

contact

A publication of the World Council of Churches on health and healing



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About this issue of Contact for Health:

Our lead topic is AIDS and malaria and we have received news from East Africa: Kenya, Tanzania, and Uganda; from Southern Africa and West Africa.

The Ecumenical HIV/AIDS Initiative in Africa was launched in Nairobi. p.14 & 41

The Ecumenical Advocacy Alliance will be active in the 2004 IAS AIDS Conference in Bangkok. p.4

“Africa could be depopulated by AIDS to an extent not seen since Slavery!”, Reverend Dr. Samuel Kobia, General Secretary of the WCC, told *Contact*: “AIDS is the enemy”. p.5

Special report TANZANIA (p.7-13)

“FAIR TRADE”, Tanzania’s Deputy Health Minister Hussein A. Mwinyi tells the world, “would best assist Africa in meeting the challenge of HIV AIDS”. p.12

Malaria: Tanzania’s best researchers are mounting a project to mass produce the best medicine: artemisinin. Today, the plant brought into the country and grown in schools and in St Benedictine’s Parish is exported for raw material extraction. p.7, 9 & 10

Why can’t Tanzania mount its own pharmaceutical industry such as to supply cheap drugs not only to its own 100 000s of malaria cases, but also to all of Africa? The project presented at the National Institute of Medical Research by Executive Director professor Andrew Kitua.

Pediatrician in the Anglican hospital, Dr Talbert called for attention to Tick Born Relapsing Fever, as a major disease among children. p11

The Tanzanian Christian Social Services Commission provides health care to 40% of the country population as shown on back page map. We met Dr Josephine Balati, AIDS coordinator and Marsha Macatta Yambi, head of Drug procurement. p.13

From **Kenya and Germany**, the **Ecumenical Pharmaceutical Network** takes issue with the US Presidential Emergency Plan for AIDS relief, PEPFAR, on drug access and generics. p.27

PEPFAR, an opportunity for FBOs? Our coverage reviews some of the ways in which FBOs can get funding, and for what programmes. We take special note of the proposal to support safe health care, by eliminating unsafe injections. p.23

From Uganda, Dr Pepper, a Southern Baptist Convention Missionary, physician and head of the HIV clinic, and internal medicine at the government teaching hospital MUTH, reports his practice of **Biblical holistic care and his use of latest technologies: syringes where the needle retracts after use.** p.15

The Safe Health Care and HIV coalition is petitioning the 2004 World Health Assembly and proposing an amendment to insure total safety. p.42

Coming together to confront AIDS, is the message of the **The Inter Religious Council of Uganda** received from Rev. Sam Lawrence Ruteikara, AIDS Director. p.15

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Christian economics are brought to us from excerpts of the beautiful **“Economy of Communion”**. p.31

We have news from the WCC’s partners and their action against AIDS:

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To keep updated on key scientific development, we took a look at the **malaria and mother-to-child HIV transmission.** p.40.

From the **World Social Forum in Mumbai**, we are pleased to publish the report of the **World Health Organization’s delegation** : as Craig McClure, Ian Grubb, Alaka Singh, Eugenio Villar, attended and presented the « 3 by 5 » initiative. p.18

We conclude with the **MUMBAI declaration** of the People’s Health forum and the first announcement for the **Second PEOPLE’S HEALTH ASSEMBLY IN ECUADOR.** p.38

Editorial

Health workers being informed, analyzing and sharing experiences, influencing decision-making and making a difference to people's lives....

CONTACT magazine has been published for over 35 years. This has been a publication that gives voices to health workers from communities and also gives a platform for discussion of key issues and has also been an important source of information. Until five years ago Contact was published from Geneva and from 1998 the publication was decentralized to partners in the various regions.

During recent years due to declining resources and capacity the traditional distribution model of the Contact magazine which has been to distribute the printed copy through post- individually to all who request, has been difficult to sustain.

From this issue of the Contact magazine we are changing the strategy of the publication. The publication will operate from an Internet base. The printed version will continue to be published and sent only as bulk mailing to key partners in regions which are under-served by the Internet technology. We will also continue the other language editions - French, Spanish, Chinese and Portuguese as much as possible.

The publication will be based on the discussion forum that would appear on the Internet in the WCC related web-site at [-www.contactforhealth.org](http://www.contactforhealth.org). The Internet based Contact for health web-site will be a hub, which will receive and reflect input from various facets of community life that has implications on the health and healing. This place will be a platform to foster discussion, dialogue, sharing of ideas and lessons learnt. There is a possibility for all to contribute directly to magazine, and in their own language, through the Internet. Mechanisms are in place that would screen these articles and allow publication of these voices on the web. We are hoping the wide networks of church and other faith based health-related interest groups and service providers will utilize this facility and convert it into an active and dynamic web-site-, which will contribute to the printed magazine. The 'Contact for health' web-site will be a collection point of the various articles- which will contribute to the printed version of Contact magazine. The contents of the quarterly issue of the Contact magazine will be periodically transmitted by an e-mail message and newsletter from the 'Health and Healing' desk of the World Council of Churches.

It is not that we have a shortage of information. The challenge is to find the relevant information in a useful, convenient and accessible manner. It is the hope that this modified venture will not just add on to information but rather help in the synthesis of it, for health workers around the world, in their own languages.

Our mission is to assist health workers

- In being informed,
- Analyze and share experiences,
- Influence decision-making,
- Make a difference to people's lives.

To allow people to understand the reality of health, and for the health workers to see themselves in the broader picture of the society.

We would like to thank our partners who have made it possible to continue the production of Contact magazine through these challenging times - Christian Medical Association of India, the Pan-African Institute of Community Health (IPASC), the Community Health programme of the Lutheran church in Chile (EPES) and The China Christian Council and the Amity foundation in China have been instrumental in publishing Contact magazine in a decentralized manner from 1998. These organizations will continue to be involved creatively in the new form of the Contact magazine. Most of all we look to the continued support of readers of Contact who continue to challenge and support us in this venture.

I also take this occasion to welcome Nance Upham who is our new Co-Editor, whose experience and dedication will help us to serve you better.

Manoj Kurian

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International AIDS Conference (IAC)

Ecumenical and Interfaith Events

Bangkok, July 2004

The IAC (www.aids2004.org) will draw more than 15,000 health workers, government representatives, journalists, activists, corporate leaders, people living with HIV and AIDS, and religious leaders to the Conference in Bangkok on 11-16 July. The Ecumenical Advocacy Alliance, with many other partners, has been spearheading planning for faith-based participation. Planning is near completion for a variety of strategic inputs to the Conference, which all are invited to join:

List serve: This is a list serve of ecumenical representatives attending the IAC for the purpose of sharing plans, ideas, and information about faith-based participation in the Conference. To join, write to: info@e-alliance.ch

Access for All: The Faith Community Responding

An Ecumenical Gathering Preparing for the International AIDS Conference: A two day ecumenical pre-conference will be held in Bangkok on 9 and 10 July. Already, more than 280 people have registered from more than 30 countries. The pre-conference will include plenary sessions, 19 skills building workshops, and daily worship. On a parallel basis, Muslims and Buddhists will also be meeting. On the afternoon of the 10th, all will come together for a multi-religious session to prepare for the IAC. For agenda and registration forms, visit the EAA website listed below or contact: coordinator@nca-interfaith.org

Interfaith Exhibit: A space has been organized to display materials from different faith-based organizations. To request an application to display, contact: interfaithexhibit@e-alliance.ch

Interfaith Chaplains Programme: A team of chaplains from different religions is being recruited to lead services at the IAC venue, and provide counseling services. For more information, contact: tmacarthur@bluewin.ch

Interfaith Satellite Session: "Combating Stigma and Discrimination: The Role of Religious Leaders in Building Inclusive Communities" is the topic of a satellite session on Monday, 12 July at 20:15 in Room K at the IMPACT Center in Bangkok. The session is organized by the World Conference of Religions for Peace, the Ecumenical Advocacy Alliance and UNAIDS.

Global Village: The Global Village at the IAC will include a "Spiritual Corner" providing a dynamic space for faith-based activities, displays, meeting and other events. For more information, visit www.nca-interfaith.org or contact: ncabkk2@loxinfo.co.th

Daily Ecumenical Caucuses: Daily ecumenical gatherings will be held during the Conference in the Global Village at the Conference Venue each day at 13:00, and each evening at the Ambassador Hotel.

Ecumenical Media Team: A team of professional communicators will be producing daily stories, photos, video and audio documentation of faith-based contributions to the IAC and will be producing a daily bulletin in Bangkok. For more information or to receive these materials, contact: sspeicher@e-alliance.ch

Global Poster Competition: The international winning posters from the Global Poster Competition Against HIV and AIDS-related Stigma and Discrimination will be on exhibit at the IMPACT Center during the IAC.

Other ecumenical efforts already completed included: training in preparation of abstracts, submission of abstracts on the faith-based experience, submission of skills building workshop proposals, and suggestions for plenary and panel speakers.

Updated information about all of these activities can be found at: www.e.alliance.ch/bangkok.jsp and questions may be directed to: info@e-alliance.ch

Africa could be depopulated by AIDS to an extent not seen since Slavery!



Interview

Reverend Dr. Samuel Kobia

WCC General Secretary

Contact: *Global strategies against AIDS tend to have an individual-based rather than a community-based approach. And yet, would you say there is a need for a specifically African approach to HIV/AIDS? And what role should churches have in this regard?*

Rev. Samuel Kobia: In Africa, society is strongly community-based. Africans respect and listen to their community leaders more than their political leaders. In Sub-Saharan rural Africa, the Church is the centre of life for many people; it is a place where people meet, and not only on Sundays. I would therefore like to make three points.

Firstly, the church provides a tremendous opportunity for meeting people. The pulpit is a powerful place from which to provide education and knowledge, yet, today, the pulpit is insufficiently put to use on the issue of HIV/AIDS. Preachers should be equipped with the knowledge necessary to communicate to their people regarding HIV; and, to do so, there is a need for training centres for preachers. The Ecumenical African Alliance is gathering information for schools and preachers. The power of the pulpit was recently demonstrated in my country - Kenya. The churches were the vehicle to inform people, it was an important forum to change political leadership in Kenya¹.

Secondly, the fight against HIV/ AIDS is an essential part of the church's mission because it is a question of life. Speaking about AIDS is a powerful imperative for us.

Thirdly, the African marketplace has a crucial role to play for it is where there is a dynamic of interactions. It is a great medium for communication, where rural people come to mingle with town people, playing an important role in community life. The African market is where information is transmitted more than anywhere else! The liberation struggles to overthrow colonialism travelled through interactions at the marketplace.

Contact: *Winston Zulu, from Zambia, a leader in the People Living with AIDS Movement – head of GNP+ for Africa, then Zambia, argued some time ago that instead of individual testing and counseling, VCT should be done on a family basis in Africa. For example, this would prevent the stigmatization and isolation of pregnant women if testing was proposed to the prospective father as well...*

Rev. Samuel Kobia: I can understand the point about family-based testing. But, if I think about my own Bantu group, the basic unit is not the family per se but rather the age-mates. Rites of passage could be used to get the information across on HIV/AIDS, for example. Age-mates are trained and educated together, and people feel free to speak with age-mates, this is an important part of African tradition.

Contact: *Last June (2003) in the Montreux meeting of WHO's International TB and HIV Working Group, we heard a presentation by Wilfred Nkoma, WHO/AFRO, where he said that only 7% of the adult population of Africa has access to VCT...*

Rev. Samuel Kobia: The time has come when HIV/AIDS should be equated to an enemy and it is the community's responsibility to struggle against it, if we are to survive as a people. Africa could be depopulated by AIDS to an extent parallel to slavery!

If only the governments of Africa could be challenged to say that everyone needs to be tested and perform mass testing just like immunization in a school or at the marketplace.

We should have places for testing everywhere, and not leave it to chance or to the individual to decide. A piecemeal approach to testing will not work. If the community as a whole is involved, it would destigmatize the disease. It would create a groundswell for access to treatment, if all the people affected by HIV were aware of that.

This would liberate people who would otherwise feel shy and afraid, it would lift the suspicion about this one or that one, when he or she goes for testing and the rumor "why is he or she doing it?" If we say that everyone should do it, it becomes less intimidating. At the general assembly in Yaounde, Cameroon, it was very encouraging when all the church leaders all agreed to be tested - that was a very important event to make it a collective responsibility.

Contact: *There is a Safe Health Care and HIV working group which brings NGOs such as Physicians for Human rights together with trade unionists like the African branch of the AFL-CIO and Public Services International which*

have raised the issue that unsafe injections in health care in poor countries are contributing to the spread of HIV. The 2003 World Health Report states that HIV is a "bloodborne retrovirus". WHO estimates that as many as 60% of injections may be unsafe (re-use of single-use syringes, lack of universal precautions), in parts of Eastern Europe and Asia, 35% of injections are unsafe in Africa. Would you deem it important to raise the issue as it would also contribute to de-stigmatize HIV/AIDS?

Rev. Samuel Kobia: There is a structural dimension to HIV/AIDS. Because of poverty, many people get HIV unnecessarily because of recycled 'single use' needles and the resulting unsafe injections. If Africa was not so poor, the HIV rate would be much much smaller.

AIDS is a disease of poverty as much as anything else. The possibility of having equipment for clinics and hospitals would contribute to solving the problem in Africa.

I would like to see funds being made available so that we could deal resolutely with the problem.

Contact: Yet there are some who maintain that the problem of unsafe injections is minor and who attack the fact that the US administration strategy on HIV AIDS has earmarked fund to solve the problem of unsafe injections.

Rev. Samuel Kobia: I would like to see funds made available to prevent people being in danger of bloodborne diseases, so that we have safe blood and safe good quality care. The sexual behaviour of people in Africa is not that different from any other people in the world. African people are NOT more promiscuous, therefore there must be other factors. Poverty is a main factor. There are some cultural practices which play a role, like wife inheritance on the continent, and should be dealt with. The myth of "having sex with a virgin" and child rape as ways for cleansing and avoiding AIDS are manifestations of insanity and have nothing to do with African cultural behaviour!

Furthermore there is a feminization of HIV and poverty, and the tendency to treat women as commodities for trade on national and international levels.

Contact: Today, in the UN, the term "sex work" is used, child prostitution has been renamed "under-age sex work", sex business is said to be a business equal to any other, and cross-border trafficking is often renamed "migration"...

Rev. Samuel Kobia: The governments of the world should get together and make it a scandal that the traffic of women and children are tolerated! The way this society views women is an economic and social problem, making them vulnerable. It is a matter of human dignity.

We have to speak out on human rights, that girls and women are treated as tradable is unacceptable. Trafficking in sex is slavery! There can be no justification to legalize trafficking in human beings, the way society treats

The struggle for food sovereignty must be as strong as our fight for independence.

Time has come to see AIDS as an enemy. It is the responsibility of the community to act!

women is what makes it easy. We must do it, humanity has to change.

The use of women as commodities has to stop. It is a violation of human rights to allow the trade of women. Accepting the notion of "sex work" and "sex as a trade" is accepting failure in the way we organize our life. This lead us to the whole question of the theology regarding the body, that Man and Woman are created in the image of God. We cannot accept the notion that some people are not created in the image of God. Within the body, lays the spirit. "Sex worker" is unacceptable as a term. This is a basic question of Human Rights.

Contact: Food sovereignty in Africa, as you say, should be a prime goal for the continent. As the FAO has shown, even nutritional intake is decreasing with the death of farmers who are heads of households...

Rev. Samuel Kobia: Family labour is critical to food production in Africa as well as Asia. If there cannot be food self-sufficiency at the family level, this has to be achieved at the community level.

Africa has the potential to become food self sufficient. I see no good reasons why Africa would need food subsidies. It is unacceptable that as a continent, we would be as unable to meet our needs as under colonialism.

The lack of food for everyone is intolerable, and AIDS is further deteriorating that situation. The struggle for food sovereignty must be as strong as that for independence, this struggle constitutes an integral part of a comprehensive strategy against AIDS. It must be part of the African Union's agenda to grow enough food, which requires good management of arable land and fair trade.

In the age of globalization, some degree of protectionism and regulation for national food production is important. For example, in horticulture, the lucrative business is moving around the globe, from Europe to Latin America, and from there to Africa.

People stop maize production to grow roses or carnations. The costs of this in terms of national food production capacities is tremendous. Eating well is a matter of health; it is a factor of success against HIV/AIDS.

Interview N. Upham

¹Rev. Kobia presided Kenya's national election monitoring unit in 1992.

Exclusive report: Tanzania

Conference of the National Institute for Medical Research

March 15-17, Arusha

“TB/HIV/Malaria: Challenges to the Health Systems in Africa in the era of globalization.”

The Resolutions of the NIMR

The NIMR conference concluded with a militant resolution, including over 15 items revolving around three main themes:

- 1. A major initiative against Malaria:** the project for national manufacturing of artemisinin not only for the needs of the country but also for export to other African countries.
- 2. Strengthening and improving health services and safety practices,** with better supplies, better drug management, and increased remuneration of health care personnel.
- 3. A call to restore effective State monitoring in the age of globalization, as privatization breeds dangerous anarchy of private practices** (such as placing meat and milk on the market without control), endangering health in some instances. Both public and private laboratories also need to be monitored by State services for quality performance.

1. Malaria: an ambitious plan for artemisinin production

The NIMR's ambitious project is to make Tanzania the first producer and distributor of Artemisinin in Africa, and even to export outside of the continent. The drug will be produced from a plant that was brought in and cultivated in a Parish.

The Resolution states:

“There is an urgent need to investigate large scale cultivation of *Artemisia annua* to facilitate local production of Artemisinin and its derivatives as a cheap source for an effective, safe and cheap anti-malaria drug for combination therapy.”

In effect the plant grows best in regions of Tanzania, yet the crop is currently being exported, and, once processed, the drug is imported from abroad. Why not mass produce

the drug in Tanzania itself where the plant grows best? To that end the NIMR deployed staff to China, which has been using the plant for 4000 years and currently manufactures the drug, to master the technical aspects of extraction and mass production.

