 million people were living with HIV/AIDS, out of this number, 29.4 million in sub-Saharan Africa. It is estimated that at the end of 2002, the number of deaths due to HIV/AIDS

globally was 3.1 million, 2.4 million of them in Sub-Saharan Africa. Ladies and gentlemen, in my country, Ethiopia, AIDS is a major problem. In Ethiopia, it is estimated that 2.2 million people are living with HIV/AIDS. The number of orphans from AIDS here is 1.2 million.

The earliest evidence of HIV infection in Ethiopia was found in 1984. The first case was reported in 1986. The prevalence of HIV was low in the 1980s, but rapidly increased in the 1990s. Now, the national prevalence of HIV is estimated to be 6.6% of the population-- 13.7% of those in urban areas, 3.7% in rural areas. The number of infected females, age 15 to 19, is much higher than that of the males in the same age group. When we talk of the treatment of HIV/AIDS, testing and counseling are an important issue to be addressed. Because knowledge of HIV infection status allows infected persons and their infected partners to seek treatment with antiretroviral agents and to receive prophylaxis for certain diseases, testing is important. It will also help in the prevention of HIV transmission from the mother to the child. And the counseling aspect of the testing will help people change their high-risk behavior or drug-use behavior. This will work to deter HIV transmission.

Testing can bring a person to treatment. Therefore, efforts to remove or lower barriers to HIV testing should be made by ensuring testing and counseling are available, accessible, and responsive to the community needs and consider the culture of the community. Thus, the importance of expansion of voluntary testing should be underlined as VCT services are in short supply in Africa, Sub-Saharan Africa, and in Ethiopia.

In antiretroviral (ART) therapy, antiretroviral drugs have three major uses. One is for the treatment of people living with HIV/AIDS, and it can prolong and promote the quality of their lives; two, to reduce the transmission of the infection from the mother to her child, and three, to reduce accidental HIV infections within health care staffs in institutes.

The number of AIDS cases is dropping in the developed world due in part to combination drug therapy. Currently, the best way of treating HIV is using combination treatment known as HAART, or highly active antiretroviral therapy. The rationale behind using the combination treatment is that the HIV virus has an unusually high mutation rate when individual drugs are used. So, the multiple drug treatment can possibly eliminate a lot of the virus or reduce it to an undetected level in the body. The hope is that this approach will substantially delay or halt the progression of HIV in the infected person.

What are the limitations and the challenges of antiretroviral treatment? First, uncertainty about the duration of effectiveness of any of the particular

combinations in suppressing the viral load over a long period or a long term. Second, resistance. Viral mutants that are resistant to treatment could lead to treatment failure. Third, drug side effects. Fourth, as mentioned previously, difficulty in maintaining a treatment schedule. Strict adherence to the treatment regimen is very important. If a patient receives drugs that are not optimal, it will actually accelerate the development of resistance. So, resistance and maintenance of the treatment become an important issue. In developing countries, maintaining treatment adherence is a major concern and, in particular, is a particular challenge to people living with HIV/AIDS who already have difficulty accessing health care services.

Cost is another factor to be considered. AIDS is a disease of poverty, and few HIV-infected persons worldwide ever get treatment. Currently, less than 3% of the 42 million people living with HIV/AIDS in the world are getting treatment. So, 97% of the people living with HIV/AIDS are not getting treatment. In Africa, Sub-Saharan Africa, and in my country, Ethiopia, the lack of food and clean water is also a challenge in the treatment of HIV/AIDS. Our people--or we--have to choose between buying food and paying for the treatment of HIV, which many of us--or all of us--cannot afford. This is a very important issue to look into. At the same time, we also have the challenge of controlling other diseases--like tuberculosis, malaria, measles--which kill millions of people per year.

What can be done? Or, what are the important activities to be undertaken in implementing or scaling up antiretroviral treatment? One is having a sustainable program for training of health personnel--doctors, nurses, pharmacists, counselors, et cetera, who are involved with ART. The second is having a system that ensures patient adherence to the treatment and having a system of follow-up suitable for our situation. The third relates to the question the lady at the back of the room asked, "How are we going to reach the rural areas?" That is a problem. We should have a system suitable to our country and to the developing world in Sub-Saharan Africa. We Africans should work in this area.

