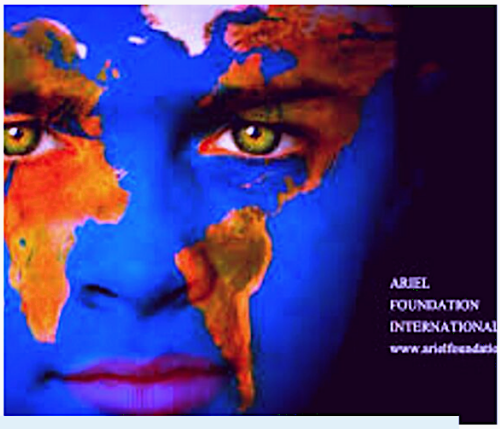
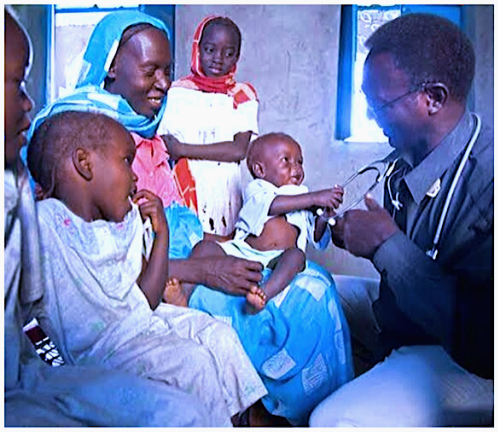
AFI CHANGEMAKERS

INTERNATIONAL HEALTH AMBASSADORS REPORT





TO THE UNITED NATIONS WORLD HEALTH ORGANIZATION

144TH EXECUTIVE BOARD 2019

DR. AYOMEIDE DR. SURBI CHAWLA
DR.EMMANUAL AGYEMANG-DUA, MPH

ACKNOWLEDGEMENTS

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Report written by Dr. Ayomide Sina-Odunsi, MD MPH; Dr. Surbhi Chawla, MD, and Mr. Emmanuel Agyemang-Dua, MPH
Edited by Dr. Ariel Rosita King

AFI Changemakers International Health Ambassadors at the World Health Executive Board Summit conceived, organised and facilitated by Ariel Foundation International, Dr. Ariel Rosita King.

Special Thank You to:

H.E. Ambassador Joseph Huggins, Chair AFI Board of Directors and Dr. Ariel Rosita King are inspirational leaders and mentors for Ariel Foundation International and for youth voices, globally.

Dr. Ariel Rosita King for dedicating so much of her life to providing young people with a platform to have their voices heard.

World Health Organization 144th Executive Board

All International Health Ambassadors of the AFI Changemakers Summit at the World Health Organization Executive Board, 144th in Geneva, Switzerland

FOREWORD

AFI Changemakers International Health Ambassadors were at the 144th World Health Executive Board at the World health Organization in Geneva.

and participation in the World Health Executive Board, youth were represented by young dynamic leaders from various parts of the world (India/ Hong Kong, USA/Ghana and Nigeria). They various sessions on a variety of health issues to discuss issues. The WHO 144th Executive Board deliberated on health issues, while our youth representatives participated and kept in mind the issues affecting youth today, and to propose topics and concrete policy recommendations that should be enacted to create lasting change to the global healthcare landscape.

The three topics that are explored in this publication are the WHO and EBOLA, The Importance of Community Health Workers, and the best way of Prevention for Non-Communicable Diseases.

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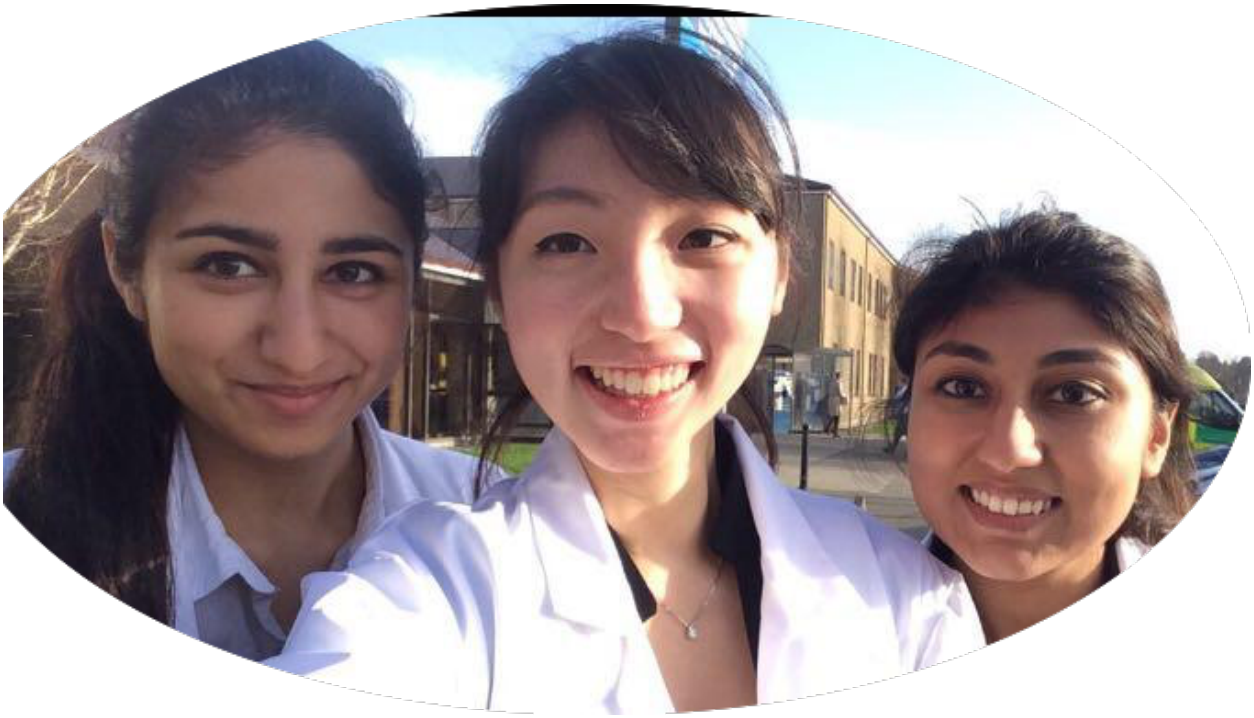

