Special Report

A Presidential Health Mission to Africa

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Secretary of Health and Human Services

A special mission representing President George Bush visited seven sub-Saharan nations in January 1991 to review progress in child health and child survival. The delegation, led by the Secretary of Health and Human Services and the Administrator of the Agency for International Development (USAID), included the following officers from the Public Health Service: James O. Mason, MD, DrPH, Assistant Secretary for Health; William L. Roper, MD, MPH, Director, Centers for Disease Control; Duane F. Alexander, MD, Director, National Institute of Child Health and Human Development; and Helene D. Gayle, MD, MPH, Chief, International Activity, Division of HIV/AIDS, Centers for Disease Control.

Officers from USAID, in addition to the Administrator, included Scott M. Spangler, Assistant Administrator for Africa; Bradshaw Langmaid, Jr., Deputy Assistant Administrator, Bureau for Science and Technology; Timothy Bork, Director, Office of Project Development, Bureau for Africa; Nancy Pielmeier, DrPH, Deputy Director, Office of Health, Bureau for Science and Technology; and Gary Merritt, Chief of the Health, Population, and Nutrition Division, Office of Technical Resources, Bureau for Africa.

Photographs accompanying the article are by Campbell Gardett.

Tearsheet requests to DHHS Office of Public Affairs, Room 638-E, Hubert H. Humphrey Building, 200 Independence Ave. SW, Washington, DC 20201.

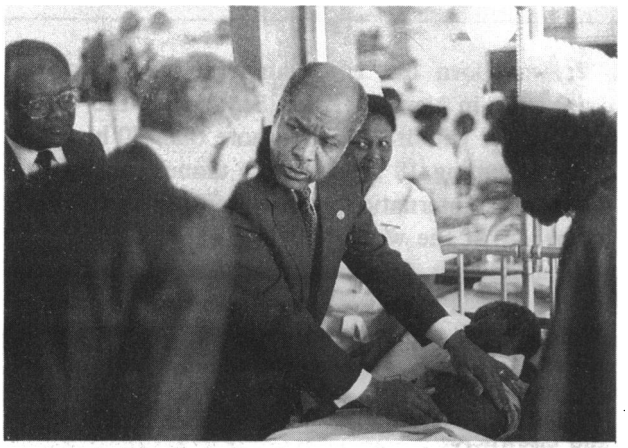
From January 4 to 18 of this year, accompanied by the Administrator of the U.S. Agency for International Development (USAID), I led a special delegation to Africa on behalf of President Bush, visiting seven nations in the sub-Saharan region. This was not my first visit to the African continent for George Bush—I had accompanied him in 1982 when he visited sub-Saharan Africa as Vice President. In addition, over a number of years, I have made several other visits to some 15 African countries. But the mission this January was exceptional in many respects.

It was born out of a unique United Nations conference in New York last September, the World Summit for Children, where more than 70 heads of state (including 18 from Africa alone) gathered to commit the international community to new efforts on behalf of the world's children and their health. At that summit, President Bush announced that he would send a delegation to Africa, led by myself and USAID Administrator Ronald W. Roskens, PhD, "to see what else America and the world can do to advance child survival" in African countries and elsewhere.

We were to examine progress made so far against conditions and diseases that claim millions of children's lives yearly in Africa; assess the new threat of HIV infection and the growing number of AIDS cases; determine what might be done to improve coordination between American and African institutions; and identify opportunities to improve the quality and impact of American assistance in Africa. The scope of this charge, the personal concern and commitment that I know the President to have, the access we were given in the countries we visited, and the enthusiasm and dedication we encountered in our meetings throughout the trip with Africans and Americans alike—all these combined to impart to this visit a special intensity and importance.

In each of the countries we visited—Nigeria, Cote d'Ivoire, Uganda, Malawi, South Africa, Zimbabwe, and Senegal—we worked with the minister of health, and in six of the seven we held discussions with the head of state, as well. We also visited with literally hundreds of others—representatives of ministries of finance and planning, community health workers, university researchers, representatives of private voluntary organizations and business leaders, representatives of our own Department of Health and Human Services (HHS) and USAID agencies working in Africa, representatives of the World Health Organization and the United Nations Children's Fund (UNICEF), and many more.

By working in teams, the 17 officials and staff from HHS and USAID who accompanied us covered considerable ground in the time available to us. Inevitably, after 15 days and 22,000 miles, we had the sensation of having been crammed, exam-style, with valuable information—and at the same time, of having only scratched the surface. We learned indelibly that the challenges facing Africans



Louis W. Sullivan, MD, Secretary of Health and Human Services, examines a young patient at the Lagos University Teaching Hospital in Nigeria. The 750-bed hospital is connected with a growing primary health care network in Nigeria.