The fourth point has to do with health delivery capacity building to implement health initiatives. Facilities are needed for voluntary testing and counseling, and for laboratory monitoring of ART. Also necessary is the equipment for blood chemistry and other tests about which I will not go into detail.

The fifth important point is expanding voluntary counseling and testing. And as I mentioned earlier, voluntary counseling and testing are vital before treatment can start. The person comes to seek treatment after the voluntary testing. So, we should expand VCT activities in our countries. Also, having a sustainable and affordable supply of antiretroviral drugs, of opportunistic infection drugs, and test-kit supplies, et cetera, is important.



**Dr. Tesfanesh Belay, Ministry of Health, Addis Ababa:** As you know, global concerns about the spread of HIV/AIDS and the well-being of populations have been expressed in many ways. To mention some of those important for us: the United Nations General Assembly in 1995, which emphasized HIV/AIDS; the Beijing platform in 1995, which emphasized women's health issues; and the large Cairo conference in 1994, which also gave due emphasis to the importance of women's health, mainly regarding reproductive health. It is understood that reproductive health and HIV/AIDS are two inseparable issues that can support each other for the better or for the worse. Also, there is the strategy for the African region's response to HIV/AIDS. Implementation of the response began in 1998 and it is planned to go through 2007.

The United Nations Development Program (UNDP) is trying to create a leadership program to reverse the deadly disease of HIV/AIDS. Conventions and treaties recently signed--my country is one of the signatories--advocate the promotion of a healthy family, with healthy maturation starting from preadolescence, with responsible and safe sex throughout our lifetimes, and with gender equality. The reproductive health long-term strategy for the African region includes integration of reproductive health programs in which HIV/AIDS prevention, care, and support as well as treatment for the special cases are emphasized. The effort mainly targets adolescents who are the workforce for change.

All of the other conventions are aimed at identifying and responding to the health problems of a given country, with main emphasis on diseases communicated to the general population by means of vulnerable groups. Other major conventions aim to review existing policies, develop new ones where necessary, and scale up existing guidelines for programs on disease prevention and control and the treatment of those victimized by the disease.

Some conventions are aimed at capacity-building of the health sector and other sectors by backing up this development to provide basic health services to meet the needs of the population through active participation of all segments of the population. These include the key role players and stakeholders in families, communities, and religious leaders. All the above-mentioned conventions and others issued later are meant to provide a courageous mobilization of the public and private sectors and relevant institutions in support of prevention and treatment of HIV/AIDS.

Excellencies, ladies and gentlemen, in disease prevention early detection and early initialization of treatment are very important. Early institutionalization of prevention mechanisms as well as treating the victims reflects the multi-sectorial and multidisciplinary nature of the issue and its solution relating to HIV/AIDS and similar deadly diseases like malaria, tuberculosis, meningitis and so forth. Early prevention and treatment underscore the role that we collectively, we from different levels of society, have in the effort to change the situation for better by using all possible means and approaches. And it needs coherent and coordinated action. It needs us to focus on targeted groups that can help us to achieve the aim of the HIV/AIDS policy and implement the subsequent strategy to prevent and control HIV/AIDS.

It is clear that HIV/AIDS poses a threat to the many young lives in our country as well as in the world. It has already become a threat to our development, which requires skilled and energetic people. At the onset of the HIV epidemic, we professionals and people working for the Ministry of Health, except for a very few, were not very well aware or had an adequate understanding of this disease and how fast-moving it would be. Lack of data made our work very difficult. This was a defect in the public health system as was the un-unified chain of command and control. (Today, there is still no continuous flow of information.) The inefficiencies of some institutions and localities also made the work of HIV/AIDS control and treatment somewhat passive at that time.