DR. SURBHI CHAWLA, MBBS (Last on Rights)

SECTION 1: STATE OF EBOLA - 2019

DR. SURBHI CHAWLA, MBBS

The Ebola virus has caused thousands of devastating deaths around the world. Spread is reported to occur when a person comes in contact with a carrying animal's bodily fluids. The virus, which has five common strains tends to have a sudden onset of symptoms, six to twelve days after exposure to the virus. Presentation may vary person to person but some common symptoms are a high temperature, chills, a diffuse rash over the trunk, arms and face, diarrhoea, nausea, vomiting, uveitis, some degree of haemorrhage and neurological manifestations. Convalescence has been found to be particularly long leading to an inability of those affected to resume work. They also are affected by long term health issues and recurrent hospitalisations as a consequence of being infected as well as an increased burden of cost of treatment.

The first report of an Ebola virus outbreak was in 1976 in the Democratic Republic of the Congo (DCR). Since then over 10 outbreaks have been reported in the DCR alone as well as numerous outbreaks in neighbouring countries such as Liberia, Sierra Leone and Guinea. An outbreak in West Africa in 2014 affecting these countries reported 29,000 cases with a fatality rate of approximately 40 percent – bringing the total number of deaths to over 11,000.

Following the West Africa outbreak of 2014, the WHO created a programme to monitor Ebola outbreaks, called the WHO World Health Emergencies (WHE). The WHE is monitored

and overseen by the Independent Oversight and Advisory Committee (IOAC). The WHE program was initiated in July of 2016 and set out to work on eight core target areas from the time of its conception till the last meeting in 2018. These areas being: structure, human resources, incident management, risk assessment, business processes, partnerships, finance and international health regulations. The IOAC reported great success in all areas at the 2018 WHO Executive Board Meeting (EBM) thus leading to the decision to continue the WHE/IOAC programme into 2018-2020.

While the WHO has had great success in the management of EBOLA Outbreak, The IOAC did identify important goals for the team going forward:

1. Planning for the future, specifically scaling up operations incase disease spreads.

2. While there has been great success in providing EBOLA Vaccines and therapeutics, further access and funding to these areas is being advised going forward.

3. Use Experiences form DRC Ebola outbreak to assure efficient and accelerated admission of experimental vaccines and therapeutics by enhancing mentorship, training and supervision.

4, Increase training of staff and recruitment of staff with one goal to get employment capacity from 47% to 76%.

5. Work on training, technical expertise and emergency responses

6. Prioritise training of high operations leads, senior epidemiologists and infectious disease specialists.

with the necessary training and under the right supervision. Second, it will connect large health systems with rural resource and poor communities a relationship that will, when established, could reinforce the importance of extending access by investing in human capital.

The most recent Ebola outbreak in the Democratic Republic of the Congo (DRC), specifically in the provinces of Equateur and North Kivu was declared on 1st August 2018. The outbreak has been categorized as a level 3 crises and is being addressed by the WHE since November 2018. As of 20th November, 2018 a total of 386 cases of Ebola Virus Disease have been reported with a massive 219 deaths.

At the 2019 WHO EBM, it was noted that the WHE has had significant impact in responding to all health emergencies, in particular the DRC Ebola Outbreak of 2018. A great success in coordination between various levels of management at the WHO was particularly well recognized. The IOAC noted that there have also been significant improvements in the areas of management structure, communication, decision making and internal coordination mechanisms with regard to the Ebola crises allowing for all persons involved to work effectively with well differentiated and specified roles.t

The WHE has seen many successes with the current program, all of which were identified and applauded by the IOAC at the WHO EBM of 2019. With the DRC being conflict ridden for over 20 years, the challenges of violence contribute to an increased difficulty in managing such outbreaks. It has been recognized that the WHO has been successfully working through difficult times and was prompt in its response to the outbreak last year. The IOAC recognized the WHO's quick deployment of careers and funds,

technical support, providence of healthcare teams and medication, within a mere 10 days of declaration of the outbreak. The implementation of adequate security measures to the Ebola response teams in such a volatile environment has been identified as crucial has been recognized to have been successful. Though, with increased demands of the WHE in conflict afflicted areas the IOAC also recognized a need for increased security measures, greater preparations for crises management in these environments and greater security capacity. The IOAC emphasized the importance of looking after their staff to ensure a safe working environment.