William L. Roper, MD, Director of the Centers for Disease Control (left), visits a maternal and child care center in Koumassi, Cote d'Ivoire. With him is Kevin DeCock, MD (center) Director of the CDC-sponsored RETRO-CI Project. A health worker at the center explains efforts to promote breast feeding.

are immense. But we left, as well, with the conviction that the potential role and contributions of Africa in the world community are great; that the United States has much to offer the people of Africa; and that we have an important stake in their future.

The findings of our mission are contained in a report to the President. In that document, Dr. Roskens and I have delineated problem areas, reported on progress to date, and made recommendations as to the role America can play in improving the health status of Africa's children. In the following account, I propose to give a shorter and more personal summary of our mission to Africa. It is my sense that this mission is of importance both for the United States Government and for all those who are concerned with public health issues worldwide.

Child Health Overview

One cannot look squarely at the problems facing Africa, as we did, without feeling almost physically the weight of those problems. In the maternal and child health area alone, the statistics can be numbing:

- Of 30 countries worldwide with infant mortality rates greater than 100 deaths per 1,000 live births, 23 are in sub-Saharan Africa.
- Of 15 countries worldwide with under-5 mortality rates greater than 200 deaths per 1,000 live births, 14 are in sub-Saharan Africa.
- Of 40 countries with a daily per capita calorie supply less than 100 percent of the requirement, 26 are in sub-Saharan Africa.
- Sub-Saharan Africa has the highest maternal mortality rate in the world, twice that of North Africa and the Middle East, three times the rate of Asia, and 42 times the rate of industrialized nations.

These health indicators are, of course, inseparable from deeper social and economic conditions that are prevalent in much of the region:

- National economies have lost ground in the past decade, with a 15-percent drop in per capita income in some two-thirds of sub-Saharan nations. Insufficient infrastructure investment and shortages of essential supplies, including medical and pharmaceutical materials, are visible consequences of economic weakness.
- Fertility in sub-Saharan Africa is thought to be as high as any in recorded human history, with women in many countries averaging seven or more live births. Population is growing 3 percent a year, with a doubling time of about 20 years. Such demographics pose enormous challenges in providing for food, housing, jobs, and schooling, not to mention adequate health care.
- Education and literacy levels are low in most countries, especially for women.
- Likewise, political stability has been elusive for many of these nations. The evacuation of tens of thousands of refugees has followed in the wake of both civil strife and famine.

Progress Being Made

At the same time, however, there is evidence of progress and improvement, both in particular

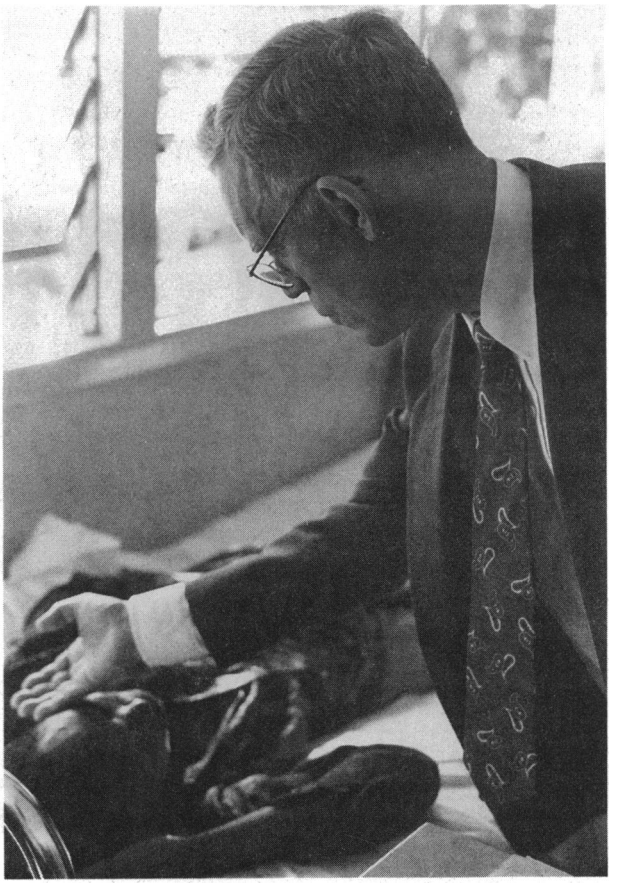
health areas and in more basic conditions in many countries. Most fundamentally, after years of leaning toward authoritarian or one-party political systems, there appears to be widespread and deliberate movement toward democratization. Overmanaged (and mismanaged) economies appear to be yielding to more realistic and more market-based systems. While there is still far to go, stronger economic development and improved health status can be expected to go hand-in-hand.

