ABSTRACTS

34th FIMA Scientific Congress

CONGRESS ON HEALTH IN AFRICA | AFRİKA SAĞLIK KONGRESİ

20-21JULY2017 WOW CONVENTION CENTER
İSTANBUL TÜRKİYE

T.C. Sağlık Bakanlığı

İSTANBUL MEDENİYET ÜNİVERSİTESİ

HAYAT SAĞLIK VE SOSYAL HİZMETLER VAKFI

FIMA

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34th FIMA Scientific Congress

Congress on Health in Africa

20-21 July 2017 - İstanbul Türkiye

The Objectives of the Conference

Africa should have a much larger space in people's hearts than the area it covers on the earth's surface. Although interregional access and communication have been only a matter of time compared to the past, Africa is still far away. New problems are being added to the old ones as the continent's humanitarian problems, which had remained unchanged for centuries, deepen day by day. The foremost of these problems are health-related issues, which also trigger other difficulties encountered on the continent. Moreover, the existence of overly individualist people in modern times overrides the conventional aid delivery methods that have been used to address these problems. This difficulty is accompanied by coordination problems of various aid agencies both with regional governments and between themselves.

For sure, it is not possible to refer to a homogeneous unit when talking about a continent. There are many stratified and diverse health problems that have their historical roots in different geographical regions and different cultures across the continent. However, it is still possible for humanity to adopt at least a common-sense vision or strategy and, most importantly, a conscientious sensitivity for the continent as a whole. But at the same time, those images that cry out to our conscience are stifling our feelings, as if the current situation of the continent was its absolute destiny. Thus, we encode the continent as an aid-dependent and passive region. Yet, with effective, coordinated, and well-planned policies it is possible to find both global and local solutions to the humanitarian problems of Africa, and it is also possible to compromise on the ways that will ensure that Africa can stand on its own feet.

Starting from these concerns, the international Congress of Health in Africa is currently being held in Turkey, the country where the landmasses of the three continents are coming the closest to one other. This congress, which will set out on a quest to find a common ground for Africa, aiming to bring participants from Africa and from different regions all over the world closer, is open for contributions of participants in a very wide range of health-related issues.

Program

July 20, 2017	
08:30-10:00	Registration
10:00-11:00	Opening Ceremony
11:00-12:00	Keynote Speech **Recep Akdağ, Prof, Türkiye** Minister of Health, Republic of Turkey
12:00-14:00	Lunch Break
Hall A	
14:00-15:30	Session-A1 **Turkey's Changing Approach to Africa and Turkey's Identity in an African Perspective** **Kani Torun, MD, Türkiye** Chair **Ahmet Kavas, Prof, Türkiye** A Multi-Faceted Approach to the Ottoman/Turkish-African Relations **Menouar Alem, Ambassador, Morocco** **Marcel Mulumba Tshidimba, Ambassador, DR Congo** Africa on the Horizon of 2063 and the Role of Strategic Partners **Ahmet Rıza Demirer, Ambassador, Türkiye** New Period for the Turkish-African Diplomatic Relationship
15:30-15:45	Coffee Break
15:45-17:00	Session-A2 **Turkish Ministry of Health's Activities in Africa** **Hasan Çağıl, Dr, Türkiye** Chair **Öner Güner, MD, Türkiye** International Health Policies of Turkey and Africa **Ali Kalyoncu, MD, Türkiye** The Field Experiences in Sudan and Somalia **Nurullah Okumuş, Prof, Türkiye** International Patient Policy Implementations **Fatih Tan, Türkiye** Possible Collabortion Areas in Medicine , Medical Devices and Cosmetics
17:00-17:30	Coffee Break

17:30-19:00	Session-A3 **Turkish Institutions in Africa: Field Experiences** **Mehmet Koç, Prof, Türkiye** Chair **Serdar Çam, Türkiye** Activities of TİKA in Health Sector for the Development of Africa **Kerem Kınık, MD, Türkiye** Healthcare in Africa and the Turkish Red Crescent **Bülent Yıldırım, Türkiye** Experiences in Africa and Problems in the Field from the Perspective of IHH Humanitarian Relief Foundatiton **Yahyahan Güney, MD, Türkiye** The Process of Evolution from Voluntary Based Organizations to Professional Non-Governmental Organization **Mehmet Cengiz, Türkiye** Deniz Feneri Association and Humanitarian Aid Models, Processes and Sustainability
Hall B	
14:00-15:30	Session-B1 **Basic Health Problems in Africa: Diseases and Epidemics** **Arif Kaygusuz, Prof, Türkiye** Chair **Magid Kagimu, Prof, Uganda** Religiosity for HIV Prevention in Africa: An Under Recognised, Under Supported and Under Utilized Intervention with Enormous Potential **Mustafa Idris Elbashir, Prof, Sudan** Socioeconomic Burden of Endemic Diseases in Africa with Emphasis on Malaria **Mamoun Homeida, Prof, Sudan** Transforming from African Programme of Onchocerciasis Control to Elimination of Neglected Tropical Diseases **Nazir Ismail, MD, South Africa** Tuberculosis in Africa: Challenges and Opportunities
15:30-15:45	Coffee Break
15:45-17:00	Session-B2 **Basic Health Problems in Africa: Politics, Infrastructure, Human Beings, Service and Finance** **Mustafa Taşdemir, Prof, Türkiye** Chair

Mamoun Homeida, Prof, Sudan
Health Problems in Africa and Fight Against Them
Muna Abdel Aziz, MD, United Kingdom
Highlights and Lessons Learnt from the Wider Health System in Sudan
Victor Sullay Kamara, MD, Türkiye
The Effect of Poverty and Opportunities in Sierra Leone's Health
Albert Mbonerane, Burundi
In Burundi the Poor People Die of Malaria. Act Together to Save Human Lives
Handan Ankaralı, Prof, Türkiye
Sociodemographic Features, Prevalence of Some Diseases, Life Satisfaction and Related Factors in Kampala

17:00-17:30 Coffee Break

17:30-19:00 Session-B3
Health and Ethics
İlhan İlkılıç, Prof, Türkiye
Chair

Aasim I. Padela, Assoc Prof, US of America
Social Responsibility and the State's Duty to Provide Healthcare: An Islamic Ethico-Legal Perspective
Alireza Bagheri, MD, PhD, Iran
Ethical Issues in Externally-Sponsored Research in Developing Countries
Ayesha Ahmad, PhD, United Kingdom
Catching Culture in the Ebola Epidemic
Arzoo Ahmed, United Kingdom
Language and Authority: Ethical Challenges at the Interface of Health and Religion in Africa
Syaefudin Ali Akhmad, MD, Indonesia
Health Challenges in Africa; Islamic Bioethics Perspective

Hall C

14:00-15:30 Session-C1
Africa and Turkey
Handan Ankaralı, Prof, Türkiye
Chair

İsmail Ermağan, Assoc Prof, Türkiye
Africa in the World Politics and African Studies in Turkish Literature
Radouan Yousfi, Türkiye
Turkey's Health Diplomacy in Africa as a Soft Power Policy

	Aslıgül Sarıkamış, PhD, Türkiye The Rise of Turkey as a Non-Traditional Aid Donor in Sub-Saharan Africa **Serhat Onur, MD, Türkiye** Health Activities of Turkish Volunteer in Niger **Semih Dinçer Yetiş, MD, Türkiye** Renovating Project of Niger Maternity and Children's Hospital
15:30-15:45	Coffee Break
15:45-17:00	Session-C2 **Health Education in Africa** **Najeeb Rahman, MD, United Kingdom** Chair **Kamada Lwere, MD, Uganda** Health Professions and Medical Education in Africa: Differences and Similarities **Serhat Onur, MD, Türkiye** Education and Problems of Circumcision in Africa **Dalila Roslan, MD, Malaysia** A Review on the Implementation of Sexual and Reproductive Health Education in School- the Malaysian Experience **Neşet Köksal, Prof, Türkiye** Laparoscopic Cholecystectomy Training in Niger-Agadez **Afolabi Joseph Fasoranti, PhD, Nigeria** Effect of Health Education Intervention on Treatment Adherence in Patients with Pulmonary Tuberculosis in Lagos, Nigeria **Aisha Nazziwa, MD, Uganda** Assessing the Learning Environment at Habib Medical School, Islamic University in Uganda **Orhan Alimoğlu, Prof, Türkiye** The Analysis of Sub- Saharan African Surgical Publications
17:00-17:30	Coffee Break
17:30-19:00	Session-C3 **Analysis on Epidemics and Diseases in Africa** **İlker İnanç Balkan, Assoc Prof, Türkiye** Chair **Azlan Helmy Abd Samat, MD, Malaysia** #MsiaEndsDengue Model; a Unique Collaboration of NGOs- Academia in Curbing Dengue Epidemics: Lesson from Malaysia to Africa

Myers Lugemwa, MD, Uganda
Is the Northern Uganda Malaria Outbreak a True Epidemic or Resurgence? Intervention Options, Challenges and Way Forward
Alain Rakotoarisoa, MD, Madagascar
Bubonic Plague Outbreak Investigation in the Endemic District of Tsiroanomandidy - Madagascar, October 2014
Endalamaw Gadisa, MD, Ethiopia
Serological Signatures of Clinical Cure Following Successful Treatment with Sodium Stibogluconate in Ethiopian Visceral Leishmaniasis
Hassan Ashmawy, MD, Zimbabwe
Tunica Vaginalis Free Graft Urethroplasty: 10 Years Experience
Orhan Alimoğlu, Prof, Türkiye
Surgical Diseases in Sub-Saharan Africa: Is it a Public Health Problem?
Fathia Mohamed Nour, MD, Somalia
Prevalence of Cardiovascular Disease Risk Factors in Sheikh-Osman Community, Borama Somaliland

July 21, 2017

Hall A

09:00-10:15 Session-A4
FIMA and Health Projects in Africa
Akif Kaygusuz, Prof, Türkiye
Chair

İbrahim Sule Babaminin, MD, Nigeria
FIMA SAVE DIGNITY Project Islamic Medical Association of Nigeria (IMAN) Experience
Parvaiz Malik, MD, US of America
FIMA SAVE SMILE Project in Africa
Misbahul Aziz, Prof, Pakistan
Blindness in Africa and Role of FIMA SAVE VISION Project

10:15-11:30 Session-A5
Modernization and Its Impact on African Health
M İnanç Özekmekçi, Assist Prof, Türkiye
Chair

Omar Hasan Kasule, Prof, K of Saudi Arabia
What can Modern Medicine Learn from Islamic Medicine: The Experience of an Islamic Medical Curriculum in South East Asia 1995-Present

	Aly A Misha'l, Prof, Jordan Why Western Paradigms are Ineffective for Modern World's Health Problems **Zeynep Demirci, Türkiye** Traditional Medical Practices in Africa in a Modernization Context: The Example of Togo **Samuel Antwi Baffour, MD, Ghana** Application of Traditional Medicine in Africa – The Issue of Modernization, Globalization and Acceptance
11:30-11:45	Coffee Break
11:45-13:00	Session-A6 **Africa and Aid Dependency** **Orhan Alimoğlu, Prof, Türkiye** Chair **Firoz Osman, MD, South Africa** Delusion of Humanitarian Aid **Maurice N Amutabi, Prof, Kenya** Paradox of NGO's in Africa's Development and Healthcare **Musa Kulaklıkaya, Ambassador, Türkiye** Africa and Aid Dependency **Obijiofor Aginam, Prof, Malaysia** Africa, Aid Dependency and the Globalization of Public Health: The Promise and Limits of South-South Cooperation
13:30-14:15	Lunch Break
14:15-15:30	Session-A7 **Addictions in Africa and Fight Against Them** **Mahmut Gümüş, Prof, Türkiye** Chair **M İhsan Karaman, Prof, Türkiye** FIMA Addiction Working Group and International Federation of Green Crescents **Osman Abdi Omar, MD, Somalia** The Effect of Addiction in Somalia **Abdrahmane Diabate, Mali** Consumption Problems and Drugs Trafficking on the Road and Gold Mine in Mali
	Hall B
09:00-10:15	Session-B4 **Student Exchange as a Solution in Medical Education** **Alper Cihan, Prof, Türkiye** Chair

	Orhan Alimoğlu, Prof, Türkiye Postgraduate Medical Training in Africa **Mehmet Köse, MD, Türkiye** Health Education within the Scope of Turkey's International Students Policy **Zahra Ali, MD, Kenya** Challenges Faced by African Students in Medical Schools in Turkey
10:15-11:30	Session-B5 **Health Professions and Medical Education in Africa: Current Situation, Problems and the Future** **Cevdet Erdöl, Prof, Türkiye** Chair **Ammar Eltahir Mohamed Ahmed, Prof, Sudan** Suggested Framework for Social Accountability to be Adopted by the Medical Schools **Abdirisak Ahmed Dalmar, Prof, Somalia** Human Resources for Health in the Context of Post Conflict Revival of the Health System in Somalia **Ahmad Kawesa Sengendo, Prof, Uganda** The Role of Universities in Healing the Sick Health Sector of Africa **Kasonde Bowa, Prof, Zambia** The Brain Drain of Health Professionals in Africa, the Zambian Perspective
11:30-11:45	Coffee Break
11:45-13:00	Session-B6 **Health Policies and Organization of Health in Africa** **Mahomed Khan, Dr, South Africa** Chair **Sarah Opendi, Minister of Health, Uganda** Social Determinants of Health in Africa **Mario J Azevedo, Prof, US America** Africa's Quest for Solutions to its Double Burden of Disease **Omoje Uchenna Kelvin, MD, Nigeria** Nigerian Health Care Organization: A Mirror to Africa's Conundrum? **Bashir Issak, MD, Kenya** Status of Maternal Health in Kenya and UNFPA's Contribution in Addressing The Challenges in High Maternal Mortality Burden Counties
13:30-14:15	Lunch Break

14:15-15:30 Session-B7

Successes and Objectives in African Health

Ali İhsan Taşçı, Prof, Türkiye

Chair

Jibrill Mulongo Kasongo, MD, DR Congo
Success Story of Partnerships for Health in Africa, Case Study of Male Circumcision Organized in the Congo DC

Apostolos Veizis, MD, Greece
Médecins Sans Frontières (MSF) &HIV/AIDS : More Positive Stories Needed

Saadet Lale Tarım, Türkiye
Health Education Experience as a University in an African Country: Mogadishu Somali Health Sciences University Recep Tayyip Erdogan School of Health Services (SHS)

Hafeez Ur Rahman, Prof, Pakistan
Responding to the Challenge of Healthcare Professionals' Deficiency in East Africa- Experience of Competency Based Multi-collaborative Postgraduate Programs in Ophthalmology at Hargeisa- Somaliland

Hall C

09:00-10:15 Session-C4

Health in Africa and Globalization-Migration and Modernization

Murteza Bedir, Prof, Türkiye

Chair

İsmail Ermağan, Assoc Prof, Türkiye
The Politics of China on Africa: Its Invests in the Health Sector in Africa and the African Health Problems

Jean Philippe Têtê Gunn, Türkiye
African Continent in the Struggle of the Globalization: Which Appreciation?

Francisco Jose Lopes Junior, Türkiye
Brain Drain as an Obstacle of Health Sector Development in Africa

Ahmad Yusuf Yahaya, MD, Malaysia
Medical Services for the Rohingya Refugees in Malaysia: Experiences to Share for Africa

Abdelhek Dahman, Türkiye
Role of Doctors Without Borders Organization in Africa: Realities and Perspectives

İlknur Çelikel, Türkiye
Aid Campings for Africa: The Humanitarian Communication Ethical Dilemma

10:15-11:30	Session-C5 **Various Health Related Problems in Africa** **Mustafa Kanat, Assoc Prof, Türkiye** Chair **Tajudeen Abiola, MD, Nigeria** Stigma from Psychoactive Substance Use: Sociodemographic Correlates of the Perceiver **Memduh Gezici, Prof, Türkiye** The Sociological Cause-and-Effect Relationship of "Female Genital Mutilation" Applied in Africa **Memduh Gezici, Prof, Türkiye** Recommended Measures to Prevent Female Genital Mutilation and its Harmful Consequences **Hacer Ataman, Assist Prof, Türkiye** Adolescent Health Analysis of the African Region **Serhat Onur, MD, Türkiye** Health and Nutrition Problems in Sub-Saharan Africa **Fatah Mokhtar Terbouk, MD, Algeria** Iron Deficiency: The Greatest Nutritional Challenge in Africa **Ibrahim Adekunle Oreagba, Assoc Prof, Nigeria** Potential Drug-Drug Interaction Occurrence In Adult Patients on Antiretroviral Therapy In Lagos, Nigeria
11:30-11:45	Coffee Break
11:45-13:00	Session-C6 **Maternal and Infant Health in Africa** **Fahri Ovalı, Prof, Türkiye** Chair **Olivier Mukuku, MD, DR Congo** Predictive Score of Severe Acute Malnutrition in Children Under 5 Years in Developing Countries **Laila Acharai, MD, Morocco** National Program of Newborn Screening for Congenital Hypothyroidism in Morocco Situation and Prospects **Türkan Günay, Prof, Türkiye** The Status of Early Initiation of Nutritional Suppliments and Its Influencing Factors Among Babies in Uganda **Olivier Mukuku, MD, DR Congo** Risk Factors of Low Birth Weight in Lubumbashi, Democratic Republic of Congo **Özlem Eskil Çiçek, MD, Türkiye** Maternal Mortality Related Factors in the WHO African Region
13:30-14:15	Lunch Break

14:15-15:30	Session-C7 **Health Workforce in Africa** **Alpertunga Kara, Assist Prof, Türkiye** **Ebuzer Aydın, Assist Prof, Türkiye** Chair **Abdelhakim Yahyane, MD, Morocco** Study on the Barriers to Use Magnesium Sulfate by Health Professionals in Morocco **Abdirizak Yussuf Abdillahi, MD, Somalia** Health Professions Gap in Somaliland: Challenges and the Way Forward **Edwin Sosthenes, Türkiye** Health Workforce in Somalia: a Policy Analysis **Yasemin Akbulut, Assoc Prof, Türkiye** Public Private Partnership in Healthcare Sector: a SWOT Analysis for Africa **Pascal Soroheye, Benin** Utility of a Biomedical Inventory: Case of Benin **Cherifa Sururu, MD, South Africa** The Views of Key Stakeholders in Zimbabwe on the Introduction of Family Medicine: A Qualitative Study
Hall A-B-C	
15:30-16:45	Session-A8 **Is it Possible to Develop New Strategies to Confront**
Problems	**in Africa** **Sabahattin Aydın, Prof, Türkiye** Chair **Naser Haghamed, MD, United Kingdom** From Emergency Aid to Integrated Community Development – the Benefits of a Holistic Approach to Health **Ali Doğan, Türkiye** Defining a Regression Model for Performance of STMM (Short Term Medical Missions): Doctors Worldwide Case Studies **Mehmet Özkan, Assoc Prof, Türkiye** How Important is Africa in the Altering/Transforming World? **Ahmad Munawwar Helmi Salim, MD, Malaysia** The Safewhere Initiative: A Malaysian Solution to Clean Drinking Water Problems in Rural Areas: A Pilot Study **Musa Mohd Nordin, Assoc Prof, Malaysia** Immunization for all in Africa
16:45-17:15	Coffee Break
17:15-18:00	Closing Session **Hakan Ertin, Assoc Prof, Türkiye** Chair **Hussein A R Gezairy, Prof, K of Saudi Arabia** Health in Africa