But the Ethiopian government soon came to realize the severity of the epidemic. We have a highly responsible government that dares to face up to difficulties and is trying its best to place the people's health and safety above all. It has taken serious measures like those mentioned earlier: HIV policies are developed, supportive guidelines for drug treatments are issued, and subsequent guidelines and protocols are under development. Some training, protocols, and curriculums are already finalized. All those efforts will help to implement the upcoming plans, and also they will help us to accept support and collaboration from our international partners. So, by having those policies and guidelines, it is understood that HIV/AIDS is one of the top agendas on the government plan of action.

The outbreak of HIV/AIDS is a tragedy to our country. Based on my own experiences and those of colleagues in the health sector, I would like to emphasize three issues, or three visions, and these I would like to share with you. Number one: it is important to give full play to the role of the governments in global health affairs and in strengthening the contributions of national and international corporations. At present, the relevant sector ministers should play a great role in information exchange, personnel training, exploiting the available technical support, exploiting the resources made available through international

assistance, and devising mechanisms to maximize utilization of other national resources.

While fighting this deadly disease, HIV/AIDS, it is necessary at the same time to promote and enhance bilateral co-operation. It is more important to participate actively with relevant institutions; to explore the existing sources of antisocial activities, and to share information on HIV control and prevention and experiences with prompt initialization of treatment, care, and support for people living with HIV/AIDS.

Secondly, it is very important to establish and improve the utilization of available resources by upgrading and up-scaling existing policy guidelines and the capacity-building of institutions dealing with HIV/AIDS.

Thirdly, it is important to coordinate and synchronize economic growth and social development so that they will complement each other to prevent and control HIV/AIDS. Healthy economic growth is the very foundation of social development. Only by a vigorous building up of the economic situation that we are in can we eradicate poverty--poverty which is the sole cause of social disintegration. In the meantime, development of public health education and other social undertakings, such as an investment in human resources, is equally important. Not only is it essential to foster economic growth but also it is an obligation of good governance. Investing in health is tantamount to investing in future economic growth; and a society of good health is one of basic wealth.

Today, globalization has increasingly turned the homeland of many into a global village where public health issues know no national boundaries. No country can hope to live a life of luxury or comfort behind closed doors. Once a social crisis breaks out, merely complaining or blaming each other does not help. Instead, mutual understanding, cooperation, and joint countermeasures are the only solutions to the crisis. Therefore, we have to stand ready to sincerely cooperate with others. This attitude is the way to help us shoulder our responsibilities, perform our duties, and play a constructive role in fighting against HIV/AIDS. This epidemic is not only a threat to individual countries, it is also a global threat. I thank you for listening.

**Dr. Elaine Wolfson:** Thank you very much. Now, we will entertain a number of questions, and then ask for responses.

**Fetuna Bekele, Executive Director, New Development Perspectives, Ethiopia:** I would like to use this opportunity to tell you a very short story that will encompass everything we have been talking about. It is a real story about a rural family. Well, the husband decides on how much of the produce in the house--the farm produce--to take to the rural town to sell. He goes to the town to sell the food, leaving his wife with very little and with her complaining. This situation involves decision-making, who decides on the food security situation in the household. He goes on to the market on Saturday, comes back on Tuesday. He sells, he spends, he enjoys himself, then goes back to a starving family, but he takes them HIV/ AIDS because he has been having friends in this rural town.

So, poverty, HIV, and gender are all implicit in this story. We all know that women are severely affected, and they have no decision-making power over their sexuality, their fertility, and now we see they can make no decision on the household food security as well. So, the whole thing is complex, as you have said earlier on. We have to have a multifaceted approach to address these issues. Also, if you have antiretrovirals on the plate, who is going to have access to it? Who is going to decide who should have it? I wanted to bring this perspective to the discussion because it encompasses all this--how to reach them, and who decides, and who is going to be alive to benefit from whatever is being offered. Thank you.