As NIMR General Director Professor Kitua says: **“Putting research at the service of an industrial project is the key to economic development and poverty alleviation.”** Discussions are underway with the government authorities and industry, and the global plan should be ready by the end of the year (see discussion with Prof. Kitua, below)

The conference also resolved to promote impregnated bed nets and to propose large scale operational studies on intermittent malaria preventive treatment in infants needed to determine treatment schedules, influence, and appropriateness of antimalarial drugs.

2. Strengthening and improving health services and safety practices

“You can't do anything against poverty without health staff!”

“Drugs won't make a difference if health services are not effective, and the health staff needs to be paid a decent wage!”

“The government ought to review the level of remuneration of health professionals to ensure the permanent retention of staff.”

Such opinion prevailed, was discussed, and a lobbying task force was set up to make sure that the authorities would understand the need for action.

According to the resolution, there must be supportive supervision of health facilities. The staff should be increased to improve the quality of care. Attention must be given to factors influencing staff performance, notably in the safe handling of blood. (A presentation on a maternity ward in Zanzibar during the group discussions showed actual

unsafe handling of blood, with wards maculated with blood)

There is a need for the government to review its drug policy, notably with regard to drug procurement and management.

Mass drug administration programmes for the elimination of lymphatic filariasis should include children who are vulnerable to other helminthic infections.

The NIMR Director, Pr Kitua, tells Contact:

“I think that what comes out of this conference is that there is a great deal of concern for maintaining the quality of care being provided. There is a need to strengthen human skills to enable them to perform effectively and to strengthen and maintain standards in laboratory work. There is a need for better safety in care delivery and assistance to health care workers exposed to disease risks.

There are many funds for drugs, from the Global Fund for AIDS, TB, Malaria to the American Emergency plan such as PEPFAR, but drugs will not be effective if the health services are weak. We need clear deliberate plans to strengthen these services. And we should monitor where good standards of care are not maintained.

Certainly, as HIV represents a serious threat to our country, I hope that we will have access to the best technologies for safe health care.”

3. A call to restore effective State monitoring in the age of globalization.

The announced title of the conference included the term ‘globalization’. What that meant was made clear by the discussions and the resolutions: privatization can at times be dangerous to public health. Professor Kambarage, a leading authority on animal diseases that can be transmitted to humans – zoonoses, estimated that a situation in which any individual producer can bring his milk or his meat directly to the consumer without any type of State control is the beginning of a serious health hazard: meat unfit for consumption as cattle was not inspected for disease, animal slaughterhouses without health inspections, raw milk that was not inspected... The resolution called for the “*Re-establishment of meat and milk processing surveillance with better links between veterinarian and medical services.*”

The shrinking of services for animal disease control also poses risks of epidemics such as sleeping sickness, which has reappeared and is spreading to other regions of Tanzania. This may also have a direct detrimental effect on revenues from tourism, considering the 12 cases of sleeping sickness among tourists visiting Serengeti national park over the past year.

“The government should establish laws and guidelines to ensure that all animal products are properly processed before being released to consumers (i.e. pasteurization of milk, safe meat processing)”.

Monitoring of public and private laboratory procedures was also called for, as well as the expansion and reinforcement of disease surveillance both within the country and in other countries in the region with better preparedness.

Trypanosomiasis: a public health problem!

Trypanosomiasis poses a risk for approximately 4 million people. There are 800 cases of sleeping sickness registered each year, but this does not reflect the magnitude of the epidemic. There is presently an active focus in West Tanzania.

Drugs are out-dated and have deleterious side effects. Melarsoprol, for example, which was discovered in 1948 can provoke a reactive encephalopathy with a 5 to 10% mortality rate. Suramin, which has been used since 1992 works (when there is no involvement of the central nervous system). Otherwise melarsoprol remains the drug of choice.

Trypanosomiasis is a growing public health problem, and it has been coming back since 1998. We know its history goes back to 1922 when it was present in the Maswa region, South of Lake Victoria. From Maswa it had spread to all regions of Tanzania. Today it is endemic in six regions: Kiguma, Arusha, Tabara, Mbeya and Ruhwa. All foci – Kigoma, Tabara, Arusha - represent threats to adjacent areas. Yet there is a big gap between those at risk and those who are under regular surveillance. There is a lack of human resources, of technologically trained entomologists and of medical staff for proper surveillance, prevention and treatment.

Nance Upham, President of the People's Health Movement - Geneva International, made a presentation on TB and Malaria as co-factors for the spread of HIV. As co-editor of Contact, she interviewed participants, including the Deputy Minister of Health and the Executive Director of the NIMR, and wrote a review of lead items discussed during the event. Considering the extensive programme, she could not pretend to cover all topics, and refers interested readers to the NIMR for coverage of more issues, presuming that, in the future, proceedings of the conference will be published (www.nimr.org).

Exclusive report: Tanzania

A plan for massive production of Artemisinin

Discussion with Professor Andrew Y. Kitua,
NIMR Director General

During the plenary session, Professor Andrew Kitua presented the situation of local production of artemisinin and its derivatives in Tanzania and plans for manufacturing the drug.

In the 1950s and 60s malaria prevalence had decreased, but it has been on the increase again in the 70s.

“What happened was that the eradication policy was abandoned on the pretext that malaria could not be eradicated in poor countries, and there were no dollars for research.”

Today the malaria situation is very serious, and efficient control tools are urgently needed. We know Artemisinin to be the best, safest and most effective treatment.

- It has a rapid effect
- It is highly effective
- It has inhibitory and gametocidal effects
- It has low toxicity

Artemisia annua grows in the West of Tanzania and plants growing in Tanzania have the highest concentrations of artemisinin. Production of artemisinin would allow Tanzania to provide cheap drugs to Africa.

We interviewed Prof. Kitua briefly at the close of the conference: **“The plant grows extremely well in Tanzania. We need to establish the proper technology for the extraction of the raw materials, and we enjoy the support of the World Health Organization to assess the technical capacities we have in Tanzania.** What is required is, on the one hand, the capacities for extraction and, on the other hand, an industry willing and able to buy the product.

Currently there is no local production of artemisinin in the whole of Africa, while malaria constitutes an enormous disease burden on the African continent! Tanzania currently produces 28 tons of the crop per year, which is then exported and processed overseas. The drug is then imported to Tanzania from abroad, as well as to the rest of Africa.

Our project represents a great economic potential. Most of our research institutions in Africa have gained considerable research experience but this has not been converted into economic development. **We will remain poor unless we can put our research capabilities to work for the transformation of our natural resources.**



We believe that we need to establish close cooperation with industry to transform research into tools for development. Our model is one of innovative research leading to product development. This has both great economic potential and represents a readily available tool for poverty alleviation. We want to develop local production in order to achieve high standards for marketing abroad, throughout Africa and even in Europe.

I am pleased that the government is eager to go ahead with project. Therefore by the end of the year, the feasibility study for the production of the raw materials will be completed and we are engaging industry to see how we can collaborate. Since we are a member of the East African Community, neighbouring countries should support us in this endeavor.”

I think that there clearly is a great potential for the development of artemisinin derivatives in Tanzania given the fact that *Artemisia* grows in Tanzania, including in the North Highlands, Kalgera, Kilimanjaro and the South.

At present, plants are cultivated and exported to Europe for processing, several tons from the South. We are seeking to assess and establish the eventual volume of production with the Ministry of Forestry and Agriculture, and which regions will ensure the best growing conditions for the plant? And we are discussing with local industries to assess absorption capacities and processing for manufacturing. We need better and cheaper drugs with production in Arusha, including raw materials.”

Local agriculture production of *Artemisia annua* in Tanzania

Vitus Nyigo presented the facts of *Artemisia annua* production in Tanzania during the NIMR plenary (Co-authors of the summary, were Hamis Malebo; Paulo P. Mhame; Mwele N. Malecela-Lazaro and Andrew Y. Kitua) M. Nyigo was returning from a trip to China, with a team from the NIMR.

Artemisia annua (called sweet Annie or annual wormwood in the U.S.) is an herb that has been used for the treatment of malaria for over 4000 years, in South East Asia and the countries in the Far East, in particular China. The herb contains artemisinin, which is a precursor for the production of dihydro-artemisinin. Dihydro-artemisinin is the best anti-malaria product. *Plasmodium falciparum* has not yet shown signs of resistance. Many drug combinations with this product have also proven to be highly effective in combating malaria parasites, in particular *Plasmodium falciparum*. For over 4000 years, the plant has been grown and used as an anti-malarial herbal drug in South East Asia and the countries in the Far East, in particular China. In the early 1970s, Chinese scientists managed to extract and isolate artemisinin, and later managed to transform it into various derivatives to improve the solubility of the drugs produced. Since then artemisinin as the basic raw material for producing the drug has been extracted from the plant in many countries in South East Asia and the Far East. Since then the plant has been cultivated in these countries commercially until the early 1990s when the plant was introduced to Tanzania, in particular the above-mentioned type *Artemisia annua* (A3).

In Tanzania, *Artemisia annua* is being cultivated in the highlands and the Kagera region; it grows better there than in the countries of origin. In Njombe district for example it reaches a height of 13 metres. The idea of local production of drugs has led to the beginning of a Pharmaceutical Industry based in Arusha for the production of dihydro-artemisinin. However, the raw material is imported from abroad.

In Tanzania, the existence of drug resistant malaria parasites called for a shift in treatment from Chloroquine to Sulphadoxine/ Pyrimethamine (SP) as the first line for malaria control. However, given the fact that there are already reports of *Plasmodium falciparum* resistance to SP in the country this new alternative may not be effective for long. Inevitably, the Ministry of Health in Tanzania has been thinking of finding an alternative drug, which is safe, efficient, inexpensive, accessible and widely available in the country especially for the rural population. If the source of artemisinin can be obtained from locally grown plants the chances of its product being even cheaper are high, which would justify the immediate promotion of its cultivation.

Availability of *Artemisia annua* in the country also makes it possible for R&D initiatives to transform artemisinin into other more versatile compounds such as dihydro-artemisinin, artemether and arteether.

A survey of the areas in which *Artemisia annua* is currently being grown in Njombe district was needed to enable the pharmaceutical industries to start thinking about investing in local drug production. During the survey on March 2003

NIMR scientists had discussions with the District executive Director; the District Medical Officer; the Head Master of Uwemba Secondary School; the Head Master of Kifanya Secondary School; the Head Master of Mtwango Secondary School; the Head teacher of Ikisa Secondary School and at St. Benedictine Uwemba Catholic Parish the discussions were held with Mr. Spittler and his wife, Brother Wendelin, Sister Matrina, Miss Flora Sirnkonda and Mr. Kawogo. Visits were made to Uwemba, Kifanya and Mtwango villages.

Institutions involved in growing the crop include Uwemba Secondary School, Ikisa primary school, St. Benedictine Catholic Parish and Mtwango Secondary School. St. Benedictine Uwemba Catholic Parish is the centre of Mr. Spittler's project which involves the seedling preparation, the distribution of seedlings to growers, buying, drying, storing, parking and shipment of leaves abroad.

He tested areas of St. Benedictine Catholic Parish of Muheza district; Ndanda; Peramiho and later on Uwemba in Njombe district. Only Njombe district was found to have the best growing conditions and to give highest yields of artemisinin. In general the Luponde farms were the best producers. In 2002 yields were about 28 tons, of which 18 tons were shipped to Europe and 10 tons were waiting to be shipped.

In addition to growing the crop M. Spittler also buys leaves from schools. Drying is carried out at the parish compound using a compressor blower.

Tanzania being a country with 80% endemicity ranging from hyperendemic to holoendemic regions, about 34.2% of all patients (about 500,000) in health facilities are malaria patients. Assuming that the minimum yield required is 0.6%, 28 tons will provide 168 kg of dihydro-artemisinin for only 276,661 cases.

Artemisia annua cultivation in Tanzania would be a boon to all African countries for potential local drug production.

REF.1. Neena Valecha, KD. Tripathi; Artemisinin: Current status in malaria; Indian Journal of Pharmacology, 1997; 29:71-75

REF.2. The GIOI Publishers 1999: Production and application of artemisinin in Vietnam)

During the discussion, questions were raised in the audience, such as:

Intellectual property rights?

Answer: The issue of patents is unlikely to come up since the patent has long expired.

Does it require much insecticide use?

Answer: It does not seem to require insecticides. In some instances, people are even using it as an insecticide because, when planted around the house, it apparently decreases the number of insects in the house.

Do we have all the know-how to go ahead?

Answer: The agricultural ministry has done the preliminary research, including a national survey to identify the best place to grow it and whether enough could be produced for industrial use. As for the extraction process, NIMR scientists are testing what others have done and have sent a team to China to assimilate know-how.

Treating children and combating neglected diseases such as Tick Borne Relapsing Fever

Discussion with Dr Alison Talbert, Diocese of Central Tanganyika, Mvumi Hospital

Dr Alison Talbert is a pediatrician at Mvumi Hospital. A British citizen, she has been working in Tanzania since 1992. Mvumi hospital, with 280 beds, is the only hospital in Dodoma, catering to the needs of a population of 400 000 in Central Tanzania. It is run by the Mvumi Mission under the auspices of the Anglican Diocese of Central Tanganyika. It has a staff of 160, with 60 nurses and three doctors, among which there are two expatriates.

Our most frequent disease here is malaria: we have had an early warning system for malaria for two years, a system whereby when the number of cases surpasses a threshold of a 50% increase, an outbreak is declared.

We are involved in a programme with Population Services International (PSI) to distribute insecticide-impregnated bed nets, which we sell for a very low price. PSI has been doing the social marketing since 1998. At present we have achieved 80% coverage, meaning that 80% of families have at least one bed net. However each family would need about three: one for the parents, one for the female children, one for the male children. There are no household spraying programmes there.

In the children's ward of Mvumi where I work, the main childhood diseases are pneumonia, anemia and gastroenteritis. Then, besides malaria, there is Tick-Borne Relapsing Fever (TBRF) and meningitis. All blood is screened for HIV, testing supplies are provided by the provincial government and the UK, however there should also be screening for Hepatitis.

As far as health care people's practice, I find it good, and injections are safe. We are supplied with single use disposable syringes, and we have not had access to retractable syringes so far. Local people bring their own syringe. It is difficult if not impossible to check if they are sterile.

Our biggest problem is malaria, and the fact that people tend to go to traditional practitioners before checking into the hospitals and they are not always using safe plants.

Although it is a frequent disease, Tick-Borne Relapsing Fever tends to be erroneously diagnosed and treated as malaria. What I am presenting at this conference here is our work on TBRF, with the hope that it will be recognized as an important disease on the national level.

Traditional medicine and plants

Dr Mainen J. Moshi, Director, Institute of Traditional Medicine, Dar es Salam (<http://www.nimr.or.tz/>)

Traditional medicines involve the use of 10 000 plant species. What is important to know is that 21% of the people who use public health facilities go to traditional practitioners first.

Dr Moshi presented the work of the institute in evaluating the effect of traditional plants in collaboration with traditional practitioners.

- Expertise for preclinical testing
- Establishing expertise for standards of herbal preparation
- Undertake the cultivation of known medicinal plants
- Investing in biotechnology to improve yields of medicinal plants
- Ensuring safety and efficacy

Giving the users what they want, while looking for patentable compounds in an understanding with the traditional practitioners.

Tick-Borne Relapsing Fever is a 'neglected' infectious disease caused by *Borrelia spp.*, and transmitted to humans either through bites or coxal fluid contamination by soft ticks of the genus *Ornithodoros*. TBRF is particularly serious for pregnant women (with a 30% risk of pregnancy interruption) and incidences in very young children as high as 38% among 1 year olds and 16% in 1-5 years old have been recorded. Since symptoms resemble malaria and epidemiology overlaps, TBRF is too often misdiagnosed. The development of a vaccine is a difficult prospect as there are three *Borrelia* species complexes each affecting West, Central and East Africa- according to W.N. Kisinza, a young Tanzanian researcher working with Dr Talbert.

Dr Talbert said in her presentation that the problem of Tick-Borne Relapsing Fever was under-reported because of the health management information system. A retrospective study at Mvumi hospital showed that the number of TBRF cases increased from 96 in 1997 to 433 in 2002.

The analysis of 2002 laboratory data revealed that 3.4% of outpatients with fever had TBRF. According to Dr. Talbert, epidemiological studies are needed in the rest of Tanzania and laboratory staff must be trained in diagnosis.

For the hospital on web. <http://www.mvumi.org/>

To fight diseases of poverty, poor countries need fair trade!

Interview: Dr. Hussein A. Mwinyi, Deputy Minister of Health of Tanzania

National Institute of Medical Research of Tanzania, (NIMR) 19th annual joint scientific Conference on the theme: "TB/VIH/Malaria: Challenges to the Health Systems in Africa in the era of globalization." (Arusha International Conference Center, March 15-17, 2004)

Contact: *Mr Minister, you opened this conference with a strongly worded presentation on the relationship between diseases and economic policy. Can you sum up your argument for us?*

Deputy Health Minister Dr H. A. Mwinyi: It is a known fact that countries which are poor usually have a high burden of diseases. In these particular times, the most disturbing big burden of diseases comes from TB, malaria, HIV, in a diseases-poverty cycle whereby the poorer you are the more chances you will get the diseases because of the inability to treat or to prevent them correctly.

We are just emphasizing the point that in the age of globalization, if the economics part of it is not taken into consideration, countries poor as ours will be at a disadvantage because of the trade imbalance

Contact: *TB and HIV work together as has been known for some time now. In the "International Working group on TB and HIV" it is reported that African countries with a heavy burden of HIV have faced a manifold increase in TB cases, what is the situation in Tanzania?*

Dr H. A. Mwinyi: What is very problematic for us, in the face of HIV, is that we used to have TB under control but we have gone backwards. We had control till 1983.

Today, 30% of all tuberculosis cases are HIV related. We might expect the number to go higher for people recently infected with HIV are likely to develop TB. As regards the effect of TB on HIV, I am not aware of research on that question in Tanzania. We are also planning to have a programme to decrease anemia incidence among children by a large deworming programme.