Program

20 Temmuz 2017	
08:30-10:00	Kayıt
10:00-11:00	Açılış Töreni
11:00-12:00	Açılış Konuşması **Recep Akdağ, Prof Dr, Türkiye** TC Sağlık Bakanı
12:00-14:00	Yemek Arası
A Salonu	
14:00-15:30	Oturum-A1 **Türkiye'nin Değişen Afrika Yaklaşımı ve Afrika Perspektifinden Türkiye Kimliği** **Kani Torun, Dr, Türkiye** Oturum Başkanı **Ahmet Kavas, Prof Dr, Türkiye** Osmanlı/Türkiye-Afrika İlişkilerine Çok Yönlü Bakış **Menouar Alem, Büyükelçi, Fas** **Marcel Mulumba Tshidimba, Büyükelçi, Kongo DC** 2063 Vizyonunda Afrika ve Stratejik Ortaklıkların Rolü **Ahmet Rıza Demirer, Büyükelçi, Türkiye** Türkiye-Afrika Diplomatik İlişkilerinde Yeni Dönem
15:30-15:45	Kahve Arası
15:45-17:00	Oturum-A2 **TC Sağlık Bakanlığının Afrika'daki Çalışmaları** **Hasan Çağıl, Dr, Türkiye** Oturum Başkanı **Öner Güner, Dr, Türkiye** Türkiye'nin Uluslarası Sağlık Politikaları ve Afrika **Ali Kalyoncu, Dr, Türkiye** Sudan ve Somali Saha Deneyimleri **Nurullah Okumuş, Prof Dr, Türkiye** Uluslararası Hasta Politikaları Uygulamaları **Fatih Tan, Türkiye** Tıp, Tıbbi Cihaz ve Kozmetik Alanında Olası İşbirliği Alanları
17:00-17:30	Kahve Arası

17:30-19:30	Oturum-A3 **Afrika'da Çalışan Türk Kuruluşları: Ne Yapıyoruz ve Saha Deneyimleri** **Mehmet Koç, Prof Dr, Türkiye** Oturum Başkanı **Serdar Çam, Türkiye** Afrika'nın Gelişmesine Yönelik Sağlık Alanında TİKA'nın Faaliyetleri **Kerem Kınık, Dr, Türkiye** Afrika'da Sağlık Hizmeti ve Kızılay **Bülent Yıldırım, Türkiye** İHH Perspektifinden Afrika Deneyimleri ve Sorun Alanları **Yahyahan Güney, Dr, Türkiye** Gönüllü Organizasyonlardan Profesyonel STK Olmaya Giden Süreç: Zorluklar ve Tercihler **Mehmet Cengiz, Türkiye** Deniz Feneri Yardım Modeli, Süreçleri ve Sürdürülebilirlik
B Salonu	
14:00-15:30	Oturum-B1 **Afrika'da Temel Sağlık Problemleri: Hastalıklar ve Salgınlar** **Arif Kaygusuz, Prof Dr, Türkiye** Oturum Başkanı **Magid Kagimu, Prof Dr, Uganda** Afrika'da HIV'den Korunmak için Dindarlık: Az bilinen, Az Desteklenen, Az Kullanılan ama Ciddi Potansiyele Sahip bir Müdahale İmkanı **Mustafa İdris Elbashir, Prof Dr, Sudan** Sıtma Bağlamında Afrika'da Endemik Hastalıkların Sosyo-Ekonomik Yükü **Mamoun Homeida, Prof Dr, Sudan** Afrika Onchocerciasis Kontrolü Programından Göz Ardı Edilen Tropik Hastalıkların Ortadan Kaldırılmasına Doğru Dönüşüm **Nazir İsmail, Dr, Güney Afrika** Afrika'da Verem: Zorluklar ve Fırsatlar
15:30-15:45	Kahve Arası
15:45-17:00	Oturum-B2 **Afrika'da Temel Sağlık Problemleri: Politika, Alt Yapı, İnsan, Hizmet ve Finans** **Mustafa Taşdemir, Prof Dr, Türkiye** Oturum Başkanı

Mamoun Homeida, Prof Dr, Sudan
Afrika'daki Sağlık Problemleri ve Bunlarla Mücadele
Muna Abdel Aziz, Dr, İngiltere
Sudan Sağlık Sisteminin Öne Çıkan Yanları ve Alınan Dersler
Victor Sullay Kamara, Dr, Türkiye
Yoksulluğun Sierra Leone Sağlık Alanına Etkileri ve Bu Alandaki Fırsatlar
Albert Mbonerane, Burundi
Burundi'de Yoksulluk Sonucu Sıtma Ölümleri ve Buna Karşı Birlikte Mücadele
Handan Ankaralı, Prof Dr, Türkiye
Kampala'da Sosyodemografik Özellikler, Bazı Hastalıkların Görülme Sıklığı, Yaşam Doyum Düzeyi ve Bunlarla İlgili Diğer Faktörler

17:00-17:30	Kahve Arası
17:30-19:00	Oturum-B3 **Sağlık ve Etik** **İlhan İlkılıç, Prof Dr, Türkiye** Oturum Başkanı **Aasim I. Padela, Doç Dr, Amerika BD** Sosyal Sorumluluk ve Devletin Sağlık Hizmeti Sağlama Yükümlülüğü: İslami Hukuksal-Etik Açıdan Bakış **Alireza Bagheri, MD, PhD, İran** Gelişmekte Olan Ülkelerde Dış Sponsorlu Araştırmalarda Etik Meseleler **Ayesha Ahmad, PhD, İngiltere** Ebola Salgınında Kültürü Farketmek **Arzoo Ahmed, İngiltere** Dil ve Otorite: Afrika'da Sağlık ve Din Etkileşiminde Etik Zorluklar **Syaefudin Ali Akhmad, Dr, Endonezya** Afrika'da Sağlık Meseleleri: İslami Bioetik Perspektif

C Salonu

14:00-15:30	Oturum-C1 **Afrika ve Türkiye** **Handan Ankaralı, Prof Dr, Türkiye** Oturum Başkanı **İsmail Ermağan, Doç Dr, Türkiye** Dünya Politikasında Afrika ve Türkiye'deki Afrika Çalışmaları Literatürü **Radouan Yousfi, Türkiye** Bir Yumuşak Güç Politikası Olarak Türkiye'nin Afrika'da Sağlık Diplomasisi

	Aslıgül Sarıkamış, PhD, Dr, Türkiye Türkiye'nin Sahra Altı Afrika'da Alışılmadık Bir Yardım Bağışçısı Olarak Yükselişi **Serhat Onur, Dr, Türkiye** Türk Gönüllülerinin Nijer'deki Sağlık Faaliyetleri **Semih Dinçer Yetiş, Dr, Türkiye** Nijer'deki Doğum ve Çocuk Hastanesi Yenileme Projesi
15:30-15:45	Kahve Arası
15:45-17:00	Oturum-C2 **Afrika'da Sağlık Eğitimi** **Najeeb Rahman, Dr, İngiltere** Oturum Başkanı **Kamada Lwere, Dr, Uganda** Afrika'da Sağlık Meslekleri ve Tıp Eğitimi: Benzerlikler-Farklılıklar **Serhat Onur, Dr, Türkiye** Eğitim ve Afrika'da Sünnet Problemi **Dalila Roslan, Dr, Malezya** Okullarda Cinsel Sağlık ve Üreme Sağlığı Eğitiminin Uygulanmasına İlişkin Bir Değerlendirme: Malezya Deneyimi **Neşet Köksal, Prof Dr, Türkiye** Nijer-Agadez'de Laparoskopik Kolesistektomi Eğitimi **Afolabi Joseph Fasoranti, PhD, Nijerya** Nijerya-Lagos'ta Akciğer Tüberkülozlu Hastalarda Tedaviye Sağlık Eğitiminin Etkileri **Aisha Nazziwa, Dr, Uganda** Uganda İslam Üniversitesi Habib Tıp Fakültesi'nde Eğitim Ortamının Değerlendirilmesi **Orhan Alimoğlu, Prof Dr, Türkiye** Sahra Altı Afrika'da Cerrahi Yayınların Değerlendirilmesi
17:00-17:30	Kahve Arası
17:30-19:00	Oturum-C3 **Afrika'da Salgın ve Hastalık Analizleri** **İlker İnanç Balkan, Doç Dr, Türkiye** Oturum Başkanı **Azlan Helmy Abd Samat, Dr, Malezya** # Msiaendsdengue Modeli; Dang Humması Salgınının Durdurulmasında STK'lar ve Akademinin Özgün İşbirliği: Malezya'dan Afrika'ya Yönelik Dersler

Myers Lugemwa, Dr, Uganda
Kuzey Uganda'daki Sıtma Salgını Gerçekten Bir Epidemi mi Yoksa Yeniden Bir Canlanış mıdır? Müdahale Seçenekleri, Zorluklar, Yapılması Gerekenler
Alain Rakotoarisoa, Dr, Madagaskar
Madagaskar Endemik Bölgesi Tsiroanomandidy'de Bubonic Veba Salgını; Ekim 2014 Araştırması
Endalamaw Gadisa, Dr, Etiyopya
Etiyopyalı Visceral Leishmaniasis Hastalarının Sodyum Stibogluconate İle Tedavisinin Ardından Klinik Tedavinin Serolojik İzleri
Hassan Ashmawy, Dr, Zimbabwe
Tunica Vaginalis Serbest Gref Üretroplastisi: 10 Yıllık Deneyim
Orhan Alimoğlu, Prof Dr, Türkiye
Sahra Altı Afrika'da Cerrahi Hastalıklar Bir Halk Sağlığı Sorunu mudur ?
Fathia Mohamed Nour, Dr, Somali
Borama-Somaliland Şeyh-Osman Topluluğunda Kardiovasküler Hastalık Risk Faktörlerinin Görülme Sıklığı

21 Temmuz 2017

A Salonu

09:00-10:15 Oturum-A4
FIMA ve Afrika Sağlık Projeleri
Akif Kaygusuz, Prof Dr, Türkiye
Oturum Başkanı
İbrahim Sule Babaminin, Dr, Nijerya
FIMA SAVE DIGNITY Projesi: Nijerya IMA Deneyimi
Parvaiz Malik, Dr, Amerika BD
Afrika'da FIMA SAVE SMILE Projesi
Misbahul Aziz, Prof Dr, Pakistan
Afrika'da Körlük ve FIMA SAVE VISION Projesinin Rolü

10:15-11:30 Oturum-A5
Modernleşme ve Afrika Sağlığı'na Etkileri
M İnanç Özekmekçi, Yrd Doç Dr, Türkiye
Oturum Başkanı
Omar Hasan Kasule, Prof Dr, Suudi Arabistan
Modern Tıp İslam Tıbbından Ne Öğrenebilir? 1995'ten Günümüze Güneydoğu Asya'da İslami Tıp Müfredatı Deneyimi

	Aly A Misha'l, Prof Dr, Ürdün Modern Dünyanın Sağlık Problemlerinde Batılı Paradigmalar Neden Yetersiz Kalıyor? **Zeynep Demirci, Ar Gör, Türkiye** Modernleşme Bağlamında Afrilka'da Geleneksel Tıp Uygulamaları: Togo Örneği **Samuel Antwi Baffour, Dr, Gana** Afrika'da Geleneksel Tıp Uygulamaları- Modernleşme, Küreselleşme ve Kabul Etme Sorunları
11:30-11:45	Kahve Arası
11:45-13:00	Oturum-A6 **Afrika ve Yardıma Bağımlılık Sarmalı** **Orhan Alimoğlu, Prof Dr, Türkiye** Oturum Başkanı **Firoz Osman, Dr, Güney Afrika** İnsani Yardım Aldatmacası **Maurice N Amutabi, Prof Dr, Kenya** Afrika'nın Gelişmesinde STK Paradoksu ve Sağlık Hizmetleri **Musa Kulaklıkaya, Büyükelçi, Türkiye** Afrika ve Yardım Bağımlılığı **Obijiofor Aginam, Prof Dr, Malezya** Afrika, Yardım Bağımlılığı ve Halk Sağlığının Küreselleşmesi: Güney-Güney İşbirliğinin Sundukları ve Sınırları
13:30-14:15	Yemek Arası
14:15-15:30	Oturum-A7 **Afrika'da Bağımlılıklar ve Bağımlılıkla Mücadele** **Mahmut Gümüş, Prof Dr, Türkiye** Oturum Başkanı **M İhsan Karaman, Prof Dr, Türkiye** FIMA Bağımlılık Çalışma Grubu ve Uluslararası Yeşilaylar Federasyonu **Osman Abdi Omar, Dr, Somali** Bağımlılığın Somali'deki Etkileri **Abdrahmane Diabate , Mali** Mali'de Altın Madenlerinde ve Yollarda Uyuşturucu Kaçakçılığı ve Tüketimi
B Salonu	
09:00-10:15	Oturum-B4 **Tıp Eğitiminde Öğrenci Değişimleri Çözümü** **Alper Cihan, Prof Dr, Türkiye** Oturum Başkanı

Orhan Alimoğlu, Prof Dr, Türkiye
Afrika'da Mezuniyet Sonrası Tıp Eğitimi
Mehmet Köse, Dr, Türkiye
Türkiye'nin Uluslararası Öğrenci Politikası Kapsamında Sağlık Eğitimi
Zahra Ali, Dr, Kenya
Türkiye'de Tıp Fakültelerinde Okuyan Afrikalı Öğrencilerin Karşılaştıkları Zorluklar

10:15-11:30 Oturum-B5
Afrika'da Sağlık Meslekleri ve Tıp Eğitimi: Mevcut Durum, Problemler ve Gelecek
Cevdet Erdöl, Prof Dr, Türkiye
Oturum Başkanı
Ammar Eltahir Mohamed Ahmed, Prof Dr, Sudan
Tıp Okulları Tarafından Kabul Edilebilir Sosyal Sorumluluk Standartları İçin Öneriler
Abdirisak Ahmed Dalmar, Prof Dr, Somali
Somali'de Savaş Sonrası Dönemde Sağlık Sisteminin Yeniden Kurulması Bağlamında Sağlıkta İnsan Kaynakları
Ahmad Kawesa Sengendo, Prof Dr, Uganda
Afrika'nın Hasta Sağlık Sektörünü İyileştirmede Üniversitelerin Rolü
Kasonde Bowa, Prof Dr, Zambia
Afrika'da Sağlık Çalışanlarında Beyin Göçü: Zambia Örneği

11:30-11:45 Kahve Arası

11:45-13:00 Oturum-B6
Afrika'da Sağlık Politikaları ve Organizasyonu
Mahomed Khan, Dr, Güney Afrika
Oturum Başkanı
Sarah Opendi, Uganda Sağlık Bakanı
Afrika'da Sağlığın Sosyal Belirleyicileri
Mario J Azevedo, Prof Dr, Amerika BD
Afrika'nın Hastalıkların Çifte Külfetine Çözüm Arayışı
Omoje Uchenna Kelvin, Dr, Nijerya
Nijerya'da Sağlık Hizmetleri Organizasyonu: Afrika'daki Sorunlara Bir Çare mi?
Bashir İssak, Dr, Kenya
Kenya'da Anne Sağlığı ve UNFPA: Yüksek Anne Ölümü Oranı Olan Ülkelerdeki Zorluklarla Mücadeleye Katkı

13:30-14:15 Yemek

14:15-15:30 Oturum-B7

Afrika Sağlıkta Başarılar ve Hedefler

Ali İhsan Taşçı, Prof Dr, Türkiye

Oturum Başkanı

Jibrill Mulongo Kasongo, Dr, Kongo DC

Afrika'da Sağlık İçin Ortaklıkların Başarı Öyküsü: Kongo Dem. Cumhuriyeti'nde Düzenlenen Sünnet Projesi Olayı

Apostolos Veizis, Dr, Yunanistan

Sınır Tanımayan Doktorlar Örgütü ve HIV/AIDS: Daha Fazla Başarı Öyküsü İhtiyacı

Saadet Lale Tarım, Öğr Gör, Türkiye

Bir Afrika Ülkesinde Üniversite Olarak Sağlık Eğitimi Deneyimi: Mogadişu-Somali Sağlık Bilimleri Üniversitesi Recep Tayyip Erdoğan Sağlık Hizmeleri Meslek Yüksekokulu

Hafeez Ur Rahman, Prof Dr, Pakistan

Doğu Afrika'da Sağlık İşgücü Açığı Sorununa Çözüm Önerileri: Hargesia-Somaliland'da Oftalmoloji Alanında Uzmanlığa Yönelik Çok Taraflı İşbirliğine Dayalı Yüksek Lisans Programları

C Salonu

09:00-10:15 Oturum-C4

Afrika'da Sağlık ve Küreselleşme-Göç-Modernleşme

Murteza Bedir, Prof Dr, Türkiye

Oturum Başkanı

İsmail Ermağan, Doç Dr, Türkiye

Çin'in Afrika Politikası: Afrika'da Sağlık Yatırımları ve Afrika'daki Sağlık Sorunları

Jean Philippe Têtê Gunn, Türkiye

Küreselleşme Mücadelesinde Afrika Kıtası: Hangi Memnuniyeti?

Francisco Jose Lopes Junior, Türkiye

Afrika'da Sağlık Sektörünün Gelişmesinde Bir Engel Olarak Beyin Göçü

Ahmad Yusuf Yahaya, Dr, Malezya

Malezya'daki Rohingya Mültecilerine Yönelik Tıbbi Hizmetleri: Afrika İle Deneyim Paylaşımı

Abdelhek Dahman, Türkiye

Afrika'da Sınır Tanımayan Doktorlar Örgütü: Gerçekler ve Bakış Açıları

İlknur Çelikel, Türkiye

Afrika'ya Yönelik Yardım Kampanyaları: İnsani İletişim Etiği İkilemi

10:15-11:30	Oturum-C5 **Afrika'da Sağlığa İlişkin Farklı Problemler** **Mustafa Kanat, Doç Dr, Türkiye** Oturum Başkanı **Tajudeen Abiola, Dr, Nijerya** Psikoaktif Madde Kullanımından Dolayı Damgalanma: Sosyo-Demografik Bağıntılar **Memduh Gezici, Prof Dr, Türkiye** Afrika'da Uygulanan "Kadın Sünneti"nde Sosyolojik Neden Sonuç İlişkileri **Memduh Gezici, Prof Dr, Türkiye** Kadın Sünnetinin ve Zararlı Sonuçlarının Önlenmesine İlişkin Alınması Gereken Tedbirler **Hacer Ataman, Yrd Doç, Türkiye** Afrika Bölgesinin Adolesan Sağlık Analizi **Serhat Onur, Dr, Türkiye** Sahra Altı Afrika'da Sağlık ve Beslenme Sorunları **Fatah Mokhtar Terbouk, Dr, Cezayir** Demir Eksikliği: Afrika'da Beslenmeye İlişkin Büyük Sorun **İbrahim Adekunle Oreagba, Doç Dr, Nijerya** Lagos-Nijerya'da Erişkin Hastalarda Antiretroviral Terapide Potansiyel İlaç ve İlaç Etkileşiminin Görülme Sıklığı
11:30-11:45	Kahve Arası
11:45-13:00	Oturum-C6 **Afrika'da Anne Çocuk Sağlığı** **Fahri Ovalı, Prof Dr, Türkiye** Oturum Başkanı **Olivier Mukuku, Dr, Kongo DC** Gelişmekte Olan Ülkelerde 5 Yaş Altı Çocuklarda Şiddetli Akut Malnutrisyon Tahmini Skoru **Laila Acharai, Dr, Fas** Fas'ta Yenidoğan Konjenital Hipotiroidi Tarama Ulusal Programı: Mevcut Durum ve Beklentiler **Türkan Günay, Prof Dr, Türkiye** Uganda'da Bebeklerde Ek Gıda Takviyesine Zamanından Önce Başlanması Durumu ve Bunun Etkileri **Olivier Mukuku, Dr, Kongo DC** Kongo Demokratik Cumhuriyeti-Lubumbashi'de Düşük Doğum Ağırlığına İlişkin Riskler **Özlem Eskil Çiçek, Dr, Türkiye** WHO Afrika Bölgesi'nde Anne Ölümlerine İlişkin Faktörler