**Samuel Braimah, Analyst, Health Economics and AIDS Research Division, University of Natal:** My name is Braimah. I am originally from Ghana, but I work for the Health Economics and AIDS Research Division at the University of Natal (HEARD), with Alan Whiteside. Over the last 21-22 years, I have worked in some of the very remote and very poor communities in Africa, both in Francophone and in Anglophone Africa. And I have some issues to raise in terms of this question of antiretrovirals (ARV) versus poverty.

I think that the existence of poverty and that millions of people die of poverty in Africa is not the reason for not going for ARVs. I think if this institution is going to push ARVs into Africa, that for every 100 dollars you put into the whole package of the implementation or the administration of ARVs, you should put another 200 dollars down to fight poverty in one way or another. Otherwise, I think the debate is going to give Alex deWaal the chance to say, "No, because of poverty, let's forget about ARVs." I think there must be a commitment to put food on the table.

The second issue is about coordination. I do not know to what extent this is true, but I am told that on September 11th in New York, one of the problems was that

very brave, committed firefighters who wanted to save lives were running up the stairs to save people, while others were running down, and that actually caused more people to die. If the firefighters had stayed out, it might have been better. I am subject to correction on this. I am afraid that we might be replicating similar circumstances in dealing with HIV/AIDS: several of us running in all directions and, evidently, nothing is really happening. That brings up the question of coordination.

I think the World Bank, through the multi-sector approach programs in various countries, has pushed a number of African countries to come up with national strategic plans for the fight against HIV/AIDS. And whatever ARV programs you have must be worked through countrywide AIDS councils to fit into national AIDS strategies. In fact, there is already so much money in the system that if we do not take this seriously, we could be in trouble. In Burundi (I have been in Burundi in the last three and a half years), they have \$36.6 million from the World Bank, \$8.8 million from the Global Fund, and about £4.15 million from DFID. Money is coming in, and coordination is becoming the problem. I think that we should look at this very carefully before we get into it further.

I want to finish up with a third issue: the effect of ARVs. If the problem in countries is just the number of people at a particular time who are sero-positive and if we do not address the poverty issue, then we are going to grow the prevalence rate in those countries to a point where 80% of people will be HIV positive. The pandemic has been driven by poverty. I know of a story that happened in Burundi: a woman got married on a Saturday, the following Friday her husband was killed in the conflict there. In six days that woman became a widow. Conflict and poverty are driving the pandemic all over Africa. So, if we do not deal with that, we will just grow the number of sero-positive population in the country. And we might be led into some very difficult dilemmas. Thank you.

**Funke Atohengbe, Analyst, Voice of Nigeria:** I must commend your NGO for a job well done. We thank you very much. Thank you to all the people who made such thought-provoking presentations. I would like you to please make available copies of your papers to us so that at least we can study them and look at how we can participate. And I want to find out if GAWH is in any way collaborating with other NGOs. And, if we want to set up a chapter of an NGO like yours in Nigeria, how do we go about it? Thank you. .

**Dr. Yodit Abraham:** I am glad that the issue of gender was raised earlier. In fact, as you rightly said, women are more affected than men because of several reasons, some of mentioned earlier: the decision on sexuality, the issue of dependence and bread-winning and poverty.

So, when we come to access to treatment, who gets the treatment? Equity in getting treatment is an important issue, because women--especially in Africa, Sub-Saharan Africa-- still do not have equity in treatment, or access to treatment, because the woman will depend on the man to give her money to go for health care, et cetera. So, this is an area in which we should work and equity in getting treatment is an important issue. Thank you for raising it.

**Dr. Tesfanesh Belay:** I would like to add a little bit to what Dr. Yodit Abraham has just said. I think women should have access to HIV/AIDS care. In the public sector, some payment-exemption systems are already established. But, with HIV/AIDS, who will be exempted, who will be asked for payment has to be worked out at a policy level.

A system of health-care financing is being piloted. Experience with this system will help us to answer our HIV/AIDS questions. But as a principal, as a public health principal, in a country that is a signatory of conventions, I feel access to treatment is a human rights issue. Here a controversy can be raised as to whether anybody should be denied of treatment because of a lack of money.