Contact: *Malaria has been shown to facilitate mother to child vertical transmission of HIV, in the recent study done by John Hopkins University (USA) in Uganda, and this role is mentioned in the United States Presidential Emergency Plan for AIDS Relief (PEPFAR). Some research points to the increase in viremia during active tuberculosis and malaria as one interaction increasing HIV spread.*

Dr H. A. Mwinyi: That is another scenario whereby this interaction between malaria and HIV could exacerbate both. We are throwing the challenge to the scientists for them to study the relationship which might be as for TB/

HIV. Certainly immune deficiency predisposes for malaria, and pregnant women with malaria are more likely to transmit HIV to the foetus during pregnancy.

People who are poor are more prone to catching diseases, for example. We know, and you are right to point that out, the link between poor housing and malaria, the link between overcrowding and TB.

Poverty predisposes to all diseases. You can't prevent yourself from getting malaria or TB if you are poor. In the case of HIV, I don't believe the difference in rates of spread between rich and poor countries can be explained by behavioural patterns. I think HIV has to do with poverty because the poorer countries have the highest burden.

Contact: *There is an intense polemic internationally as to the part of unsafe blood in HIV spread... unsafe injections.*

Dr H. A. Mwinyi: We know that to be an important risk. In Tanzania among the five priority interventions, we have placed safe blood and disposable syringes, prevention of STDs, VCT. We are glad that the Centers for Disease Control have agreed to help in setting up five regional blood banks with capacities to screen for HIV. Recently there was the news that perhaps up to 40% of all HIV could be due to needles, unsafe health practices rather than sexual behaviour. I can't comment on that.

Contact: *The association of manufacturers report that selling about 1.5 billion syringes a year for the African continent, whereas WHO estimates are 3 billion injections a year. That says potentially a lot of unsafe injections, with re-use of soiled syringes. Now the US PEPFAR proposes to assist in helping 15 countries get safer health care. Perhaps you could ask for the best equipment?*

Dr H. A. Mwinyi: We are using auto disable devices now in immunization, vaccination programmes, and it would be good if we could expend and use safe technologies for curative services, and hospital services.

Contact: *If you had a platform to speak to the entire world, what would you say?*

Dr H. A. Mwinyi: What I would advocate for is fair trade! Because the poverty we are in is not because of lack of resources, but rather unfair trade. We are exporting our crops and primary resources and rich countries set the prices for them, and it is always very low. But once they are processed in the Western world, they are sold back at a very high price. So it's unfair trade we are complaining about, for we have plenty of resources!

The Tanzanian Christian Social Service Commission

Interview: Dr Josephine Balati, AIDS Coordinator, and Marsha Macatta Yambi, Head of Drug Procurement.

Contact: *Faith based organizations are responsible for 40 % of all health care in Tanzania?*

M. Macatta Yambi: The Christian Social Service Commission is an ecumenical board of the Christian Council of Tanzania and the Episcopal conference. The Commission came out of the decision of the churches to unite their efforts in 1992 in an attempt to reverse the increased impoverishment of social and health services in the preceding decade. Some of the notable programmes set up by the CSSC included the Revolving Drug Fund, the Science teaching innovation programme, as well as the rehabilitation and construction of both education and health facilities and staff houses. The CSSC represents a coordination body for the churches. Activities are many, for



example, the Commission is improving the environment for teachers and doctors working in rural areas. Such as building staff housing at the Namanyere District Designated hospital, Sumbawanga. This is an important initiative to retain staff. We provide close to half of all health care in the country.

We assist churches in accessing funds and assistance for health as well as for developing programmes.

There has been harmonization of the care and treatment plan. Room was made for other donors, for there are the Canadian, the Swedes, the Clinton Foundation and so forth are coming in with assistance now. Our programmes include VCT, prevention of MTCT, home-based care, orphan support, nutrition, monitoring and evaluation.

Contact: *You are the person in charge of HIV AIDS*

Dr J. Balati : My function in the HIV/AIDS department is mostly to coordinate and facilitate activities ongoing within the church institutions, the hospitals, and community-based church organizations such as those helping orphans, or providing home-based care to people living with HIV/AIDS

I finished a public health degree, and then did research in Muhimbili, our national hospital, before joining this programme last November. The AIDS programme is a new one, we are putting together a strategic plan on HIV/AIDS. We have five implementing partners, two referral hospitals, the Kilimangaro Mission hospital, the one in Mwanza, the Anglican Church of Tanzania and the Lutheran Church in Kalgera, on lake Victoria, and Passada (it's a pastoral Catholic NGO assisting in home care). All of these will receive funding from the global fund and we will help them with the evaluation.

Contact: *Are you supervising everything?*

Dr Balati: At the Commission, we are not the implementers, the churches are. What we do is the work of facilitators, and collecting of funds.

We wrote a proposal for the Global Fund on AIDS, TB, Malaria, round 4. We are asking for ARV, and support for orphans. We are waiting to receive the funds from round 3, as they have yet to arrive.

We met the people from the WHO 3by5 team as they send people here. They made a lot of recommendations for the care unit of the Health Ministry which will be managing the distribution of drugs.

Contact: *Tanzania is very poor and has a high burden of poverty diseases, a lot of malaria, a lot of tuberculosis. What are your thoughts on these issues?*

Dr J. Balati: Scaling up HIV work is important but we must take into consideration that poverty is so widespread. Now they want to give people ARV, but it's so hard for people going hungry to swallow these drugs. If people don't have enough food how can we plan to give them such strong drugs and insist on compliance? Some people only have porridge once a day!

In programmes to prevent pregnant women from transmitting HIV to the child, it is also very difficult: you give Nevirapine to the woman but then she has no alternative but to breastfeed the child. So she may still transmit the infection.

The Ecumenical HIV/AIDS Initiative in Africa (EHAIA)

In November 2001, at the “Global Consultation on Ecumenical Responses to the Challenges of HIV/AIDS in Africa” in Nairobi, Church leaders of Africa, international and African ecumenical organizations developed a coordinated “Plan of Action” <http://www.wcc-coe.org/wcc/what/mission/ehaia-e.html#4>.

The Plan of Action includes the following Vision: With this Plan of Action, the ecumenical family envisions a transformed and life-giving church, embodying and thus proclaiming the abundant life to which we are called, and capable of meeting the many challenges presented by the epidemic. For the churches, the most powerful contribution in combating HIV transmission is the eradication of stigma and discrimination: a key that will open the door for all those who dream of a viable and achievable way of living with HIV/AIDS and preventing the spread of the virus.

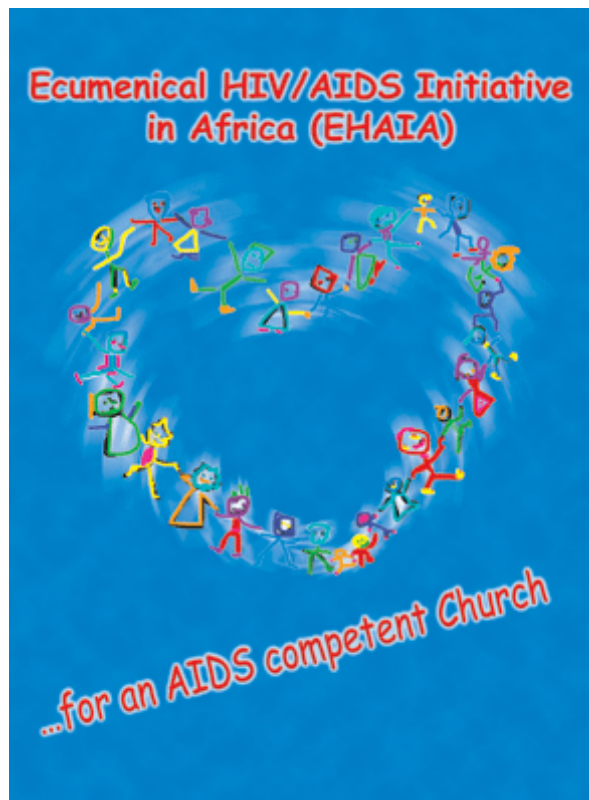
In 2002, this led to the formation of the Ecumenical HIV/AIDS Initiative in Africa. EHAIA describes the AIDS competent church through five main objectives:

1. The teaching and practice of churches indicate clearly that “stigma and discrimination against PLWHA is sin and against the will of God”.
2. Churches and ecumenical partners have a full understanding of the severity of the HIV/AIDS pandemic in Africa.
3. Churches in Africa reach out and respond to collaborative efforts in the field of HIV/AIDS.
4. Churches find their role in prevention of HIV/AIDS taking into consideration pastoral, cultural and gender issues.
5. Churches use their resources and structures to provide care, counselling and support for those affected.

EHAIA is present in Africa through four regional coordinators and a theology consultant.

What can churches expect from EHAIA's Regional Coordinators?

- Advice on how to start or intensify own implementation of the Plan of Action through denominational or local policy papers;
- Special HIV/AIDS retreats for church leaders;
- Courses to include HIV into the curricula of clergy and lay-training institutions;
- Training of trainers for church group leaders (women, youth, men);
- Capacity building for planning of programmes and resource mobilisation to implement them;
- Exchange visits with churches for sharing of good practice;



- Resource persons for HIV/AIDS discussions in synods, assemblies, and gatherings;
- Printed and visual material for work with the congregations and communities.

Achievements of 2003:

During the year, four regional offices run by coordinators and guided by regional reference groups have been established (East, West, South and Central Africa). The theological consultant has also consolidated work with theological training institutions and resource persons.

The focus has been on church leadership and workers - focusing on HIV/AIDS - in strengthening capacity on policy and programme development. Over 6300 resource persons from over 1000 institutions were directly trained during the year. There were further equipped with tools and training to reach out to their wider constituencies.

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The Inter Religious Council of Uganda

COMING TOGETHER TO CONFRONT HIV/AIDS

Introduction

The Inter Religious Council of Uganda (IRCU) is an initiative that brings together different religious organizations in Uganda to work together along areas of common interest. IRCU brings together the Roman Catholic Church, the Uganda Muslim Supreme Council, the Anglican Church of Uganda and the Uganda Orthodox Church. IRCU was formed for, among other reasons, the realization that there was a need to respond to the pandemic of HIV/AIDS in a more concerted manner. It has the Council of Presidents (COP) who are the heads of the participating religious organisations and the Executive Council made up of eight representatives, two from each religious institution.

The policies and programmes are implemented by the IRCU secretariat through the committees that have been formed. The secretariat is headed by a Secretary General who is assisted by a number of other staff both at the secretariat and in the committees. There are, at the moment three committees, namely:

- The HIV/AIDS committee
- The peace and conflict resolution committee
- The education and development committee

The HIV/AIDS office is institutionally located within the office of the Secretary General and it is mandated to link various religious institutions and organizations that are involved in HIV/AIDS work through joint planning, information sharing and implementation and sometimes direct provision of technical support to the organs of these religious organizations in scaling up their responses to the HIV/AIDS epidemic. Whereas IRCU largely plays a coordination role for its members' efforts in their HIV/AIDS responses, it also facilitates them and other grassroots implementers to access the much needed resources to scale up their response.

The United States Agency for International Development, USAID, is helping this young organization to take up the challenges of HIV/AIDS in Uganda and, perhaps, build up a programme that could be copied or adopted elsewhere in Africa and beyond. For instance, IRCU is the Lead Agency for Faith Based Organizations (FBOs) for the Global Fund for HIV/AIDS, TB and Malaria. The coming together of these religious institutions has provided more strength and a wider constituency.

Also, the Inter Religious Council of Uganda (IRCU) would like to express appreciation for the financial support of US dollars 400,000 from the US President's Emergency Fund for AIDS Relief (PEPFAR) that is coming to help orphans and other vulnerable children (OVC) in the areas of basic vocational skills training and scholastic and home care materials for a period of 1(one) year. These resources will also build on and support the on-going OVC projects under IRCU some of which were supported by USAID through their programme, Policy II.

The role of IRCU in the Program

The role of IRCU in the execution of these programmes has been and will be:

- Selection of implementing institutions for support.
- Providing guidance and support in planning.
- Making periodic financial disbursements to the implementing institutions
- Developing easy to use monitoring tools
- Determining monitoring indicators in conjunction with implementing institutions.
- Providing overall project monitoring and support through regular visits
- Making periodic reports to USAID, in liaison with the implementing institutions.
- Providing full accountability to the donor agency.
- Doing project follow up evaluation

Monitoring and Evaluation

The beneficiary institutions shall have a monitoring and evaluation mechanism to effectively track progress regarding on-going activities of this programme. Reports (both narrative and financial) shall be received by IRCU from these institutions at periodic intervals of two months.

Rev. Sam Lawrence Ruteikara

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ANGLICAN PROVINCIAL HEALTH SERVICE

In Faith Breaking Ground Slowly!

...For verily I say unto you, if ye have faith as a grain of mustard seed, ye shall say unto this mountain, remove hence to yonder; and it shall remove and nothing shall be impossible unto you. And all things, whatsoever ye shall ask in prayer, believing, ye shall receive. (St. Matthew 17:20; 21:22.)

Earlier this year the Anglican Provincial Health Service Office was opened in Accra, Ghana. Previously health activities were conducted on an ad hoc basis through specific diocesan groups but the need for a centralized, more formalized and comprehensive Health Service Programme Office to address the complex and growing health issues confronting the church became apparent.

CPWA consists of six countries, namely Cameroon, Gambia, Ghana, Guinea, Liberia and Sierra Leone. The six countries are comprised of approximately 50 million people, of which there are 14 Anglican Dioceses and more than 150 parishes and congregations. In light of the geographic spread and resources constraints of the Province, the Health Service is breaking ground slowly, country-by-country and diocese-by-diocese. Later this year, in collaboration with the Council of Anglican Provinces of Africa (CAPA), the Province hopes to conduct its first Provincial HIV/AIDS Strategic Planning Workshop, which will bring together representatives from all over the Province to focus on implementing successful health programmes in their dioceses.

Meanwhile, the Health Service initiated in the Diocese of Accra a 'Health Sensitisation' campaign via "Congregation Health Talks" and "Youth Health Workshops" in order to mobilize each congregation to strategically plan and implement health programmes in their communities; to enhance behaviour change; reduce stigma; encourage home-based care; and reduce transmission rate of infection. "Congregation Health Talks" and "Youth Health Workshops" focus on Sexual and Reproductive Health with emphasis on Sexually Transmitted Infections (STIs) including HIV/AIDS. They are facilitated by health professionals and take the form of videos; discussions; questions and answers sessions; and poster sessions, with translation between English and Twi or Ga, that is, the most popular local languages of the audience. "Congregation Health Talks" are usually held for ¾ to 1 hour on Sundays during the usual Bible Study period or immediately after the worship service. "Youth Health Workshops" are usually held on Saturdays.

In addition the Health Service collaborates with other faith-based organization in the fight against STI/HIV. Two very close collaborations are, (1) With the Calvary Baptist Mission, Adenta in a "Preparation For Marriage" workshop of approximately 100 young women. The Health Service presented a session on the theme "Vibrant Health: Sexual Health For Quality Life – It's Your Life...It's Your Choice". Topics included Basics Facts on STIs (transmission, prevalence, pathogenesis/health dangers, signs and symptoms, treatment and risk factors) and Methods of Protection Against STIs including HIV/AIDS, as well as unwanted pregnancy. (2) With the Evangelical "Hour Of Visitation Ministries" in a school evangelism programme of approximately 1070 15-18 year old Secondary School Students. The Health Service presented a session on the theme "Be Young and Wise... Sexually Wise: Your Health is your Future and your Wealth! Protect your Health Now – Practice Sexual Wisdom." Again the Basic Facts on STIs were presented as well as Methods of Protection Against STIs. Abstinence was emphasised as the appropriate method of protection in this situation.

The vision of the Health Service is to improve the overall positive health behaviour evidenced in healthy lifestyle and preventive health care practices of the people living in the Province. Three underlying diseases, namely, Sexually Transmitted Infections (STI); Tuberculosis (TB); and Malaria, have been designated priority and are especially targeted for service because of their potential and or actual impact on health and household resources, particularly the poor.

The main goals are:

- A reduction in all vulnerable persons and groups;
- A reduction in the socio-economic, psychosocial and other consequences of STI/HIV, TB and Malaria infections on the infected and affected persons; and
- The promotion of a healthy lifestyle and strong moral values and family values.

The objectives are:

- To implement the package of priority health interventions for STIs, TB and Malaria;
- To empower individuals, households and communities, to improve their health and gain access to basic health care; and
- to reduce the number of new infections of STIs, in particular HIV/AIDS, and TB and Malaria.

The Health Service recognizes Health as a complete state of physical, mental, social and spiritual well-being and embraces health care in its entirety. However, the primary strategy is prevention, which deals with lifestyle issues and the maintenance of health rather than treatment, which deals with the acute, and the painful level of the illness.

The key activity is that of strengthening the National Health Sector through:

- A) STI/HIV/AIDS control and prevention strategy of promoting safer sex behaviour (ABC); Prevention of mother to child transmission (PMTCT); Voluntary Counselling and Testing (VCT); Home Based Care (HBC); early STI diagnosis, treatment and management; and Providing information on available programmes to increase access to basic health care.
- B) Tuberculosis control and prevention Strategy of promoting care with emphasis on symptom detection and early treatment to improve case detection; and encouraging treatment compliance to reduce defaulter rate.
- C) Malaria control and prevention strategy of promoting home-based care of fever with emphasis on symptom detection and early treatment; encouraging treatment compliance; promoting the use of insecticides treatment material and bed nets particularly for children under five and pregnant women; promoting chemo-prophylaxis-intermittent treatment for pregnant women; and advocating for improved environment sanitation.

The key programmes are:

- Health Promotion by way of Telephone Hotlines and Internet Chat-lines; and
- Health Education by way of Libraries – Health Resource Centres; Training / workshops / conferences on Basic Health Care; HIV/STI; HBC, PMTCT; VCT; Church Health Education, including sexual and reproductive health by Sensitisation, mobilization and integration into Church Ministries, Programme and activities.