13:30-14:15	Yemek Arası
14:15-15:30	Oturum-C7 **Afrika'da Sağlık İşgücü** **Alpertunga Kara, Yrd Doç Dr, Türkiye** **Ebuzer Aydın, Yrd Doç Dr, Türkiye** Oturum Başkanı **Abdelhakim Yahyane, Dr, Fas** Fas'taki Sağlık Çalışanlarının Magnezyum Sülfat Kullanımının Önündeki Engellere Dair Bir Araştırma **Abdirizak Yussuf Abdillahi, Dr, Somali** Somaliland'da Sağlık İşgücü Açığı: Zorluklar ve Yapılması Gerekenler **Edwin Sosthenes, Türkiye** Somali'de Sağlık İşgücü: Politika Analizi **Yasemin Akbulut, Doç Dr, Türkiye** Sağlık Alanında Özel Sektör Kamu Ortaklığı: Afrika'ya İlişkin Bir Swot Analizi **Pascal Soroheye, Benin** Biomedikal Envanterlerin Kullanışlılığı: Benin Örneği **Cherifa Sururu, Dr, Güney Afrika** Zimbabwe'de Aile Hekimliğinin Uygulanmaya Başlanmasına Yönelik Temel Paydaşların Görüşleri: Kalitatif Bir Çalışma
A-B-C Salonu	
15:30-16:45	Oturum-A8 **Problemlerle Mücadelede Yeni Stratejiler Mümkün mü?** **Sabahattin Aydın, Prof Dr, Türkiye** Oturum Başkanı **Naser Haghamed, Dr, İngiltere** Acil Yardımdan Topluluğun Bütünleşik Geliştirilmesine- Sağlığa Holistik Yaklaşımın Faydaları **Ali Doğan, Türkiye** Kısa Dönemli Tıbbi Görevlerin Performansına İlişkin Bir Regresyon Modeli Tanımı: Yeryüzü Doktorları Vaka Çalışmaları **Mehmet Özkan, Doç Dr, Türkiye** Değişen/Dönüşen Dünyada Afrika Ne Kadar Aktör? **Ahmad Munawwar Helmi Salim, Dr, Malezya** Safewhere İnisiyatifi- Kırsal Bölgelerde Temiz İçme Suyu Sorunlarına Malezya Çözümü: Pilot Uygulama **Musa Mohd Nordin, Doç Dr, Malezya** Afrika'da Herkes için Aşılama
16:45-17:15	Kahve Arası

17:15-18:00	Kapanış Oturumu **Hakan Ertin, Doç Dr, Türkiye** Oturum Başkanı **Hussein A R Gezairy, Prof Dr, Suudi Arabistan** Afrika'da Sağlık

ABSTRACTS

34th FIMA Scientific Congress

Congress on Health in Africa

20-21 July 2017 - İstanbul Türkiye

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WOW Convention Center - İstanbul Türkiye

July 20, 2017

14:00-15:30 Session-A1

A Multi-Faceted Approach to the Ottoman/Turkish-African Relations

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The interpretation of mutual relations between Ottoman Empire and Africa as an expansion of one of the dominant powers of the period into new territories would be inappropriate. It is known that in the period when the surroundings of Africa were embraced by the Europeans to annihilate themselves and helpless to repel the colonies, the bases of the first Ottoman-African relations were laid down with the positive answer given by Istanbul to the aid demands of the north and eastern communities of the African continent. Since the colonies were considered as the first immense strike and they attacked the region with all their forces, the activity was established and continued with the maritime and land wars made with numerous navies that were called to stop it. The atmosphere of confidence in the region, including the loss of the Muslim majority in the Andalusia and the resettlement of millions of people in North Africa, continued to expand until the end of the 20th century, sometimes to the halfway point of the continent, and sometimes to only one area. The Ottomans saw a great deal of loyalty to their own values and their possessions of the Ottomans, while in the same way they were shared with them in the same way as their own. Turkey-Africa relations are so multi-dimensional not to be explained merely by military and political interventions. As a matter of course, when this exemplary situation is examined with all details including socio-cultural, financial, religious, military and political aspects, more of its unknown aspects would be shed light on and become more revealing.

Keywords: Ottoman-African Relations, Turkey-African Relations, Turkish Foreign Policy

New Period for the Turkish-African Diplomatic Relationship

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Africa is undergoing immense change. The positive transformation is fueled by the hard work, resilience and perseverance of Africans young and old who are determined to turn the page of poverty. We have every reason to believe that Africa's future looks promising. In fact, we can see the positive momentum reflected through reduced geopolitical risks, sustained stability, economic growth, expanding trade, enhanced welfare and better living conditions across the Continent. Challenges to peace and security still exist. But they can certainly be overcome.

As we look to the future, Turkey is determined more than ever to extend its cooperation with Africa to new domains. We are seeking to develop mutually beneficial partnerships that will assist in building a solid foundation for relations that are long lasting and productive. Unlike past colonial powers history is on our side. On the one hand there is the human element. Turkey has deep rooted historical and cultural ties with the Continent dating back to the Ottoman Empire. We are also looking to build on the human element by encouraging people to people contacts.

Keywords: Turkish-African Diplomacy, Cooperation, Partnerships

15:45-17:00 Session-A2

International Health Policies of Turkey and Africa

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As it is a historical responsibility of civilizations as well as a duty for our common future; needs of African people constitute one of the main pillars of Turkey's foreign policy and developmental aid approach. Moreover, Turkey has implemented a successful health transformation program since 2003 thereby supporting to reform health systems around the world through sharing experience and expertising from the planning to the implementation.

Obtaining concrete results on the culture of operating together with the African countries, Turkey has signed international health agreements with around 20 African countries, located its developmental aid offices in 37 different regions across the continent, hosted several events of international organizations such as UN World Humanitarian Summit, and backboned the policy for development of Africa in different international fora, just like G20 Summits.

Against that background, there are several issues on the field needed to be identified showing the helping hand to the African people. Building and modernizing hospitals, health screening campaigns, specialized treatments to local people, and vocational trainings for the developing countries can be regarded as the programs of Turkey have had in the area for health cooperation across the continent.

Consequently, Turkey's health cooperation with African countries has wide and deep aspects. The roots of this policy come from Turkish humanitarian diplomacy and 'human is the first' approach under the phenomenon of 'leaving no one behind'. The efforts also continue in striving to achieve Sustainable Development Goals which will increase steadily and expand exceedingly. In this regard, to the extent of which international development policies have been programmed, the value of human-first approach is the vital norm for health cooperation.

Keywords: Turkey, Africa, Cooperation

The Field Experiences in Sudan and Somalia

Ali Kalyoncu

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Cooperation in health is needed to achieve the Sustainable Development Goals, particularly for ensuring healthier lives and well-being at all ages; case studies can be seen as proper attempts to discuss the policy implementations whether they meet the expected outcomes or enhanced limited progress. Along with an analysis of the current situation of policy implementations, the casualty connections ensure both understanding the mismatches between the planned and the realised, and also facilitating then extpolicy development process.

There will be a comparative analysis of two hospitals of which financed by Turkey as a development assistance in order to exemplify the different angles of responding what to do, why to do, how to do questions.

The main area of discussion will be taken place between the Nyala Turkish-Sudanese Research and Training Hospital which has been service since February/2014, the Recep Tayyip Erdoğan Hospital (Digfer) which started to operate since 2015. They have different characteristics, obviously; however, the approach of Turkish development assistance is constant relying on the immense experience of implementing a successful health transformation programme for 14 years.

Keywords: NyalaTurkishSudaneseHospital, Recep Tayyip Erdoğan Hospital, Turkish Development Assistance

International Patient Policy Implementations

Nurullah Okumuş

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It is considered that today, approximately 30 million people traveltoothercountries in ordertoreceivehealthcareservices. The most important reasons for this growth in international patient traffic are: the absence of required health services in thegivencountry, long waiting periods or high costsfortheservicesoffered.

Interms of 'International Patient Practices', Turkey has an important geographical position addressingabout 1.5 billion people and 57 countries at the 4-hour flightdistance. Besides the fact that most patients come from the neighboring countries, people from

the African continent, Americaand Europe alsorequesthealthservicesfromTurkey.

In addition to the high level of specialized human resources, especially in the field of medicine, Turkey is a shining star in the world with its geographical structure, seasonal advantages, high quality health care services, technological and medical equipment in world standards, favorable price advantage upto 60% in comparison with Europe, top rated thermal underground resources, young and dynamic population compared to the rapidly growing elderly population in the world, combined with traditional Turkish hospitality.

Keywords: International PatientPractices, International PatientTrafffic, Turkey

Possible Collaboration Areas in Medicine, Medical Devices and Cosmetics

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Turkish Medicine and Medical Devices Agency is an authority that carries on its activities by closely following all the scientific developments in the world to safely convey medicine, medical device and cosmetics to Turkish people for more than 70 years. The first medical legislation came into effect in 1928 and in the ongoing process our medical authority has leaded private sector in all the fields we regulate.

The Agency is pleased to share this experience that it gained as a regulatory, supervisory and guiding authority with all the fellow countries in order to make contribution to their access to effective and safe products. Within this context, we offer training programs prepared by our Agency to our fellow countries that we will cover the expenses of the participants. The first one of these trainings will be organized with East African Countries and we are ready for solidarity and cooperation with our friends on the continent for a common future.

Keywords: Turkish Medicine and Devices Agency, Collaboration Areas, Turkey and Africa

17:30-19:00 Session-A3

Activities of TİKA in Health Sector for the Development of Africa ??????????????

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According to the United Nations reports, more than 6 million children still die before their fifth birthday each year. Only half of women in developing regions receive the recommended amount of health care they need. Over 6.2 million malaria deaths have been averted between 2000 and 2015, primarily of children under five years of age in sub-Saharan Africa.

Access to health services continue to be one of the major issues of the global development agenda. "Good Health and Well-being", the Goal 3 of Sustainable Development Goals, aims at ensuring healthy lives and promoting well-being for all at all ages. In compliance with the global agenda, TİKA, the official technical cooperation and development agency of Turkey, carries out health projects in nearly 170 countries with his 58 country offices. Particularly, African countries and terror victim geographies take the priority for strengthening health infrastructures.

To make health systems function properly, health projects of TİKA cover many areas including construction of hospitals, laboratories and clinics, technical equipment, training programs for health personnel, medical treatments and surgeries such as cataract and cleft lift disease.

Acting in close cooperation with non-governmental organizations and partner countries, TİKA fundamentally attaches importance to the capacity building and improving the quality of health sector in African countries, as in other geographies.

Panel presentation of TİKA mainly intends to share his experience with country specific cases and to discuss for new opportunities in order to improve the quality of health sector in Africa.

Keywords: Capacity building, Inclusive Access to Health Services, Experience Sharing and Close Cooperation, Terror Victim Geographies and Least Developed Countries

Healthcare in Africa and the Turkish Red Crescent (Kızılay)

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The last ten years have been particularly challenging for the International Humanitarian Community with mounting devastating natural and man-made humanitarian crises

across the globe. According to UNHCR data, 65.3 million people are forcibly displaced and there are 21.3 million refugees all over the world, which is the highest number since the World War II. Millions of people are suffering from migration, armed conflict, natural disasters, droughts, famines and other humanitarian crises.

Turkish Red Crescent Society (KIZILAY), a 149-year-old humanitarian organization and a strong member of the International Red Cross and Red Crescent Movement, is an important global actor and often the first responder to disasters globally. Over the last decade, the TRC has provided humanitarian assistance in multiple sectors in 137 countries including many African countries.

Healthcare services for all are vital to the growth and prosperity of Africa. Africa has one of the fastest growing economies but it also has the highest disease burden in the world.

By the Strategic Plan of 2015-20 of KIZILAY, a road map has been drawn for public health sector, including African's. According to the Plan, fulfilling human rights in accessing life-saving and essential health care, HIV prevention, protection and treatment, reproductive health services, food security and nutrition, water, sanitation and hygiene services – WASH are the top priorities of KIZILAY

Keywords: Turkish Red Crescent, Humanitarian Aid, Africa

Experiences in Africa and Problems in the Field from the Perspective of IHH Humanitarian Relief Foundatiton

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Conducting humanitarian aid projects in Africa for 20 years, IHH Humanitarian Relief Foundation is carrying out its efforts within the perspective of brotherhood. IHH's activities in Africa can be gathered under two main categories. The first one is emergent humanitarian aids when needed due to drought, internal war and etc. And the second category can be called as permanent developmentary aid projects such as building up orphanages, schools, hospitals, clinics and mosques. However, as like other humanitarian aid foundations IHH also encounters with some certain problems. In this presentation, we will underline these problematic fields and suggest possible solution ways.

Keywords: IHH, Humanitarian Aid, Africa

The Process of Evolution from Voluntary Based Organizations to Professional Non-Governmental Organization

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Aim: Our aim is to describe process of evolution nongovernmental organizations in context of general governing structures and operational models, based on literature review and experiences of Doctors Worldwide Turkey (DWWT), and highlight factors those trigger this process.

Methodology: The study was conducted in three phases: 1) Reviewing literature about general governing structure and operation models of nongovernmental organizations (NGO) 2) Making a survey with DWWT board members and staff under supervision of an experts 3) Determining the key factors that lead NGOs to change.

Results: Undoubtedly, there is a need for community based NGOs. For example in Turkey, there is more than 90.000 associations and more than 4.000 foundations which are small organizations. But in communities where these organizations based, they operate they contribute immensely. However, when abroad missions are concerned, there is merely 100 of these organizations are capable. Although some local call for help is unanswered because of organizational myopia, primary advantages of these organizations are their competence and institutional memory.

Conclusion and Discussion: There are three distinct types of authority which are charismatic, traditional and legal-rational. Each of them corresponds to a brand of leadership that is operative in contemporary society. In many societies, NGOs are initially formed around community charities that share similar values and the stereotypical founder is usually possesses either a charismatic or a traditional authority. The operational model of this type of NGOs revolves around their founding figures. But when NGOs grow their social capital also grow, so, importance of transition from part time, voluntary based friend circle to a more professionally organized structure become paramount. If this transitional process is postponed, problems stemming from new conjuncture become more complicated to tackle. It is suggested that the required steps must be taken if the sustainable growth wanted to achieve.

Keywords: Doctors Worldwide Turkey, Non-Governmental Organization, Performance Evaluation, Sustainability, Voluntary Management

Deniz Feneri Association and Humanitarian Aid Models, Processes and Sustainability

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Deniz Feneri Association is an international NGO aimed to serve humanity in the field of humanitarian issues based on a system focusing on productivity, transmission, sharing, distribution, and surveillance with respect to efficiency and security. Within this scope Deniz Feneri is the first NGO who has ISO Quality Certificate. In doing so, it has aimed to produce better quality in its projects and activities. Deniz Feneri uses a software program called "Yardım Organizasyon Programı" developed by the association itself to register and record every step of any activity of the humanitarian project. This means any aid given to persons or to other institutions in kind and cash can be traced back in the system. All items in kind received by Deniz Feneri logistics are segregated, counted, and made barcoded which allows it to be accountable and transparent.

Aid processes start with the application supported by some documents. The related department inspects the demand, a report is issued, then submitted to the aid assessment committee which will decide if the aid is appropriate -all based on objective criteria which rely on the social investigation report. Deniz Feneri's activities are subject to five different inspections; a) internal auditing, b) the biannual inspection made by Minister of Interior Affairs, c) ISO inspection, d) external auditing, e) inspection by donors and volunteers. These steps are aimed to keep the system accountable, transparent and sustainable.

Deniz Feneri is consistently aiming to strengthen its departments, to make its projects more productive, and aims to keep the public, its donors, and volunteers, both local and abroad, informed through the use of its website, social media, and call center both local and abroad.

Keywords: Deniz Feneri Association, Humanitarian Aid, NGO

14:00-15:30 Session-B1

Religiosity for HIV Prevention in Africa: An Under Recognised, Under Supported and Under Utilized Intervention with Enormous Potential

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Background: HIV/AIDS is still a major health problem in Africa. The major religions in Africa are Islam and Christianity. These religions have teachings that encourage their followers to

adhere to behaviors that are likely to prevent transmission of HIV infections. These behaviors include abstaining from sex before marriage, being faithful in marriage and avoiding intoxicants. If religiosity is increased with individuals and communities, adhering to these faith teachings, this is likely to reduce new HIV infections.

Objective: To assess the association between religiosity and HIV infections

Methods: Muslim and Christian youth, 15-24 years old, in a community in Uganda were interviewed to assess their level of religiosity. They were then tested for HIV infections.

Results: Muslim and Christian youth with higher levels of religiosity had significantly lower rates of HIV infections compared to those with lower levels of religiosity. The youth with higher levels of religiosity were significantly more likely to abstain from sex and avoid taking alcohol and using narcotics for recreation.

Conclusion: Increasing the level of religiosity in individuals and communities has a great potential to reduce new HIV infections.

Recommendations: Religiosity for HIV prevention is an under recognized, under supported and underutilized intervention in Africa. Religious leaders and their assistants in Africa should be supported to provide reminders to individuals and communities to adhere to their faith teachings that promote HIV prevention. These reminders should include sustained interpersonal as well as mass media education campaigns on a large national scale. National and international partners seeking to improve health in Africa should support this behavioral intervention which has an enormous potential to promote the health of the people in Africa.

Keywords: HIV Prevention, Africa, Religiosity

Socioeconomic Burden of Endemic Diseases in Africa with Emphasis on Malaria

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In resource-poor settings, as the case in most African countries, illness imposes high social and economic burdens on the patients and their families. The major endemic diseases in Africa include Malaria, Human Immune Deficiency Syndrome (HIV/AIDS), Tuberculosis, Leishmaniasis, Trypansomiasis, dengue, Rabies, Diarrhoeal diseases, Helminth: Cysticercosis/Taeniasis, Dracunculiasis –Echinococcosis, Lymphatic filariasis, Onchocerciasis, Schistosomiasis, Ascariasis, Trichuriasis, Hookworm disease, Leprosy, Trachoma, Mycetoma…. Endemic diseases in addition to the challenge they pose on household spending, they are major impediments of economic productivity ensuing from long-term illness and

disability related serious morbidity and high mortality. In sub-Saharan Africa, where we have the main malaria burden, the number one killer parasitic disease, 25–40% of all outpatient clinic visits are for malaria, and between 20% and 50% of all hospital admissions are a consequence of malaria, and it causes at least one-fifth of all young child deaths in Africa. It has also been estimated that direct and indirect costs of illness for malaria are not less than 10% of the household income in average. Health service weaknesses; including low coverage, user charges, and poor quality of care, contribute to the high burden of these endemic diseases in Africa. In addition, late presentation, unavailability or stock-outs of effective drugs, parasite and vector resistance to most available cost-effective drugs, and political instability all contribute to the heavy socioeconomic burden of endemic diseases in Africa. There is urgent need for a substantial increase in health sector investment to expand access to preventive and curative health services including community-based interventions, large scale education and counseling. Both governmental and non-governmental, local and international, interventions should be broadened to encompass measures that reduce the burden of endemic diseases in Africa.

Keywords: Endemic Diseases, Malaria, Socioeconomic Burden

Transforming from African Programme of Onchocerciasis Control to Elimination of Neglected Tropical Diseases

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The donation of ivermectin (Mectizan®) for free as long as necessary in 1987 by Merck & Co. Inc. was a landmark in the history of public health. Ivermectin kills microfilaria in the skin and inhibits their release by female worms, reducing transmission of Onchocerca volvulus by Simulium vectors. To interrupt transmission, a minimum of 15 years annual treatment is required, the duration of life of adult worms. Ivermectin has only limited impact on adult onchocercaworms, but relieves pruritus (itching) and delays the progression of ocular morbidity that can lead to irreversible blindness, in addition to reducing transmission. Mobile teams were initially deployed to distribute ivermectin in the Onchocerciasis Control Programme (OCP) in West Africa as a supplement to vector control in 1988. The effectiveness ofivermectin as a microfilaricide led to the creation of the African Programme for Onchocerciasis Control (APOC) in 1995, targeting disease control in 20 endemic African countries not included in the OCP. APOC's success has been built on the development of community-directed treatment with ivermectin, an approach that shifts responsibility of drug delivery from the health system to distributors selected by the community, who collect the drugs from the health service and decide on the time they would distribute drugs to their community. This is a sustainable approach, with successful coverage maintained over periods as long as 20 years, a key issue in the context of the endgame.