At the EBM the IOAC also noted the importance of collaborating with other organisations based in the affected areas. The significant progress by the WHE in collaboration and partnerships with government bodies, local organisations and other countries has been well recognized in regards to improving response to the DRC outbreak. Three notable organisations working on ground with the WHE are the Global Outbreak, Alert and Response Network, the Global Health Cluster and the Emergency Medical Teams. The IOAC is encouraging continuous and increased collaborations in the coming year to ensure continual in field progress, especially considering the lack of other highly experienced and technical organisations in the DRC.

The success of the WHE in the last two years in responding to Ebola has been very promising. The effectiveness of a new program in such a short amount of time has been commendable and sets a great example and template for responses to other health emergencies in the future. Though, eradicating Ebola will be a slow process and problems have been identified with the current program, the coordination between local government bodies, organizations and the WHO ensure that till that happens, mortality rates are being kept at as

low as possible and that the best care is being provided to those who are suffering. It is promising to see the constant review of goals and progress on such a large scale as well as the united front and contributions to this epidemic from various countries. In this next year, if further success in achieving the goals set at the WHO EBM of 2019 is seen, it will only encourage greater responses and work towards seeing the end of Ebola and many other devastating diseases.

In Conclusion, provide the necessary training and under the right supervision. Secondly, it will connect large health systems with rural resource and poor communities a relationship that will, when established, could reinforce the importance of extending access by investing in human capital.

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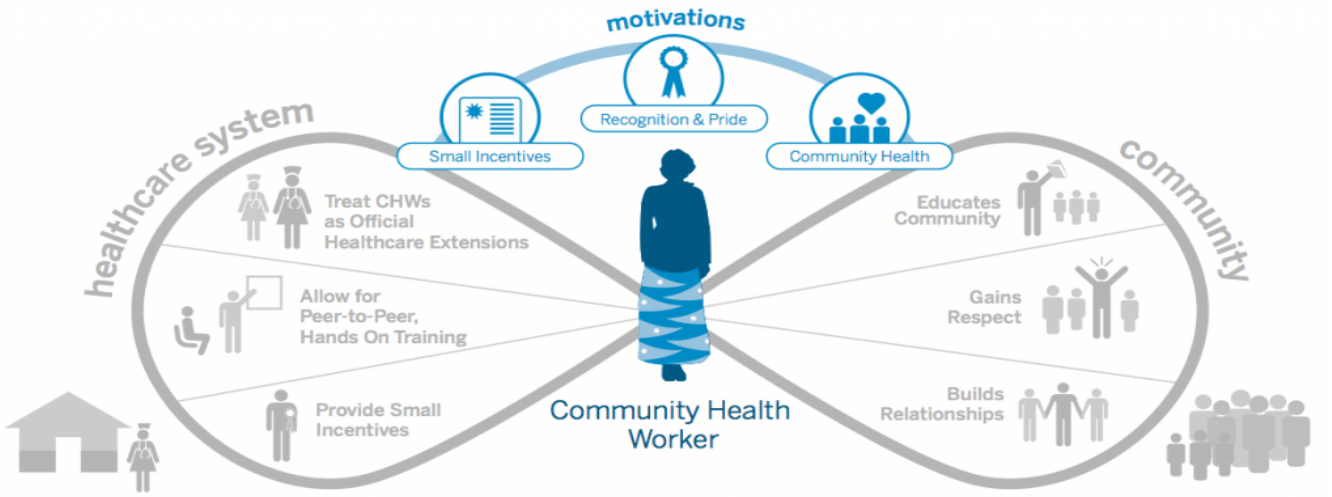
EMMANUEL AGYEMANG-DUA, MPH

AT THE WORLD HEALTH ORGANIZATION

SECTION 2: A CASE FOR VALUING COMMUNITY HEALTH WORKERS

EMMANUEL AGYEMANG-DUA, MPH



The employment of Community Health Workers (CHWs) is not an innovative end in itself, but rather, a method of practice, which enables the reach of medicine to be extended beyond conventional means or allows medicine to be practice more effectively and efficiently than conventional means.

Investing in a community health system approach to epilepsy can be an important milestone for sub-Saharan Africa. However,

making such strides in a resource-limited region does not come easy as there are many challenges to overcome including, buy-in of leadership from key-stakeholders in the community (Wootton, 2015). Another challenge of a CHW approach may be assurance in quality of the health care. Lastly, there is a concern that

while clinical intervention, programs and resources can be deployed to the social advantage of these communities, the nature of community health workers somewhat subtracts liability constraints on the grounds that judgments of what constitutes acceptable, or unacceptable quality should be independent of constraints on resources. The knowledge and the cost to train these non-doctors (CHW) to properly and safely execute this role must be accounted for.

When I acknowledge these challenges, I do not believe they outweigh the benefits of utilizing Community Health Workers and the expansive possibilities they offer with respects to providing their communities with access to timely and personable healthcare. Community buy-in and receptiveness of CHWs is rarely a challenge because there is already an established relationship between the community and the health worker. There are many benefits with investing in Community Health Workers. They help to expand access, improve quality and help organizations deliver cost-effective health interventions as well as collect more accurate patient information. Community Health Workers hold the promise to significantly impact some of the most challenging problems in global healthcare systems like: access to care, cost- effective medicine, researching patient populations, and distribution of healthcare resources in a timely and culturally appropriate manner.

As I reflect now on the benefits of Community Health Workers, all I can do is wonder about the parallel outcomes for my mother's kin that October morning in 2011. What if she had received timely care from a trusted church member or relative who was trained to diagnose and direct her to the proper care for her condition? What would the impact be for global public health if we invested in community

health workers? Maybe less people will die because of access to health care, late diagnosis, and routine check-ups in managing their disease conditions and contaminated water. Imagine the nurse has gotten a job a city like Addis Ababa to help manage new HIV/AIDS programs for higher pay and better living conditions. Imagine the aftermath of her departure: multiple cases of cholera, guinea worm, typhoid and dysentery that results as an effect of discontinued dependency on the expertise of a nurse.