While this is the Health Service strategic plan, its success is dependent on individual and collective will and action of the church, and a range of different organizations and agencies, each of which is integral to achieving the health service goals, objectives and strategies. The Health Service is always looking for partnership with others whose policies and services impact health outcomes and look forward to working in a collegial way with many partners to protect people's health by enhancing the effect of mutually conducted Health Services efforts throughout the Province.

Church of the Province of West Africa, Anglican Provincial Health Service, Accra, Ghana

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TB-HIV Togo - Churches act on World TB Day in Togo

1. Some statistics

From 1987 to 2000: 12,527 cases

Seroprevalence: between 6 and 7%, i.e. 200,000 people infected with HIV in a population estimated at 4,900,000

- Age group 19-49 years: 81.5% of cases
- Sex ratio: 0.8
- BY mode of transmission:
- 82.4% heterosexual
- 6.5% Mother to child
- 11.1% Other routes
- Urban areas: 67.07%
- Rural areas: 32,3%

Tuberculosis in Togo

- 20011547 cases
- 2000731 cases
- 19991250 cases
- 19981395 cases

Treatment objective: to treat at least 85% of the new cases
Treatment regimen: 8 months

2. Celebration of World TB day:

The set up is this: every year the event is honoured in one district. This year, the World TB day was celebrated in WAWA district which is located in Plateau Region. During two weeks awareness raising is carried out in schools and villages of that district. Community DOT activities are carried out. Nurses are trained in case management. The later train community health workers in screening and treatment of TB, etc., etc.

3. WHO initiative of "3by 5"

As far as church related institutions are concerned, needs assessment is under way. After this survey which is conducted by representatives of Catholic network, Protestant network and Moslem network, a capacity building seminar will be carried out. And the "3 by 5" approach will be taken care of.

The Government is planning a training of 81 Physicians in ARV treatment management.

Tsogbe Kodjo ktsogbe@yahoo.fr

WHO's report of contributions to the International Forum for the Defence of People's Health Jan. 14-15, and the World Social Forum, Jan. 17, 2003

Mumbai, India

A delegation of four staff from WHO headquarters and one staff member from the SEARO office attended these two meetings. They were:

Eugenio Villar, Coordinator Pro-Poor Health Policy Team, HQ/SDE/HDP/PPHP

Alaka Singh, Technical Officer, Pro-Poor Health Policy Team, HQ/SDE/HDP/PPHP

Craig McClure, Technical Officer, '3 by 5' Core Team, HQ/HTM/HIV (now CEO at the International AIDS Alliance)

Ian Grubb, Human Rights, Advocacy and Community Mobilization, HQ/HTM/HIV

Tej Walia, Regional Adviser on Health Systems and Human Resources, SEARO

Background to the Meeting and the People's Health Movement

The People's Health Movement (PHM) is an international, multisectoral network aimed at bringing together individuals, groups, organizations, networks and movements involved in the struggle for health. It believes that health is a fundamental human right that cannot be fulfilled without commitment to equity and social justice.

The goals of the PHM are neatly summarized in the People's Charter of Health, a document which sets out guiding principles to make 'Health for All' a reality for dispossessed and disadvantaged people in all parts of the world. The Charter has become the key advocacy tool of this worldwide citizen's movement in promoting Alma Alta and 'health for all' as an equitable, participatory and intersectoral movement as well as a rights issue.

For further information: <http://www.phmovement.org/>

PHM members have long been active in scrutinizing WHO's efforts in relation to realizing the Alma Alta principles and the Organization's commitment to promoting primary health care approaches. In recent years, PHM activists have expressed criticism of WHO's commitment to primary health care approaches in certain areas. Accordingly, a delegation of PHM observers attended the World Health Assembly in May 2003 to advocate for a greater commitment on the part of WHO to primary health care.

The Conference

The International Forum for the Defence of People's Health was held at the YMCA in downtown Mumbai and attended by 750 members (45 nationalities) of the People's Health Movement (PHM) and their affiliate organizations from around the world.

Prominent among the topics included in the two-day conference programme were issues relating to the impact of globalization and health sector reform on health care gen-

erally and primary health care in particular; women's health; and health care for marginalized populations. At a plenary session titled 'HIV/AIDS: Confronting the Crisis', Craig McClure of the '3 by 5' Core Team made a presentation on the key elements of the '3 by 5' strategy and its relevance to primary health care. Key points included:

HIV/AIDS disproportionately affects the most marginalized people of the world

Treating AIDS successfully requires sustained improvements to chronic care, acute care, prevention and comprehensive care and support

Treating AIDS successfully requires intensive community mobilization to reduce stigma and discrimination, advocate for resources and provide direct support and services.

The key principles of primary health care (universality, equity, multisectoral approaches and community participation) are essential to the implementation of '3 by 5'

WHO is reaffirming its commitment to primary health care, including in the delivery of HIV/AIDS treatment, care, support and prevention, as described in the 2003 issue of the World Health Report.

The presentation emphasized that the support of PHM is important to implementing '3 by 5' because:

- Grassroots advocacy in developing countries will help ensure government commitment to and stewardship of HIV/AIDS treatment programmes
- Advocacy for and constructive critical analysis of '3 by 5' can help ensure that ART scale up is grounded in improvements to health systems and primary health care, and that ART scale up is equitable and promotes and protects human rights.
- Community mobilization is critical to the roll-out of '3 by 5', for example in undertaking treatment education and support.

Treating 3 million BY 2005

3by5: What, why, where and how

- **scaling up ART** from the 400,000 cases currently treated to 3 million by 2005
- in response to a **"global health emergency"** (J.W. Lee, D.G. WHO) to avoid a crisis of unprecedented magnitude, '(T)his crisis is not about numbers, it is about human suffering and the failings of development' (Peter Piot, EXD, UNAIDS).
- focusing on **34 "highest burden countries"** which together account for 91 % of the global need for ART.
- within **core principles** of urgency, equity and sustainability, WHO's strategic activities fall into **five 'pillars'**:
 - (i) global leadership;
 - (ii) country support;
 - (iii) standardized tools for delivering ART;
 - (iv) secure supply of drugs and diagnostics; and
 - (v) dissemination of new knowledge and replication of 'successes'.

3by5: Issues to address in setting priorities for access to ART

- **Eligibility criteria** for individuals to receive ART
- Medical eligibility
- Psychosocial criteria
- **Key ethical principles** for fair distribution of ART
- Formal principle of equity: treat like cases alike
- Substantive (material) principles of equity (justice as fairness)
- Utilitarian: maximize public utility; more specifically, maximize health benefits for the society as a whole
- Egalitarian: concern for equity understood as minimizing group differences
- Equity as maximizing benefits for the least advantaged (maximin): concern for those who are worst off
- Justice as reciprocity or compensation
- **Priority groups** that may be considered preferential care

3by5, priority in treatment and the poor

- The **key issue** in addressing the treatment needs of the poor through 3by5 is the distribution of ARVs through weak health systems
- However, 3by5 has the opportunity to capitalise on a **unique political momentum** around HIV/AIDS at both global and country level to overcome systemic bottlenecks

Lessons learnt from country experience in delivering ART

- as a **policy** primary health care is the relevant approach with respect to its essential components - addressing the health needs of the community through a mechanism anchored at the lowest level of care and in the context of overall country characteristics.
- as a **strategy** to deliver particular health goals of 3by5, especially to the poor, and to strengthen health systems, certain areas need to be strengthened. Specifically,
- **Strong government leadership**
- with respect to ART, especially in legislation; setting standards and guidelines; and disease surveillance and systems monitoring needs to be combined with decentralised and participatory approach to implementation
- to implementation
- **Sustainable** ART through mechanisms that provide protection to poor
- **Fair distribution** and secure procurement of ARV
- **Community based service delivery** that can draw on community participation to overcome human resource constraints in the short run
- **Informing communities** on the epidemic and its treatment to stimulate demand

The Global AIDS Crisis, '3 by 5', and a Renewed Commitment to Primary Health Care

WHO, World Social Forum, 2004

Craig McClure, Ian Grubb, Alaka Singh, Eugenio Villar, WHO

Mumbai, 17 January, 2004

On September 2003 at the United Nations General Assembly, the new Director General of the World Health Organization, Dr. Lee, stated: **"The AIDS treatment gap is a global public health emergency. We must change the way we think and change the way we act. Business as usual means watching thousands of people die every single day."** To address this AIDS treatment crisis, WHO and UNAIDS have committed to leading the **"3 by 5" initiative**, which targets delivering antiretroviral treatment (ART) to 3 million people in developing countries by the end of 2005.

As evident from the experience in industrialized countries since 1996, access to ART has turned HIV/AIDS into a manageable condition, dramatically reducing mortality and morbidity, and allowing people living with HIV/AIDS to live productive, healthy lives. However, in developing countries, these drugs are currently available to only a fraction of those in need. WHO launched the "3 by 5" strategy in December 2003, basing the key elements of the strategy on information gained from numerous pilot programmes that show that it *is* feasible to provide ARTs in even the very poorest of settings.

- The **key elements** of WHO's "3 by 5" strategy are:
 - Simplified, standardized drug regimens, clinical monitoring and other tools, which make ART much easier to deliver than in the past;
 - The training, certification and support of 100,000 health care workers, emphasizing the role of nurses and community health workers providing ART in primary health care settings;
 - Providing much greater support to countries to deliver ART
 - A major initiative to ensure that anti-retroviral drugs and diagnostics can be procured by countries in a secure and sustainable manner;
 - Advocacy, including health sector financing, primary health care delivery models, and community mobilization
 - Monitoring, operational research and promotion of best practices
- **The focus** of WHO's efforts to achieve "3 by 5" is in countries with the highest burden of HIV/AIDS disease. Over 80% of resources will be for country and regional offices to meet this challenge.
- **Principles of equity** will guide the "3 by 5" strategy implementation. Country experience in successfully overcoming health systems bottlenecks to provide ART to the poor show that ART can most effectively be delivered using a **primary health care approach**. Increasing the availability of ART through primary health

care necessitates **improvements in overall health systems** and unprecedented efforts to **mobilize communities as equal partners** in the delivery of their own health care.

Delivering ART through primary health care in a way that strengthens health systems must confront key challenges in workforce development and retention, information management, health financing, and pro-equity stewardship (World Health Report 2003). WHO and its partners on the 3 by 5 initiative will be working hard to address these challenges, to ensure that the care we provide for our communities is truly comprehensive. Treatment supports a comprehensive approach to care by also strengthening HIV/AIDS prevention, and contributing to our efforts to curb other major scourges such as tuberculosis and child mortality.

The 3 by 5 initiative signifies and encapsulates WHO's renewed commitment to the principles enunciated at Alma Alta 25 years ago. It aims to embolden the global community's will to promote and protect the right of every human being to the highest attainable level of health, including ensuring access to HIV/AIDS treatment for those who need it.

"3 by 5" cannot be achieved by WHO alone – the ultimate goal of universal access to HIV/AIDS treatment must be owned by all of us, by multilateral organizations, governments, foundations, the private sector, non-governmental organizations, faith-based organizations, affected communities and people living with HIV/AIDS, if the lives of the many millions who need treatment now and in the future are to be saved.

Addressing the HIV/AIDS treatment crisis is essential if we are to realize this vision, and to achieving health for all.

As the Director General of WHO states in the most recent issue of the World Health Report: *"Twenty-five years ago, the Declaration of Alma-Ata challenged the world to embrace the principles of primary health care as the way to overcome gross health inequalities between and within countries. "Health for all" became the slogan for a movement. It was not just an ideal but an organizing principle: everybody needs and is entitled to the highest possible standard of health. The principles defined at that time remain indispensable for a coherent vision of global health. Turning that vision into reality calls for clarity both on the possibilities and on the obstacles that have slowed and in some cases reversed progress towards meeting the health needs of all people. This entails working with countries – especially those most in need – not only to confront health crises, but to construct sustainable and equitable health systems"*.

Strengthening Health Care Systems for Scaling up HIV and AIDS Responses

Dr Christine Sadia, AIDS Desk, Lutheran World Federation

The scaling up HIV and AIDS response as a strategy for improving access to prevention, care and treatment as well as mitigating the socioeconomic impact of HIV/AIDS is a noble idea. Providing more quality benefits to more people over a wider geographical area more quickly, more equitably and more lasting should be the basic principle.

The three by five (3x5) initiative by WHO offers a great opportunity to examine community participation and its nobility cannot be down played yet there are gaps and areas to be addressed in order to achieve the desired objectives.

The historical events cannot be left out while considering scaling up strategies. Mobilizing communities is a principle which is well known following the Alma-Ata Declaration in 1979, but which has been applied differently by different stakeholders. Some of the initiatives served the communities well for a good number of years with many benefits, but later the initiatives were difficult to sustain for various reasons. It is therefore imperative that the lessons learnt in the Primary Health Care (PHC) concept be analyzed and used if similar concepts are being used in scaling up

Over the past decade, HIV/AIDS initiatives, inventions and actions have proliferated nationally, regionally and across international development arena and within global policy networks. At the same time, this expansion for HIV/AIDS response offers many possibilities for social change and transformations that have potential tensions and challenges.

Health care delivery systems were initially dominated by state and religious organizations. This may still be the case in some cases where religious health facilities account for up to 45% of facility based care. In the recent decades, many other actors have joined in since the emergence of HIV/AIDS pandemic. Therefore, there has been remarkable contribution by FBOs, NGOs, and CBOs sometimes known as AIDS Service Organizations (ASOs) that have done a tremendous work in the response especially to rural communities more than most governments. The proliferation of these NGOs have occurred with full knowledge of governments who allowed this in order to address gaps that otherwise would not have been filled by state actors. The coordination machinery of these NGOs and CBOs in my view needs strengthening, so that the government does not control but knows exactly what each is

doing in order to ensure quality of care and address issues around equity.

The health planning or any national planning processes need to have a strong linkage with the community groups if one has to achieve a real partnership with community groups as a continuum system of health care system. However, this aspect is usually overlooked for whatever reasons. The effect overtime has led to neglect of systems that were supposed to ensure community welfare and survival rights.

In the recent past due to changes in geo-political and economic climate, the adversarial relationship between State and CBOs has shifted toward one of increased dialogue and collaboration, but this needs to be taken sometimes with a pinch of salt. It is more symbiotic for survival, but still both sides are skeptical of each other. Further, neo-liberalisation has led to reduced state commitment to development activities and has moved to an emphasis on private sector involvement in social arena. This has left most governments vulnerable in the sense that there is little if any of the capital infrastructure development and maintenance. Coupled with influx of social emergency funds to mitigate impacts of poverty through PRSP, HIV/AIDS and other initiatives such as HIPC - coded structural adjustment whatever name it is given. This phenomenon has opened opportunities for existing, but professionalised CBOs, NGOs and in effect Civil Society Organizations, many new ones enter the development business by carrying out welfare-oriented programmes rather than pursuing prior concerns with social justice issues.

The approach is emphasizing their institutional effectiveness and capacity-building skills rather than empowerment and mobilization roles. The claims to legitimacy as key players in strengthening civil society has led to credence in the eyes of donors who view them as entities best equipped to fill in the social service gap left by neoliberal public sector shrinkage.

The global response to HIV/AIDS has relied heavily on nongovernmental organizations (NGOs) to provide timely and responsive prevention, care and support services. Many NGOs utilise community development strategies, but without evidence of their effectiveness, or that, the costs are justified. Most NGOs do not have adequate capacity weighed against the resources they attract and therefore the government could use this opportunity to second staff for the strengthening and improvement of

services they offer to communities. A case in point is that NGOs have been critical in mobilizing and sustaining the community response to HIV/AIDS, often well ahead of governments. These successes are not sustainable in longer-term, therefore the issue of sustainability is critical. It is also known that as much as 70% of USAID 's funding for HIV/AIDS are directed through or involving NGOs. This being the case, what is it that has prevented scaling up?

The Ministries of Health with most run down health care delivery system coupled with high-trained personnel may be the missing ingredient in this puzzle of scaling up. What capacity do they require?

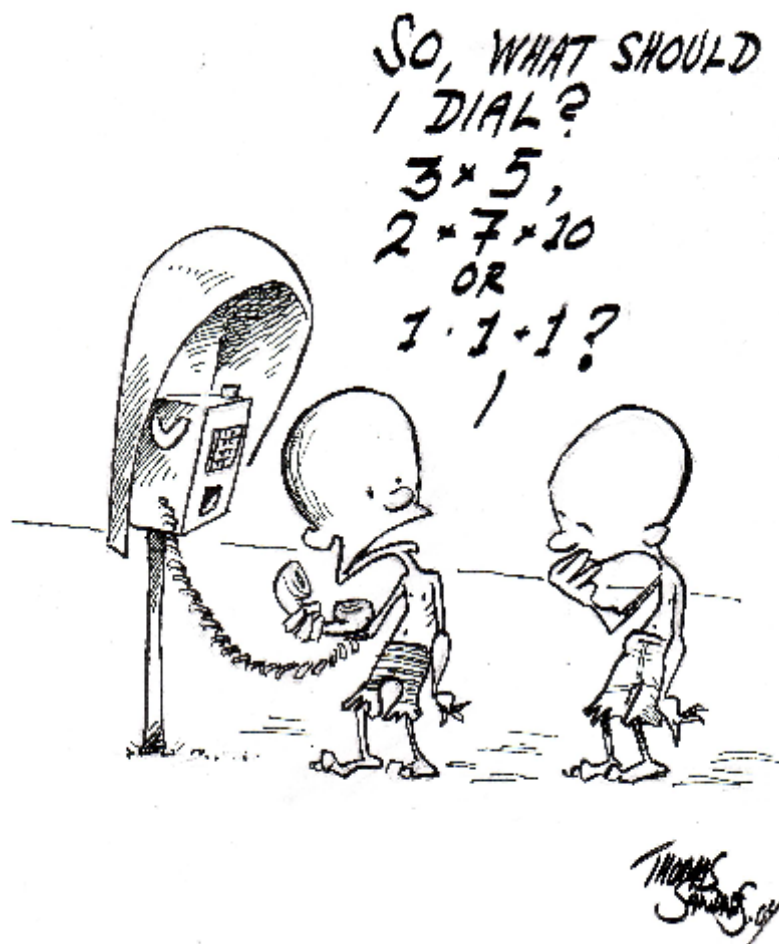
The health care system must be strengthened in its totality for effective scaling up in AIDS care. Some of the burn-out among communities could easily be taken by government and private delivery systems. NGOs/CBOs alone may not be the answer, each stakeholder must appreciate their own capacity and limitation and learn to appreciate/recognize the others stakeholders' niche and comparative advantages.