**Dr. Elaine Wolfson:** Thank you very much. Now, I can get the last word here. I have a lot of things to say, but I cannot keep you for as long as I would like. I will welcome, though, any comments you would like to make to me later.

First of all, the Global Alliance for Women's Health has not established chapters, but we do have alliances and coalitions. We really want to work as partners with women's groups in Africa because we do not feel that we have to reinvent the wheel. Women's groups are already in place, and the women are powerful, but we may be able to partner in ways that expedite and make things perhaps a little more effective. We may bring new things to the table. So, let's talk about it. I think this is something we should explore.

I keep hearing about poverty driving HIV/AIDS. I hear about war driving HIV/AIDS. Also sex, famine, food. Well, yes, all of these things are interrelated, but HIV/AIDS is a virus. HIV is a virus that requires medical attention. Because of its rapid proliferation, it has become a public health issue and a public policy issue. If you -- not you personally--but if countries want to group it in with

enormous problems they have with poverty, with water, with sanitation, with lack of electricity, with lack of roads, they will not address the medical issue involved.

HIV/AIDS is a virus that has a very highly infectious aspect to it. And it is critical to face the reality that although food and poverty play into it, full stomachs will never drive the virus away. There are well-to-do people who have HIV and who can die if they are not treated. The alternative to not having treatment is to say "farewell" in the next five to ten years to those 29 million people in Africa--over half of whom are women--who will be going to their graves.

Are there any options? Well, there are no easy answers. Antiretroviral treatment is not simple, and it may not totally work. But isn't it worth a try? I think we need some "Can-Do-ism" here. Many say, "Oh, Americans are always enthusiastic. They always want to say we can-do." Well, I would like to hear more of "can-do," because things will never change unless you are willing to try and explore new ways to accomplish your goals. The problem of women and gender inequality has existed for thousands of years. Yet, we can indeed make inroads in our time. We can make advances. But we have to be willing to consider the possibilities and not hide from the realities.

I do not know that I have answered your questions, or that I have even pleased you with my response. I am sorry that the woman in the back of the room left, who said she does not know that partnerships work. Well, we have many examples of them working. Take for instance the case of river-blindness. It is well on its way to being eradicated because of public-private partnerships. Because, yes, of WHO; yes, of countries; yes, of NGOs that help to distribute the medicines to more than 30 million people each year; and, yes, of Merck, the company that has donated the necessary medicine for more than 15 years, without any charge.

There is an unwillingness by many people to acknowledge the fact that we can find win-wins by partnering with the private sector. That is not to say that pharmaceutical companies have become charitable institutions, but for them and many others there are incentives that can be put in place. In the United States we have tax incentives for donations. These are not just for corporations but also for wealthy individuals so that they are encouraged to donate to NGOs, or to universities or to other non-profit organizations.

Is it not worth investigating some of the ways that the resources can be found to address some of Africa's serious issues? And particularly with HIV/AIDS, when

the outcome for those infected is certain, should we not be exploring all of the possible ways that we can extend life?

I want to thank everyone very much for coming to our roundtable. I am really delighted that so many of you have stayed with us through to the end. Thank you again.

## SPEAKER BIOGRAPHIES

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### **Dr. Yodit Abraham**

Internist, Medical Director  
Armed Forces General Hospital  
Addis Ababa, Ethiopia

Since 1995, Dr. Yodit Abraham Kelit has been Medical Director and Commander of the Armed Forces Hospital in Addis Ababa, a teaching hospital under the Defense University. This hospital is a tertiary level referral hospital delivering health services to the Defense forces, civilians in the Defense Ministry and their dependants, as well as public patients referred by other specialty hospitals. Between 1984 and 1991, she was affiliated with Central Command Hospital where she was Medical Director and Commander of the hospital between 1991 and 1995.

She is currently a member of the HIV/AIDS Prevention and Control Committee of the Ministry of National Defense and is the chairperson of the Technical Committee on the TB Control Program in the Army. She is also a member of the National AIDS Council of Ethiopia.