The African Programme for Onchocerciasis Control formally ended in December 2015 [11], but the Expanded Special Project for elimination of Neglected Tropical Diseases (ESPN) is now building on its considerable achievements. In addition to working to eliminate onchocerciasis, this expanded programme is also focused on accelerating the reduction and elimination of other NTDs from the African Region by 2020, namely lymphatic filariasis, schistosomiasis, soil transmitted helminthiases and trachoma.

The medicines are now available for all the diseases target by ESPN, the knowledge and the will to end the burden of these diseases are all available. However, a new sense of urgency, additional resources through a multilateral trust fund implemented by one fiscal agency, continued country commitment and regional coordination are needed to ensure that efforts are consistent and successful throughout the continent and lead to elimination and freedom from NTDs for future generations.

Keywords: Onchocerciasis, Neglected Tropical Diseases, African Programme for Onchocerciasis Control

Tuberculosis in Africa: Challenges and Opportunities

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Africa carries a disproportionate burden of tuberculosis with 2.6 of 9 million cases globally occurring on the continent. A major driver has been the uncontrolled increase in the number of human immunodeficiency virus (HIV) infections in the 1990s and early 2000s. TB-HIV co-infection occurs in 36% of cases and is above 50% in some sub-Saharan countries (SSA). Drug resistant TB is another major concern with almost all countries under reporting and of the cases reported the success rate is only 55%. Furthermore, of the 1.1 million TB deaths globally, 390 000 are estimated to have occurred in Africa. Despite the challenges seen, progress has been made with several initiatives gaining traction and making an impact. The large-scale roll-out of anti-retroviral therapy particularly in SSA is showing positive signs of reducing new TB cases annually. The use of a new rapid diagnostics has also gained momentum with 39 of 47 member states introducing the technology. These advances however are insufficient to achieve the World Health Organization's END TB targets for 2035. Missed cases remain a major obstacle with 42% of these cases globally occurring Africa. The underlying problem is the lack of diagnostic infrastructure and skills to reach the most needed cases early enough. This also leads to late presentation and poor outcomes despite highly effective first line treatment being available. Another challenge is the high loss to follow up rates with many diagnosed cases not returning for treatment leading to ongoing transmission. The reason for these losses is multifactorial including behavioural and socio-economic factors. Challenges in Africa are many but come with

excellent opportunities. Small improvements are likely to yield large benefits while applying strategic and targeted improvements to existing programs that have been setup over the past decade will be cost-effective with long lasting benefits.

Keywords: Tuberculosis, Africa, Fight against Tuberculosis

15:45-17:00 Session-B2

Health Problems in Africa and Fight Against Them

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As at 2015, the total population (1 186 178 in thousands) of the 58 countries of the African countries represents the 16.1% of the world populations (7 349 472 in thousands); however the population growth rate of the continent of 2.55% is more than the double of the world growth rate (1.18%). Concerning the life expectancy (a summary measure of mortality rates at all ages), in the overall, there was a global increase of 5.0 years between 2000 and 2015, with an even larger increase of 9.4 years observed in the WHO African Region. The combination of these two elements (high growth rate and increased life expectancy) could boot socio-economic development of the continent. Unfortunately this not the case as pointed out by the 2015 human development index (HDI). It ranged from 0.352 (Central African Republic, HDI rank 188) to 0.782 (Seychelles, HDI rank 63) with an average of 0.530 for 53 of the 58 countries continents Endemic diseases, epidemics and wars/conflicts with its consequences on disease transmission, education and nutrition and access to safe drinking water hinder the socio-economic development of the continent. In the framework of this conference, our contributions will be focus on (i) on the burdens eventeen neglected tropical diseases (NTDs); (ii) the strategies to control/eliminate them while providing safe water, sanitation and hygiene (WASH); and (iii) the public-private partnership for fighting the vast misery caused by these ancient diseases of poverty.

Keywords: Health Problems, Social Determinants of Health , Disease Burden

Highlights and Lessons Learnt from the Wider Health System in Sudan

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The traditional view of the health system according to the WHO health system building blocks focuses on healthcare and services. Meanwhile, there are greater opportunities in the wider policy system to improve health. An approach to 'health in all policies' covers

the wider determinants of health like education, transport infrastructure, agriculture and economy. In my talk, I will give examples of health in planning in the UK and Sudan, health in business, mobile health and digital innovations. Much of the deterioration in health and health care are actually the result of wider context changes in the economy and unintended consequences of policy decisions that did not consult widely with stakeholders.

I will make the case for setting up strategic development oversight at national and local levels to ensure that there is adequate impact assessment of policy and programme decisions. Tools for system leadership and collaboration are needed to arrive at locally responsive and appropriate solutions for each country and for local needs. There are win-win solutions that can be adopted now. Meanwhile, communities and decision makers need to maintain their own and community resilience when the right solutions can only arise from a win-lose scenario.

Keywords: Health Systems in Africa, Sudan Health System, Public Health

The Effect of Poverty and Opportunities in Sierra Leone's Health: Why Sierra Leone Health Sector is Poor?

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The 11 years civil war which started in 1991-2002. And from 2002-2007 Sierra Leone was under rehabilitation and clearing it government debts. From 2007-2013, the Sierra Leone government was able to clear it debts and building up its economic growth and strengthening it health sectors where some students had the opportunities to receive scholarship to pursue their health education both locally and internationally. In 2014-2015, the Ebola Virus Disease (EVD) struck Sierra Leone again where thousands of people including the most qualified doctors and nurses died.

"Life expectancy is 47 years, infant mortality rate is 89 per 1000 live births, under-five mortality rate is 140 per 1000 live births and maternal mortality ratio is 857 per 100 000 births" The majority of causes of illness and death, especially of children, in Sierra Leone are preventable with most deaths being attributable to nutritional deficiencies, pneumonia, diarrheal diseases, anemia, malaria, tuberculosis and HIV/AIDS. Malaria accounts for about 41% of all hospital deaths among children aged under 5 years.

Studying in abroad like in Turkey where medical learning do have greater advantages because of modern medical technology, friendly environment to do their studies, the better Africa medical health facilities will be improved and the high mortality rate, malnutrition. In Sierra Leone today, the health status of people is still among the worst in the world. Because poverty and unequal opportunity ungloved the chances of health education

Keywords: Poverty, Opportunities, Health and Sierra Leone.

In Burundi, the Poor People Die of Malaria. Act Together to Save Human Lives

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The Non Profit Association "Action for the fight against Malaria', A.LU. MA-Burundi, was founded in 2001 and accredited by the ministerial order No. 530/001 dated 02.01.2002. Since its foundation, it has carried out its mission which is to improve living conditions through the fight against malaria, a disease which remains the first public health threat. In Burundi, as in many other sub-Saharian countries, malaria remains the first cause of mortality and morbidity, the most affected groups being children under 5 years of age and pregnant women.

A.LU. MA-Burundi's work perfectly fits the two thrusts acknowledged the national protocol for the fight against malaria, i.e. prevention and adequate treatment.

Keywords: Burundi, Malaria, A.LU.MA

Sociodemographic Features, Prevalence of Some Diseases, Life Satisfaction and Related Factors in Kampala

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Aim: This study was to assess the sociodemographic structure, the frequencies of some diseases and the factors affecting satisfaction in life, in Kampala central region.

Materials-Methods: Adults (> 18 years) were voluntarily recruited for the study. Data were collected over 2 months (February to March, 2017) in this cross-sectional questionnaire survey. Face-to-face interview technique was used as the survey method. A questionnaire for sociodemographic information and disease distribution was prepared. A Life Satisfaction Questionnaire (LISAT-9), consisting of 9 questions, was used to assess participants' satisfaction with life. This questionnaire have likert type questions with six responses.

Results: In the study, a total of 117 volunteers who were 42.7% Muslim and 57.3% Christian.

60.5% of them were living in city center, and 86.3% were female. About 73% were between the ages of 18-40. 75% of adults were married. The unemployment rate was 53.1% which included housewives. The proportion of those who have five or fewer children is 85.5%. In addition, 82.8% of participants stated that they benefited at a low level from health services. Alcohol use rate was 8.5% and smoking rate was 0.9%. The ratio of illiterate persons was 8.7%, and the ratio of those who received university or higher education was 10.2%. The frequency of alcohol use, and the rate of living in the villages were significantly higher in Christians. There was at least one disease in which 40.9% of the participants were diagnosed The most common disease was malaria with a rate of 45.1%.This was followed by stomach complaints with 14.3% and hypertension with 9.9%.The frequency of the disease was not related to the sociodemographic characteristics taken into account in the study. When the answers to the life satisfaction scale were examined, it was seen that the participants had the best level of satisfaction with their friend relationships, relationships with acquaintances, their sexual lives, and business relations. Moreover, when we examine the relationship between the total score of the scale and the sociodemographic characteristics, it is seen that the satisfaction score of the married people, the city center residents and the Muslims is significantly higher.

Discussion and Conclusion: The two most important issues that negatively affect life satisfaction are economic situation and unemployment. It is unlikely to produce a general conclusion about the unemployment rate because the vast majority of participants are women. Belonging to Islamic religion, and living in the city center was associated with higher life satisfaction higher. It can therefore be concluded that individuals' religious beliefs affects life satisfaction, in addition getting women employed and therefore improving their economic situation will increase life satisfaction. As in many parts of the African continent, precautions must be taken to reduce Malaria frequency.

Keywords: Life satisfaction, Kampala, Prevalence of Diseases, Sociodemographic Features

17.30-19.00 Session-B3

Social Responsibility and the State's Duty to Provide Healthcare: an Islamic Ethico-Legal Perspective

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The United Nations Educational, Scientific and Cultural Organization's (UNESCO) Declaration on Bioethics and Human Rights asserts that governments are morally obliged to promote health and to provide access to quality healthcare, essential medicines and adequate

nutrition and water, to all members of society. According to UNESCO, these "rights" are part of fundamental human rights and emerge from the principle of social responsibility. In this essay I reflect upon notions of social responsibility and the state obligation to promote health and provide healthcare from an Islamic ethico-legal perspective. The extent to which the UNESCO Declaration, and other statements that link together human rights doctrine and concepts of a universal bioethics, can impact health policies in Muslim contexts rests upon utilizing cognate constructs for social responsibility and human rights or using other foundational ethico-legal constructs from the tradition to build a moral argument for the state's obligation to promote health and to provide healthcare. In this article I will comment on the ways in which the concepts of huquq Allah, fardh kifaya, and hifz al-hayat may service an argument for their being a state duty to provide healthcare. By bringing into view the concordances and discordances between the Islamic ethico-legal values and the more secular analogues this presentation seeks to inform efforts that aim at a global moral consensus around the right to healthcare.

Keywords: Bioethics, Islamic Ethics, Human rights

Ethical Issues in Externally-Sponsored Research in Developing Countries

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In developed and developing countries alike, biomedical research is an essential component of improving human health and welfare. However, in the last two decades, clinical research conducted by foreign sponsors from developed countries to be carried out in developing countries has increased dramatically.

This presentation elaborates on some of the existing concerns and ethical issues that may arise when biomedical research protocols are proposed or funded by research institutes in developed countries but human subjects are recruited from resource-poor countries. The article examines the situations in which vulnerable populations in developing countries are likely to be exploited and/or there is no guarantee of any benefit from the research product, if proven successful, to the local community. By examining the structure and functions of ethics committees in developing countries, the article focuses on the issues which a local ethics committee should take into account when reviewing externally-sponsored research especially in issues such as protection of human subject as well as ensuring benefit-sharing with local community.

Keywords: Ethics, Externally-Sponsored Researches, Developing Countries

Catching Culture in the Ebola Epidemic

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The humanitarian crisis suffered during the Ebola epidemic in West Africa during 2014 created challenging conceptual and ethical reflections on the role of culture in shaping a health disaster. In this presentation, the context of Ebola in post-conflict and post-colonial societies will be explained. Against this backdrop, the space for traditional African beliefs of health and illness will be critically analysed within the humanitarian response. Finally, these considerations will be further viewed from a mental health perspective of the psychological consequences of a deadly viral epidemic, using a recent case study from Sierra Leone of a former war child refugee who faces persecution and stigma due to being an Ebola survivor.

Keywords: Ebola, Epidemic, Sierra Leone

Language and Authority: Ethical Challenges at the Interface of Health and Religion in Africa

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Introduction: Religious leaders engage with health and disease at multiple levels, and inform understandings of suffering and wellbeing in light of their traditions. Religious language and authority influence their conceptualisations of such notions, and also characterise their engagement with disease prevention, education and healthcare delivery.

Method: This presentation offers an analysis of different forms and levels of religious engagement with HIV/AIDS in Africa. It includes findings from a literature review thematically assessing the role of language and authority of religious leaders' involvement with HIV/AIDS, through legal edicts and practical contributions.

Results and conclusion: The use of language and authority as implements for constructing religious narratives related to health and disease in the case of HIV/AIDS, poses ethical challenges. Religious efforts can positively promote or hamper holistic approaches towards addressing disease, at the conceptual and operative levels, through compassion or condemnation of stigmatised diseases. Tentative ways of addressing ethical issues resulting from the interactions of religion and health in light of the findings are offered.

Keyword: Ethics, Health and Religion, HIV

Health Challenges in Africa; Islamic Bioethics Perspective

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Africa still left behind in health sector among other countries in the world. The problem of human resources and natural resources as well as low quality of infrastructure is still becoming mayor problem beside political problem. The status of health of people among African countries is still low and need to develop faster. Barriers of cultural and barriers of society mentality is growing advance because of information technology and materialism as well as secularism. In term of Islamic bioethics African countries have been facing problem of justice and autonomy. The conflict of autonomy and justice principle still dominated over beneficence principle. This paper will analysis about health challenges in Africa from Islamic bioethics perspective. With the high impact of poverty in the health sector the implementation of Islamic bioethics is very tough on health services. Dilemma of Islamic bioethics in health services and health development programs emerge in hospital and community. The concept of Islamic bioethics will explain more detail in comparison with Indonesia as the same developing countries with the same historical background. Western bioethics is not showing enough concerns for the moral challenges and dilemmas arising from Africa. As such Africa need to develop its principles and values based on the existential realities of its people needing appropriate solutions to problems affecting them. The first problem encountered is whether African bioethics can dismantle the encrustation of foreign values and view the African thought materials in their true light rooted on traditional African values and indigenous heritage as well as in framing of Islamic values. There is no doubt that modern Western medicine, based as it is on the scientific method, is superior to traditional African medicine, which was rather weak in diagnosis, pharmacology, and the systematization of knowledge. The four principles of bioethics, from Beauchamp and Childress, autonomy, non-maleficence, beneficence, and justice have dominated the field of bioethics in the world. Their simplicity and practicability make them easily applicable to any ethical dilemma to determine the best or right course of action. Some African bioethicists have adopted these principles directly rather than within the context of local values

Keywords: Islamic Bioethics, Health Challenges, Africa

14:00-15:30 Session-C1

Africa in the World Politics and African Studies in Turkish Literature

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First of all, it should be asked: Why "Africa in world politics?" In May 2000, the headline of the Economist was "The hopeless continent", in December it became "Africa rising". Correspondingly, the reaction of African politics between these two dates had a significant meaning: "Thanks to Chinese people... They "re-discover" Africa is not only a continent of famine and crisis but also it has a potential of 800 billion consumers. (Business Day, 19 October 2007) Now, the population of the continent is far beyond one billion and seven of the World's Top 10 Developing Economies belong to African states. Regardless of the popular early sayings of African nationalist "21st century will be an African century", it is clear that Africa is rising in global politics.

On the other hand, there are not enough academic studies in Turkey related to Africa, though Africa is one of the most successful foreign policies of Turkey in recent times. Neither the general issues for the continent nor the Ottoman presence in Africa and the politics of the Republic of Turkey have attracted enough attention in Turkish literature. The series "Africa in the World Politics" edited by İsmail Ermağan have been carried out for the purpose of clearing this gap. Each unit in this book has been drawn out by those who are professionals in these areas of studies.

The main title and themes selected for this study can be expressed in the following way:
Africa's Panorama: Political-Economic-Social and Cultural Characteristics
The Relations of Global Actors with Africa: EU, China, the US, Russia, Brazil, Japan
Analysis of the African Countreis: Algeria, Angola, Madagascar, Burundi, Bostwana
Basic Problems on the continent: The Tuareg Rebellion in Mali, The Problem in Darfur, Terrorist Organizations Shabaab and Boko Haram etc.
Education and Development in Africa: South Africa, Nigeria, Ghana, Mozambique
Various Topics in Continent: Kenya's Political System and Human Security in Africa
Economy in Africa: Africa in the World Economy, One Success Story: Botswana, The macroeconomic analysis of Ghana, Nigeria, South Africa
Turkey-Africa Relations: Politics and Economy

Keywords: Africa, Turkish African Politics, African studies in Turkish literature, Global Actors in Africa

Turkey's Health Diplomacy in Africa as a Soft Power Policy

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Today, the most effective aspect of foreign policy is implemented utilizing soft power. In last few years, it become clearer how much of a failure hard power was. This failure opened the door on seeking alternative foreign policies and as a consequence the need for soft power has gained a significant magnitude. For Turkey, it has been emphasizing the role of her proactive foreign policy in the recent years.

In this light Africa was granted a big share of the Turkish foreign policy. After 1998 the announcement of the African expansion plan agreement can be described as the most comprehensive agreement for the development of relations with Africa. After 2002, taking advantage of this mellow platform, then elected government carried the diplomatic relations with the black continent to its highest levels. One of the key elements boosting this process is the medical diplomacy. The continent's biggest dilemma is its battle with health problems. Turkish institutions are conducting several projects in order to attenuate those problems. Such activities are leaving permanent impact on Africans. It is undeniable that this is a reliable foundation for the future with this continent.

Keywords: Soft Power, Health in Africa, Turkey.

The Rise of Turkey as a Non-Traditional Aid Donor in Sub-Saharan Africa

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The aim of this paper is to examine Turkey's engagement with Sub-Saharan African countries in the last decade and elaborate Turkey's distinctive approach as a donor country. Sub-Saharan Africa was one of the neglected areas of Turkish foreign policy until the AKP era. Turkey's Africa policy gained momentum with the declaration of Year of Africa in 2005. In addition to increase of high-level bilateral visits, Turkey expanded its diplomatic representations in this region. Turkey's opening to Sub-Saharan Africa took place at the time of a new scramble for Africa. Southern powers such as China, Brazil, India started to compete with the former colonial powers from Europe for resources of African countries. In this context, Turkey followed neither the path of Southern powers nor European powers. Rather than making use of African natural resources and economic benefits, Turkey was concerned with the improvement of lives of African people. Turkey used its non-colonial history as an asset and adopted a partnership approach in its relations with Sub-Saharan

African countries. Consequently, Turkey acted as a benevolent country and achieved hundreds of health projects and improved African people access to health in the different parts of Sub-Saharan Africa.

Keywords: Turkey, Africa, Donor, Development Aid, Health Project

Health Activities of Turkish Volunteer in Niger

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Objective: Africa is the most difficult continent to obtain of health services in worldwide. This study examined the health care organizations we have done in Niger. The results were evaluated and proposals were made to civil society organizations and public institutions for further health work to be carried out in Niger.

Methods: We organized 21 health care organizations by 401 volunteer health personnel between 2006-2017 from Turkey to Niger, one of the poorest countries in the African continent. We organized these organizations in partnership with TIKA (Turkish Cooperation Development Agency) and Turkish Ministry of Health. Health services were provided by our volunteer health personnel in local hospitals with the help of medical devices, supplies and medicines we brought from Turkey. Retrospectively, our outpatient of clinic, imaging, laboratory and surgical procedures were examined in terms of quality, quantity and variety of medical procedures.