The issue of accountability on the part of both State and NGOs usually remain well behind the administrative scenes. Consequently, stakeholders may perceive the results of operational overload, project delays as inefficiency, lack of commitment and negligence on the part of supporting institution. The tension can particularly be pronounced in rural settings where difficult logistics constrain communication.

Issues to be addressed while considering strengthening health systems for scaling up:

A crucial issue in managing systems that are more complex is the need to separate the overall strategic control of the system from day to day operations and actual care delivery. The former can be carried out on a voluntary basis without the need for greater technical or management training, however, in any but the least complex systems the latter requires professionalism.

Linking communities with other agencies and government sectors is crucial for sustainable management and improves coordination and collaboration where all actors including community own resource persons share experiences and knowledge. These helps to harness maximize benefits and compliance, but also improves collective responsibility for successes and shortcomings without apportioning blames. Governments through the Ministries of Health must create enabling environment that ensures quality of care is achieved and maintained and is equitable and accessible first to those who most need it such as poorest of the poor. States must also protect communities from exploitation and ensure that private sector, macroeconomic policies are balanced, and communities are cushioned from any unwarranted effects. It must harmonize the interest of public-private partnerships while balancing the role of international NGOs, private sector and donors for stimulating growth and development of health care delivery system.



US AIDS Strategy

PEPFAR: An opportunity for FBOs?

The “President’s Emergency Plan for AIDS Relief” - PEPFAR

US Five Year Global HIV/AIDS Strategy

« We will:

- Provide treatment to 2 million HIV-infected people;
- Prevent 7 million new HIV infections; and
- Provide care to 10 million people infected and affected by HIV/AIDS, including orphans and vulnerable children. »

United States’ President G. W. Bush’s 2-7-10 plan

PEPFAR represents a new US involvement in HIV/AIDS in Africa with a focus on 15 high burden countries - Botswana, Côte d’Ivoire, Ethiopia, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, and Zambia in Africa; Guyana and Haiti in the Caribbean; and a 15th country yet to be determined.

A bit of history

The United States and the United Kingdom as the major donor group to multilateral institutions have historically jointly decided on strategies against HIV/AIDS since the beginning of the epidemic.

The Centers for Disease Control were the source of expertise and leadership for the Global Program on AIDS of the World Health Organization, then, in 1996, they were the main donors behind the removal of the Global AIDS Program from WHO to create a new UN agency with the task of coordinating the response to AIDS : UNAIDS. Similarly with the creation and launch of the Global Fund Against AIDS, TB and Malaria, the GFATM, in which the U.S. had a leading role along with other partners in the G7.

This does not mean that all those initiatives agree with one another, in fact, at present, there seem to be a variety of approaches among the WHO’s 3by5, the Global Fund, or the PEPFAR initiative.

While the disagreement over generics Vs patented drugs has come to the forefront, that is not the only issue on which opinions may differ; the Global Fund leaders, the

3by5, or PEPFAR, or the disputes between the WHO’s HIV department and UNAIDS are public.

Coming a few months after the WHO announcement of the 3 by 5 initiative (to treat 3 million PWA with ARV by 2005), and at a time when WHO acknowledges failure to gather donor support - the 2-7-10 appears as presenting itself to supercede WHO’s. More recently UNAIDS announced the “One, One, One Initiative” (also called “the 3 ones”) with the US, the UK and other European countries, leaving some perplexed on all the number slogans.

Yet, there may be aspects better covered by one plan than by another.

Structure and global approach:

Twenty years into the epidemic, and with all time high and rising HIV seroprevalence, the United States is now undertaking a new initiative that is bi-lateral, mammoth, and indicates a strong will to 1) do it alone 2) innovate from the past 3) impose itself as the new lead agency in AIDS, 4) favor Faith based organizations and approaches.

“We will use a new leadership model. The United States Global AIDS Coordinator will oversee and direct all U.S. Government (USG) international HIV/AIDS activities in all departments and all agencies of the Federal Government.”

Later on, we are told that “Each U.S. chief of Mission will lead a coordinated U.S. Government country team to identify the ‘how’ through program implementation...”

PEPFAR partakes of a military like strategy and proposes a military like top down structure, and it is also electoral, in the sense that it is meant to show U.S. President Bush as a resolute leader.

PEPFAR claims that “The Emergency plan will turn the tide”, the strategy is “evidenced based and results oriented”.

The new command and control structure of PEPFAR is not only pyramidal. The US Government country teams will also “assist countries in developing their own strategic plans” and will have the task of insuring coordina-

tion and guidance for existing multilateral programs on HIV/AIDS. Up until recently, the task of coordination was only devolved to UNAIDS.

PEPFAR places strong emphasis on the need to strengthen health care systems and has some damaging figures on the poverty of health care structures and manpower in Africa.

PEPFAR proposes a vertical structure, with additional input into the "Network" concept of health systems.

There is talk of deploying peace corps like volunteers to Africa, an idea first made public by Health Secretary and GFATM chair Tommy Thompson three years ago.

What opportunities for FBOs?

Leaving the politics aside, the practical question is that PEPFAR represents additional funding and support, and might assist in areas not otherwise supported.

For Faith-based organizations which are very important health care providers in Africa, what areas could be supported by PEPFAR?

1. Strengthening health care systems and improving standards

Act to stop transmission of HIV in health care settings:

"Overstressed and poorly functioning health care systems also contribute to the spread of disease. Medical transmission of HIV continues to be a problem, spread through unsafe injections, unnecessary medical procedures, and use of unscreened blood supplies."

Prevention of HIV infection through safe blood, improved medical practices, and post-exposure prophylaxis

Globally, evidence is striking that the collapse of health care systems has a share of responsibility in the AIDS catastrophe. This was also acknowledged in the WHO's World Health report 2003.

The World Health Report 2003 published last December, spoke of HIV as a "bloodborne retrovirus" and spoke of the increasing transmission risk through blood transfusions and unsafe injections in run down health systems.

PEPFAR takes up this issue in a major way. It has the dual advantage of being an issue little talked about so far, while a massive effort on this score will be very popular among Africans.

"HIV transmission in medical settings, including through blood transfusions, is a significant contributor to the HIV pandemic. Thus, the rapid implementation of safe blood

programs and precautions against medical transmission of HIV is a priority area for the President's Emergency Plan." (see box)

The legislature in the United States has voted for several millions (75 millions) to be spent on that issue and PEPFAR calls for it to be spent in the immediate months ahead. The decision to include safe health care into the U.S. plan came as a result of lobbying from the Safe Health Care and HIV International Working Group that is unlinked to the Republican administration altogether. It brings together the representatives from the AFL-CIO, Public services international, Physicians for Human Rights and other NGOs. (see *the Safe Health Care proposed Amendment, WHA p.42*)

FBOs who are suppliers of health services in all the African countries mentioned, and sometimes large ones, as in Nigeria, have the opportunity to put forth plans to establish safe health care: training, supplies, even manpower, and call for additional monies for much needed investments in that area in each national government plan.

In fact the 5 year plans that must be devised by governments with NGOs and FBOs on AIDS should include significant spending in that area. This could represent a bonus for the nurses and health care staff who have been often times "abandoned" in a difficult situation with HIV plus patients occupying over 50% of hospital beds in the most HIV affected countries.

2. The issue of staff

The shortage of human resources has been clearly identified as a major hazard for health today.

Main FBOs' care giving personnel complain that there are insufficient national staff and that they need government backing to deploy more human resources, especially in rural areas.

The WHO's World Health Report had identified the shortage of staff as a big issue.

What form of support could PEPFAR take for strengthening human services? Perhaps FBOs who are strong partners of state health services in many African countries could elaborate short term plans to scale up capacities.

2.1 PEPFAR proposes to mainly fund sexual faithfulness and abstinence programmes

Individual prevention:

PEPFAR insist on the "A" of the ABC strategy (Abstinence, Be faithful, wear a Condom). This aspect of PEPFAR has sparked a "hot" international debate, although ABC was always central to most AIDS programmes in Africa, as in Uganda. Fact is that as the African countries undergo the experience of the AIDS death epidemic, abstinence mounts simply out of fear.

This is important for FBOs. Leaving polemics aside, there is a clear need for a sexual prevention initiative which starts from the local culture, the African family culture, with local people's norms, and the model cannot be the same in New York City as in Johannesburg.

The issue, therefore, is not for Faith-based community groups to adapt to this or that conservative Catholic group in the US, the issue is, rather, for African women involved in FBOs to work together to figure out their own ways to go at prevention, and then to submit that to PEPFAR for funding.

Taking a militant Christian stand, PEPFAR insist on the importance of promoting the identity of women in society, insist on absolute refusal to accept the notion of trading in women, proposes to act to devalorize the image of masculinity associated with many partners.

There too, if the U.S. were to implement a crack down on trafficking, it could win its bet on the 7 million figure.

Prevention of MTCT HIV infection from Mother to Child is also put forth as a main priority.

The 10 million under care initiative proposes to assist what are, in fact, women, in delivering home care and community care. This will be especially important for FBOs who are traditionally leaders in palliative care and orphan care.

What PEPFAR requires:

Organizations are poised to rapidly and accountably scale up programs in the following priority areas:

- Prevention of HIV infection through abstinence and behavior change for youth;
- Prevention of HIV infection through HIV testing, targeted outreach, and condom distribution to high-risk populations;
- Prevention of HIV infection from mother to child; and
- Prevention of HIV infection through safe blood, improved medical practices, and post-exposure prophylaxis.

5- Prevention and treatment demand testing

Testing of 300 million individuals is now recommended of the WHO, and PEPFAR calls for implementation of mass testing, using mobile units and community workers and community volunteers.

Two new orientations: go for massive testing of the population through advocacy for testing and deploying the means to do so.

Of the approximately 40 million people infected with HIV worldwide, it is estimated that as many as 95 percent do not know their status. Without knowledge of their status,

people continue to spread the disease unwittingly and do not seek treatment. Given the sheer numbers of people who do not know their status, this factor alone represents an enormous challenge to turning the tide against HIV/AIDS. Limited testing strategies, insufficient testing services, and a lack of enabling policies have thus far proven inadequate for making sufficient progress against the disease.

Ever since the start of the epidemic mass testing was opposed and individual testing was firmly set to be voluntary and to be preceded by counselling.

The WHO's 3 by 5 and the CDC have already presented a shift of emphasis announced by the proposal for "opt out" instead of "opt in". Instead of the individual asking for counselling, or the counsellor proposing VCT to the individual, today the pre-counselling goes out of the window, for the obvious reason that pre-test counselling of hundreds of millions of individuals for potential ARV distribution is too cumbersome and would demand a lot more resources. Therefore opt out is proposed which means, for example, that pregnant women will be systematically tested unless they oppose the test. The idea of "opt out" had also been introduced by the tuberculosis and HIV trial projects known as PROTEST.

Excerpts

- Equip health facilities and mobile units to provide testing and counseling and STI services;
- Strengthen public and private sector capabilities to design and produce behaviour change materials;
- Upgrade routine health information systems to improve prevention services data management;
- Strengthen qualitative and quantitative research capability;
- Support effective product procurement, storage, and distribution, particularly for HIV testing and targeted condom distribution programmes;
- Strengthen NGO/CBO financial and administrative systems; and
- Improve laboratory capacity to perform HIV testing.

Engage with faith-based leaders on international, national, and local levels

The United States will:

- Engage with community leaders such as mayors, tribal authorities, elders, and traditional healers to promote correct and consistent information about HIV/AIDS and combat stigma and harmful cultural practices....

- Engage with faith-based leaders on international, national, and local levels. Religious leaders have enormous reach and authority. In many countries, as many as 80 percent of citizens participate regularly in religious life, and the pulpits of religious leaders are a powerful platform from which to promote correct and consistent infor-

mation, encourage behavior change, combat stigma, and strengthen community responses to HIV/AIDS.

The United States will identify, train, and partner with faith-based leaders.

- Work with national and international business coalitions and labor organizations...

Heavy emphasis is placed on media campaigning

Assist journalists in promoting responsible reporting on HIV/AIDS; and

Use exchange programs to provide key people with participatory involvement in a range of activities that serve to enhance their skills and knowledge related to HIV/AIDS. These exchanges will be customized for specific sub-groups of people who are in a position to demonstrate leadership in their home countries, including health care workers, journalists, and others.

PEPFAR includes lobbying to raise more funding and partnership with corporations.

Drugs

If the 3 by 5 and the 2-7-10 differ, it is in the access to drugs feature. PEPFAR insists heavily on respect and enforcement of TRIPS agreement, and rebukes detractors of the pharmaceutical industry, and says that the market works. Also pointed out is that US pharmaceutical manufacturers are the main providers of drugs, existing ones and drugs to come, and stands to benefit from agreements to supply AIDS drugs. The argument against the WHO endorsement of generic fixed dose combinations is evident, and the US had convened a conference in Botswana where the issue was hotly debated. (see article by EPN on generics this issue)

The “Prevention Objective” is to prevent 7 million HIV infections in the focus countries, to be estimated by mathematical modelling, says the PEPFAR plan.

It might be said that if health care transmission came to be recognized as more important than is acknowledged within the UN system today, a real safe injection plan in those 15 countries might bring the U.S. close to fulfilling its 7 million target !

2000 review of “safe” practices during implementation of the EVP (enlarged Vaccination programme) by WHO field technical staff indicated massive re-use of single use syringes (non sterilisable plastic syringes) equipment in most African countries studied.

The WHO reports up to 60% unsafe use of “single” use syringe in parts of Asia, Eastern Europe, and 35% for Africa, yet places HIV transmission as a low percentage of

The President's Emergency Plan will help build the health infrastructure necessary to strengthen infection control programmes, reduce medical transmission of HIV, and build the capacity of health care workers to treat STIs and prevent mother-to-child infection. Last, the fundamental principle of the President's Emergency Plan – to integrate prevention, treatment, and care – is intended to stimulate a cycle that will reduce stigma and fear, create incentives for testing, and thus amplify prevention efforts.

total transmission, the U.S. action plan could change that estimate.

Safe health care

Much can be done to reduce the likelihood of transmission, improve infection control, and increase the quality of health care services overall. President Bush's Emergency Plan will provide technical assistance and training to prevent medical transmission of HIV and improve the quality of services through the network model. Support will be provided to improve blood safety, increase the use of safe injection practices, ensure the practice of universal precautions, and increase the availability of post-exposure prophylaxis.

Specifically, expert guidance, support, and assistance from organizations currently providing training and technical assistance will be provided to ministries of health and national transfusion services to develop and implement comprehensive national safe blood programmes. Suggested activities include:

- Providing technical assistance for developing effective national, generic, and site-specific policies, protocols, guidelines, and practices related to blood donation; safe injections; obtaining, handling, storing, testing, transporting, distributing, and disposing of blood, sharps, other injection equipment, and medical wastes; and universal precautions for infection control and prevention and management of occupational exposure to HIV;
- Training health care staff in the use of protocols and guidelines – the Emergency Plan will support training, supervision, and other performance improvement measures for health care professionals in the areas listed above as well as education about alternatives to injection in primary care practice;
- Ensuring effective supply chain management of the range of products and equipment needed to prevent medical transmission of HIV; and
- Providing technical assistance, training, and products for post-exposure prophylaxis in health care settings and for other types of potential exposure (such as sexual violence) once protocols have been established and trained personnel and supplies are in place.

Access to HIV/AIDS drugs endangered?

It is estimated that every hour 600 people die due to HIV/AIDS! It is no wonder then that HIV/AIDS has been declared a world emergency. In this context, efforts have been under way in the last few years to not only raise awareness in the fight against the disease, but also bring the benefits of technology such as drugs to those who need them. Such efforts have included the access campaign that brought down the prices of antiretroviral drugs (ARVs) down from ~\$12,000 to ~\$250 per person per year. This can come down ever further as exemplified by the Bill Clinton Initiative, which has managed to get an agreement with three generic manufacturers, for a price of \$145 per person per year!

The improved access and availability was made possible when this was put on the WTO agenda and the subsequent Doha Declaration on TRIPS affirmed that the agreement should not prevent members from taking measures to protect public health.

Other achievements include the WHO's interventions such as the addition of 12 ARVs to the Model WHO Essential Medicines List, the development of a prequalification system for these drugs, and more recently, the announcement of the "3 by 5" campaign (3 million people on treatment by 2005). Furthermore there has been an increase in funding for activities through the Global Fund to fight HIV/AIDS, TB and malaria. This means more countries are being supported for training, infrastructure and procurement of drugs and other commodities. In addition the availability of preparation such as fixed dose combinations has meant less pill burden and better compliance.

These are achievement worth protecting and developing further. However, today, frightening dark clouds with the potential to destroy these crucial gains, hover over the horizon! These are the approaching WTO deadline of January 2005 and the US-funded President's Emergency Plan for AIDS relief (PEPFAR).

What will happen in January 2005?

The date 1st January 2005 is of special significance for the developing countries. Although they are free to use the flexibilities such as Compulsory Licensing (CL) in the TRIPS agreement, in reality they face difficulties due to lack of or insufficient manufacturing capacity. Even if they could, the process for application of CL is cumbersome, needing complex information and having no clear instructions. To overcome these obstacles, they have obtained

their supplies of cheap ARVs generics from countries such as Brazil and India. However according to the WTO agreement, middle income countries such as these two, must comply with the TRIPS fully from 1st January 2005. They therefore cannot export drugs that were patented after 1996.