Dr. Yodit Abraham completed her specialty training in Internal Medicine in 1991 at Addis Ababa University, where she received and MD in 1984. She received certificates for postgraduate training in the areas of HIV Prevention, Epidemiology, Laboratory Diagnosis and Medical Management in January 2003 from the University of California at San Diego and the Naval Medical Center in San Diego, California. In 2002, she also received certificates in Epidemiology of HIV/AIDS from Johns Hopkins University and in Management Development from the Ethiopian Management Institute, Addis Ababa.

She has authored and co-authored articles on leishmaniasis and HIV/AIDS in medical and AIDS journals.



### **Tesfanesh Belay, MD, MPH**

Ministry of Health  
Addis Ababa, Ethiopia

Sine 1995, Dr. Tesfanesh Belay has been the head of the Family Health Department in the Ministry of Health of Ethiopia, where she has coordinated the formulation of 5 country programs for UNICEF, UNFPA and WHO. She has organized operational research in Safe Motherhood initiatives and in contraceptive logistics. She has worked with Non-Governmental Organizations (NGOs) in technical communities to review and approve project documents. She was the head of Maternal Health in the Ministry of Health of Ethiopia in 1993-94. She has also worked as a nurse tutor in Gondar and as a physician in one of the regional hospitals, before joining the Ministry of Health and going abroad for studies.

Dr. Tesfanesh Belay received her medical degree from Tivier Kalinin Medical School in the Soviet Union, in 1976. She also has a MPH in International Health from Tulane University, School of Public Health and Tropical Medicine. She received community nursing training at the Gondar School of Public Health.



**Alex de Waal**

Director  
United Nations Commission on  
HIV/AIDS and Governance in Africa

Alex de Waal is Program Director for the UN Commission on HIV/AIDS and Governance in Africa. He is a writer and activist, who has written widely on issues of HIV/AIDS, war, famine and human rights in Northeast Africa. He is the author of several books including "Famine Crimes: Politics and the Disaster Relief Industry in Africa" (James Currey 1997) and "Demilitarizing the Mind: African Agendas for Peace and Security" (Africa World Press 2002). He has served as director of Justice Africa and Chair of the Mines Advisory Group.



**Robert Dintruff**

Director, Global Care Initiatives  
Abbott Laboratories Inc.

Rob Dintruff is a Director for Abbott's Global Care Initiatives. He has worked with Abbott Laboratories over the past 23 years since completing his graduate work at the University of Michigan. His assignments have included various production, sales, business development and marketing management positions in both the Diagnostics Division and the International Division.

In recent years, Mr. Dintruff has worked to develop Abbott's Sept Forward program, an initiative that assists children orphaned by HIV and AIDS in developing nations. He currently oversees the Abbott Access and Determine® HIV Testing Donation programs along with a new initiative being developed for the treatment of malaria.

Abbott Access is a program that provides the antiretroviral drugs, Kaletra and Norvir and Determine® HIV, a rapid test for HIV antibodies, at no profit to Abbott in Africa and the Least Developed Countries as defined by the U.N.

The Determine® HIV Donation Program provides Abbott's rapid HIV antibody test free of charge to programs in that same geography where the product is used for the prevention of mother-to-child transmission of HIV.

Mr. Dintruff, and others in his organization, travel frequently at the 68 nations where these programs are offered. Their efforts provide access to critical products from Abott where the need is greatest.



**Niraj Doshi**  
Health Science Associate  
Merck & Co., Inc.

Mr. Doshi, a national of Kenya, is Business Manager for HIV products at Merck Sharpe & Dohme since 1997. He represents Merck Sharp & Dohme in Kenya, Uganda, Tanzania, Rwanda and Burundi. His responsibilities include implementing cooperate strategy for policy, business and management decisions, developing and implementing of regional marketing strategy, developing and maintaining a business relationship with regional distributors and key government institutional heads, and developing a contact base with key opinion leaders in the field of HIV/AIDS.