Of particular interest is the role that health care can play, especially primary health care systems, in helping bring about improved political and economic conditions. It is natural to conclude that better public health may follow as a result of stronger economic performance. But just as important for the sub-Saharan nations is the fact that health care investment can be an important *contributor* in developing the social structures of democracy.

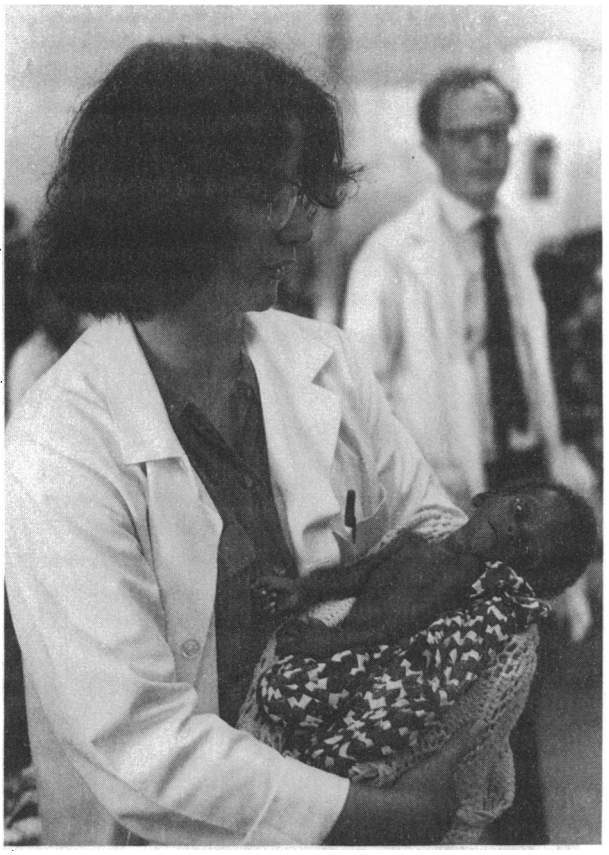
Primary health care systems can be a sentinel agent of decentralization and local community empowerment in countries that have too often been over-centralized. Community level health systems engender immediate interest and support among people at all levels; they can serve as a natural introduction to self-governing and grassroots decision making; and in areas where little else may be in the control of the community, the ability to effect health related choices is highly valued and vigorously exercised. Even in countries where civil strife has torn at the social fabric, the decision to invest in health care and to involve individuals and community organizations can have a strong healing effect. Ultimately, when the result is better health status and when people perceive that benefit, the very stability of society and its foundation are made firmer.

Health projects, of course, are integrated into the mix of assistance provided by the United States, and this has helped African nations make progress in specific areas:

- Nearly all African countries have adopted formal policies that encourage child spacing. Many national policies now encourage smaller families, as well; and significant progress in a few countries shows that rapid increases in the use of contraception and decreases in total fertility rates are feasible. USAID allocated about $80 million in 1990 for child health activities in Africa, and another $80 million for voluntary family planning activities.
- Immunization coverage has increased significantly. Measles vaccine coverage doubled in the region from 1985 to 1990, and in several countries we saw that measles no longer tops the list of causes of hospitalization and death. Yet preventable disease remains substantial, including neonatal tetanus, whooping cough, polio, diphtheria, and tuberculosis. Furthermore, immunization programs and other efforts must be sustainable: a striking reduction in child mortality occurred in Cote d'Ivoire following a nationwide immunization outreach effort in 1987, but deaths rose again when the outreach effort could not be sustained.
- Access to oral rehydration salts has increased significantly, as has knowledge of oral rehydration therapy (ORT). Diarrheal diseases have been the leading cause of infant and child deaths throughout the developing world, but we found that hospital admissions because of diarrhea have been reduced dramatically due to management of dehydration with ORT.



James O. Mason, MD, DrPH, Assistant Secretary for Health, talks with a patient at the Uganda Cancer Institute. In spite of civil unrest and supply shortages, the institute has made contributions in understanding and treating Kaposi's sarcoma and other conditions.



Gina Dallabetta, MD, holds an HIV-infected child at Queen Elizabeth Central Hospital, Blantyre, Malawi. Dr. Dallabetta directs the NIH-funded AIDS research project at the hospital.

U.S. and International Assistance

International assistance, both public and private, has been important in helping Africans achieve these improvements, and I was especially proud to encounter many dedicated Americans who are working side by side with African health professionals and volunteers. In particular, HHS-supported medical personnel are performing invaluable services, in collaboration with USAID, the international health agencies, the Peace Corps, and the U.S. embassies.

