Constituency for Africa

Comprehensive Health for Africa

"The problem of the twentieth century is the problem of the color-line – the relation of the darker to the lighter races of men in Asia and Africa, in America and the islands of the sea" (WEB du Bois, The Souls of Black Folk; 1903)

Introduction

We are increasingly interdependent and mutually vulnerable: the AIDS pandemic, global security issues, global environmental degradation and economic globalization all make us so. There is a real risk that as the HIV and AIDS pandemics devastate Africa, the world will turn away from the suffering and concentrate on more mutable problems and problems that are in the interest of the northern stable democracies.

The Constituency for Africa has been an outspoken voice for Africa, diligently and assiduously speaking truth to power and vested interests. At the start of the third decade of the HIV and AIDS epidemics, it has become important to once again advocate for a comprehensive strategy for African health that increasingly speaks to the extraordinary burden of disease carried by the individuals, communities and countries that form part of the African Diaspora.

The HIV/AIDS pandemics

What is known as the AIDS epidemic by the Joint United Nations Program on HIV/AIDS (UNAIDS) is better understood in terms of three epidemics that require very different public health approaches: the first is the epidemic of infection; the second is the epidemic of disease and the third is the epidemic of death. UNAIDS publishes an annual report that concentrates on the first and second epidemics – the total number of people living with HIV in any particular year represents both those individuals who have newly acquired the infection and those living with the infection. Among the latter group are the people who have the syndrome called AIDS – the acquired immunodeficiency syndrome. Most of the individuals who are newly infected appear healthy and live fairly normal lives. UNAIDS estimates that at the end of 2004 there will be 39.4 million people living with HIV; 4.9 million new HIV infections and 3.1 million deaths due to AIDS. In sub-Saharan Africa where 25.4 million (64%) of HIV infected individuals live, 7.4% of the population is infected and in countries like Botswana and South Africa almost 30% of the population is infected with the human immunodeficiency virus. South Africa represents almost 10% of all the individuals in the world who are living with HIV and 12% of the individuals who are estimated to be dying from AIDS (less than 0.1% of the world's population). Among the truly disadvantaged of the world, HIV/AIDS is increasingly becoming a disease of the most vulnerable, women and children.

The Public Health Responses to the Pandemics

There are three public health questions that have been asked by the world community in the development of responses to the HIV and AIDS pandemics:

1. Drug costs (e.g. the WHO "Three by Five" program)
2. Vaccine development
3. Health promotion and disease prevention

The great scientific advances of the 20th century have led us to believe that there are magic bullets in public health – these are usually in the form of simple primary health care programs or, for developing countries, global disease eradication programs. But public health rarely works through magic bullets, even in the presence of simple, easy to apply interventions. Vaccines have had an enormous impact on global public health – the most impressive example being the eradication of smallpox. In contradistinction to the eradication of smallpox and the control of many vaccine-preventable diseases, we have failed to eradicate malaria and to control tuberculosis – in fact both diseases are in the midst of new epidemic cycles. The most successful eradication and control programs work at the proximate ends of epidemiologic cause where there are simple and straightforward interventions that are highly effective. It is not surprising then that six of the fourteen goals and challenges of the Gates Foundation focus on vaccines:

To improve childhood vaccines:
GC 1: Create effective single-dose vaccines that can be used soon after birth;
GC 2: Prepare vaccines that do not require refrigeration;
GC 3: Develop needle-free delivery systems for vaccines.

To create new vaccines:
GC 4: Devise reliable tests in model systems to evaluate live attenuated vaccines;
GC 5: Solve how to design antigens for effective, protective immunity;
GC 6: Learn which immunological responses provide protective immunity.