Community Health Workers with proper training and less expertise can play the role of a healthcare professional, and be a solution to health disparities (lack of access to healthcare).

A Solution :

The presence of community health workers in global health care delivery is a cost-effective health policy solution to address the issue of access just by its nature. Addressing rural healthcare access challenges as a human capital issue in a health delivery sense is a viable policy that is often underutilized. Consider the perspective of a community health worker (one who lives with and understands the physiopathology of epilepsy patients in their community) and is trusted with knowledge to support the management of epilepsy. Imagine the impact of this pursuit. Epilepsy is a common global disease that causes physical and social disability (Wootton, 2015).

"The condition is highly stigmatized because of the commonly held misconception that epilepsy is contagious and the negative meanings attached to its outward manifestation, seizures" (Paul et. al, 2012). Over 85% of epilepsy cases are found in underdeveloped countries, most of which occur in poor regions of Africa that have the greatest

number of the world's population under the age of 15. It is known that about 70% of people with epilepsy could lead full, seizure–free lives if treated. Despite this, over 90% of people in Africa with epilepsy do not receive treatment (Paul et al, 2012). While it is one of the most treatable neurological diseases, in rural underdeveloped countries like Ghana, many people with epilepsy are not undergoing treatment often because they lack access to trained physicians.

An Approach :

While Americans have better equipped and more effective health delivery systems that enables them to benefit fully from a multiple health care system, other people, like my mother's cousin, face barriers that make it difficult to obtain basic health care services. In thinking conventionally, it can be appreciated that perhaps doctors are not the solution and that allowing community health workers to treat epilepsy may be better. The community health worker (CHW) intervention may offer a two-step approach in diagnosis and review, but also in helping to understand the intricacies of communities and clinical populations. First, it will provide to non-doctors the resources to diagnose epileptic episodes with the necessary training and under the right supervision. Second, it will connect large health systems with rural resource and poor communities a relationship that will, when established, could reinforce the importance of extending access by investing in human capital.

The employment of Community Health Workers (CHWs) is not an innovative end in itself, but rather, a method of practice, which enables the reach of medicine to be extended beyond conventional means or allows medicine to be practice more effectively and efficiently than conventional means.

Investing in a community health system approach to epilepsy can be an important milestone for sub-Saharan Africa. However, making such strides in a resource-limited region does not come easy as there are many challenges to overcome including, buy-in of leadership from key-stakeholders in the community (Wootton, 2015). Another challenge of a CHW approach may be assurance in quality of the health care. Lastly, there is a concern that while clinical intervention, programs and resources can be deployed to the social advantage of these communities, the nature of community health workers somewhat subtracts liability constraints on the grounds that judgments of what constitutes acceptable, or unacceptable quality should be independent of constraints on resources. The knowledge and the cost to train these non-doctors (CHW) to properly and safely execute this role must be accounted for.

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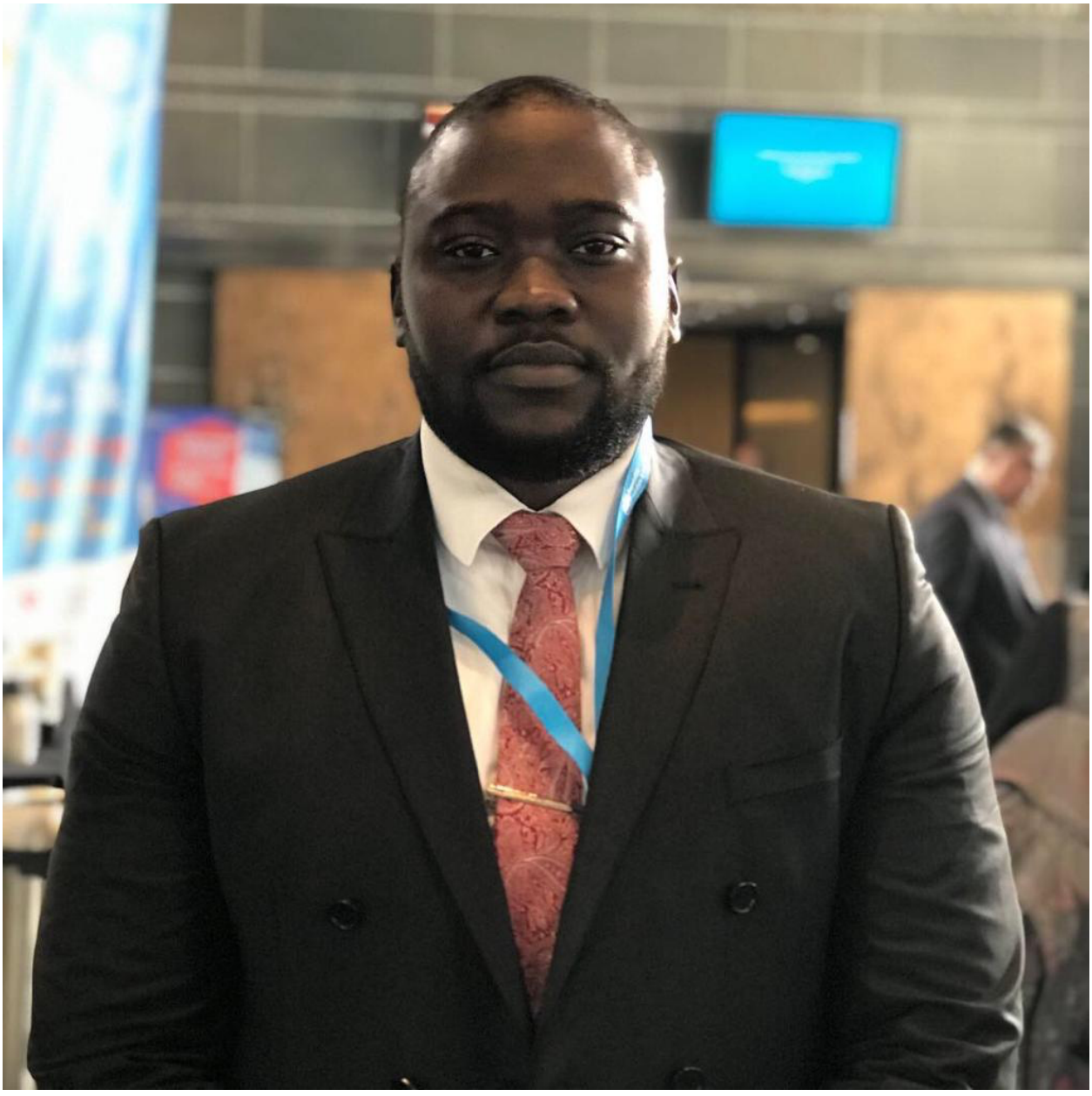
Once I began to understand the nuances of health care systems delivery and the policies therein, it became clear to me that the future of providing efficient public health services hinges not on building infrastructure, but on creating a sustained provision to affordable medicine and access to healthcare organizations. For the pitiful majority in this world who live in resource-poor communities, access to quality health care has been a challenge. Globally, healthcare reforms center on two central problems: controlling costs and effectively expanding access. These problems are interrelated; expanding access to rural and underserved communities contributes to the aim of closing gaps in health care coverage while reducing the costs in resources and cost of care to patients.