This presents a second problem: whereas the ARVs patented before 1996 (a crucial year for WTO) will continue to be available in generic forms, exactly which drugs are to be included or excluded is not clearly known. The danger is that patients may be using newer ARVs in generic form and, come 2005, they will be forced to change treatment regimes or pay much higher prices. Coupled with that is the real possibility, hopefully not to soon, that the virus will develop resistance to the off patent ARVs. Newer ARVs will be needed and only expensive branded forms will be available.

The difficulty also applies to raw materials, which will only be available in the developed countries. This will add to the burden of developing countries' struggle to increase their local production in the face of low capacity and complicated bureaucratic obstacles of WTO procedures. Even the alternative government order option has little to offer and no incentives to invest (no export, no sale), as has been experienced in Zimbabwe and Kenya. The system therefore seems skewed such that least developed countries (LDC) may never be able to produce ARVs.

This cloud is only less than nine (9) months away!

What are we doing about it? What concrete steps must be taken to prevent this disaster? Are people on the front-line informed? Are we doing too little too late? There is an obvious need for partners in North and South to share information and to advise and assist each other as necessary.

US-funded HIV/AIDS programme (PEPFAR), a Trojan Horse?

Last year the US government announced an HIV/AIDS programme that offered 15 billion US\$ for five years. That sounded good! But looking at the conditions of the programme makes one wonder if this is not a Trojan horse likely to destroy the generic competition. For example, the drugs that will be bought by these funds have to fulfil US quality regulations. This means that the system of prequalification by WHO, which is known to be as strict

as the best regulatory bodies, and has made it possible for those in the field to get good quality generic drugs, is deemed worthless. In other words, good quality generic products from India and Brazil are excluded and only expensive branded drugs offered by Big Pharma are taken. Due to the higher prices the number of beneficiaries will also be markedly reduced!

The second problem is that the well-received fixed dose combinations would also be excluded as Big Pharma is not able to produce triple combinations since the ingredients come from different companies.

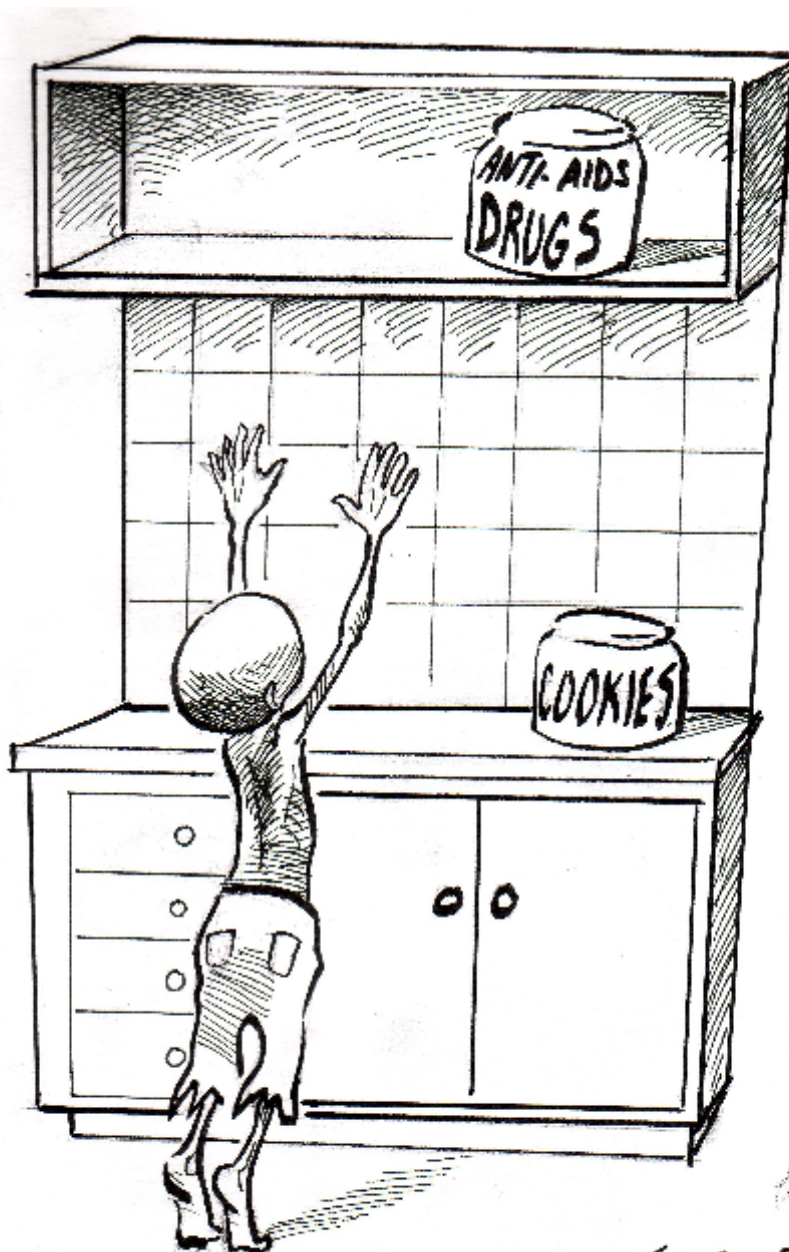
Finally, the initial statement seems to indicate that the programme intends to have its own vertical supply system! This procedure will further weaken the developing countries' health infrastructure, destroy working relationships between different in-country partners and possibly ignore or disrupt the national treatment guidelines.

The threat by PEPFAR was felt to be of such magnitude that a world-wide protest campaign ensured that this was clearly brought to the attention of the US authorities during their meeting in Botswana in March 2004. Will that have an effect? We wait to see. But one is left to ask: Will we all have to go to the streets? Will humanity win over profits?

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THOMAS SAUPE 04

Biblical holistic HIV care in Uganda :

From quality safe health care to caring for communities

Discussion with Dr Larry Pepper

Department of Medicine, Head of the HIV clinic, Mbarara University Teaching Hospital Missionary, Southern Baptist Convention

MUTH has 320 beds with an average daily census of approximately 300 patients. Ambulatory care far exceeds inpatient care. In 2002, over 56,000 patients were seen as outpatients.

Dr Pepper is a physician and a Southern Baptist missionary, a Texan, and former NASA physician, who left America to go to work in Uganda. He is seconded to the department of internal medicine of MUTH from the Southern Baptist Convention.

Dr Pepper: My approach as a missionary is biblical holistic care: the individual must be cared for and healed both physically and spiritually.

The institution where I work is a government hospital and a medical school. I have many students and interns to train.

Contact: *Please tell us about your HIV clinic.*

Dr Pepper: The HIV clinic provides treatment, prevention and management of opportunistic infections. We have a programme for antiretroviral delivery. Our outpatient follows 2700 people, of whom 900 are treated with ARV.

People must pay for their treatment, about 25 dollars a month thanks to the fact that Uganda has initiated generics manufacturing. Farmers have families who support their costs; middle class people can afford that.

Contact: *Is there any support to provide care for patients unable to pay?*

Dr Pepper: Through the Ministry of Health, we hope to gain access to free ARV delivery for about 2000 patients too poor to pay starting this September.

Funding is coming through not just the Global Fund for AIDS, TB, Malaria, but also the MAP programme of the World Bank and the U.S. Presidential plan, PEPFAR. In Uganda the PEPFAR programme is being handled by the US embassy and operates in phases.

Our clinic is the main one in the South West region. We are hoping for a comprehensive pack that includes voluntary counselling and testing, treatment and prevention of opportunistic infections, as well as injection safety.

We work with Dr. Peter Mugenyi, head of the Joint Clinical Research Center in Kampala, Uganda, a world authority in HIV/AIDS.

We hope to get funding for that plan and also for orphan and community care.

The nurses and the staff really like this new retractable technology because it is very effective and just about eliminates the risk of needle stick injuries.

In a sense, we are a hybrid whereby the Baptist mission of Uganda is providing all the support, or say, 95% for the HIV clinic, but the Mission works alongside a government institution.

Contact: *Is PEPFAR going to assist you with injection safety, they have a big component on that topic which is a new thing from donors, although it was mentioned in the World Health report of 2003...*

Dr Pepper: Regarding health care safety, we have always had training in universal precautions, the standard training for nurses and medical students and staff. But in reality safe handling of sharps and needles has always represented a problem. For example, we use plastic containers for waste disposal, but this system is not ideal.

Lately, we have been experimenting with retractable technologies for the patients in the HIV/AIDS clinic.

Contact: *Could you explain to us what are these retractable technologies?*

Dr Pepper: These are syringes where the needle retracts after use.

The nurses and the staff really like this new retractable technology because it is very effective and just about eliminates the risk of needle stick injuries.

We gave a questionnaire to health care workers after a month of use and all the staff would like to keep that technology. There are made by Retractable technologies, a small US firm.

Contact: *Would it also facilitate waste management?*

Dr Pepper: We indeed have a perennial problem with waste management of sharps and needles.

Our hospital burns the waste but does not have a pit for sharps, so we just have a place set aside for our waste, but this is far from ideal. In this situation syringes where the needle retracts after use simplifies the waste problem, as this reduces the problems of dangerous needles to get rid of.

Contact: *Would you say there is blood safety in Uganda?*

Dr Pepper: Blood safety is a well established programme in Uganda. Our hospital which is in a rural area 250 kilometres from Kampala provides safe screened blood for all the hospitals and care centres of the region. Unfortunately we don't screen for Hepatitis C as of now, but I hope that we shall be able to do so in the future.

Even in our hospital, where we have both single use and retractable syringes, we have nurses using the same single use needle for IV on the patient.

The needle is sitting right next to the bed of the patient.

We have not had accidents documented yet, but this is not really "single use", even in a teaching hospital. It is also dangerous for the care giver.

Now, if we get out of a teaching hospital situation with bad supplies and lesser training, I am sure, unfortunately, that the same single-use disposable syringe may be used on several patients.

Contact: *What would you like to tell the World Health Assembly?*

Dr Pepper: We want to propose a comprehensive package, similar to what Dan Fountain, M.D., a missionary to Congo for many years, has proposed for a decade as biblical holistic care. This is an approach to transform communities, transform lives as we heal the heart of people; for people need spiritual and holistic care. We can never forget that the person we try to treat also needs our spiritual care.

For Uganda we need a comprehensive programme: everyone must be offered a test and receive clinical and holistic types of care; for hearts need care as well!

I hope that we will get a number of churches interested in doing home care.

Caring for the sick in a community is so important; it heals the soul!

Dr. Larry Pepper
Mbarara University Teaching Hospital
Kabale Road, Mbarara, Uganda,

From the South African Catholic Bishops' Conference AIDS Office

The Catholic Church and ARV

In South Africa, AIDS is regarded as an invariably fatal condition. Being diagnosed as HIV positive is a death sentence. This is not so in countries like the USA, Great Britain and Brazil. There AIDS is seen as a "chronically manageable condition", similar to hypertension and diabetes – conditions that can lead to death if left untreated, but that can be kept under control with the correct medication. This is due to the availability of anti-retroviral therapy. In fact, anti-retroviral therapy is so successful, that in Britain, all hospice wards for AIDS patients have been closed, because they are simply not dying any more. In Brazil, deaths due to AIDS related causes have been reduced by more than two thirds.

In this country, the debate surrounding anti-retroviral treatment has been clouded by obstructionist government statements and policies. Whereas most South Africans consciously reject dissident influenced thinking emanating from high political offices, they have nevertheless subconsciously internalized ideas that anti-retrovirals are highly toxic, and should be treated with extreme caution. Slightly more than a year ago, two representatives of a UK based charity that makes anti-retroviral treatment available for free to destitute patients, visited a Cape Town home based care programme, offering their services. Not one person made use of their offer.

The SACBC has, since 2000, been funding more than 140 home-based care and orphan care programmes, with the support of its international partners. It has, however, become increasingly clear that these are, at best, inter-

ventions that treat the results of AIDS, not the causes. The only way to directly treat the causes is by making anti-retroviral therapy available. It would then be unnecessary spending financial and human resources on home based care and hospice projects, as HIV positive people would not be getting sick any more. Similarly, it would become unnecessary spending large sums of money on orphan care programmes, as parents on anti-retroviral therapy would be living for long enough to take care of their children.

Since the middle of last year, the SACBC AIDS Office has been working on a proposal to make anti-retroviral therapy available at 12 sites (hospitals, clinics, hospices and home-based care programmes) throughout the country. To date, sufficient funds have been raised to commence in 6 sites. These are situated in KwaZulu/Natal, Gauteng and North West Province. It is anticipated that the programme will begin in February 2004, and that 100 patients will receive anti-retroviral therapy at each site in the first year.

This development once again places the Catholic Church in the forefront of the struggle against AIDS. It is hoped that a model will be developed, showing that partnership between the church, international donors and local health authorities is the best way to ensure that those who need it most receive anti-retrovirals.

J. Viljoen
SA Catholic Bishops' Conference AIDS Office

Economics

Economy of Communion Movement

Geneva WCC seminar, 17 November 2003

Summary report

The first part of the Seminar reviewed *“The Economy of Communion Experience: a proposal for economic activity from the spirituality of unity”* of Movement founder Chiara Lubich (talk at a congress held to celebrate the 50th anniversary of the European Council, Strasbourg, May 31, 1999.)

“This Movement’s vision of the world is that of a universal brotherhood where all people act as brothers and sisters, in the hope of contributing toward a more united world.

For this reason, everyone is asked to practice with determination what is called love, Christian love, or for those who belong to other faiths: benevolence, which means wanting the good of others, an attitude which can be found in all sacred books. And it is present also in men and women who do not have any particular religious affiliation. All human beings instinctively build relationships with others.

In fact, every person, notwithstanding personal limitations and weaknesses, naturally possesses a culture inclined more to giving than to having, precisely because all persons are called to love their fellow human beings.”

Typical of the Focolare Movement is the “culture of giving,” which, from the beginning, has been translated into practical terms through a communion of goods among all the members and through social works, including some very substantial ones.

In addition, if this love (or benevolence) is lived together, it becomes mutual, and gives rise to solidarity. A solidarity which can be kept alive only by silencing one’s selfishness, by facing difficulties and overcoming them.

(...) *The EoC Movement started in 1991.* Today 654 enterprises adhere to this project, including 91 minor productive activities.

It involves firms operating in different economic sectors, in more than thirty countries.¹

¹ To see the full original text of the speech, go to : <http://www.edc-online.org/testi-e.htm>

Economics of Communion continued:

Luca Crivelli, Gerti Wachmann: *Focus on selected issues of Chiara Lubich’s talk in Strasbourg. We excerpted their presentation to highlight the Movement’s original concepts in economics.*

A Trinitarian Anthropology

We encounter a different type of economic actor in the EoC... especially different from the individual economic actor (the so-called homo oeconomicus) that dominates most of economic theories and can provide undesired legitimacy for the behaviour of many people in business. Nevertheless, the EoC does not question the centrality or autonomy of the subject that chooses and decides in an autonomous way. What it does, is to “complicate” the image of human being, proposing a new anthropology. It doesn’t substitute the individual subject with the community or with the group. Rather, it substitutes the subject – defined without reference to its relational dimension – with a relational-subject which has been called person by a typically Christian tradition coming out of 20th C. philosophy. The EoC challenge is to go from the methodological individualism – which explains collective phenomena as a result of individual’s actions and choices – to a methodological personalism in which the person, seen intrinsically and ontologically as being in relation to others, is at the centre of the theory.

Solidarity as “Brotherhood”

(...) In seeking a new relationship between market and society, the Economy of Communion challenges today’s dominant ideologies. It shows with its own existence that economic activity can and must allow space for ethics. Since the EoC perceives the company as a community, it wants to create authentic relationships in and outside the company. It perceives every commercial contact and every contact among workers as an opportunity to build such relationships. The EoC sees companies as a social good and as a collective resource and it transcends the idea of the market as a place where relationships are only self-serving. In envisioning and living business in this way while remaining fully inserted in the market, the experience of the EoC joins together the market and civil society, efficiency and solidarity, economy and communion. And this is not trivial. If market economy wants to function and to have a future which is sustainable and human, it must allow for the development of behaviour founded on these other principles. (...)

Humanizing the Economy

«The experience of the Economy of Communion aligns itself with the many individual and collective initiatives which have attempted and are attempting to give economics a human face »

The EoC can be seen as a silent but radical alternative to the conventional way of understanding private property

and profit within the company. There are three ways the EoC challenges economics:

First of all the companies that adhere to the EoC are privately owned, fully inserted into the market and they therefore keep private property intact. According to common classification these companies would be defined as « for profit ». In fact there are only a few, but nonetheless significant, non-profit activities that adhere to the project. When Chiara Lubich launched the Economy of Communion in 1991, she did not suggest the creation of foundations, of charity or social assistance organizations – as one might naturally expect. Instead, from the very beginning, she spoke of companies as an unusual instrument for resolving a problem of solidarity. The fact is that “communism” penetrates these seemingly “normal economic organizations” and installs itself therein. With the creation of production areas which have been built beside the “settlements” of the Focolare Movement in recent years, something new is occurring. The construction of these areas gets the entire community involved in a kind of “popular shareholding”. It enables the raising of capital necessary to start up new companies, especially in developing countries where it can be very difficult and costly to access capital markets (“we are poor, but many” was the slogan of the EoC from the beginning). These areas are becoming an original and important form of production. They are not classical business groups (holdings) nor are they a simple industrial district (meaning areas characterized by the almost exclusive presence of one industry which leads to the development of many small companies), even if the social culture that accompanies them plays an important role as it does in traditional industrial “districts”. The development of these zones represents a new stage for the EoC, a “coming out” of the project into public life and a qualitative leap on the institutional-organizational level. In Brazil, where the “Spartaco Zone” has been operating for a few years already with its 7 companies, the EoC is flourishing and in continual development, thanks in part to the significant role of the zone. It is probable that much of the physiognomy and future development of the EoC will depend on the physiognomy and development of these production zones.