Mr. Doshi has worked in the pharmaceutical industry since 1993 at Bristol-Myers Squibb/Phillips and Sanofi Pasteur.

Mr. Doshi received a M.Sc. in Biochemistry in 1993 and a B.Sc. in Biochemistry and Zoology in 1990 from the University of Nairobi. He has completed courses in biological training programs on HIV/AIDS, Hepatitis, CMV, the new diagnostic trends in HIV, and on the use of PCR technique in the monitoring of HIV-RNA viral loads during HIV Antiretroviral use. Mr. Doshi has attended key world conferences on HIV/AIDS in Côte d'Ivoire, Turkey, Switzerland, Scotland, Portugal, Zambia, Austria and South Africa.



**Fantaye Mekbeb, Ph.D.**

Vice-President, Global Alliance for Women's Health  
Manager, Association for the Rehabilitation of Girls  
Addis Ababa, Ethiopia

Dr. Fantaye Mekbeb is Vice-President of the Global Alliance for Women's Health (GAWH) and a member of its Advisory Board as Primary Health Care Expert. Dr. Mekbeb is also Manager of the Association for the Rehabilitation of Girls, an NGO based in Addis Ababa.

Between 1996 and 1998, Dr. Mekbeb worked in the Ministry of Health of Ethiopia as an expert in health management and training team, and as a team leader of Health Professional's Registration and Licensing Team Leader at the Ministry of Health in Addis Ababa. She also worked as Health Education Counselor at the Metro Health Center, Cleveland, Ohio, 1993-1994. She designed, developed and coordinated a course on early-intervention programs for high risk groups, on heart disease, diabetes, high blood pressure, alcoholism and drug abuse, cancer, sexually transmitted diseases and health and nutrition education. She also introduced and developed the "Sunlight" health education program on HIV/AIDS and other sexually transmitted diseases. From 1981 to 1985, she was Chief of the Health Centers Division, where she assigned and developed a literacy health campaign, along with the national literacy program, supervised and allocated literacy health budgets to all regions that participated in the campaign, and prepared the final report for dissemination to the Ministries of Health and Education.

Dr. Mekbeb received a Ph.D. from Michigan State University, East Lansing in 1993 with a dissertation on "Assessment of Community Health Agent's Teaching Effectiveness Related to Diarrhea Disease Prevention and Treatment in Ethiopia." In 1986, she received a Master in Public Health, Health Systems Management from Tulane University, School of Public Health and Tropical Medicine in New Orleans, Louisiana. She received a Bachelor's Degree of Science in Nursing from Indiana State University in 1975 and a diploma in Community Nursing, Gondar Public Health College, Ethiopia, 1964.

Dr. Mekbeb has received several honors, scholarships and fellowships that helped advance her work on international women's health and related issues.



## **Prof. Alan Whiteside**

Director

Health Economics & HIV/ AIDS Research Division  
University of Natal, South Africa

Alan Whiteside was born in Kenya but grew up in Swaziland where he attended Waterford-Kamhlaba College. He has a BS (Development Studies), a MA (Development Economics) from the University of East Anglia and a Ph.D. Econ from the University of Natal.

From 1980 to 1983 he was an Overseas Development Institute Fellow working as a Planning Officer (Economist) in the Ministry of Finance and Development, Gaborone, Botswana. In 1983 he joined the Economic Research Unit of the University of Natal as a Research Fellow. In 1998 he established the Health Economics and HIV/ AIDS Research Division at the University and he is currently the Director of this division.

His main research interest at present is the economic and development impact of HIV/ AIDS. He started and edited the newsletter "AIDS Analysis and Africa" from 1990 to 2002. In 2000 he co-authored, with Clem Sunter, "AIDS: The Challenge for South Africa", published by Human and Rousseau/ Tafelberg. This sold over 22,000 copies. In 1992 he devised a four week training programme on 'Planning for AIDS in the developing world' run initially in Norwich and subsequently with Professor Tony Barnett in Norwich, Durban, Jaipur and Calcutta (India), Penang (Malaysia), Manila (Philippines) and Nepal.