Dr. Ayomide Sina-Odunsi, MD, MPH AT WHO EB 144TH

SECTION 3: TOWARDS SUSTAINABLE INTERVENTIONS FOR NON-COMMUNICABLE DISEASES (NCD)

DR. AYOMIDE SINA-ODUNSI, MD, MPH

TABLE 1: BEST BUY INTERVENTIONS FOR NON-COMMUNICABLE DISEASES

Risk factor / disease	Interventions
Tobacco use	• Tax increases • Smoke-free indoor workplaces and public places • Health information and warnings • Bans on tobacco advertising, promotion and sponsorship
Harmful alcohol use	• Tax increases • Restricted access to retailed alcohol • Bans on alcohol advertising
Unhealthy diet and physical inactivity	• Reduced salt intake in food • Replacement of trans fat with polyunsaturated fat • Public awareness through mass media on diet and physical activity
Cardiovascular disease (CVD) and diabetes	• Counselling and multi-drug therapy for people with a high risk of developing heart attacks and strokes (including those with established CVD) • Treatment of heart attacks with aspirin
Cancer	• Hepatitis B immunization to prevent liver cancer (already scaled up) • Screening and treatment of pre-cancerous lesions to prevent cervical cancer

A Non-Communicable disease is a medical condition or disease that is non-infectious and non-transmissible among people. Today, NCDs are the leading causes of death and disease burden around the world. According to the World Health Organization (WHO), Noncommunicable - or chronic - diseases are diseases of long duration and generally slow progression.

There are four main types of noncommunicable diseases. They are diabetes, cancer, chronic respiratory diseases and cardiovascular diseases.

NCDs pose an increasing burden to health care systems worldwide. It is responsible for some 36 million deaths every year and it is a growing threat to human health and development in this generation. Increasing numbers of people with diseases such as chronic obstructed pulmonary disease and asthma, strokes and heart attacks created a greater need for a more effective health system.

The risk factors of noncommunicable diseases can be a combination of environment, lifestyle and genetic factors such as lack of physical activity, unhealthy diets, alcohol abuse, smoking and genetic predisposition. Some of these diseases are driven by forces that include urbanization, globalization and population ageing. Even though these conditions are associated with older age groups, there are proofs that support the fact that 15-million of all deaths credited to NCDs occur between the ages of 30 and 69 years. NCDs are often more prevalent in areas of deprived or disadvantaged socioeconomic classes as over 85% of these NCDs related premature deaths are estimated to occur in low-middle income countries and it represents a major stumbling block to the economic development of many countries around the world.

WHO's efforts on preventing, managing and coordinating action to prevent and control NCDs has been done through numerous means. This includes developing and strengthening policies and programmes on healthy lifestyles and NCD prevention while also supporting member states in the efforts to address the NCDs burden.

The WHO developed a global monitoring framework to enable global tracking of progress in preventing and controlling major noncommunicable diseases - cardiovascular disease, cancer, chronic lung diseases and diabetes - and their key risk factors.

And to support countries with their national efforts to address the burden of NCDs, the WHO Global Action Plan for the Prevention and Control of NCDs 2013-2020 was developed and endorsed at the 66th World Health Assembly.

The global action plan offers a paradigm shift by providing a road map and a menu of policy options for Member States, WHO, other UN organizations and inter-governmental organizations, NGOs and the private sector which, when implemented collectively between 2013 and 2020, aims to attain 9 voluntary global targets, including that of a 25% relative reduction in premature mortality from NCDs by 2025.