Secondly the Economy of Communion shows that it is possible to overcome the dichotomy between the production of wealth and the distribution of it. This is an old dichotomy. Many think that in business one can behave in the following way: no ethical norm must be binding at the moment of production since the only objective is to maximize profits and efficiency. Once the maximum profit has been obtained (even if it means that a certain behaviour violates fundamental norms and infringes upon fundamental human rights), that’s when one can remember the existence of others and their needs and can therefore be generous at the time of distribution. This is the conception that dominates in today’s economy, even among Christians at times. Many think that, when all is said and done, the important thing is to make a lot of money and then to try to distribute it in an equal way according to some law of redistribution. Unfortunately this is a perverse logic



because it tends to dichotomize the person. It makes people schizophrenic, disassociated. The same person can not ignore others to obtain better economic results or more profit and then go on to handle the distribution of that wealth. And that’s because he will never be able to do justice for the evil produced at the moment of generating that wealth, even if he works towards a more equal distribution. The EoC represents an example of going against the trend demonstrating that it is possible to remain in the market successfully without following this dichotomizing logic.

The third contribution to the humanizing of economy is the following: the Economy of Communion shows that economic transactions are inseparable from human relationships. For this reason exchange – even that which takes place in the market – cannot be anonymous or impersonal. This hypothesis is scandalous for economic scholars. Why? Because modern economic science has adopted an antique tradition of thought which has led to sustain the hypothesis that you needn’t look anyone in the face to do business, or it’s better to do business with « strangers ». So we can say that the Economy of Communion radically goes against this conviction. The principle language used by economists today is the language of incentives. Economic science tells us it is necessary to offer an economic incentive in order to direct the choices of the individual towards desired behaviour (for example the effort to realize the objectives of the company, determinant decisions concerning consumption, etc.). Using systems of incentives always hides a relationship of power.

(..) The alternative is persuasion. Perhaps this is the ultimate secret of the Economy of Communion model: those who are involved act without a scheme of incentive – which is always expensive ; they act because they are deeply persuaded.(..)

The Logic of the Three Parts and of Communion with Everybody

“A part of the profits would serve to bring ahead the business; a part to help those in need, thus making it possible for them to live with a little more dignity until they could find a job, or offering them a job in these very businesses. Finally, a part of the profits would be used to develop structures for the formation of men and women who desire to base their lives on the culture of giving.”

The poor are at the centre of attention in the EoC. Primarily they are the poor belonging to the Focolare community and those who have close contact with it. Long term solutions, such as finding a job, are preferably sought for the poor but sometimes it is necessary to offer them direct financial support, at least as a temporary measure. Financial help is often given in order to pay for the children’s studies or health care. Economically speaking, those are investments with high productivity.

The part of the profit that goes to spreading the new culture (which can be translated into publications, conferences, scholarships, etc.) aims at an integral development of the whole person. In fact, the social problem of the world doesn’t depend on the lack of economic resources but it depends above all on precise visions and “cultural” choices. The spirituality of the Focolare sets its sight on a world that is more united – on universal fraternity. It is not surprising, then, that from this spirituality a view on economic affairs has sprung up that isn’t satis-

fied with a mere redistribution of income but aims at the transformation of the culture and promotes an authentic Christian humanism which is therefore profoundly human.

The third part (of the profit) remains in the company. The company must develop and grow and in order to do so it necessitates self-financing and investment, especially in certain phases. This is a sign that the project isn’t short-sighted, that it isn’t an emergency intervention. Rather, it is a proposal for the ordinary functioning of economic and business life.

These firms are committed to promoting within one’s business as well as with consumers, suppliers, competitors, local and international communities, public administrators... relationships of mutual openness and trust, always with an eye towards the common good;

They put into practice and spread the culture of giving, of peace, of lawfulness and of respect for the environment, inside and outside the business

Since the very beginning of the project it was understood that “communion” is much more demanding than the mere sharing of profit. Profit is only one aspect, and certainly not the most important of the added value of a company. In one of the first comments concerning the project it is written as follows: “of all the economic results produced by a company’s activity, the profit is only the tip of the iceberg, that which emerges.

Conference announcement

The Pan African Christian AIDS Network (PACANet) is organizing a conference for Christian organizations, churches and networks involved in HIV/AIDS that are working in French-speaking West Africa.

The conference will be held in Ouagadougou, Burkina Faso from the 7th of June (arrival) to 12th of June (departure). The conference aims at mobilizing the church in French-speaking Africa towards a coordinated joint Christian response against HIV/AIDS.

The objectives of the conference are two-fold:

- To mobilize towards coordination and networking between existing Christian interventions in francophone Africa with the view of ensuring quality, efficiency and scaling those interventions up.
- To stimulate the Church towards massive community mobilization through the church constituency. To achieve these aims, it is planned that at the conference, there will be discussion on issues of quality, professionalism and organizational capacity. Above all, it is hoped the conference will encourage the Church to make use of its comparative advantage in the fight against HIV/AIDS.

Registration for the conference has been extended to 15th May 2004. Interested participants are requested to visit the PACANet website – www.pacanet.org – for a registration form which they should fill in and send to pacanet@it.bw or pacanet@botsnet.bw

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Caritas Internationalis will take part in the Bangkok International Conference on HIV and AIDS

Interview Rev. Robert J. Vitillo, Special Advisor to Caritas Internationalis on HIV and AIDS.

Caritas Internationalis is a confederation of 162 Catholic relief, development and social service organizations working to build a better world, especially for the poor and oppressed, in over 200 countries and territories.

Contact: *AIDS is among the most devastating pandemics of all times, what does it teach us as Christians?*

Rev. R. J. Vitillo: AIDS teaches us first of all to be faithful to the mission and gospel that were entrusted to us Christians by Jesus Himself – that is, to serve the poor and vulnerable so that they could enjoy their God-given dignity and to advocate for a more just world so that the root causes of poverty and marginalization could be overcome. Since HIV/AIDS causes its most devastating impact among the poor and vulnerable, Christians do not have a choice on whether or not they could respond to HIV and AIDS – the gospel of Jesus mandates them to do so.

Contact: *Are you involved in the 3 by 5 initiative of the WHO as presented by Jim Kim at the Ecumenical Pharmaceutical Network meeting in the fall of 2003 in Geneva?*

Rev. R. J. Vitillo: Caritas Internationalis has joined with other Catholic development and service organizations to support HIV and AIDS care and treatment initiatives, especially in the developing countries. It has been involved in such efforts since 1987. More recently, Caritas Internationalis, in keeping with efforts promoted by Pope John Paul II and other Church officials at the Vatican, has advocated for increased access to Anti-retroviral medications in the developing countries. Caritas Internationalis recently collaborated with the World Council of Churches and the World Conference of Religions for Peace to sponsor a consultation in Nairobi, Kenya, in May 2003, in order to assist church-related and other faith-based organizations to access needed funds in order to initiate and expand such projects as the 3 x 5 Initiative.

Contact: *WHO sent a delegation to the Mumbai World Social Forum this year where the People's Health Movement organized a seminar on health, and Craig McClure of WHO*

said that WHO must take precedence over WTO on health issues?

Rev. R. J. Vitillo: Pope John Paul II has spoken on several occasions of the place of the needs of the human persons, especially of the poor and vulnerable, at the centre of globalization efforts. He speaks of a “social mortgage” on all economic endeavours and of the need to examine how business ventures have an impact on the most vulnerable members of society. These person-oriented concerns are perhaps even more compelling than the debates about whether the WHO or the WTO should take precedence in diplomatic circles.

Contact: *Is your organization going to participate in the Bangkok conference on AIDS and what message will it bring?*

Rev. R. J. Vitillo: Caritas Internationalis will take part in the Bangkok International Conference on HIV and AIDS. Our organization will collaborate with the Ecumenical Advocacy Alliance in promoting a pre-conference seminar on HIV and AIDS –related stigma and discrimination. The Catholic Commission for Health Commission, an office of the Thai Catholic Bishops' Conference, coordinates much work in response to HIV and AIDS in Thailand and will join many other Thai organizations in sponsoring activities linked to this conference.

Contact: *At the Geneva EPN meeting, participants from RDC Congo said that it would be important for FBOs to work more closely with National TB programme to make sure treatments are appropriate, notably drugs, what is your experience?*

Rev. R. J. Vitillo: In many developing countries, Catholic organizations, including those linked with Caritas Internationalis, already work closely with national TB programmes in order to sponsor effected DOTS treatment programmes as well as other projects to improve the quality of life for those affected by tuberculosis and for their families as well. In East Timor, during the phase of the transitional United Nations Administration of the country, Caritas Dili in fact coordinated the national TB programme.

BOOK REVIEWS : The Reality of AIDS

TROCAIRE and CAFOD

The book is the result of collaboration between Trocaire (the Irish Catholic Agency for World Development) and CAFOD (the Catholic Fund for Overseas Development of England and Wales). HIV/AIDS is placed in a Christian perspective and the book addresses scriptural and theological insights into profound questions raised by the virus, such as suffering, death, sex and healing. It also spells out the sort of diverse response required for prevention, care and advocacy. **Foreword by** Bishop John Kirby, Chairman of Trócaire

The Reality of HIV/AIDS, Ann Smith & Enda McDonagh, Dublin: Veritas, 2003. ISBN 1 853905429. Price: 6.50 euros.

“On a visit to Tanzania in September 1990, Pope John Paul II pointed out that “The drama of AIDS threatens not just some nations or societies, but the whole of humanity. It knows no frontiers of geography, race, age or social condition.”

The book reviews the unspeakable tragedy of HIV/AIDS, a pandemic which has grown way beyond early predictions, as we are reminded. “Almost a three-fold underestimation”, if we compare the analysis of 1990 with the reality of 2000!

Which is to say, we can only be uncertain of the future, but time to act is now.

Important to remember is that “12 % of those providing care to AIDS patients world-wide are agencies of the Catholic Church and 13% are Catholic Non-governmental Organisations (NGOs). The Catholic Church is thus carrying 25% of the total care given to people with HIV/AIDS, which makes the Church the major supporter of states in the fight against this disease” (June 2001, Archbishop Javier Lozano Barragán, President of the Pontifical Council for Pastoral Assistance of Health Care workers addressing the United Nations Assembly Special Session on HIV/AIDS).

The book tells of the early involvement of Christians in combating the epidemic and proposes further steps to do so, **in every way possible : from the international level to the individual level.**

In the first part, we are reminded of the terrible reality of the epidemic, how it is transforming the population pyramid in the worse affected countries, such as Botswana, how HIV/AIDS strikes more where there is more poverty, and how the later fuels AIDS.

“() a vicious circle becomes established with poverty fuelling the spread of HIV, which in turn fuels poverty. HIV causes gradual erosion of resources within families, communities, industry, schools and the health services. Even within churches the infection affects laity, religious and clergy. Similar to its action at a personal level, the virus disables society’s immune systems, the very systems that might afford protection. At a socioeconomic level HIV disables the human and material resources that should be at the forefront of HIV care and prevention initiatives. This is especially and disproportionately so among those who are already living in poverty.”

The response called for is comprehensive and in agreement with the teaching of Christ:

To achieve more justice, the book calls for debt cancellation for « *the combination of heavy external debt burden and HIV/AIDS pandemic have doubly devastated many developing countries.* »

« *Currently out of the 24 countries due to receive debt reduction under HIPC, 16 will spend more on debt than on health and 10 will spend more on debt than on primary education and health combined. In countries with high prevalence of HIV/AIDS this means that health services cannot afford the drugs needed to treat the TB, pneumonia and other opportunistic infections that actually kill people with AIDS or even the paracetamol that can reduce pain and bring down temperatures.*

Independent assessments show that the enhanced HIPC Initiative’s current debt-to-exports criterion is failing to produce a “robust exit” from unsustainable debts.”

Latter on we are reminded that “*Sub-Saharan Africa pays \$13.5 billion in debt repayment every year, more than the target set for the UN Global Fund for HIV/AIDS, Malaria and TB*”

“To do justice, in the phrase of the prophet Jeremiah, is to know God. Achieving economic justice in the world of contemporary global capitalism appears to many who might help in the task entirely utopian and to some unnecessary. Yet so many further injustices, including exposure to HIV and its consequences, are linked to present global economic disparities that Christians must, at least, seek a much more just economic system.

The impact of the Jubilee 2000 campaign in raising awareness about the injustices involved in the demands

by creditors for external debt repayments and the, albeit limited, debt relief achieved has given some grounds for hope that real macroeconomic change is possible. However, social justice is not reducible to economic justice essential though that is and although they are usually closely associated. Racial, gender and other injustices which are based on prejudice, and in this context injustice towards those infected with HIV or living with AIDS, must be tackled" (16)

The book proposes a comprehensive programmatic response which includes a whole array of initiatives for prevention.

Information, Education and Communication (IEC), for example, need to adapt to specific groups and individuals. For example: "Tailored IEC programmes are essential for health care workers, in order to improve their response to the needs of people with HIV and to ensure that they employ adequate protective measures when dealing with blood and clinical waste."

Prevention is advocated that would better inform the individuals of risk reduction and choices in a situation of understanding and loving of the person, and one of guidance and support for the persons afflicted with HIV.

"Christians need more systematic analysis of scriptural teaching and its development and application to crises in the history of the Christian community if they are to understand and respond effectively to the pandemic."

Care is placed in perspective. "In some of the late eighties and early nineties the time from diagnosis with AIDS to death was significantly increased because of this, even before treatment with ARVs had become widely available.

However, in some of the worst affected areas of the world, the treatment of OIs is still not routine, largely because of the prohibitive costs of medication (relative to earnings and resources), and the lack of necessary infrastructure to ensure that the treatment is effectively administered. The basic kinds of treatments required are antibiotics, antifungals, anti-TB medication and chemotherapy services for a common skin cancer associated with HIV. The majority of these treatments and medications are very cheap and are widely available in developed countries. Hence it is a scandal that the vast majority of people living with HIV do not have access to them. People in the developing world are dying every minute from illnesses which could easily be treated with medication that costs less than the price of a daily newspaper."

The book reminds readers of the "3 million under treatment by 2005" initiative of the WHO, and places the issue of access to treatment as a fundamental issue for the Christian community.

But, simultaneously, it begs the question of a more comprehensive battle against poverty by reminding readers that : *The reality for many people living with HIV in some*

of the world's poorest countries is that they are also malnourished. Simon Chanda Fikansa, the then Deputy Director of the Ndola Home Base Care Programme in Zambia, when interviewed in 1999 on Channel 4 TV in the UK about the lack of essential drugs for the treatment of people with HIV, responded that in fact, for those living in the community where he worked, their greatest need was food because they were hungry. He asked: "What is the point of giving people sophisticated drugs when they will die from hunger?"

Sometimes, HIV patients infected with TB stop taking their medicine because as they are getting well they begin to feel hungrier. They come to realize that the TB treatment, as it takes effect, improves their appetites. As they cannot afford the food that they are now well enough to eat they stop taking the medicine because the distress caused by hunger is worse than the illness itself.

The book speaks of violence and wars as agents for HIV/AIDS and does not mince words:



“Sexual violence and abuse. Rape as a weapon of war is used to control the behaviour of civilian population or to weaken an enemy by destroying the bonds of family and society. Sexual violence may also be a feature in the chaos and destruction of cultural norms resulting from natural emergencies and disasters.

“Increased HIV prevalence because of an “imported” military presence. It is a cruel irony that troops dispatched to bring peace to an area may also be found to have brought considerable increases in HIV infection among local populations.

“Relocation of people to or from areas of higher HIV prevalence and, perhaps, to or from areas of differing awareness about HIV and their subsequent return to their home communities carries the further risk of new infections and of new viral strains being introduced in the home as well as the host setting.

People look to the Church to put into practice what it is saying. The prophetic voice of the Church needs also to be continually heard in its actions with priests, religious and lay people. It needs to be heard in models of good practice that address gender and economic injustice. It is through these actions that the prophetic voice of the Church rings true. The Church must be prophetic simultaneously in its actions and in its words. (...)

By daring to work fearlessly to eradicate these injustices, and by owning its own role in perpetuating them, the Church makes its prophetic voice heard within a world living with HIV and AIDS.

From a Christian perspective, this book develops an understanding that bears a strong resemblance to the ActionAIDAsia recent publication on HIV/AIDS, and both provide an overview grounded in the development challenges of our times

Nance Upham
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The MUMBAI Declaration

(Excerpts)

PREAMBLE

We, the 700 persons from 50 countries, gathered at the III International Forum for the Defense of the People's Health at Mumbai on 14-15th of January 2004,

reaffirm the validity and relevance of the People's Charter for Health, the foundation document of the People's Health Movement, which describes increasing and serious threats to health in the early 21st century.

Since the Charter's adoption in December 2000 at the first People's Health Assembly, at GK Savar, Bangladesh, the health of the world's poor has worsened and more threats to people's health have emerged.