We at CFA believe that the great public health questions of the 21st century should be reframed:

1. Drug costs and Access to care
2. Vaccine development and the development of political and intellectual leadership
3. Health Promotion and disease prevention and comprehensive programs

To understand of the challenges of community-based and global public health we must understand the stark differences in health between developing countries and poor and marginalized communities within developed countries and developed countries and non-poor communities within developing countries. These differences are summarized below:

Developing Countries and Poor Communities in Developed Countries	Developed Countries and Non-poor Communities in Developing Countries
1. Five-fold Burden of Disease a. Infectious Diseases b. Chronic diseases of lifestyle c. Environmental diseases d. Interpersonal violence e. Diseases associated with global security	1. Single Burden of Disease (Chronic diseases of lifestyle). The combination of causal factors within these communities is mostly expressed in a single burden of disease
2. Falling life expectancy and a young population (Mali 39 years, Swaziland 36 years)	2. High life expectancy and aging population (USA 77 years)
3. High fertility, high morbidity and mortality	3. Low fertility, low morbidity and mortality
4. Poor access to inefficient health care	4. Expansive access and increased efficiency
5. Incoherent health policies which lack connections between politics, policies and health care	5. Subtle and complex health policies that are central to the political discourse
6. Lack of local health advocacy	6. Extensive rooted health advocacy

A focus on global public health is vitally important within an increasingly small world where communicable and non-communicable diseases share transnational risk, and causal factors and the political stability of countries and communities affect both the health of communities and globalization. Since the middle of the 20th century health has increasingly become a global public good. The improvement of the health status of countries and communities is seen as central to the process of poverty reduction. Poverty reduction is a global public good. The causes and effects of disease have been recognized as being trans-national.

Effective global public health programs require three components: access to available health knowledge, functioning and accessible public health systems and adequate public and private spending on health. Economists recognize three types of input that are required for functioning and accessible public health systems:

1. Well-educated and trained individuals who can detect changes in disease incidence, channel public health interventions and conduct surveillance on the management and control of disease.
2. Health systems infrastructure where all individuals within a community have a similar probability of access to care.
3. Sufficient public goods in the form of pharmaceutical and other health technologies – global public health goods.

In the management of simple public health problems such as communicable disease eradication using vaccines, the three types of health inputs can be viewed as single interventions. In complex diseases where the interventions are not simple and often

require a partnership between public health and medicine, the importance of the first two inputs is disproportionate to the importance of the third input. Simple interventions allow for a central command and control model for public health where much of the decision-making power is in the hands of global public servants. This is a negative aspect of public health as a global public good – the interventions are assumed to belong to the global community. Complex diseases with complicated interventions require that decision-making is devolved to the countries and communities directly impacted. In order for the devolution to take place there must be a sufficient number of trained individuals from the communities and countries who are responsible for the design and implementation of population-based interventions. These public health professionals must be an integral part of the international community of public health experts.

There is currently a disproportionate interest in the third type of input – sufficiency of public goods for public health. This interest often results in tension between health advocacy for developing countries and poor communities and the health actions of the developing nation states and poor communities in developed nation states. This tension is philosophical and sets the principles of distributive justice and autonomy on a collision course. The choices that are made for developing countries are almost always in violation of the autonomy of nation states and communities – outside forces define the health needs of these nations and develop the interventions required. In the late 20th century and early 21st century these heteronymous actions are placed at the service of distributive justice; early in the modern era the same actions were in the service of self-interest.

Ideas for Intervention

In order to bring resolution to these colliding principles our conceptualization of the comprehensive public health program for Africa and the African Diaspora offers communities the following:

1. We believe that all health care programs must strive to be comprehensive and integrated and that HIV/AIDS programs must be part of the health care systems. There must be a comprehensive approach to the HIV and AIDS epidemics that includes health promotion, the prevention of infection and AIDS-associated diseases and the earliest treatment of AIDS. A single focus on access to anti-retroviral agents will not solve the current crises. Gender inequality must be on the health care agenda – especially with regard to unequal access to health care and education for women.

2. There are a number of seemingly insurmountable obstacles to a comprehensive health care agenda for Africa:

    a. Although the African Union has demonstrated an admirable response to the health and development problems of the continent, there are countries where political will is absent. This lack of will is, in part, a function of political instability and an excessive debt burden.

    b. Brain drain: This brain drain occurs in multiple directions. The south-to-north brain drain is most talked about but there is major movement of professionals

from unstable to more stable African countries. Additionally, there is movement of professionals from the government to the non-governmental and private sectors. There is a need to access the skills of the vast professional class of the African Diaspora.

   c. Many countries have poor absorptive capacity for money and other resources.