Towards addressing the burden of NCD, all member states' ministries of health need to set national NCD targets and lead the development and implementation of policies and interventions to attain them.

The WHO Global NCD Action Plan 2013-2020 follows on from commitments made by Heads of State and Government in the United Nations Political Declaration on the Prevention and Control of NCDs, recognizing the primary role and responsibility of Governments in responding to the challenge of NCDs and the important role of international cooperation to support national efforts.

The increasing burden of non-communicable diseases (NCDs) in sub-Saharan Africa is causing a further burden to the health care systems that are already ill- equipped and resource constrained.

The WHO also developed a costing tool to enable member states to evaluate interventions according to national needs or priorities. These "best buy" interventions have been deemed cost-effective for low-middle income countries and feasible to implement within the constraints of their health systems.

Currently the use of taxation in preventing NCDs had been increasingly adopted by some European countries as a means of intervention to address the burden. A good example is Hungary which introduced a public health product tax (PHPT) aiming to promote healthy diet and reduce the consumption of food not healthy to the public. This tax targeted different products that fell under different groups that ranged from sugar drinks to alcoholic beverages. A 4-year assessment done after the introduction of PHPT clearly revealed that the consumption of the taxed products had reduced drastically and remained maintained.

Another example is Rwanda, which introduced the Car Free day in 2017. This is a day set aside to limit movement of vehicles and encourage physical activities. On this day every month, screening and counselling services are provided at different locations to improve awareness about NCDs.

Looking at the NCDs policy process in many African countries, it is noticeable that some countries have made effort to develop strategies, but they face issues with implementation and a national level commitment to these policies. These issues can range from financial, information or political forms.

But it is good to notice that many African countries have begun processes in implementing the WHO best by interventions. Policy process for tobacco is progressing in some countries, notably South Africa.

Solutions to reducing the global burden of NCDs lies in improving the prevention, detection and treatment through a global cooperation while making use of the best available technology and trying to put more effort in reaching vulnerable populations. The world is a global village and should work as one in tackling factors that determine the state of health head on. These factors can be social, physical, environmental or behavioral.

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initiatives will help reduce the risk of developing NCDs on the long run.

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About the Authors

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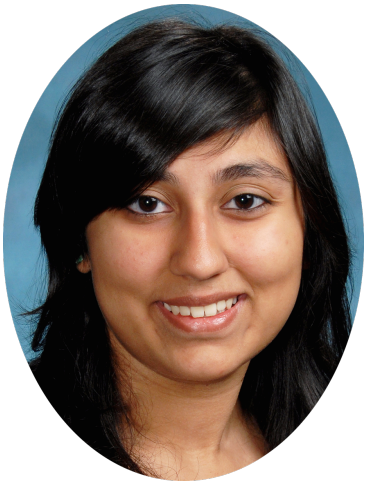


Surbhi Chawla is an Ariel Foundation International I Health Ambassador. She is a physician who graduate of the Royal College of Surgeons Ireland with a MbCHb LRCPI LRCSI BAO qualification in 2018. Dr. Chawla is currently pursuing a course Masters in Surgical Science and Surgical Practice and has completed a course in Health Innovation.

Through her exposure to different medical systems worldwide and her travels, especially to India and South East Asia, Surbhi has developed a keen interest and passion for advancing access to medical care and improving awareness of diseases worldwide.

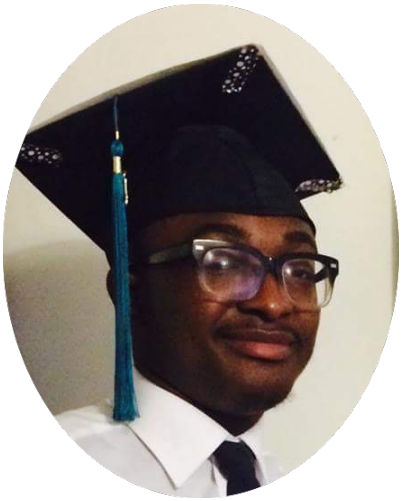
In trying to pursue her passion Dr. Chawla has patented a design of a thermometer with a temperature sensitive warning system consisting of both a visual LED light and a verbal warning system. The thermometer is a modification of a regular home use thermometer which has a target of providing people, particularly in lower socioeconomic groups with a simple way of knowing when to seek medical attention. The goal of the device is to ultimately reduce mortality rates, in particular infant mortality and under 5 mortalities through early identification of illness. The thermometer is currently in its production phase and will be distributed soon.

Dr. Chawla is the co- founder of a charitable foundation based in India which works towards improving access to medical care and improving education for children in rural areas.

During her time in medical school Dr. Chawla has worked in multiple specialties of medicine and has cultivated experience in different parts of the world including Ireland, India, Hong Kong and the United States. She has worked on and published four research papers in the areas of Cardiothoracic Surgery and Infertility Medicine.

Dr. Chawla is currently working towards becoming a fully qualified Surgeon and aims to continue pursuing her passion of creating greater avenues for healthcare access and awareness in rural parts of the world, as well as trying to reduce mortality rates worldwide through many more upcoming projects.

MR. EMMANUEL AGYEMANG-DUA, MPH, 25, GHANA/ USA



Emmanuel Agyemang-Dua is an AFI International Health Ambassador who is currently working as a Quality Training Program Administrator with the American Society of Clinical Oncology (ASCO).