Personnel from the Centers for Disease Control, and others sponsored by the National Institutes of Health, are in countries throughout Africa, working cooperatively with USAID and host governments on a variety of projects, especially involving children's health, malaria, and AIDS:

- Child survival activities are carried out primarily through the successful Combatting Childhood Communicable Diseases Project, funded at $120 million over 10 years, with activities in 12 countries. Funding and direction are provided by USAID, with technical support by CDC.
- Malaria, already a problem of vast proportions in Africa, is becoming even more complicated with the rapid increase in resistance to chloroquine treatment. Of the 110 million cases of malaria reported annually, 90 million occur in Africa, and a million African children die each year from the disease. Research into alternative treatments includes a project supported by CDC and USAID at the Mangochi District Hospital in Malawi, involving treatment of pregnant women with the newer drug mefloquine; and in an NIH-supported project by Michigan State University at Queen Elizabeth Central Hospital in Blantyre, investigating the pathogenesis of severe pediatric malaria and improved treatment for children with malaria. The United States has invested more than $200 million in the past decade in malaria control and research, but the problem has new urgency with the spread of drug-resistant variants.
- In confronting HIV-AIDS in Africa, important research and prevention activities are being carried out by HHS-supported efforts. The first HIV-AIDS research project in Africa, Projet SIDA, was established in 1984 as a unique collaboration among the Zaire Ministry of Health, CDC, NIH, and the Belgian Institute of Tropical Medicine as well as the Armed Forces Institute of Pathology. The project was instrumental in providing much of the early epidemiologic information about the epidemic in Africa, including conclusive studies showing the preponderance of heterosexual transmission.
- The investment in Projet SIDA has paid back handsomely, and a second CDC-supported project on HIV-AIDS, Projet RETRO-CI, was established in 1988 in Cote d'Ivoire. RETR0-CI is also involved in activities regarding all aspects of AIDS, but with special attention to the HIV-2 virus, which is prevalent in West Africa.

HIV-AIDS and Africa's Children

The challenge that is presented by AIDS in Africa is, almost literally, unmeasurable. With their limited health care and epidemiologic resources, African nations had reported a total of only 81,000 cases of AIDS in adults as of January 1, 1991. But in fact, the World Health Organization conservatively estimates some 600,000 cases so far in Africa, representing almost two-thirds of the world total. Even more significant, WHO estimates that some 5 million or more African adults are already infected with HIV. And even in areas where the

Secretary Sullivan visits an outdoor village child health program near Mangochi, Malawi. Behind him is Dr. Ronald W. Roskens, Administrator of the U.S. Agency for International Development. Women at left are waiting to weigh their young children in the basket hanging from the scale.

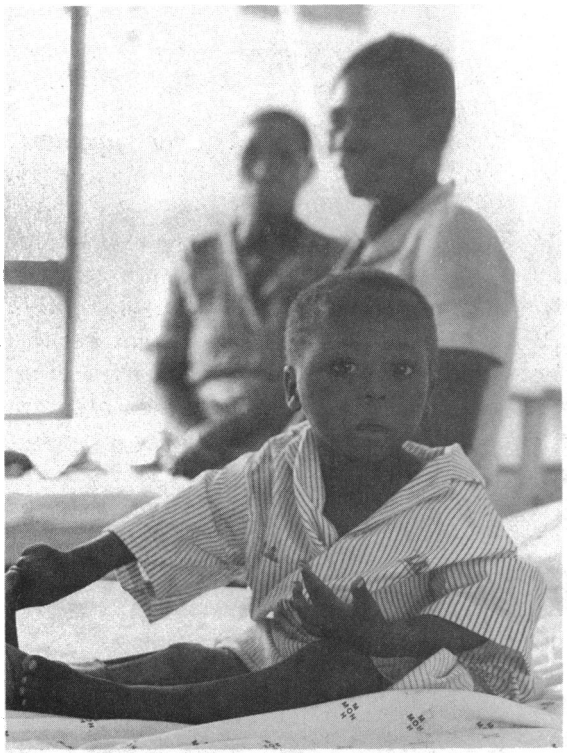
virus has not yet spread widely, health care workers report that cases in some populations are doubling as fast as every 8 months.

AIDS is rapidly becoming a major cause of death for African children, as well. During the last 10 years, some 500,000 infants in Africa were born with HIV infection. By the year 2000 it is estimated that there will be an additional 10 million HIV-infected children in Africa. AIDS will set back the advances made in other child health areas, with child mortality rates in some African countries increasing some 50 percent due to HIV infection.