Results: A total of 156 study active days, 82,573 outpatient services, 5530 ultrasonography examinations, 24,567 laboratory process, 14,832 tooth extraction, 8296 external ear aspiration, 10,115 circumcisions and 9302 operations were carried out during all trips. In total 155,215 health care treatment were performed. 37,382 of the outpatient services were adults and children, 17,151 were ophthalmology, 15,857 were otolaryngology, and 12,183 were dental policlinics. Laboratory procedures as hepatitis and HIV tests were performed for pre-operative patients. 416 HBsAg (+), 279 HCV (+) and 196 HIV (+) patients were detected in these tests. Of the operations, 5606 were ophthalmology and 3696 belonged to other branches. General Surgery 1526, Urology 1125, Gynecology 649, ENT 327, Plastic surgery 54, Orthopedics performed 15 operations. In the outpatient

services, there were 374 patients who were given indications for surgery but could not be done due to inadequacy of the hospital infrastructure and lack of specialist physicians.

Conclusion: 995 health services have been provided per active day in Niger, and we believe that it is necessary to improve the quality and quantity of health benefits from Niger in Turkey by improving the infrastructure of Niger rural hospitals in cooperation with NGO and Ministry of Health of Turkey and becoming fully equipped hospitals..

Keywords: Niger, Turkish Volunteer, Health, Africa

Renovating Project of Niger Maternity and Children's Hospital

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Niger which has a population of 17 million is one of the poorest countries in the world. Poverty causes serious health problems which are especially related to gynecological diseases, birth and children's disease. Also, Niger has the second highest mother death rate and children death rate. In this respect, the project was conducted to make contribution to Niger in order to overcome these problems. Firstly, the ministerial clinic in Saga region which has a capacity of 20 bed space, 3 obstetrical tables was restored completely after certain permissions were received. 8 bathrooms and restrooms, separately for man and woman, were built at the garden of the clinic. Also, reservoir, holding bay in garden for patients, annihilation area for medical and domestic waste, environmental monitoring, hot water system and pharmacy were built. All medical supplies and patient rooms were changed to new ones. The clinic became the most modernized maternity clinic at Niger.

After that, it was detected that Gazoby Maternity and Newborn Hospital at the capital city Niamey was in very bad conditions and it was the most crowded hospital. Hundreds of women was waiting a long queue for gynecologic operations and childbearing at garden.

As a charity, instead of old and worn equipment, we provided; 3 electronic obstetrical tables

2 operation tables, 2 surgical operating lamb, 4 hydraulic stretcher,3 surgical aspirator, 40 immediate aid set, 4 medicine trolley, and lots of surgical hand tools and thus, it became one of the most modern maternity hospital in Niger.

Currently, the hospital has a capacity to do 20 operations on a daily basis. Also, at Madarounfa district which is connected to Maradi close to Nigeria border, 244 health center focusing on gynecology and children diseases and serving for 400.000 people in this region are constructed with medical devices and it is handed over to the Board of Health. Within the scope of the project, the negotiations about the construction of health centers and modernizing medical devices in Agedez region are in progress. Projections and planning process about the region will be completed at the second half of 2017.

Keywords: Niger, Renovating Project, Hospital

14:00-15:30 Session-C2

Health Professions and Medical Education in Africa: Differences and Similarities

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Introduction: Scarcity of medical schools in Africa threatens efforts to improve health professionals education (HPE). Critical to the development of a sturdy workforce is improving HPE, a strategy that has faced challenges.

Issues of concern for Africa

Paradigm shift: Only a few centers in Africa have adopted student centered learning, as medical schools still retain their old curriculum started in the pre-colonial era.

HPE goals: Africa needs to address inequalities for the education of locals who understand the health needs.

Standards: Regional and local standard should be aligned with global standards.

Culture of learning: To-date there are no published studies detailing the cultural attitudes of African students to these new pedagogies.

Stability: Socioeconomic and political stability are essential for the close monitoring and strategizing needed to continually revise and update educational programmes.

Management: In most of Africa, Medical schools are managed and teaching delivered by specialists with little training in higher education practice.

Migration: Doctors migrate from their countries to those with a perceived higher standard of living hence affecting would be medical teachers.

Demand and supply: Many African leaders and those with the financial capability seek medical care abroad, as they perceive that the kind of care they require will not be provided within the continent.

Integration of traditional and complementary health systems into medical education.

Conclusion: Medical education in African should tailored towards addressing African health needs

Keywords: HPE, Challenges, Africa

Education and Problems of Circumcision in Africa

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Objective: In Africa, circumcision is performed to protect religious beliefs and diseases. But most of the circumcisions are carried out by unqualified persons with traditional methods. In this study, we evaluated the results of circumcisions and our circumcision training performed in different countries of Africa.

Material-Method: We provided circumcision training to local health personnel in different countries with 29 health care organizations we made from Turkey to Africa. We performed the circumcision procedure by open surgery under local anesthesia. We used bisturia or thermocautery to cut the penile skin. The cauterization with thermocautery and the suturation with the absorbable sutures were applied and finished the operation after dressing. First-time observers who was local health personnel taken part in all stages of circumcision as follow-up, passive assistant, active assistant, passive practitioner and active practitioner, respectively. Observers performed ten cases in per step.

Results: Active circumcision training was given in 7 of the 29 health organizations, in the other 22, circumcision training was given during the surgical interventions. A total of 10.115 circumcisions were performed, 8951 in active journeys and 1164 in others. Active circumcision training was practiced in Chad, Niger, Uganda and Comoros. In total, we gave circumcision training to 58 local health personnel. 19 of them were doctors, 39 were medical officers and nurses. In Chad, Niger and Uganda, one from each of thermocautery devices and necessary medical supplies were left for local health care institutions. After returning to Turkey, we shared their questions and experiences about circumcision through social media communication tools with our African colleagues.

Conclusion: Circumcision in Africa is the most common surgical procedure. In circumcision; Asepsis, excision, hemostasis and cosmetic appearance are the four main principles. In particular, asepsis and hemostasis are neglected due to the inadequate health infrastructure in Africa, the lack of trained staff and the large number of cases of circumcision. We think that the ideal method for circumcision in Africa is thermocautery method that is less needed asepsis and hemostasis, and for circumcision training we need to go to different countries of Africa periodically.

Keywords: Africa, Circumcision, Thermocautery method

A Review on the Implementation of Sexual and Reproductive Health Education in School -The Malaysian Experience

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Introduction: Increase number of high risk sexual behaviours among Malaysian teenagers calls attention to the implementation of Sexual and Reproductive Health (SRH) education in school. Delivery of SRH in Malaysia has created different reactions among the public. Malaysia, similar to other countries like Africa is not without issues and challenges. This study aims to review research done in Malaysia pertaining to the delivery of SRH education in school.

Methods: A literature search was conducted from publications of Medline, EBSCOHOST and PubMed and Education ProQuest on research done on sexual and reproductive health education in Malaysia from year 2000 till 2017. 15 articles were retrieved.

Results: 4 themes were elicited from this review; development of sexuality education in Malaysia, preferred types of sexuality education, issues and challenges of implementing sexuality education. Malaysian SRH education has progressed from 1989 with constant change in method of implementation mainly incorporated in other subjects like Biology and religious study and now in the physical health subject. 3 decades of SRH delivery however does not tally with the increase in prevalence of high risk sexual behaviours among teenagers. Students perceived their teacher's teaching method as shallow and not complete. Sensitive topics were vaguely described or in many cases skipped. Between the abstinence only versus comprehensive type of SRH education, some argue that too much information is being transmitted if using the comprehensive type of education. Nevertheless, majority of the studies found that teenagers, parents and even teachers think that the comprehensive type of SRH education should be used in school provided that it is being integrated and taught in the religious mainly Islamic context.

Conclusion: Mass media highlights bone of contention among the community towards the implementation of SRH yet very scarce study are done focusing on its implementation. There is a dire need to understand the progress and effectiveness of SRH education being delivered in school by the teachers as they are the one currently shouldering the responsibility. Understanding differences and similarities of the SRH implementation in Asia may be helpful to its implementation in African countries.

Keywords: Sexual and Reproductive Health (SRH) education, school, teachers, preparedness.

Laparoscopic Cholecystectomy Training in Niger-Agadez

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Background: Through the health support by BISEG Organization for Africa on August 2015, we came across with some unused and expired laparoscopic equipment's that wasted in operating room (OR) yards. We brought this system to work, and we performed laparoscopic operations first time in Agadez. This was met with enthusiasm by surgeons and local authorities. In this regard, courses and training are requested from us. For this purpose, Agadez, neighboring Fizan, one of the most remote places of the Ottoman Empire, was re-visited between 14 and 27 May 2016. In the present study, we reported our experience and the results of this training program.

Methods: In morning lessons, the surgical staff of the hospital was educated for the basics and the general principles of laparoscopy and laparoscopic cholecystectomy procedures; and then the same staff was trained on anesthetized patients in OR to increase their practical capability by an experienced team from Health Sciences University, Umraniye Training and Research Hospital General Surgery Clinic. Operations were participated all together in Agadez Accueil Hospital Operating Rooms afternoon.

Results: A total of six education meetings were done in morning hours for theoretical education of the local staff. A total of eight operations (laparoscopic cholecystectomy; n=6; laparoscopic oophorectomy; n=1; laparoscopic liver cystectomy, n=1) were done during this period. Local team was composed of 3 general surgeons, 1 obstetrician and gynecologist and 3 Anesthesia and Reanimation Technician and 1 operating room staff. All participants whom completed the course successfully were granted with the certificate of attendance. Early postoperative outcomes were followed-up by our team of the operated patients. It has been stated that education in Turkey will help those who want to continue, but there is no demand in this regard. In later communications, the Surgical Clinic Chief of Agadez Accueil Hospital was stated that they did not perform laparoscopic surgery due to administrative and material related problems.

Conclusions: Besides the demands of health employees, the conditions of the socioeconomic and health system in such areas need to be better assessed so that such training programs can be useful.

Keywords: Laparoscopy, Niger, Training

Effect of Health Education Intervention on Treatment Adherence in Patients with Pulmonary Tuberculosis in Lagos, Nigeria

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Non adherence to anti-tuberculosis treatment increases the risk for the development of Multi-drug resistant tuberculosis, re-occurrence and mortality. Therefore, this research examined the effect of health education intervention on treatment adherence among pulmonary tuberculosis patients in Lagos state, Nigeria. The study adopted the Quasi-experimental research design and one hundred tuberculosis patients were randomly selected from two chest clinic hospitals. Fifty participants were each selected for the control and experimental groups. The experimental group undergo the normal routine tuberculosis care and health education session while the control group received only the routine care. The health education intervention lasted for eight weeks. Morisky 8-Item Questionnaire and tuberculosis knowledge and attitudinal Questionnaire were used to measure the rate of adherence before and after the intervention. The descriptive statistics of frequency counts and percentages was used to analyse the demographic variable of the participants while inferential statistics of independent t-test was used to determine the mean difference of the stated hypotheses at 0.05 level of significance. The result revealed that there is great improvement on treatment adherence among the experimental group and also knowledge and attitude of the experimental group significantly improved compared to the control group. The study recommend that health education intervention should be adopted as part of the DOTS Strategies in combating and controlling tuberculosis in the society

Keywords: Health, Treatment Adherence, Tuberculosis Patients

Assessing the Learning Environment at Habib Medical School-Islamic University in Uganda

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Background: The learners' environment is crucial for development of professionals. In Uganda, there was no studies assessing the learning environment have been found.

Objective: This study was performed to assess the undergraduate students' perceptions of medical education in general and educational environment in a newly established facul``ty of medicine in Islamic University in Uganda.

Materials-Methods: The Dundee Ready Education Environment Measure (DREEM), a validated inventory was distributed among undergraduate students in the first year of Bachelor of Medicine and Bachelor of Surgery study. This scale consists a 50 item inventory each of the50 items is scored on a 5-point Likert scale (0 to4).

Results: The average total DREEM score was found to be 127.5 (maximum point is 200 in the scale) for the students. This score was interpreted according to the practical guide of McAleer and Roff that students' perceptions of their learning environment were more positive than negative. In addition, the descriptive values of 5 sub-dimensions of the scale were found as follows. The Perceptions of Learning dimension average is 33.68 ± 6.10 (this sub-dimension has 12 items, maximum score is 48), the Perceptions of Teachers dimension average is 25.89 ± 4.44 (this sub-dimension has 11 items, maximum score is 44) 23.35 ± 3.91 (this sub-dimension has 8 items, maximum score is 32), Perceptions of Learning Atmosphere dimension average 29.83 ± 7.01 (this sub-dimension has 12 items, maximum score is 48) and Social self-perceptions dimension average 13.90 ± 3.92 (This sub-dimension has 7 items, maximum score is 28).Only the mean Social Self Perceptions sub-dimension score were below the expected average score (maximum score/2), and all of the other mean of dimensions were higher than the expected average. The best score is obtained from Perceptions of Learning. The items with low scores (less than 2) on the DREEM questionnaires were identified as in need of rehabilitation. Conclusion: On the whole, the study showed that the students' perception of the educational environment and the teaching delivered were positive but the student's social self-perception was not good. Measures to improve student's social self perception will be adopted.

Keywords: Medical Educational Environment, DREEM, Student's Perceptions, Classroom Environment

The Analysis of Sub- Saharan African Surgical Publications

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Introduction: Some of the countries in Sub-Saharan Africa (SSA), following gained independence, made financial investments into education and health, especially for the training of health workers and research scientists. But still most of the significant scientific contributions from SSA emerge from collaborative work with western countries. Some of the graduate physicians left their countries as a result of financial and security reasons. Highly trained biomedical scientists and doctors are also remunerated and they practice in other fields due to issues such as lack of laboratories, institutions or funding.

Methods: This study was conducted via searching the database of PubMed by using the words "Sub-Saharan Africa, AND Surgery", between 01.01.2016 and 31.12.2016.

Results: A total of 582 articles were found and reviewed. Irrelevant 305 (52%) articles were excluded. There were 277 (48%) surgical articles and 82 (30%) of the studies were conducted in the field of general surgery which were reviewed for this study. Fourty-two (51%) articles were published by local scientists from 15 SSA countries; 15 (18%) articles by the researhers outside of Africa and 25 (30%) articles were collaboration studies between African and western countries. Twenty (24%) articles were published in African based journals whereas 62 (76%) were published in international journals. The most common topics among articles were gastrointestinal system diseases, trauma and breast cancer, respectively.

Conclusions: In conclusion the number and subjects of publications held by local scientists is inadequate, and therefore, scientific researhers should be supported.

Keywords: Sub Saharan Africa, Surgery, Research, Publication

17:30-19:00 Session-C3

#MsiaEndsDengue Model; a Unique Collaboration of NGOs-Academia in Curbing Dengue Epidemics: Lesson from Malaysia to Africa

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Since 2014, dengue endemic hits the nation worse than before resulting in triple rise in the dengue mortality. Empirical findings of trend, pattern and the associated dengue virus serotypes indicate that dengue outbreaks is expected to continue in Malaysia throughout the 21st century. Today, 40% of the world's population lives in high risk dengue areas with the World Health Organization estimating 50 to 100 million infections annually. This study aims to introduce the first national community-based-model known as #MsiaEndsDengue, comprising of academia and Non-Governmental Organizations (NGO) formed to complement the Ministry of Health in the effort to curb dengue. This collaboration creates a holistic platform integrating science of medicine, entomology, building designs and structures, information technology, as well as the human factor en-route to provide a more sustainable environment. Under the umbrella of #MsiaEndsDengue project, the Islamic Medical Association of Malaysia (IMAM) alongside University of Malaya (UM), National University of Malaysia (UKM), IM4U, Malaysia Integrated Medical Professional Association (MIMPA), and Pertubuhan IKRAM Malaysia, have been working together to create aware-

ness and empowers the community in risk reduction programs. Throughout the three years of collaboration, this project shows positive impacts from myriad perspectives. The first Dengue 1-Stop Center (D1SC) was officially launched in November 2014. Student volunteers from the University of Malaya (UM) were engaged to equip the center which was utilized as a center to educate local communities about dengue. This blue-ocean model offers platform for community empowering programs such as Train of Trainers, Seek and Destroy, and even door-to-door facilitation on dengue prevention. Under the niche of education, #MsiaEndsDengue project have spearheaded a dengue awareness module for children which was successfully incorporated into series of edutainment program known as Teddy Bear Hospital. From another perspective, #MsiaEndsDengue project has won several awards from UM and received intellectual property registration for the invention of anti-mosquito floor trap. Research output too has been published in indexed journal contributing to the pool of knowledge. This model has proven that NGOs and academia have huge potential in empowering the community to curb dengue. This is one experience we will share, from Malaysia to Africa.

Keywords: Dengue, MalaysiaEndsDengue Project, Prevention, Academia, NGO.

Is the Northern Uganda Malaria Outbreak a True Epidemic or Resurgence? Intervention Options, Challenges and Way Forward

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Background: Concern over the persistence of the malaria outbreak in ten districts in Northern Uganda since April, 2015 with an estimated 3 million people at risk and over 1000 deaths recorded.

Outbreak is chronic (> 11 months), with no sign of receding despite interventions.
Affected districts lack resources to control the outbreak and determinants remain unexplained.
Since 2008, PMI initiated IRS Project in Northern Uganda with DDT, Lambda cyhalothrin and Bendiocarp
IRS project ended in 2014 with impressive results- Malaria morbidity brought down to 19%.
April / May 2015 high malaria cases were observed giving rise to the current malaria outbreak in all ten districts.

Diagnosis of issues: Analyzed malaria data and plotted epidemic curves and evaluated malaria trends against case definitions for malaria epidemic or resurgence respectively. Analyzed baseline characteristics of each district to assess if they were different or not. Evaluated each district against published list of known malaria epidemic precipitating fac-

tors (Beales P.F et al.1989) and causes of reported malaria resurgences from 1930-2000s (Cohen J.M et al 2012) to assess which factor / cause was significant in the genesis of current malaria outbreak.

Conclusion: Known causes of Malaria resurgence were almost absent. To wit: Wars, disaster or strife*

The current outbreak is due to malaria resurgence following cessation of IRS interventions in Northern Uganda. (Sharma V.P 1986, WHO 1980, Roberts JM 1964, Mohr C 1972)

Way Forward: The current malaria outbreak is in chronic phase and long term interventions are needed for the control. Additional resources (man power, funds and supplies) are needed for effective management of the current outbreak. Weakness in the health system require immediate remedy if late detection, preparedness and response to malaria outbreaks are to be avoided in future.

Keywords: Malaria, Epidemic, Resurgence, Intervention

Bubonic Plague Outbreak Investigation in the Endemic District of Tsiroanomandidy - Madagascar, October 2014

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Plague remains a major public health problem in Madagascar, endemic in 44 of 111 districts, with multiple epidemics every year. Our aim was to describe an outbreak reported by local health authorities between August 1 and October 12, 2014 in the district Tsiroanomandidy and look at previously reported associated factors to improve plague control strategies.

Suspected cases were individuals with sudden fever with lymphadenopathy or cough with hemoptysis and/or chest pain and/or breathing difficulty, probable cases were patients with positive test strip and confirmed cases were patients with positive culture. We identified cases from health registers and used a questionnaire to collect socio-demographic and clinical information, and performed a retrospective environmental survey of rodents and vectors in five villages.

We identified 30 cases of bubonic plague, 28 probable and two suspected, including 14 deaths (46.7%) in four of the district's 17 municipalities. Median age was 15 years and 56.7% (17/30) of cases were under 15 years. The sex ratio (male/female) was 4:1. Ninety percent (27/30) of cases occurred in two municipalities (Tsinjoarivo and Ambatolampy). Recent murine mortality was reported and Yersinia pestis was isolated from four out of 42 rodents in two villages. A flee trap set in a house 10 hours after insecticide spraying still collected 45 fleas. Slash and burn culture, cohabitation with animals and generalized poor sanitation were observed or reported.

In this outbreak the majority of cases were young men and nearly half of the cases died. Insecticides used appeared to be inefficient. Raising awareness among the population, establishment of community surveillance, rodent and vector control are crucial prevention strategies, as well as controlled use of insecticides to ensure their effectiveness.