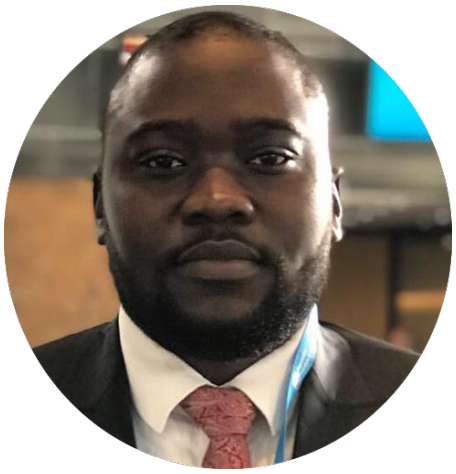
He formally worked as a Global Health Consultant with the World Health Organization, with their World Health Emergency's Learning Development team, where he helped to monitor and manage the "OpenWHO" online learning platform for frontline health emergency responders and facilitated pre-deployment training production.

After spending nearly 6 years working as a social entrepreneur with Citizen Initiative Africa, Emmanuel has assisted in using his knowledge and platform to create young social entrepreneurs across Africa by equipping young students with the skills and resources to transform their communities through social impact projects in healthcare and education. He developed intersections between his social impact work and his global development work as a consultant with the WHE.

Mr. Agyemang-Dua firmly believes that global change that starts from "all one needs is the mindset that they can be an instrument of change".

Emmanuel holds a Bachelor of Arts (BA), in Leadership and Public Policy and a Master of Public Health (MPH) degree with a concentration in Health Policy, Ethics, and Law from the University of Virginia.

DR. AYOMIDE SINA-ODUNSI, MD, MPH, 28, NIGERIA



Dr. Ayomide Sina-Odunsi MD, MPH ide Sina-Odunsi, is the Deputy Director for Ariel Foundation International, where he also serves as AFI's Permanent Representative to the United Nations, and European Union. He is a medical doctor and public health expert with a special interest in Emergency Response and Crisis Management.

Dr. Sina-Odunsi is the Co-founder of AB Global Health Initiative Nigeria and over the years has acquired ongoing professional experience in clinical medicine, public health, project and program management, Health systems strengthening and Innovation from working in his home country Nigeria and a range of international agencies after graduating from the Ivano-Frankivsk National Medical University in Ukraine.

He had his postgraduate studies at the University of Aberdeen, United Kingdom where he received a Master of Public Health, and he also completed a Certificate-Mini-MBA from the London School of Business and Finance.

In 2018, He joined the World Health Organization at the Rwanda Country Office where he worked both with the HIV, Hepatitis and STDs Department and the Health Systems Department. During this time, he participated in various health programs in association with the Rwandan Ministry of Health and with partner organizations like the Rwanda Biomedical Centre, UNICEF, UNAIDS, CDC.

In addition, Dr. Sina-Odunsi worked on the WHO country office's technical operations and liaisons with Health Sector partners involved in Health policy and Health care system monitoring. He has participated in many high-level conferences and summits and is passionate about influencing policy in service of communities worldwide.

Dr. Sina-Odunsi is a keen volunteer, a research enthusiast, loves to travel and has participated in various medical volunteer missions in different countries around the world. He is also passionate about creating a community of young and vibrant global health leaders.

DR. ARIEL ROSITA KING, PRESIDENT and EDITOR

Dr. Ariella (Ariel) Rosita King founded The Ariel Foundation International (in 2002 as a non-profit organization with an international focus on children and youth Leadership and Participation worldwide. The Ariel Foundation Chair is H.E. Ambassador Joseph Huggins (USA) and Vice Chaired by H.E. Ambassador Molelekeng E. Rapolaki (Kingdom of Lesotho).