Professor Whiteside has worked throughout the world on HIV/ AIDS. In addition to Southern Africa, he has worked in Ukraine and parts of Asia. Western clients include USAID, UNAIDS and Swedish SIDA. His most recent book (with Tony Barnett) "AIDS in the 21st Century: Disease and Globalization" was published by Palgrave MacMillan in June 2002. He is an elected Member of Governing Council of the International AIDS Society and a member of the Governing Council of Waterford Kamhlaba College.



**Elaine M. Wolfson, Ph.D.**

Founder and President

Global Alliance for Women's Health (GAWH)

A political scientist and academic since 1967, Dr. Wolfson became a representative of a non-governmental organization at the United Nations in 1991. As a result of her research in the formation of social policy, more than two decades of work on women's health policy, and her experience at the United Nations, she noted the consistent under attention and inadequate information available about all stages of women's health throughout the world. She founded Global Alliance for Women's Health (GAWH), a non-governmental organization, in 1994 in order to help address these shortcomings through women's health advocacy, education and promotion internationally.

Her research on the formation of social policy in the United States during the 1960's convinced her of the importance of the private sector in the development of sustainable economic opportunity. It also became apparent to her that many of the advances in women's health garnered in the twentieth century in the US often originated from private initiatives – from individuals as well as corporations from foundations and academia and from the profit as well as the not-for-profit sectors. In those instances, the role of government in developing public policy for women's health was reactive.

In the early 1980's after finishing a special program for Ph.Ds in the arts and sciences at the Wharton School of the University of Pennsylvania, Dr. Wolfson began teaching courses on business and society in an MBA program at Baruch College, a branch of the City University of New York. Her lectures and her research on women's health reinforced her understanding of public-private partnerships. With her founding of the Global Alliance for Women's Health, these ideas coalesced. Public-private partnerships became a cornerstone of GAWH's mission and its method for advancing women's health internationally.

Dr. Wolfson was educated at Smith College (BA) and New York University (MA and Ph.D.) and the Wharton School of the University of Pennsylvania (certificate). She has taught at New York University, the State University of New York, Long Island University, Rutgers University and the City University of New York, and she has held an adjunct appointment at the Columbia University School of Public Health. She has lectured on women's health at international

seminars in Spain, Italy and Korea, and has consulted on women's health with UNDP and WHO. Her publications on women's health include articles, monographs and edited compilations.

## PARTICIPANTS

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### **Representatives of Governments at the Economic Commission for Africa (ECA) and African Development Bank (ADB) meetings 2003**

#### **Angola**

- Miguel Goncalves, First Secretary, Angola Embassy in Ethiopia
- Jose Pinto, Counsellor, Angola Embassy in Ethiopia

#### **Botswana**

- B.K. Molosiwa, Secretary for Economic Affairs, Ministry of Finance & Development Planning

#### **Ethiopia**

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- Lt. Col. Dr. Yodit Abraham, Ministry of Defense
- Dr. Tesfanesh Belay, Head of Family Health, Ministry of Health
- Dr. Yohanes Desta, Ministry of Health
- Lt. Col. Teka Saba, Ministry of Defense
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- Alex de Waal, Director

### **United Nations Conference on Trade and Development (UNCTAD)**

- Dr. Samuel Gayi

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- Veena Kulkarni, Product Manager, Determine Donation

### **Addis Ababa University, Ethiopia**

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### **Association for the Rehabilitation of Girls (ARG)**

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- Zerihn Mekbebe, Project Coordinator
- Bebele Shewandague, Program Coordinator

### **Candle Theater House**

- Ayalneh Muratu, General Manager

### **Channel Africa**

- Dennis Tshethame, Journalist

### **Fistula Hospital, Addis Ababa**

- Dr. Tadesse Birok, Gynecologist
- Dr. Andrew Browning, Gynecologist

### **German Foundation for World Population**

- Mekoes Alemu, Country Director

### **Global Alliance for Women's Health (GAWH)**

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