Keywords: Madagascar, Bubonic Plague, Outbreak, Fleas, Insecticide

Serological Signatures of Clinical Cure Following Successful Treatment with Sodium Stibogluconate in Ethiopian Visceral Leishmaniasis

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Background: In Ethiopia, visceral leishmaniasis (VL) is a growing public health threat. Among the key challenges in VL control in Ethiopia is lack of an effective test of cure. The recommended test of cure is parasite detection. As sterile cure is not expected with the current widely used drugs, the value of parasite detection as test of cure is questionable. Moreover, the sampling is invasive, requires a well-equipped facility and highly skilled personnel, which are all hardly found in endemic set-ups.

Objective: Our aim was to assess the value of sCD40L, MMP9 and IL-10 serum levels as signature biomarkers of clinical cure in VL cases from Ethiopia. METHODS: A total of 45 VL cases before and after treatment and 30 endemic healthy controls were included in the study. Sandwich ELISA was used to measure serum levels of sCD40L, MMP9 and IL-10.

Result: The mean sCD40L, MMP9 and IL-10 serum levels changed significantly at clinical cure. At individual case level sCD40L and MMP9 showed an increasing trend. Yet, the

degree of increase in serum level of MMP9 seems to be affected by nutritional status of the individual VL case. The mean IL-10 serum level was significantly reduced at clinical cure. As seen on case by case basis, all demonstrated a declining trend except that two VL cases had a high IL10 level at clinical cure.

Conclusion: Our result is suggestive of the possibility of developing a signature biomarker to monitor VL treatment in Ethiopia using one or a combination of parameters

Keywords: MMP9, sCD40L, IL-10

Tunica Vaginalis Free Graft Urethroplasty: 10 Years Experience

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Objective: To evaluate 52 patients who were treated with tunica vaginalis (TV) free graft urethroplasty with a follow-up period of over a 10 years.

Methods: Between October 2005 and December 2015, a total of 52 patients had TV substitution urethroplasty. Patient's mean age was 46.3 years and follow up period between 6 months to 120 months.25 cases had one stage free graft dorsal urethroplasty while 27 cases had augmented anastomoses urethroplasty. Successful criteria were: patient satisfaction, urine flow rate above 16mL/sec, patent urethrogram, and no need for dilation or any instrumentation during the follow-up period.

Results: Overall success rate was 80.8%. During the follow-up period 5 cases completely failed due to severe wound sepsis and the TV urethroplasty redone successfully 6 months to one year later. Recurrent urethral stricture occurred in 5 cases over a period of 3-18 months. Superficial surgical site infection occurred in 7 cases that responded well to parental antibiotics and daily wound dressings. In the 42 successful cases patients were voiding well, with an average flow rate>16 mL/sec. None of the patients had any scrotal pain or discomfort in the follow-up period.

Conclusion: Over a 10 years period, tunica Vaginalis free graft urethroplasty has been used in our department with encouraging results. To the best of our knowledge this is the first long term study using this technique. Comparative studies with existing urethral substitution procedures are needed. This method needs to be considered as an additional option by reconstructive genitourinary surgeons.

Keywords: Tunica Vaginalis, Urethroplasty, Urethral Stricture

Surgical Diseases in Sub-Saharan Africa: Is it a Public Health Problem?

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Africa accounts for 24% of the global disease burden but only 3% of the global health workforce. WHO recommends one general surgeon per 13.250 individuals while this number is one surgeon per 400.000 population in some African coutries. According to the 2012 data of WHO; the need for surgical interventions accounts for 4664 per 100.000 individuals. However, this is less then 100 per 100000 in Sub-Saharan Africa (SSA).

Almost over one quarter of a million woman died from complications of childbirth, and most of these deaths could have been prevented by providing basic obstetric surgical care for women. According to the estimation of WHO; low- and middle-income countries have 90% of all road traffic deaths and Africa's road trauma burden, which is the highest in the world, and is expected to increase by the year 2020. The same facts and trends may also be attributed to war surgery as well. The overall disease burden associated with surgical conditions in SSA is estimated at 38 DALYS (disability adjusted life years) lost per 1.000 population.

Surgically treatable conditions account for a significant proportion of the disease burden in resource-limited settings, but are underestimated due to lack of trained staff or equipments. Significant perioperative morbidity and mortality in these settings are preventable. An analysis between the diseases defined as concerns of public health and surgical conditions will be presented in this study. Surgically treatable diseases should be acknowleged as a public health issue and this awareness may significantly reduce mortality.

Keywords: Africa, Surgical Disease, Public Health

Prevalence of Cardiovascular Disease Risk Factors in Sheikh-Osman Community, Borama Somaliland

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Background: Cardiovascular disease is the number one cause of death globally. Low- and middle-income countries are disproportionally affected; There is lack of data about prevalence of CVD risk factors throughout Somaliland

Objectives: To determine the prevalence of modifiable cardiovascular risk factors in Sheikh-Osman community, Borama.

Methods: Crossectional community based study in sh.osman village borama was done by using the WHO Stepwise approach questionnaire for non communicable diseases. The questionnaire consists of three steps which are: step one: sociodemographic and behavior risk factors questionnaires, step two: physical anthropometric measurements and blood pressure measurement and step three: blood glucose measurement

Results and Conclusion: A total of 137 participants were recruited in Sheikh-osman village,the participants were mostly females 77.4%. the results of the study found that prevalence of HTN is high 16% most people compared to diabetes mellitus 3.6% are illiterate 73%, 38% are unemployed, most of the people don't do exercises, only 6% do sport fitness exercises. Most of the people in this community get no fruit diet and vegetables per week 57% and 51.8% respectively, none of the participants reported alcohol and obesity is very low, this needs further research looking for why some risk factors are more common than the others.

Keywords: Cardiovascular, Risk Factors, Non Communicable Diseases

July 21, 2017

09:00-10:15 Session-A4

FIMA SAVE DIGNITY – Islamic Medical Association of Nigeria (IMAN) Experience

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The Islamic Medical Association of Nigeria (IMAN) in collaboration with the Wife of the Governor of Niger State, Dr. Amina Abubakar Sani Bello, the JAIZ Charity and Development Foundation and Engender Health (Fistula Care) held a Vesico Vaginal Fistula (VVF) Repair camp in July 2016 at Sabon Wuse Hospital, in Niger State of Nigeria as part of the pre-conference activities of the IMAN-FIMA International Conference which held in Abuja, the Nigeria Capital. Two other camps were held at the Maryam Abacha VVF Hospital in Sokoto, Sokoto State in December 2016 and February 2017.

JAIZ Charity Foundation donated the sum of Five Million Naira only (N5, 000, 000.00) ($14,285.7) to IMAN for the repair of one hundred patients. Dr. Amina Abubakar Sani Bello also donated the sum of One Million Naira only (N1, 000, 000.00) ($2857.1). Engender Health brought in the Fistula Surgeons and took care of part of the logistics for the camp like honorarium, accommodation, feeding and transportation of the surgeons, provision of consumables for the surgery and provision of diesel for the generator during surgeries. The Islamic Medical Association of Nigeria (IMAN) fed the patients and their relatives during the period of the surgery and the post-operative hospital stay as well as provided post-operative drugs and some consumables.

Virtually all of the patients are poor illiterate housewives with no financial or family support and are mostly Muslim women from Northern Nigeria. A total of 83 patients have been operated so far with 63 being dry; giving a cure rate of 77.9%. Arrangements are currently being made for the repair of at least 17 more patients in the month of April, 2017.

Keywords: FIMA, Save Dignity, Nigeria

FIMA SAVE SMILE Project in Africa

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In Africa with the population over 1.2 billion and more than half the population below the age of 15, the incidence of orofacial congenital anomalies is significant. Cleft lip and palate

represents one of the most common developmental deformities seen in maxillofacial and plastic surgery clinics. It is usually associated with problems which include not only cosmetic and dental abnormalities, but also speech, hearing and facial growth difficulties. Due to low socioeconomic lifestyle, shortage of trained surgeons and facilities, a large number of the affected individuals live and grow with the deformity, untreated for their entire life. The incidence of cleft lip and palate varies in African countries. According to one study, there is a 0.9 incidence of this anomaly in 1000 live births in the city of Khartoum, Sudan. FIMA SaveSmile project has held several camps in Sudan, Somalia and several other countries. In spite of all logistical difficulties, the short term camps have produced good results. The task of holding these camps have been a huge challenge due to lack or deficiency of local availability of medications and supplies. Since its launching in year 2008, Islamic Medical Association of North America (IMANA), Doctors Worldwide-Turkey (DWW), in collaboration with Sudanese Medical Association have performed 1837 surgeries to repair cleft lip and palate to date and future camps have been scheduled.

Keywords: Cleft lip/palate, Orofacial defects, FIMA Relief, SaveSmile,

Blindness in Africa Role of FIMA SAVE VISION PROJECT

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Background: 1% of African's population is blind (using the WHO criteria of <3/60). The major cause of this blindness is cataract, trachoma (6.8%), Glaucoma (15%), including other causes like childhood blindness (5.3%), corneal opacities (10%), onchocerciasis (4%) but the half of the avoidable blindness is due to cataract (WHO). Bulk of blindness in this region is preventable (WHO). Refractive problems trachoma, onchoceraciasis and vitamin-A deficiency can also be prevented by primary healthcare measures. It is estimated that around 300 000 children are blind (BJO). Prevalence of blindness ranges from 0.5 to 1.1 per 1000 children (Foster, A.1991). Women are more affected than man (95% CI 1.29–1.54) (BJO). There is an approximate backlog of three million blind due to cataract (Foster, A.1991).

Poor practitioner-to-patient ratio is one of the big problems. In some parts of Africa, such as Chad, Niger, Gabon, Central African Republic and Equatorial Guinea, there are fewer than 10 ophthalmologists for the entire population (web: health24.com).

FIMA Save Vision: FIMA Save Vision is working in African countries since last many years with strategy to decrease backlog, capacity building and to establish sustainable facilities. FIMA Save Vision has done 11,86,834 OPD; Surgeries 127,689 and Eye Camps 653 across 22 Countries which are Sudan, Chad, Somalia, Somali Land, Nigeria, Mali, Senegal, Sri Lanka, Barkino Fasso, Niger, Indonesia, Cameroon, Morocco, Zimbabwe, Gambia, Gaza, Bangladesh, Maldives, South Africa and Pakistan.

In capacity building we have started Diploma (Clinical Opthalmology) and Masters Program in Hargeisa, Somali Land. Our partners are WAMY, IIRO – KSA, WHO (Ecosoc Partner), MOH Sudan, SIMA, IMA Zimbabwe, Serendib Foundation, Arab Medical Union, Alwaleed Bin Talal Foudation Nigeria.

Keywords: Blindness, Africa, Save Vision Project, FIMA

10:15-11:30 Session-A5

What Can Modern Medicine Learn from Islamic Medicine: The Experience of an Islamic Medical Curriculum in South East Asia 1995-Present

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This paper describes the author's experience in integrating Islamic concepts and Islamic values in a scientific medical curriculum and clinical practice over a period of 22 years. The experience has three major components: (a) integration of Islamic epistemological values in the teaching of basic and clinical disciplines (b) teaching the legal and ethical aspects of medicine, fiqh tibbi (c) establishment of hospitals based on an Islamic world-view. This experience is set within an Islamic Medicine Movement that can be described in 7 phases. In the first phase, pre-1980, period some medical colleges like Azhar in Cairo and Yarsi in Indonesia required their students to memorize certain parts of the Qur'an and acquire specified Islamic knowledge before graduation. The motivation was to produce a religious doctor who would be a model to the Muslim patients. There was no interest in reforming or changing the medical curriculum itself. The second phase, 1980-1995, was a struggle between two views of 'Islamic Medicine': (a) a historical view that called for rediscovery of Muslim medicine practiced in the golden era of Islam and surviving as the Unani and other Muslim traditional medical systems (b) a modern view that looked at Islamic medicine and values that if applied to modern scientific medicine would make it 'Islamic'. The author subscribed to the modern view and has been working in it since 1995. The third phase 1995-present, saw the establishment and operation of medical colleges within universities that used integrated curricula. The author working at the International Islamic University in Malaysia 1995-2005 and with colleagues developed an Islamic Input into the Medical Curriculum Program (IIMC) which has 5 objectives: (a) introduction of Islamic paradigms and concepts in medicine, mafahiim Islamiyat fi al Tibb for example concepts of life, death, causality. (b) Strengthening faith, iman, through using basic medical sciences (like anatomy, physiology, biochemistry) to study and appreciate Allah's sign in the human body (c) appreciating and understanding the juridical, fiqh, aspects of health and disease,

al fiqh al tibbi. (d) Understanding the social issues in medical practice and research and (e) Professional etiquette, adab al tabiib, from the Islamic perspective. The fourth phase starting in 2004 was the emergence of the concept of Islamic medical ethics based on the Purposes of the Law, maqasid al shari'at, and Principles of the Law, qawa'id al fiqh. The fifth phase was the wide dissemination of the program. It spread to other universities in Malaysia such as Universiti Islam Malaysia. The period 2004-2010 witnessed intense efforts in Indonesia to introduce elements of IIMC to Islamic universities that did not have it or to enhance it in universities that already had it. The period 2005-2010 witnessed the rapid dissemination of IIMC in other countries in Asia, Africa, and the Middle East. Parallel to this was the development of the Consortium of Islamic Medical Colleges (CIMCO) that adopted the integration of Islamic values in the medical curriculum. The sixth phase was the establishment of the consortium of Islamic hospitals that applied the principles of integration of Islamic values in both the clinical practice and environment of the hospital. Islamic hospitals exist in Southeast Asia, Africa, and the Middle East and more are being established every day. The seventh phase that is just starting is the concept of an Islamic healthcare industry consisting of polyclinics, hospitals, health insurance, pharmaceuticals etc. all based on the Islamic perspective. This phase parallels the development of the Islamic banking and financial industry, the Islamic insurance industry, the Islamic tourism industry, etc.

Keywords: Modern Medicine, Islamic Medicine, Medical Curriculum Program

Why Western Paradigms are Ineffective for Modern World's Health Problems

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Traditionally, the public all over the world, look upon the medical profession as a noble, reliable and respected source of care for human life, health and wellbeing.

In all civilizations, ancient and contemporary, the medical profession was associated with morality and ethical conduct worthy of public trust.

Over the past several decades, this dignified status deteriorated gradually, with the dominance of monoculture of the western globalization of health governance, with its philosophical background that considers human health as a commodity, with marginalization of healthcare promotion, spiritual aspects of health, and pushed towards profit, cost and waste.

Although several codes of medical and research ethics have been adopted since World War II, unethical practices continued to proliferate.

The Western culture of healthcare became increasingly controlled by giant drug-medical equipment firms that seek profit, dominance and control, and often respect no moral standards.

Academic leaderships that advise official governmental agencies and professional medical and research institutions, and medical professionals at large became gradually under strong influence, by various means, of drug- equipment firms.

Across the world, complicated ethical, socioeconomic and legal implications have erupted and proliferated.

This presentation will address this global dilemma, review the extensive world literature on its various dimensions, and outline efforts of concerned health planners in the west, and elsewhere, to try remedy this situation.

Keywords: Healthcare, Globalization, Codes Of Bioethics, Pharma Industry.

Traditional Medical Practices in Africa in a Modernization Context: The Example of Togo

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The modernization process started in Africa with the colonization and it concerns all social areas. Especially in medical area, the modern medical practices are being imposed at the place of the ancient traditional one since the colonization period. At the middle of 1990's, modern medical practices had been almost adopted in some urban and rural African society. This happened with the effort of governments and international civil society organizations. At that time, populations can easily access to modern medical institutions. However, at the end of 1990's, due to the social and economic crises, almost all African States' social and medical systems had collapsed. The government social and medical politics had almost completely disappeared and populations are left to their own destiny. The medical system had almost been privatized. From that period, the access to medical institutions in Africa became a luxury. In this situation, due to poverty, population especially rural ones, resorted to the traditional medical practices. At the other side, the modern medical actors including laboratories, according to their interests and in capitalist logics, with the complicity of governors, continue to try to impose the modern practices to the populations without taking in account their living conditions. These impositions are generally not violent and are often been done through media and national awareness. At the same time, populations are living according to their traditional medical institutions and are trying to thwart the capitalist and modern medical institutions' practices. In this situation, how can traditional medical system be improved to make it more helpful for population? How can African States conciliate the traditional and modern medi-

cal systems? Can the traditional medical system be viable in the globalization context? By taking the example of Togo, this study is aiming to answer these questions. Furthermore, it will try to understand the future of the traditional medical system. In this study, we made the hypothesis that, in Africa, if the traditional medical system is performed with modern technics and is controlled either by States or by responsible private organizations, it can help populations to access good medical practices.

Keywords: Capitalist Medical Mechanisms, Medical System, Modern Medicine, Modernization Process, Traditional Medical Practices, Togo

Application of Traditional Medicine in Africa – The Issue of Modernization, Globalization and Acceptance

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Traditional medicine (TM) sometimes referred to as complementary or alternative medicine is the oldest form of health care system in many parts of the world that has stood the test of time. African TM like others found elsewhere is therefore a health care system as well as knowledge that has been accumulated and brought down by generations for centuries. The practitioners have an in-depth knowledge of medicinal properties of herbs and plants, and act as holistic as well as spiritual healers to communities where they have strong social ties and interact with the people with some amount of trust. Although the methods of practice of some practitioners are doubted and clouded with some misconceptions, there has been a huge interest in TM in modern times. This stems from the fact that TM has gone through a lot of modernization in recent years from the primitive ways the practice was enshrined in, such that it is now taught in universities and the preparations are made in modernized factories. However, if TM practice is to be properly modernized, then its integration with modern medicine (MM) must be full and complete whereby the use of TM in the mainstream health system is encouraged and accepted. We must get to a level where traditional and modern medicines are practiced side by side. This will subsequently lead to the globalization of TM so that not only people in developing countries will use TM but those in developed countries as well. The truth is, herbal medicines are now finding their way into developed countries and it is only a matter of time for its use to be global. Even though there are some concerns with TM use, the acceptance level is still rising steadily. For example some hospitals in Ghana allow the use of TM alongside MM and it is refreshing to note that preliminary investigations show some of the herbal based medications are having good effects on diseases such liver damage. Truly speaking, TM has evolved over the years and gone through periods of modernization and globalization and is now enjoying a relative acceptance. It is our believe that with proper policies in place, TM will cement its place in primary health care and give people an alternative when it comes to seeking healthcare.

Keywords: Traditional Medicine, Africa, Modernization, Globalization

11:45-13:00 Session-A6

Delusion of Humanitarian Aid

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The African continent conjures up images of conflict, carnage, famine, poverty and disease. This, together with the endless cycle of invasions and foreign-orchestrated civil war perpetuates the constant stream of refugees, rape, pillage and destruction that necessitates the need for humanitarian aid.

From Libya and Egypt in North Africa, Nigeria and Niger in the West, sweeping past central DRC, Mali, Rwanda and Burundi, Sudan to Somalia and Kenya in the East, and the AIDS pandemic in sub-Saharan Africa, the immense suffering of over a billion people requires continuous aid.

Why is it that this mineral rich continent, big enough to fit in almost every other continent in the world, is in need of humanitarian aid? Why is this aid not effective in ameliorating the suffering? Billions of dollars in aid have been poured into the region, and yet its people become more impoverished. There is in fact a net outflow of wealth from the continent, with corruption enriching the donor countries.

Using the iceberg model explained by Andre Huigens, this paper will attempt to delve deep below the tip of the iceberg to the structure and ideological framework that perpetuates the systemic plunder of Africa thereby necessitating the need for humanitarian aid and dependency.

The Multi National Companies (MNC) and Military Industrial Complex based in Western countries are the primary benefactors of the disasters plaguing Africa, where more than 50% of the population is Muslim.

By undertaking such a study, this paper puts forward the need for mental shifts in order to prevent the continuous dependency of Africa on the West and the need for humanitarian aid.