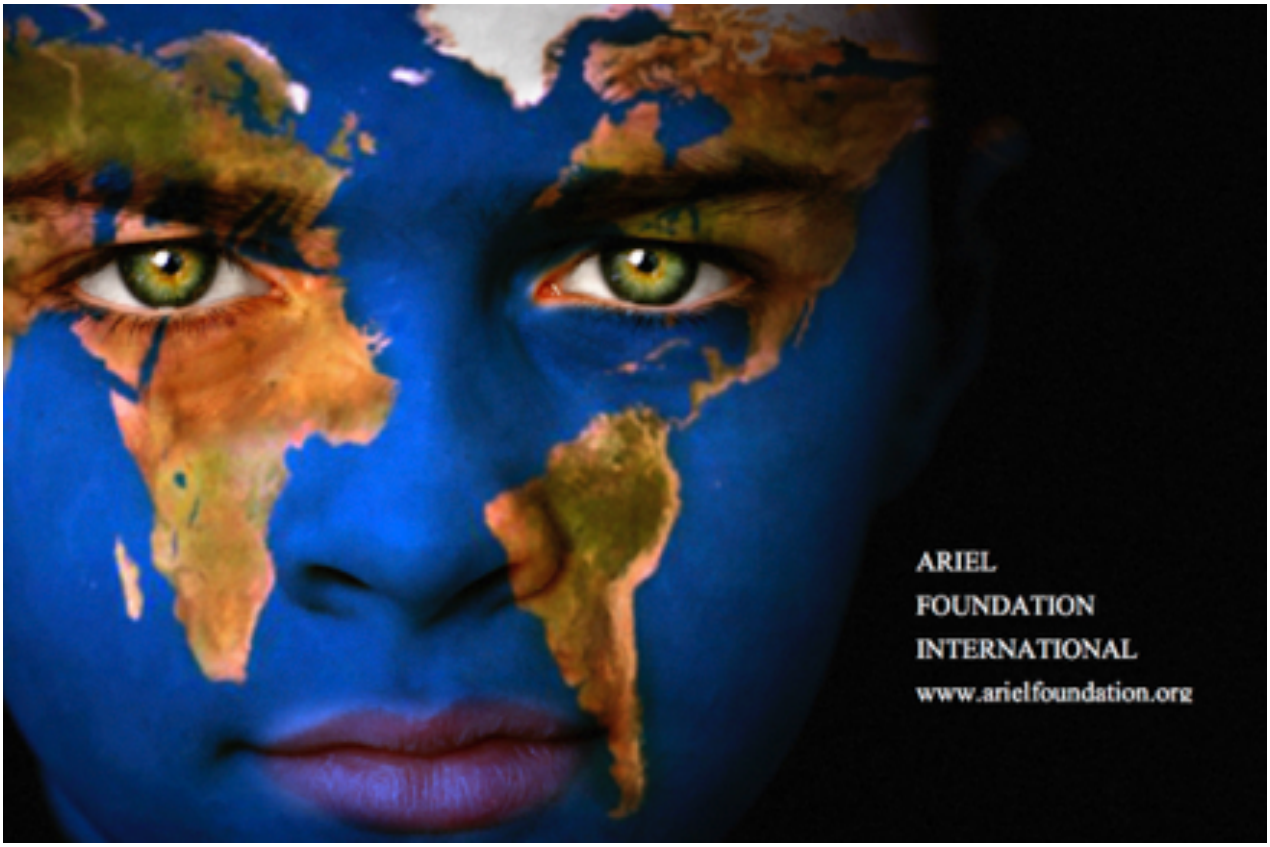
Dr. Ariel King is the Main Representative for AFI with Special ECOSOC status, Economic, Cultural and Social Council at the United Nations in Geneva, New York and Vienna. She has also represented other NGOs in Geneva since 2008, the United Nations in Vienna (UNOV) since 2010 and United Nations in New York since 2000. Dr. King's life focus is on inspiring leadership and participation of worlds' children and youth. Ariel Foundation International is a member of EuroChild, Dr. King was a Trustee for Children's Rights Alliance England (CRAE) and the Acid Survivors Trust International (ASTI) with work in India, Bangladesh, and United Kingdom.

Dr is the Founder, and President Ariel Consulting International, Inc. (http://www.ArielConsult.com) founded in 2000, a company that creates and enhances Public-Private Partnerships in international health, policy, and management with focus on developing countries. She. King has over 35 years of experience in international public health policy and international management in government, business and NGOs and international health. As a Professor in International Health, Management, Policy and Environment she has taught at Universities in the USA, Europe and Africa. Dr. King has published on the topics of Kangaroo Newborn Baby Care, International Health Policy and Management, Medical Ethics, Organ Transplantation, National Essential Drugs Policy, HIV/AIDS; Breast Cancer; Violence Against Women; Youth Participation at the United Nations and Children's Human Rights.

Dr. King is a world expert on HIV/AIDS and has worked in the field since 1983. She was chosen to be on the Expert AIDS Prevention working Group with the Bill and Melinda Gates Foundation (USA) and Human Science Research Council (South

Africa). Dr. King was a part of SAHARA: Social Aspects of HIV/AIDS Research as the Chair of the Continental Advisory Board, and worked on forging public private partnerships, including a MOI between University of Bayreuth (Germany) and SAHARA. She was on the Friends of Madagascar Advisory Council (FOMAC) led by the late Ambassador Jocelyn Radifera of Madagascar to the USA. Dr. King's focus is on International Public-Private Partnerships in Development that has its foundation of 35 years of living and working in 13 countries and traveling to over 70 countries.

She has served as a representative for the International Council of Women (Paris) at various UN meetings and has served on the board of directors of the National Black Women's Health Project (Atlanta, USA), Positive Art: Women and Children with HIV/AIDS (South Africa), The Life Foundation: AIDS Foundation of Hawaii (Honolulu, Hawaii) , The Black Alliance for AIDS Prevention, the Pediatric HIV/AIDS Care, Inc., and the Ronald McDonald House. Dr. King is a Founding and Board member of Women Impacting Public Policy (WIPP), member of the Women's Foreign Policy Group (WFPG), and has been an active member of Rotary for twenty years as a Group Study Exchange member to Madagascar, An Ambassadorial Scholarship Recipient for South Africa (and UK) and Member for various Rotary Clubs around the world. Dr. King recently (December 2018) completed a second research degree (PhD) in Sociology on Community Engagement in the Psychosocial Care of Their Traumatised Children – A Case Study of Botswana, Liberia and Morocco at the Unitersité de Franche-Comte, France. She also has completed advance certificates in the study of Children's Human Rights, from the UER Droits de l'enfant/Children's Rights Unit, Institut Universitaire Kurt Bösch (IUKB) in Switzerland. Dr. King holds a Diploma Tropical Medicine and Hygiene (DTM&H); Doctorate (PhD) in Philosophy in Public Health and Policy from the London School of Hygiene & Tropical Medicine, University of London; a Master in Business Administration (MBA) in International Health Management from Thunderbird American Graduate School of International Management, Master in Public Health (MPH) in international Health from the University of Texas School of Public Health; and a Bachelor of Arts (BA) from the University of Hawaii.



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