3. The political leadership shown by the African Union with regard to the health problems has been critical in the re-ordering of priorities; but the execution of these priorities has been adversely affected by global and local political considerations, inequity in the north-south partnership and the lack of sound contextual health care reasoning. There must be paradigm shift in African government investments that reflect stated priorities. Governments must arrange their priorities to reflect the scale of the health care problems. However, HIV/AIDS and the many health problems among Africans cannot be resolved in the absence of dealing with poverty and its consequences. Good health care is a starting point for the larger development agenda for Africa.

4. Health and education are public goods and are provided for free in many African countries. However, many state-run health care services are poorly staffed, often with inadequately trained health professionals, and an absolute lack of infrastructure and resources. This poverty in the health care systems has led to the development of local non-governmental organizations and the insertion of large global non-governmental organizations into the countries. These organizations often operate alongside the government agencies and often result in a local drain on human and other resources. We believe that it is vital that government structures are strengthened and that NGOs play a bridging role.

5. Development of human resources capacity: Education and training that allows for the development of skills that leads each community to the development of their own health policies and practices. In addition to the technocratic gap that is prevalent among the educated health, social services and education professionals in sub-Saharan Africa, there are also literacy and communications gaps that affect rural communities more that urban communities. There is a need for greater investment in community literacy and education using traditional educational resources, faith-based organizations, community groups and civil society groups. The education and communications programs must be based on north-south partnerships of equity and must be sensitive to the north-south and south-south brain drain. Electronic learning using modern technology should be used to reduce the spatial and conceptual distances between north and south.

6. North-south health care efforts must be culturally sensitive and must be well coordinated in order to maximize the effective use of resources. These efforts must reflect the stated policy goals of the African Union and the countries that receive aid. There must be north-south equity in the development of intervention strategies. The resources that come from northern governments, northern foundations and large

multi-national companies must be bent to the will of the Africans. It is critical that public-private partnerships and partnerships between multi-national and local companies are part of a comprehensive plan. It is important to ensure that programs are well localized and that they provide a comprehensive approach to health and development problems.

Constituency for Africa Plan of Action

The Constituency for Africa (CFA) has developed an advocacy program that builds on the groundbreaking work in the areas of debt relief for the continent and the political, advocacy and policy work done over the last seven years in defining solutions for the HIV and AIDS epidemics. The Constituency for Africa must enlarge its role as the safe meeting place for the diverse community that is committed to the African Diaspora.

1. CFA will host a series of African Healthcare Advisory roundtable meetings that involve individuals and organizations that have an African focus. Over the next six months CFA plans to have at least three such meetings. These roundtable meetings are designed to:

    a. Share information and action plans.
    b. Bring political, policy and business leaders into a common forum to discuss the health and healthcare issues of the African Diaspora.
    c. Define a policy framework for CFA that is proactive and that resonates with the needs of the countries of the African Union and the communities that are an integral part of the African Diaspora. This policy framework will form the basis of the continued advocacy of CFA.
    d. Develop an information resource that informs the actions of leaders in the public and private sectors of the developed countries of the north and the countries and communities of the African Diaspora.

2. CFA will host a Dialogue on the “Comprehensive Health Strategy for Africa” during the Ronald H. Brown African Affairs Series in Washington, D.C. in September in conjunction with the Congressional Black Caucus leadership. This signal event will form a culmination of the roundtable series and be the basis of a legislative action agenda.

3. CFA will develop a comprehensive policy document on African Health and Healthcare that will be shared widely with the political and government leadership of the United States and other northern democracies. This document will be developed in close consultation with the leaders and intellectuals of the African Diaspora.

4. CFA also plans to send a delegation to meet with African Health officials, and to hear their ideas and to get their reaction to our advocacy plans in the United States.