Keywords: Humanitarian Aid, Africa, Western World

Paradox of NGO's in Africa's Development and Healthcare

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Africans suffer from many pandemics and epidemics largely due to poorly developed heath infrastructure. Health tourism to countries such as India, Israel, Singapore and Malaysia is heavily dominated by Africans. Many Africans still die from treatable and pre-

ventable diseases such as malaria, typhoid and tuberculosis despite many years of work in Africa by the Third Sector as Non Governmental Organizations (NGOs) are fondly known. There are many factors that account for this anomaly. First, NGOs do not always invest in Africa what their books show that they invest on the Continent. Second, NGOs occupy a very strategic position in Africa's development and governments are reluctant to ask them to be accountable due to the fear that they can pull out. Third, governments fear the wrath of NGO solidarity and allow them to do very much what they want to do. Thus, NGOs occupy very strategic and powerful position in health sector development in Africa where governments are not able to deliver medical services to the majority of their people. NGOs provide the much needed funding gaps especially in rural areas where governments have not developed adequate health infrastructure. In my book The NGO Factor in Africa (New York: Routledge, 2006) I pointed out various ways in which some NGOs have been conduit of exploitation of Africa. I showed bow many NGOs had used Africans as guinea pigs in vaccines such as yellow fever. The problem is that as soon as the vaccinations prove efficacious, they became unavailable to Africans. using examples from Africa, this paper will show the positive and other side of NGOs, where the net investment on the continent is lost in many complicated accounting processes that leave very little for real development. Why is Africa still reeling from heath problems many years after NGOs set foot on the continent? why do NGOs support research efforts in drug development and not help Africa when the drugs are finally developed. in what ways are NGOs abetting or preventing exploitation of the African continent? These are some of the questions that my paper will address.

Keywords: NGO, Africa's Development, Healthcare

Africa and Aid Dependency

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While talking about "Africa and Aid Dependency, it is important to first understand the definition of "foreign aid" as well as the specificity of Africa as a geographically, culturally, ethnically and economically fragmented continent. In addition, as the main idea behind providing aid to a country is to support the country's development, this speech will raise the following questions: how development happens in reality? How recipient countries could pass from a situation of unbalanced and externally subsidized survival to one of self-sustained growth? How would development aid help a least developed country transform into a lower-middle income country, into an upper-middle income country, and finally into a fully developed country?

The speech will highlight as well the difficulties and problems facing development organizations towards improving the self-sustainability of beneficiary countries. The speech

will cite some of the international community advancements towards aid dependency in Africa and will conclude with the role of the international community in general and SESRIC in specific towards the problem of aid dependency and the healthcare situation in Africa.

Keywords: Africa, Aid Dependency, SESRIC

Africa, Aid Dependency and the Globalization of Public Health: The Promise and Limits of South-South Cooperation

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"The world is just one village. Our tolerance of disease in any place in the world is at our own peril" – Nobel Laureate Joshua Lederberg

Recent intellectual accounts of the globalization of public health theorize the vulnerability of national/geo-political boundaries to disease pathogens. Infectious diseases do not respect the sovereign boundaries of nation-states neither do they carry national passports. Despite the irrelevance of state sovereignty to microbial threats in a globalized world, contemporary policy frameworks remain isolationist. Emerging and re-emerging epidemics and pandemics in history – including Severe Acute Respiratory Syndrome (SARS), and the recent Ebola Virus Disease (EVD) – and the looming crisis of non-communicable diseases have challenged the governance architecture for global health. Drawing from the lessons of the recent Ebola crisis in West Africa where technical aid and assistance arrived too late, this presentation seeks to articulate a coherent African perspective on the globalization of public health based on the promise and limits of historical and emergent south-south cooperation.

Keywords: Globalization, Public Health, Africa

14:15-15:30 Session-A7

FIMA Addiction Working Group and International Federation of Green Crescents

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FIMA Addiction Working Group was formed with our initiative as the Turkish Green Crescent Society 3 years back. We have shared our knowledge and experience in every step of our collaboration. We have informed Addiction Working Group members about our

international activities as Turkish Green Crescent and encouraged their participation to these events. In 2014, the representatives of FIMA Group honoured our International Symposium on Drug Policy and Public Health with their participation. We held the "National Green Crescents Consultation Meeting" in the last day of the Symposium. The consultation meeting gave us a chance to explain our vision to other Green Crescent representatives and to suggest a roadmap for the establishment procedures. I should say that the Addiction Working Group members within the Federation of Islamic Medical Associations played an important role in the enlargement process. Members of the working group took initiative for the establishment of the national Green Crescents in their countries. Among them were Palestine, Bangladesh, Pakistan, Uganda, Thailand, and Lebanon.

So far, 34 national Green Crescents have been officially established. We are planning to reach 60 countries by the end of this year. In addition to the national Green Crescents, the "International Federation of Green Crescents" was established as an umbrella organization with the leadership of the Turkish Green Crescent in Istanbul. Speaking of its works, the International Federation of Green Crescents and member organizations will focus on prevention, advocacy, rehabilitation and coordination by using evidence-based methods in the struggle against addiction. It will seek solutions to local problems of member countries, by considering local values and cultural characteristics. The Federation will coordinate addiction-related studies, researchs and activities in the member countries. The Federation and member Green Crescents together will develop active collaborations with different social groups and other international organizations.

As the Turkish Green Crescent, we shared our materials and content with colleagues from the FIMA Addiction Working Group just after its formation. Thereby, they became suitable candidates to be the leading organisation for the activities against addiction in their countries. Several doctors from FIMA member countries led the establishment of Green Crescents and contributed to the global struggle against addiction as well as the establishment of the International Federation of Green Crescents.

Keywords: Addiction, FIMA, Green Crescents

The Effect of Addiction in Somalia

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The histories of psychoactive substances use in Africa are relatively short except for the reports on the use of traditional substances such as alcohol, drug addiction and khat/qat. In context of Somalia, Khat/Qat, alcohol (Glue, Alaq- Locally made alcohol), Tobacco and Drug addiction are more popular. However Khat/Qat remains the most common addiction in Somalia. Apart from these addictions, technology addiction is also dramatically increasing in Somalia.

The main objective of our desk review is to determine the effect of khat on socioeconomic and health in Somalia.The Socioeconomic effect of khat/qat includes family conflicts, damage of personal dignity, less time spent with the family and children, less responsibility and more effectively diverts daily family and saving. Apart from these, khat sessions are mostly created bad propaganda against social development and country stability.

While health problems associated with khat addiction are dental, sexual, Hygiene and mental problems and some associated disease such as STDs. According to WHO khat/Qat is classified as drug of abuse that can produce dependence. Khat leaves contains psychoactive stimulants cathinone, which is similar to amphetamine. Khat/Qat is widely consumed in east African countries and Arab countries including Somalia.

In Conclusion, it is the first ever time that patriotic Somali scholars established Somali Green Crescent Society (SGCS) which made efforts fighting against khat addiction including awareness, lightening the magnitude of khat addiction among Somalis. SGCS is planning to combine different effort against khat addiction.

Keywords: Addiction, Somalia, Green Crescent Society

Consumption Problems and Drugs Trafficking on the Road and Gold Mine in Mali

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The phenomenon of addiction is new to Malian society, but reference to the new study of a group of (NGO) addiction is getting place in Mali, especially after invasion of North Mali by terrorists in 2012-2013. So this region became a center of drugs trafficking. For this reason (GCM) green crescent Mali created a local radio in sikasso city to aware the population 1 hour every 2 days against addiction and drugs trafficking in Mali.

Keywords: Addiction, Drugs, Gold Mine, Mali, Green Crescent Mali

09:00-10:15 Session-B4

Postgraduate Medical Training in Africa

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The aim of this report is to evaluate the current status of postgraduate medical training in Africa, and to offer recommendations in light of certain references.

Although Sub-Saharan Africa (SSA) encounters a quarter of the global burden of disease, it possesses only 2% of the global physician workforce. Africa has the smallest number of doctors when compared to its population. Medical education and knowledge are dynamic, as they alter with the development of new technologies and advances in medicine. Postgraduate medical education necessitates intensive training to update knowledge and skills and maintain an effective health service under variable conditions. According to the 2013 data of the World Health Organization there were 173.677 (2.4 per 10.000 population) physicians in the African region. According to the 2011 American Medical Association Physician Masterfile (AMA-PM), 10.819 physicians were born or trained in 28 different SSA countries. Sixty-eight percent (n = 7370) were trained in SSA, 20% (n = 2126) were trained in the United States of America, and 12% (n = 1323) were trained outside both SSA and the US. In many African countries, a national board or an association to validate the qualification of the physicians' sufficiency to practice medicine in a certain field does not exist. Presence of such an institution creates a competitive environment for physicians to rich higher goals. However, in underdeveloped areas, doctors lack motivation, time, opportunity and finance in order to continue their postgraduate medical educations. Poor conditions coupled with technological underdevelopment and brain drain are one of the major obstacles against a proper postgraduate education.

We recommend that local physicians should be invited to developed countries to gain perspective and learn new methods via bilateral agreements. Long-term relations should be built in between institutions in developed countries and hospitals with limited resources. Education programmes that exchange physicians from developed countries must be established, thus when local doctors recieve education, native people may receive improved health services. In conclusion, physicians should accept that postgraduate education is a must to practice medicine competently. Accordingly, networks and collaborations should be supported and established to train specialists. Additionally, physicians should be monitored and evaluated by qualified associations.

Keywords: Medical Training, Postgraduate Training, Africa

Health Education within the Scope of Turkey's International Students Policy

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With the implementation of Turkiye Scholarships since 2012, Turkey has taken important steps to be the regional and global point of preference in the mobility of international students. One of the benefits Turkey expects from the flow of international students is to make its universities internationalize. Within the Turkiye Scholarships that provides many

areas of education and specialty, one of the mostly preferred one is "health". Turkey being one of the most prominent countries in the world with its health professionals and health system, has utilized its own health resources in the international aid activities very effectively. The aid activities of Turkey in the health field dates long back and there are some countries (e.g. Afghanistan) whose health system was established by Turkey.

Given the fact that Turkiye Scholarships are more impactful in the countries that are busy with their basic infrastructure and that need well-trained people, the number of international students that demand to be educated in Turkey is expected to rise from those regions where the health is the most prominent basic infrastructure issue. This international interest in the medical education in Turkey brings some issues that are directly related to the international students policy in the agenda that Turkey needs to adopt.

The difficult and costly education period that medical education demands, and hence the limited number of the scholarships, the needs of the countries and their student capacity needs to be evaluated carefully, the efficient resource and application planning needs to be prioritized before the configuration of scholarships in this field. Besides, as a part of the international students policies, the future students who are to be educated in this field needs to be provided with qualified Turkish language education and peaceful study conditions (e.g. dormitories etc.). Finally the employment of those students once graduated to contribute to themselves, their homelands as well as Turkey should be considered as the final conclusion of the international students policies and considered to have its own place as "post-graduation relations".

The steps to be taken to accomplish this task requires a general policy regarding the international students, that is closely related to the planning, education and post-graduation process which should be set as objectives within this very policy. Therefore it is important that related institutions and organizations should cooperate closely and should benefit from each other's experiences and recommendations in order to achieve a socially acceptable international students policy.

Keywords: International Students, Turkiye Scholarships, Health Education

Challenges Faced by African Students in Medical Schools in Turkey

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As well known, Turkey with its strategical geographıcal position, plays a major role as a bridge between continents, cultures, trade and business, and development as well as education. For decades Turkey has long been playing host to international students. With the latest investments in education. The current internationalization efforts of the Turkish

government and universities has made Turkey an even more attractive destination. This has resulted into a rapid increase in international student recruit with the total number amounting to over 86 900 students from more than 187 different countries as per May 2017.

This paper discusses the challenges experienced by International students in Turkey especially from Africa and specifically those in Medical Sector. Data is collected through focus group interviews with international students from various countries studying at the different universities in Turkey. Findings of the study will provide guidance to university management in Turkey's medical schools to improve preparations in receiving and guiding international students in adaptation throughout their stay here.

Keywords: Education, Turkish Medical Schools, International Students

10.15-11.30 Session-B5

Suggested Framework for Social Accountability to be Adopted by the Medical Schools

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Social accountability (SA) is defined by the WHO as: "the obligation to direct education, research and service activities towards addressing the priority health concerns of the community, or nation they have a mandate to serve. The priority health concerns are to be identified jointly by governments, health care organizations, health professionals and the public". The values of SA include relevance, quality, cost-effectiveness and equity.

The modified global standards of SA set by the world federation of medical education include mission & objectives, educational-programme, evaluation, staff development, service & educational-resources, governance & continuous renewal.

Areas of SA include: Health needs of the community, partnership with the health system and stakeholders, roles of doctors and other health team providers, outcomes-based education for the students to strengthen the concept of the socially accountable medical schools and ensure effective and responsible governance, executive committees and leadership.

Framework of SA for the medical schools: The first step is to do situational analysis of the objectives, mission and bye-laws of the curricula of medical schools. This targets domains

like management, leadership, education, research activities and health service to the community. Tools include: questionnaires and experts' advice. The second step is to set an action plan through advocacy workshops then setting our priorities.

Keywords: Social Accountability, Adopted, Medical School

Human Resources for Health in the Context of Post Conflict Revival of the Health System in Somalia

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Two decades of civil conflicts and political transition has left the Somali health sector with enormous challenges ranging from the collapse of the health infrastructure, inadequate and poorly trained human resources, inequitable distribution of health facilities and inherent weak managerial capacities. A major WHO global report on health workforce in 2006 identified 57 human resource crisis countries characterized by having fewer than 23 health workers (doctors, nurses, midwives) per 10,000 people. Somalia was among the worst with only two health workers per 10,000 people, making it inevitable to falter on attaining its health MDGs. When the number of doctors and qualified nurses and midwives was considered, the urban and rural percentage of birth assisted bydoctors, nurses and midwives' was estimated at 20.7% and 2.8% respectively, illustrating the severe disparity in workforce distribution. Recognizing the magnitude of these challenges, Somalia needs to revisit its human resource situation at federal, state and regional level and develop corresponding policies and strategic plans for implementation. The objective of this paper is to reveal the enormous health workforce shortage and inequalities in distribution across Somalia; share Benadir University's successful contribution to health personnel development in Somalia and generate operational propositions that can guide the future health workforce policy and planning in Somalia. In conclusion it highlights the support needed from International community to support the re-establishment of the public health services in Somalia.

Keywords: Public Health in Somalia, Medical Education, Health Policy

The Role of Universities in Healing the Sick Health Sector of Africa

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Life is the most important gift that Allah has given to mankind. Good health is important for productivity as well as being able to enjoy the bounties of Allah in this world. Unfortu-

nately, despite having attained independence for over 50 years for most African countries, the health sector in Africa is very sick – completely unwell. The World Health Organisation (WHO) in 2015 reported that in 2013, the life expectancy at birth was 58.5 years in Africa as compared to the Global average of 70.5 years, 76.5 years for Europe and 77 years for the Americas. Only three countries in Africa had a life expectancy greater than the global average of 70.5 years (WHO 2015)! Many children in Africa are still dying before they reach their fifth birthday. Infant mortality rates per 1,000 live births in 2015 were reported by WHO to be 55 for Africa as compared to the Global average of 32 and only 10 for Europe (WHO 2015). Pandemics such as HIV/AIDS have not helped matters. According to the WHO, in 2012 HIV/AIDS was the leading cause of death in Africa accounting for 11.7% of the total deaths; followed by lower respiratory infections at 11.2%, as malaria accounted for only 6%.

In 2016, the WHO reported that while Africa had 25% of the world's disease burden, she had only 3% of the world's health workers. Indeed, between 2007 and 2013, Africa's nursing and midwifery personnel density per 10,000 population was report at only 12.4 as compared to the Global average of 28.6 (WHO 2015). The physician density, per 10,000 population, was reported at only 2.7 as compared to 13.9 of the Global average (WHO 2015).

Besides, shortage health workers caused by a cocktail of reasons, in most African countries the health infrastructure is in a very sorry state as Africa's per capita total expenditure on health (pp Int. $) was 222 compared to the global average of 1,339. What is even more disturbing, is the fact that in four countries of Africa, life expectancy at birth reduced (in one case by 11 years) as the rest of the world saw improvements in life expectancy (WHO 2015)!

This paper discusses what universities in African can do to help the African peoples access better health services and improve their quality of life. Universities have a responsibility to serve the social good – to address as far as possible, the challenges facing the communities in which they exist. Practical examples by which the Islamic University has been able to contribute to the improvement of health care in Uganda will be highlighted. Possible practical and affordable interventions by universities in Africa will be suggested. A case will be made for focusing on universities as the key game-changers in fighting ill-health in Africa as the continent waits to wake-up from its political quagmire.

Keywords: Universities, Health Sector, Africa

The Brain Drain of Health Professionals in Africa, the Zambian Perspective

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The Brain drain has had a severe effect on Africa in general, in sub-Saharan Africa and Zambia in particular. The attrition rate in Zambia for health professionals has been, his-

torically, at slightly over 49%. The Health work force is working at less than 50% of the stated health professional establishment. The country has a growth rate of over 2.4% per annum, which exceeds the rate of growth of the work force. The rate of production is far outstripped by the demand for the health work force.

There is a maldistribution of the work force with most of the work force in the urban areas rather than the rural areas. The patient to health worker ratio is one of the lowest in the world and the region. The country like many others suffers from a growing dual epidemic both of communicable disease, such as HIV, TB and Malaria, as well as a resurgence of non communicable diseases such as hypertension, Diabetes and Renal Failure.

In this environment where the demand for the health work force, far outstrips the supply, the Brain drain, can only be regarded as a Brain haemorrhage. There are pull and push factors at play in the brain drain scenario in Zambia, which has resulted in an attrition rate from health training programs from 30% to 40%. Some of the key pull factors have been better salaries overseas, better working environments, better postgraduate and specialist training and better social protection schemes. In addition to these pull factors have been the local push factors. Key among these have been the low salaries, poor health care infrastructure and equipment, lack of postgraduate training and poor national economic indicators.

The country has recognised these many challenges in the health work force. Over the last 10 to 20 years, and have attempted, to address many of the key drivers of the brain drain. Notable among the key strategies have been rural retention schemes, improvement in the remunerations, introduction of postgraduate training, introduction of health financing schemes and improvement in health care services. With these strategies there has been a reduction in the attrition rates of the health workforce to between 5 to 10%.There has been a modest reversal in the brain drain and an improvement in the health infrastructure, health financing and quality of health services. The number health training institutions have been developed to increase supply. However still more remains to be done to address the brain drain problem in Zambia.

Keywords: Brain Drain, Zambia, Health Workforce

11:45-13:00 Session-B6

Africa's Quest for Solutions to its Double Burden of Disease

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Objective: This paper addresses first the health problems Africa has experienced over the decades, which, for many observers and health professionals, has turned into a permanent crisis the Africans seem unable to solve. Second, it purports to look at how the leaders

have dealt with the issue of health for their people, taking into account the continent's difficult geographic conditions and the challenging early influx of foreign populations that often brought with them disease and pestilence unknown to the various populations, particularly during the 19th century. Third, it re-examines the use of Africa's health resources by leaders, and the impact of international organizations on Africa's health status. Fourth, and finally, the author takes a serious look at the competing interface between resilient traditional cultural habits and the health benefits and requirements of modern global and technological advances, which have also been challenges other people of the world have faced but have been able to resolve to their benefit.

Thesis: This researcher holds the view that the primary reason why Africa lags behind in the area of health, compared to other continents and nations of the world, is a lack vision on the part of its leaders, who have mismatched and bungled the continent's priorities. This condition has been worsened by a globally known misuse and waste of Africa's vast resources, camouflaged by the clamor, even among intellectuals, health professionals, and the leaders themselves (in defense of their failures), that Africa is too resource-poor to take care of its own disease burden. The theoretical framework undergirding this study is that people have certain inalienable rights, which include: health and education, the two determinants of life that are directly and intrinsically related to one another, and equal opportunity that allows people to care for themselves. These constitute rights that only leaders and the state, and not individuals or civil society, can enforce. Indeed, the modern state remains the most realistic and powerful social contract man has imagined and created not just for the maintenance of law and order but also for the physical and mental well being of all people who live under the umbrella of a national flag.