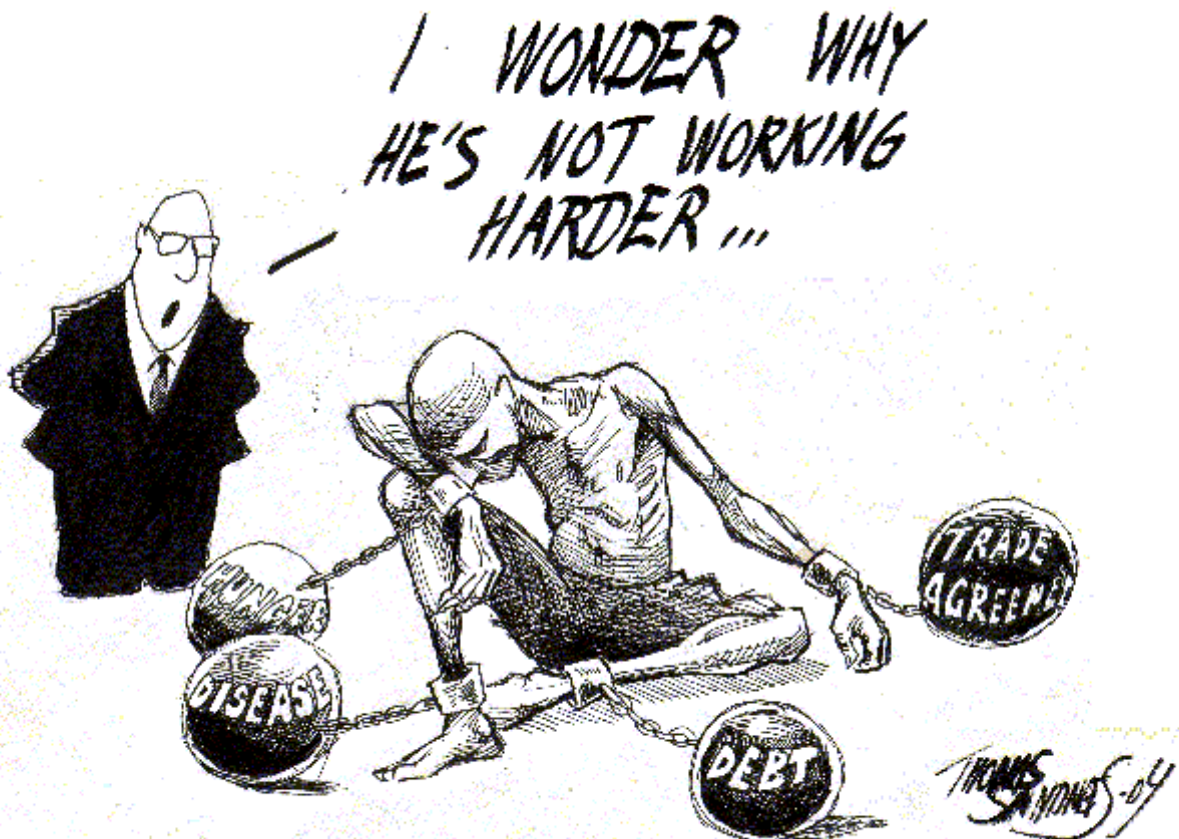
Social, political, economic and environmental threats to health identified as the basic causes of ill health and the inequitable distribution of health within and between coun-

tries have increased. This Declaration provides an update on the state of global health in beginning of 2004 and calls for actions in areas that are most urgent.

The III International Forum for the Defense of the People's Health provided opportunities to hear inspiring testimonies, from the world's poor and health activists:

- Denouncing the denial of health to their communities and their efforts to overcome this injustice, and,
 - Threats to health from the unfair system of global trade and the imperialist policies of developed countries including unjust wars and efforts to counter them,
- Demands acknowledgement of health as a universal human right and the implementation of Comprehensive Primary Health Care as a strategy to achieve Health for All.*

Go to www.PHMovement.org for the full text.



THE ECUADOREAN NATIONAL FRONT FOR THE HEALTH OF THE PEOPLE

FIRST ANNOUNCEMENT

Second People's Health Assembly

QUITO, ECUADOR, JULY 19-23, 2005

VENUE: Ecuador is located in the North-western part of South America. It has a history of people's struggles in the defence of health and life. There is a huge contrast between rich and poor and social inequality is vast with dominant economic and political groups being directly responsible for this situation.

THE PROCESS: The Second People's Health Assembly will be the end stage of a preparatory process of local and national reflection, of discussions and debate, and of an exchange of experiences of communities and networks; national and regional conferences and workshops will precede the Assembly discussing all aspects influencing the health and well being of everyone.

At the same time, there will be a joining together of campaigns and a mobilization of organizations and groups of people from around the world. Campaigns coalescing will be those on Health For All Now, No to War, and Reform the WTO.

OBJECTIVES OF PEOPLE'S HEALTH ASSEMBLY II

- To promote and strengthen the People's Health Movement as a network that works for the revival of the spirit of Health for All.
- To boost global action on the Right to Health as a fundamental human right.
- To promote open debate and to exert the needed resistance towards all mechanisms that violate the right to health of the people (many dressed in the form of neo-liberal reforms, globalization or militarization).
- To share knowledge and practical experiences on alternative models promoting and providing community health.

THEMES OF THE PEOPLE'S HEALTH ASSEMBLY II

The preliminary themes that have been identified for the PHA II

- Health as a fundamental human right.
- Health care reforms and the right to health.
- Health and Indigenous Peoples; Natural and Traditional Medicine.
- HIV and AIDS.
- Population Sectors and the demand for health: youth, women, children, the elderly.
- Militarization: an open challenge to health.
- Free trade agreements: The World Trade Organization and its repercussions on the health of the people.

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The International People's Health Council



People's Health Movement

The role of malaria in facilitating mother to child HIV transmission

Heena Brahmhatt & Ronald Gray, John Hopkins B. SPH, USA
www.HTM-journal.info . Interview Rel. Dec 1, 2003

The AIDS Journal (AIDS 2003, vol. 17, N°17) reported a community-randomized trial in the Rakai district, examining the effects of placental malaria on HIV mother to child transmission. The study covered 746 HIV positive mother- infant pairs, with a 20.4% rate of HIV transmission to the child. It was found that among HIV-positive mothers, 13.6% (21/155) had placental malaria, compared with 8% (41/510) in HIV-negative mothers. MTCT rates were 40% (6/15) with placental malaria and 15.4% (12/78) without malaria. Main author was Heena Brahmhatt.

HTM-Journal: *Is this the first time that the association between placental malaria and vertical transmission of HIV is examined?*

H. Brahmhatt & R. Gray: In the published literature, there is nothing else demonstrating an association between placental malaria and vertical transmission of HIV.

HTM-Journal: *The fact that malaria could be an opportunistic disease in case of immuno-suppression, in affected countries has long been recognized, but the notion that malaria could have an effect on HIV is little researched or recognized. Could you explain to our readers what its effects are?*

H. Brahmhatt & R. Gray: Although a majority of the infectious disease mortality in sub-Saharan Africa are attributable to HIV and malaria, very little is known about the interaction between these two infections. HIV infection may reduce immunity and hence increase the frequency and severity of malaria infection. Conversely, malaria infection leads to immune activation which upregulates HIV replication and HIV-viral load. It is also possible that malaria may enhance progression to clinical AIDS. However, there is limited data on effects of HIV and malaria co-infection in pregnant women. In malaria-endemic areas, frequency and severity of malaria is more common in pregnant compared to non-pregnant women. Women infected with HIV seem to have a diminished immunity to malaria infection, and studies have found higher placental malaria infection rates in HIV-positive compared with HIV-negative women. Malaria and HIV both independently have been associated with higher risk of low birth weight, stillbirths and premature births, hence co-infection of malaria and HIV-1 during pregnancy may have severe consequences for morbidity and mortality of infants, and prevention of these infections during pregnancy might be an important public health priority.

HTM-Journal: *You seem to refer to two different effects: malaria would increase the HIV risks of transmission by increasing the viral load? But malaria would also increase it independently of viral load increase?*

H. Brahmhatt & R. Gray: There are several hypotheses, but no conclusive evidence to help us understand the mechanism that facilitates the role of malaria in MTCT. One possibility is that the host's ability to mount an immune response to malaria is diminished because CD4 cells, which produce anti-malarial antibodies, are depleted in an HIV-infected individual. This could

explain the higher malaria infection rates in women who are HIV-positive. Another possibility is that malaria infection may damage the placenta which could increase exchange of maternal and fetal blood and hence facilitate transmission of HIV to the infant in utero. More work is needed to try and tease out these effects and to better understand the role placental malaria plays in facilitating the increased HIV transmission to the infant.

HTM-Journal: *This past July at the GFATM meeting in Paris, Jeffrey Sachs was explaining to the press that while the effect of HIV on malaria are well known, the reverse is also true, and thus preventing malaria would contribute to the struggle against HIV. Your thoughts?*

H. Brahmhatt & R. Gray: As outlined above, they both contribute independently to morbidity and mortality in adults and children and hence a multifaceted approach could potentially be significant in reducing the burden of morbidity and mortality further.

HTM-Journal: *What would be your comment on that? You seem to propose more clinical trials?*

H. Brahmhatt & R. Gray: We suggested clinical trials because if prevention of malaria would reduce rates of MTCT, one way to examine this would be to have a trial where we can examine the impact of intensive malaria prophylaxis during pregnancy compared to the standard 2 doses of malaria prophylaxis currently recommended for pregnant women.

HTM-Journal: *Back in 1996, NIAID Director Anthony Fauci, having just uncovered a synergistic relationship between the TB bacilli and HIV, once told people at a conference that to be serious against AIDS in poor countries, there should be a Marshall plan against common parasitic and bacterial diseases like TB and Malaria". Do you agree?*

H. Brahmhatt & R. Gray: Given our findings and of others demonstrating the interactions with TB as well, interventions which prevent/control bacterial and parasitical risk factors, along with HIV, could potentially result in the greatest reductions in morbidity and mortality.

HTM-Journal: *Do you think that the wide differences in HIV epidemics between Northern and Southern countries might be due to diseases of poverty?*

H. Brahmhatt & R. Gray: In the backdrop of other risk factors, infectious diseases, recurrent infections, malnutrition, access to health services, etc progression to AIDS is faster in developing compared to developed countries. There are other reasons (access to condoms, knowledge about HIV/AIDS prevention, gender roles, mode of transmission, strain of HIV, etc), which explain the differences in the way the epidemic spreads in different regions of the world. Vertical transmission differences could in part be due to the presence of other infections during pregnancy and then further risks as a result of transmission of HIV via breastfeeding.

The power of community involvement

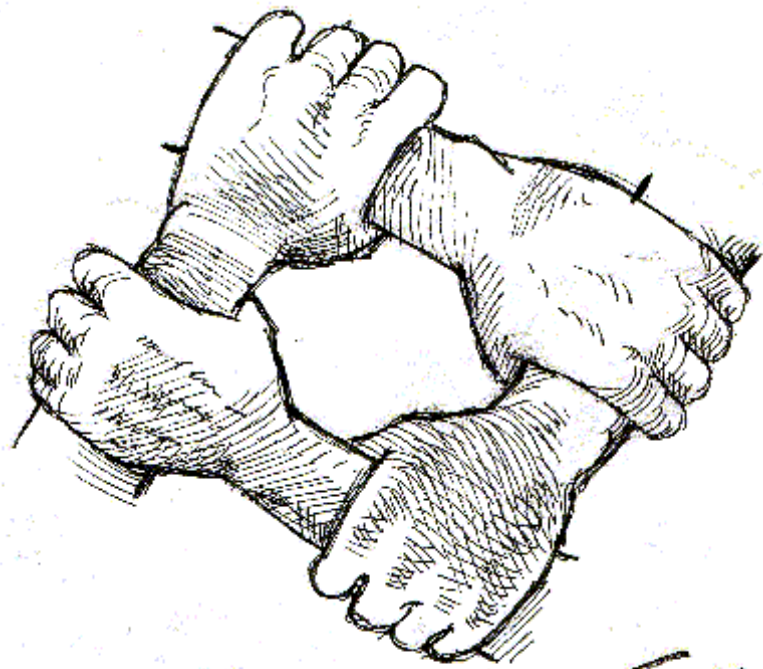
By Jacinta M. Maingi,
EHAIA Coordinator – Eastern Africa region

Over twenty years after the first clinical evidence of HIV/AIDS was reported, it has become the most devastating disease humankind has ever faced. Since the epidemic began, so many lives have been lost on daily basis making it the worst disaster, worse than all wars combined. The impact and consequences of HIV/AIDS continues to pose extraordinary challenges at all levels.

The challenge of addressing HIV/AIDS in the Eastern Africa region is increasingly wide-ranging due to the pandemic's unique pathological characteristics that make it rather mysterious to many people. Although everyone is affected to a certain degree, it is not far-fetched to note that those most affected are women and children. It is for this reason that a group of elders in a community called Ndenyeru in Kenya got together men and women from 50 years and above to address HIV/AIDS as it was affecting their communities.

They started meeting once a week to deliberate on how to curb the AIDS pandemic because it was depleting their meager resources. They realized they were spending too much time on funeral arrangements and were constantly contributing too much money towards funerals. Consequently, they formed a community HIV/AIDS control group of 27 members, who started mobilizing the churches around to join them in the campaign. At that point, they realized it was necessary to include youth and make the combination more gender focused. This meant recruiting more people and opening the membership to all ages especially from the interested churches. In less than one year, they had mobilized 10 different denominations that became part of the initiative. After this step, the group changed from a community group to an inter-denominational HIV/AIDS campaign initiative. As part of the community and church contribution, the Anglican Church of Kenya gave a venue for holding meetings and later, the local government representative gave them a building for their income generating activities.

Early this year, World Council of Churches – Ecumenical HIV/AIDS Initiative in Africa (EHAIA) facilitated a training for the inter-denominational /community leadership to train them on HIV/AIDS, the role of the church and community and how to recognize and address stigma and discrimination. After the training, they formed awareness and



mobilization groups that have been going from one church to another. They usually go in groups of twos or threes to churches where they are not members of that church. The church that invites them contributes transport and meals for the volunteers. They also go to market places and other community functions and talk about HIV/AIDS especially emphasizing on reduction of stigma and discrimination and promoting care for those affected directly or indirectly.

The lesson to be learned from this scenario is that there is power in the community and Faith-Based Organization but what they might lack is appropriate skills and knowledge to strategize their approach. It also shows that churches are able to work together if they see their role as important if they see the problem as directly affecting them. I also find it quite exciting that the group was started by the older generation after realizing they were losing their children and felt challenged to make the first step. One thing we ought to keep in mind is that communities bear the brunt of the HIV/AIDS problem but they also can provide the solution. All they need is to be supported to actualize their potential. All this is without external funding but on voluntary base.

WHA resolution (amendment) on safe health care

Proposed at the The Fifty-Seventh World Health Assembly. May 2004

Affirming the need to fully address all forms of HIV transmission, including sexual transmission, mother-to-child transmission, transmission through injecting drug use, and health care-related transmission,

Recognizing that unsafe injections, blood transfusions, and other medical procedures continue to transmit HIV and other bloodborne pathogens to patients, health care workers, and members of the community;

Recalling the commitments on universal precautions, blood safety, and injection safety contained in the Declaration of Commitment on HIV/AIDS of the United Nations General Assembly special session on HIV/AIDS;

Noting that the inability of health care workers to implement universal precautions because they lack adequate supplies and training contributes to health sector discrimination against people with HIV/AIDS;

Noting that the inability of health care workers to adequately protect themselves from HIV, tuberculosis, and other infectious diseases harms vital efforts to recruit and retain health care workers;

Committed to ending health care-related transmission of HIV and other bloodborne pathogens,

1. CLARIFIES that the core component of the health sector response to HIV/AIDS of promoting universal precautions, as described in the Global Health-Sector Strategy for HIV/AIDS developed by the Director-General pursuant to resolution WHA53.14, is necessary to protect health care workers, patients, and communities, and includes the safe and appropriate use of injections.

2. URGES Member States to:

- a. Develop and implement infection control and prevention strategies, including for the safe and appropriate use of injections and waste management, involving all cadres of health care workers, as well as patients, community representatives, and other stakeholders, in developing these strategies;
- b. Provide public education on the importance of the safe and appropriate use of injections, including, as appropriate, patient-provider dialogues to reduce the prevalence of unnecessary and inappropriate injections, and educate the public on their rights to be free from discrimination based on their real or presumed HIV-status;
- c. Consistent with principles of confidentiality and voluntary consent, monitor and investigate health care-related HIV transmissions by,
 - I. establishing a public registry of unexplained HIV infections,

- II. routinely testing mothers of children found with HIV infections, and

- III. arranging exhaustive outbreak investigations when clusters of unexplained infections point to HIV transmission through health care, and reporting results to the public;

- d. Ensure that health providers have adequate supplies and training needed to implement infection control and prevention measures, including by adhering to universal precautions for all patients with whom contact with blood or other body fluids of is anticipated;

- e. Provide prophylactic therapies to health care workers and other groups at high risk of contracting bloodborne infections in health care and other settings;

- I. Provide free post-exposure prophylaxis, including anti-retroviral medications, for health care professionals who become infected with HIV because of exposure at work;

- II. Provide free post-exposure prophylaxis and counseling to survivors of sexual assault;

- III. Provide free Hepatitis B vaccinations to health care workers and other groups at high risk of contracting Hepatitis B;

- IV. Invest in developing a vaccine for Hepatitis C;

- f. Develop and implement programmes to educate health care workers on the rights of all patients, to ensure the dignity of both patients and health care workers and to reduce HIV/AIDS-related stigma and discrimination in health care settings;

- g. Establish and progress towards the goal of using protected medical devices that provide added safety to patients, health care workers, and the community;

- h. Mobilize the necessary resources, including through the Global Fund to Fight AIDS, Tuberculosis and Malaria and other forms of bilateral and multilateral assistance, to implement the above steps and fulfill all obligations under the Declaration of Commitment on HIV/AIDS of the United Nations General Assembly special session on HIV/AIDS.

3. REQUESTS the Director-General to provide Member States technical assistance for the aforementioned activities.

4. COMMENDS the Director-General for including universal precautions, injection safety, blood safety, and waste management as part of the 3 by 5 emergency anti-retroviral scale-up initiative.

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DIRTY NEEDLES KILL!

James Stewart S.04

Special report from TANZANIA

“FAIR TRADE would best assist Africa in meeting the challenge of HIV AIDS”, says Deputy Health Minister Hussein A. Mwinyi.

Malaria: Tanzania’s best researchers are mounting a project to mass produce the best medicine: artemisinin, today, the plant brought into the country and grown in schools and in St Benedictine’s Parish is exported for raw material extraction, then re-imported. The project was presented at the National Institute of Medical Research by Executive Director professor Andrew Kitua.

Pediatrician in the Anglican hospital, Dr Talbert speaks of Tick born relapsing fever, a major disease among children.

The Tanzanian Christian Social Services Commission provides health care to 40% of the country population. We met Dr. Josephine Balati, AIDS coordinator and Marsha Macatta Yambi, head of Drug procurement.