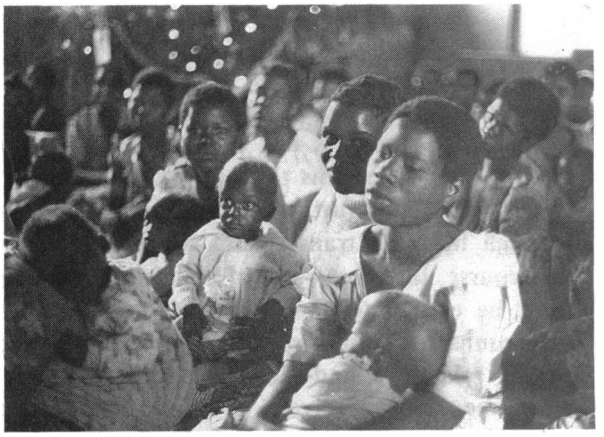
And beyond those infected by HIV, as many as 10 million children may become orphans due to the death of parents from AIDS, while economies are also subverted by the loss of productive adults. If this indeed comes to pass, it would appear to be without precedent in history. War has left millions of fatherless children in the past, and famine and disease have affected families indiscriminately. But when, previously, have parents in particular died, leaving children and the elderly to care for one another? The African extended family may support much of the weight of this burden—but not without stress, strain, and sacrifice.

Significant progress has been made in reducing the spread of the virus through blood transfusion. But to contain further spread of the disease through its main transmission route, heterosexual intercourse, the most basic of beliefs and behaviors must be confronted and changed. Just as in our own country, discomfort over talking openly about sexual relations, and about condoms, must be overcome to save lives. Most difficult of all, behavior changes must come *before* people see the disease all around them, since at that point the latent infection is sure to be widespread—perhaps as high as 20 to 30 percent of young adults in some cities, to judge from experience so far in Uganda and elsewhere. In societies with low literacy, high rates of sexually transmitted disease, and increasing mobility, containing the spread of this disease presents enormous challenges.

The key hurdle is the one that faces every nation confronting AIDS: how to translate knowledge about the virus and its transmission into personal



A young patient is recovering following treatment for malaria at Mangochi District Hospital in Malawi. A CDC-sponsored project at the hospital is investigating treatment of malaria in pregnant women, including chloroquine-resistant variants of the infection, which are spreading rapidly.



Women with young children attend a nutrition class at Queen Elizabeth Central Hospital in Blantyre, Malawi. Instruction in nutrition and oral rehydration therapy is given when children are treated for diarrheal diseases.

action and consistent, self-protective behavior choices. I wish that we in America, or indeed any country, knew the answer to this riddle: how to convert learned facts about health into positive behavior choices. Perhaps in the end we will learn something from those African nations that are today tackling this problem vigorously.

Our mission found very different levels of commitment regarding AIDS in the different nations we visited. Awareness was highest, predictably but tragically, in those countries already hardest hit, notably Uganda. In nations where the virus is apparently not yet widespread, like Nigeria, there is cause for hope but a great deal of work to be done. Under the leadership of Nigerian Health Minister Olikoye Ransome-Kuti, Nigeria is building a strong primary health care network that may form a good foundation for disseminating AIDS information.

In South Africa, decades of enmity and distrust must somehow be bridged if the government and black political organizations are to be able to work together and avoid a catastrophic spread of the disease. HIV is apparently not yet widespread in South Africa, but the window of time for containing the virus is small. In Cote d'Ivoire, the epidemic has begun more recently than in Uganda, but is spreading rapidly due to highly mobile population.

Africa's Interests, U.S. Interests

The challenges in Africa are indeed great. But the stakes for America and the rest of the world are great, as well. Our help for Africa is prompted by humanitarian concern—but our interests go beyond these concerns alone.

Disease does not respect national boundaries, and in a world as mobile as today's, we must be alert to and concerned about morbidity and mortality patterns worldwide. More important, health care and health assistance constitute an important avenue for a foreign policy that seeks to better the lives of individuals and families in nations across the globe.

I begin from the premise that when people have a stake in a society, they will work to preserve and protect that society. What stake is more fundamental than life and health itself? Americans likewise have a stake in a stable and productive world, a "world order" that is grounded in individual well-being. Our concern and our help to the nations of Africa in matters of health can serve our own interests precisely because they serve the interests of individuals, families, and communities.

In the sum of our efforts on the world stage, this is the unique contribution of the health assistance quotient: that it focuses inescapably on the individual and on his or her well-being. What better measure to use in judging our opportunities, and our responsibilities, in the world community?