Methodology: This study is based on primary sources and secondary writings available on health and related issues in Africa. The primary sources were obtained from the historical and health archives of Maputo in Mozambique; N'Djamena in Chad; Fort Portal in Uganda; Lisbon in Portugal; Foreign Affairs in London, England; the Biblioteque Nationale de Paris, France; the United Nations in Geneva, Switzerland, New York, and Washington, D.C.; the immense African Studies Center's collectionat the University of Florida in Gainesville, Florida; the Library of Congress in Washington, D.C., as well as from the author's health studies in Yaounde and Batouri, Cameroon, and Harare in Zimbabwe; and the several towns he has visited in Malawi over the decades. Even though the literature on health in African is still scanty, some useful secondary materials are now available in the various libraries and collections in the US and elsewhere.

Conclusion: This study concludes by noting that what many experts and observers have called "the crisis of health" in Africa will continue to spiral as long as there is no clear leadership vision of people's health needs and emphasis on preventive rather than curative health embedded in a strong primary care agreed by the nations of the world at Alma-Atta's Summit in 1978. Thus, while Africa's abundant resources are to be used wisely, corruptive practices that benefit primarily the health of the wealthy and certain ethnic

groups must be eliminated. In addition, while reliance on international hand-outs needs to be stopped, a new set of priorities must be adopted. In this context, the solution to the health problems in Africa require a new generation of leaders whose priorities must be focused on providing the tools, the infrastructure, and the know-how for people to be able to feed themselves and enjoy a clean and hygienic-sanitary environment. This can only be achieved through free and true compulsory secondary education and free preventive care for all, while issues of culture and acceptable health habits are seriously tackled in the cities and the villages of Africa.

Keywords: Africa, Burden of Disease, Health

Nigerian Health Care Organization: A Mirror to Africa's Conundrum?

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Nigeria, the world's largest congregation of black Africans and the most populous country in Africa is a plural country with multiple cultures, languages and religions. Its centrality to the African context, its huge, teeming population, and its vast, untapped potential makes it crucial to the discussion on organization of healthcare in Africa. Unfortunately, despite its enviable appellate, "Giant of Africa", it has a checkered history of political instability, civil strife and socio-economic upheavals that have hindered all spheres of human existence, especially the health sector.

The currently pertinent healthcare problems in Nigeria revolve around a lack of facilities and manpower, complicated by an ever-increasing rate of emigration of healthcare professionals; poor political will to improve health and healthcare; deep-seated and negative trado-religious beliefs; a general tendency to focus on intervention rather than prevention; and of recent, medical tourism. This is further exacerbated by the demographics of the population, as almost 70% of the population live in rural areas even though most intervention efforts focus on urban areas; the re-emergence of infectious diseases, despite the increasing prevalence of non-communicable diseases; and donor-dependence, all of which create a toxic mix hindering concerted development.

While these problems and their immediate causes are mirrored in other African countries, there are distinct differences in the complexion of these problems all over Africa. For example, in some parts of Africa, healthcare disorganization is more related to widespread poverty. In Nigeria however, the effect of poverty may be secondary to socio-demographical and geographical disorganization of the country, hampering the effect of policies and

health intervention efforts. Also, healthcare utilization rates may be more related to inability to access care in some countries. In most parts of Nigeria, anecdotal evidence indicates that the cost of treatment is a bigger deterrent to healthcare utilization instead.

Despite these differences, the key to solving each individual and Africa's collective healthcare organization problems is simultaneous re-organization both within and between countries, and this must begin with regional coordination, so that countries with similar realities can take mutually beneficial decisions. This re-organization will be expansive in scope, and include policies, national programs, data sharing etc., necessarily including other sectors with sway over the major socio-economic determinants of health. Subsequent country efforts can then be retrofitted from successful efforts elsewhere to accommodate individual country peculiarities. Therefore, the way forward starts at global cooperation with regional focus; followed by an individual country commitment towards smart decisions that advance healthcare.

Keywords: Nigeria, Health Care Organization, Africa

Status of Maternal Health in Kenya and UNFPA's Contribution in Addressing The Challenges in High Maternal Mortality Burden Counties

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Background: Improving Maternal, Newborn, Child and adolescent health is a key global agenda and is a priority for the Government of Kenya as is reflected in its Vision 2030, the Constitution of Kenya 2010 and the Health Sector Strategic and Investment Plan 2014-18. Kenya's Maternal Mortality Ratio (MMR) has declined from 488/100,000 live births to 362/100,000 between 2009 and 2014. Despite the reduction, the current MMR still means that more than 5,000 women and girls die each year as a result of pregnancy and birth-related complications and nearly 200,000 suffer disabilities.

The national average however, masks major in-country variations in MMR. A rapid situation analysis on the burden of maternal mortality (based on the 2009 Population and Housing Census data) demonstrated disparities in MMR ranging from 187/100,000 in Elgeyo Marakwet County to 3,795/100,000 in Mandera County. Using this evidence, UNFPA designed a project to address the gross inequalities by focusing on the six counties (Mandera, Wajir, Marsabit, Isiolo, Lamu and Migori) that account for an estimated 50% of the maternal deaths in the country. The project was implemented between July 2015 and December, 2016 financed with a grant received from the RMNCH Trust Fund.

Methods/interventions: The project's catalytic interventions addressed the following four

objective areas;

1. To increase access and improve quality of RMNCAH services
2. To generate community demand for RMNCAH services
3. To support institutional capacity building at county and national level to deliver on RMNCAH
4. Strengthen Monitoring and evaluation systems

Achievements from the two first years of the project:

A total of 507 additional health care facilities received MNH equipment and are now providing Basic emergency obstetric and newborn care (BEmONC) services in the 6 counties while 14 Comprehensive emergency obstetric and new born care (CEmONC) centers were operationalized with direct support of the project.

The project has provided a platform to engage the Private Sector Health Partnership (PSHP) that brings together multinational companies in support of RMNCAH. By engaging with the private sector it has become possible to harness the strength, resources and expertise of the private sector to design, test and scale innovations for improving access, availability and quality of care.

Examples of initiatives supported by PSHP include support for establishment of Mandera Community Life Centre spearheaded by Philips Ltd, the Lamu Telemedicine project spearheaded by Huawei Technologies and the Mobile obstetric monitoring (MOMs) in Wajir and Migori counties supported by MSD.

Results: Significant improvements in service delivery were recorded for antenatal, postnatal and skilled birth attendance in all 6 counties. The 4th ANC visit improved three times the base line for Mandera, the utilization of FP services doubled and skilled birth attendance also doubled in most of the counties during the two years of the project period.

As a direct result of the project many counties have reported almost twice the demand for RMNCAH services as illustrated by increased uptake of ANC and Family planning services. These can partly be attributed to the innovative demand side financing initiatives, revamping of the community health strategy and engagement of religious leaders as advocates for maternal health.

Conclusion: Data analysis to generate evidence for effective programming is critical in addressing key health challenges such as the burden of maternal mortality and for selecting areas of focus by unmasking the disparities that are masked by national averages for key statistics.

Keywords: Maternal Health, Kenya, UNFPA

14:15-15:30 Session-B7

Success Story of the Partnerships for Health in Africa, Case Study of Male Circumcision Organized in the Democratic Republic of Congo

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Michael R. Reich (Harvard 2000) mentioned that many organizations in public health have declared partnerships with private-sector organizations. Academic institutions have created partnerships with private companies for specific research activities, such as the development of new treatment therapies.

From our experience regarding the PPP for health we present the case study of Male Circumcision conducted in The Democratic Republic of the Congo from 2004 to 2016. Different from other countries, our case study concerns a special partnership involving five groups, the International NGO (Doctors Worldwide), the local NGO (RADEM), the Ministry of Health of the DRC, and the University of Lubumbashi, and the local Communities living in Katanga region. Our key results we have reinforced the capacities of our local staff, by Learning the new technology of Alisklamp devices and we have reduced the time and cost of circumcision operation.

Our PPP Model is the same has the one developed by Charles Boelen (WHO 2001) as the « Penthagon of the Partnership », involving the five groups of actors: Political Authorities, Managers of Health Services, Health Workers, Academic Institutions and the local Communities.

Regarding the report of Jeffrey Barnes (USAID 2011) providing the new definition of the PPP in Health, there is broad recognition that the private health sector can expand its contribution to improve health system and health outcomes in the developing countries.

Keywords: Partnerships, Health, Africa, Male Circumcision, Democratic Republic of Congo

Médecins Sans Frontières (MSF) &HIV/AIDS: More Positive Stories Needed

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Médecins Sans Frontières (MSF) is an international medical humanitarian organization founded by doctors and journalists in France in 1971. MSF provides emergency medical care to millions of people caught in crises in more than 60 countries around the world. In 1999, MSF received the Nobel Peace Prize. In 2015, MSF had 450 projects in 69 countries

in addition to search and rescue operations. Around 54 per cent of activities were carried out in settings of instability. Some 57 per cent of programmes were in Africa, while 28 per cent were in Asia and the Middle East, 5 per cent in the Americas, 9 per cent in Europe and 1 per cent in the Pacific. Largest country programmes based on expenditure are Democratic Republic of Congo,South Sudan ,Central African Republic.

In 2000, MSF began providing ARV treatment to a small number of people living with HIV/AIDS in projects in Thailand, South Africa and Cameroon. At the time, MSF witnessed first hand the toll that HIV/AIDS was taking on communities in lower-income countries, and there was much internal debate about whether or not MSF should get involved with ARV treatment provision. At the time, treatment cost more than US$10,000 per person per year and some questioned whether treatment was too complex to be used successfully in low-income countries. Research conducted by MSF in Uganda, Kenya, South Africa, Malawi and Thailand played a historical role in demonstrating the feasibility and effectiveness of HIV treatment in resource-limited settings. Coupled with activists' work to bring down the cost of drugs, this evidence helped drive efforts to scale up access to lifesaving ARV treatment.

MSF now provides MSF provided care for 333,900 people living with HIV/AIDS and ARV treatment for 240,100 people in 2015.

MSF implements treatment strategies to reach more people earlier in their disease progression, and places people living with HIV at the centre of their care. MSF focuses on community models of care, which separate appointments to see a doctor or nurse for a check-up (which is only necessary once or twice a year for patients whose HIV treatment is working optimally) from picking up a supply of daily ARV drugs (which, depending on the context, can be as often as once every month).

In addition to treatment, MSF's comprehensive HIV/AIDS programmes generally include health promotion and awareness activities, condom distribution, HIV testing, counselling, and prevention of mother-to-child transmission (PMTCT) services. PMTCT involves the administration of ARV treatment to the mother during and after pregnancy, labour and breastfeeding, and to the infant just after birth.

While progress has been made in recent years, persistent treatment gaps in many countries threaten lives and compromise globally agreed goals to curb the HIV epidemic by 2020. In most of the 25 countries of West and Central Africa, for example, fewer than one-third of those in need of ARV treatment receive it. The international community's narrowing focus of support on high-burden countries and HIV 'hotspots' in sub-Saharan Africa has led to greater neglect of people in West and Central Africa. These lower-prevalence regions account for one in five new HIV infections globally, over one in four AIDS-related deaths, and nearly half of all children infected by the virus.

MSF challenges policy barriers that reduce access to affordable medicines such as HIV

treatment, including patents and intellectual property barriers that keep drug prices out of reach. Each year MSF documents the impact of patents or other forms of intellectual property rights on drug prices through the report.

Keywords: Médecins Sans Frontières, Africa, HIV

Health Education Experience as a University in an African Country: Mogadishu Somali Health Sciences University Recep Tayyip Erdogan School of Health Services (SHS)

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Our "Recep Tayyip Erdogan School of Health Services of Somali Mogadishu Health Sciences University" started its training activities by the Health Sciences University in September 2016 at the campus of Somali Mogadishu Turkey Recep Tayyip Erdogan Research and Training Hospital.

Having obtained the required permissions from the Council of Higher Education of Turkey, and the Ministry of Health and Ministry of Education of Somali, our SHS started to enroll students in September 2016. A total of 250 students were enrolled to our school in 2016 and a one-year Turkish preparatory education was started. Currently we have about 230 students who are carrying on with this education. We receive instructor support from the "Yunus Emre Institute" for the Turkish language education of the students. Our school has 5 (five) instructors within the framework of this support.

The training has been planned to be carried out by Turkish and Somali teaching staff together. For this reason, presently we have 6 (six) local teaching staff at our school. This staff is taking Turkish lessons for the science education which will start in the next term. A two-month's visit has been planned to Turkey for this staff during the summer term to both continue their Turkish education and provide them with the opportunity to observe the system in Turkey at the departments related to their fields of study.

With a good quality and need-specific education, our school has focused on raising professional staff who will work in the field of health which is most needed by the people of Somalia. After the Turkish language preparation year, our school plans to provide training on five programs during the 2017-2018 term which are Medical Laboratory Technician, Imaging Technician (Radiology), Pharmacy Services Technician, Anesthesia Technician and Medical Device Technician training programs.

Keywords: Somali, Mogadishu, School of Health Services

Responding to the Challenge of Healthcare Professionals' Deficiency in East Africa- Experience of Competency Based Multi Collaborative Postgraduate Programs in Ophthalmology at Hargeisa- Somali Land

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Somalia is located on the east coast of Africa with a population of 12.8 million. Blindness cataract being the major cause is a major public health problem in Somalia and Somali Land. The estimated blindness prevalence rate is 1.4%, with about 174 000 blind people.

Eye Care services remain destroyed due to long civil war. NGOs provide services only in a few places. The Cataract Surgical Rate is low, at 284 per million population. Postgraduate training for ophthalmologists is nonexistent. Urgent support is needed for planning of Vision 2020 and undertaking prevention of blindness activities. Somali Land is peaceful for the last 15 years and is suitable for sustainable interventions in the field of human resource development.

Capacity Building in Ophthalmology for Somalia and Somali Land

FSV started a two years postgraduate Diploma in Ophthalmology in JAN 2014 and Master program in JAN 2017 at Hargeisa University, Somaliland. First batch of six students graduated in Dec 2015. Second batch of 5 students was inducted in Jan 2016. The course is delivered by the resident faculty comprising a qualified Senior Faculty Member and an Assistant Lecturer and visiting faculty which is contributed by FSV from Pakistan and Jordan who visit for 1-2 weeks once every two months.

There were only 5 practicing ophthalmologists in Somalia and Somali Land, with the graduation of first batch the number enhanced to eleven. This capacity building post graduate program will produce at least 40 eye specialists till 2024. The successful continuation of this program will benefit not only Somalia but various neighboring countries as well.

Impact of the initiative by end of 2016: The first batch graduates have organized themselves into Horn Africa Save Vision and during the year 2016 they performed more than 850 cataract surgeries in various parts of Somalia and Somali Land.

Keywords: Blindness, Cataract, Capacity Building

09:00-10:15 Session-C4

The Politics of China on Africa: Its Invests in the Health Sector in Africa and the African Health Problems

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If we contrast Africa with the other parts of the world it can easily be seen that health is one of the most important sectors where the Africans meet crucial problems which should be solved. In this context, there are some huge infrastructure deficiencies like hospitals. China as a big power is interested in Africa. And it shows this interest also by investing in the healthcare. For that reason, it is important to examine China's African policy.

While China is achieving a consistent development both economically and politically at the global level since 1980, the relations of this East Asian country with global actors and regions are naturally affected by this fact. China is an open/effective rival for the other global/developing power/states in the continent, in terms of her indispensable strategic relations with African countries and potential to improve this. However China's contribution to the continent cannot be denied while her dominant statistics in China-Africa relations bring "A new colonialism in Africa?" question to the agenda. It can be claimed as the major hypothesis of the study that there is more progress to be made and it is not risk-free relation either China's differentiation from the West with her unconditioned support models and investments in Africa to date or absence of colonialist past in the continent render China advantageous over other actors. In this presentation, it will be firstly analyzed the Chinese politics in Africa and then focused on Chinese politics in the health sector in some African countries.

Keywords: China, Africa, African Health Sector, Chinese Healthcare Invests.

African Continent in the Struggle of the Globalization: Which Appreciation?

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The end of the cold war has opened a new political system in the world and the African continent has been embedded into this new order without any preparation. Few years after this scramble, Africa was started to be submerged by the economical development of the world based on the interrelation of economics and exchanges of different part of the world called Globalization. The population of the continent is young and has increased for some

decade. This situation constitutes a richness but also a challenge for the whole Africa. The aim of this paper is to point out the role of Africa in this worldwide system characterized by the transformation of the old structure and the emerging of new systems for example the development of new technologies. This paper will talk about the concept of globalization in African context through historical perspective. It will base on different topics which treated about the topic through a selective bibliography. The results of the research will be outlined in three aspects. The first aspect, will describe the process of the globalization in Africa and the second result will be based on the different actors who contributed to the entrance of the African continent in this new system. The last aspect will focus on the consequences that occurred since Africa is opened to the globalization and the way African leaders try to find solutions to the problems of the continent.

Keywords: Globalization, Struggle, Emergence, Development, African Leaders

Brain Drain as an Obstacle of Health Sector Development in Africa

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Background and Aim: Brain drain is the abnormal form of scientific exchange in favour of developed countries. Brain drain is not only a symptomatical phenomenon but it is an expressive of fundamental difficulties as well. For Africa, it means a great number of qualified health professionals' imigration. What are the reasons of this imigration; why are these African health professionals deciding not to return back to Africa and what can be done to gain these brains back?

Methods: In this research we interviewed 22 students of Adnan Menderes University Medical Faculty and Health Sciences Faculty. Students were from ten different African countries. We asked the reasons of their studying abroad and their plans after graduation.

Results: The reasons of their studying abroad were listed as; war, political instability, social agitation, low wages, declining quality of educational system, lack of intellectual freedom, lack of research facilities and career opportunities, inadequate research funds, tribal discrimination in recruitment. And as they told their plans after graduation are as not to return back! Students told that "African students are still being forced for going to the developed countries to study medicine and health sciences because problems are still going on" .

Conclusion and recommendation: We think that medical students need to be supported morally with ideas that they are the only ones who can change the health sectors. African countries' governments should focus on the motivating factors for these qualified people such as offering higher wages and income, higher standards of living; better working con-

ditions, job career opportunities and professional facilities; substantial funds for research, advanced technology, modern facilities and availability of experienced support staff; political stability; modern educational system, prestige of foreign training; meritocracy and transparency in promotions; intellectual freedom to ensure that the brain remain in the continent otherwise in a few decades the continent may lose all the brains.

Keywords: Brain Drain, African Health Professionals

Medical Services for Rohingya Refugees in Malaysia: Experiences to Share for Africa

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In 2012, there was a surge increased of Myanmar refugees into Malaysia due to a wave of mass violence broke out in Rakhine state, which resulted in death, forced displacement, destruction of homes and properties, and loss of livelihoods. These violence was targeted to one ethnicity, the Rohingya people. Rohingyas, is a Muslim minority ethnic group from Rakhine state of Myanmar. As of end January 2017, there was 56,135 Rohingya refugees registered with UNHCR in Malaysia.

Since Malaysia has not ratified the 1951 United Nations Convention Relating to the Status of Refugees, Federal Government does not have obligation to protect or grant any legal status to the refugees. Rohingyas who have arrived safely in Malaysia have no legal status and are unable to work. Many of them are illegal workers, surviving on part time jobs with relatively low wages, leaving their families cut off from access to education and healthcare. Lack of education and employment opportunities, as well as access to healthcare services, place the Rohingya people to face a cycle of poor infant and child health, malnutrition, waterborne illness and lack of obstetric care.

IMARET is a relief team under Islamic Medical Association of Malaysia (IMAM). IMARET have been directly involved in the healthcare of the Royingya refugees in Malaysia for the past two years through the set-up of bi-monthly mobile primary care clinics in Klang Valley, Malaysia.

Methodology: This retrospective, cross sectional study aim to uncover the health determinants and pharmaceutical use of the Rohingya refugees in Malaysia based on the data recorded from our clinics for the past one year.

Results: Out from 1402 patients, diagnosis related to respiratory system is on the top rank (25.5%, n=446) while the reproductive system is the lowest (0.2%, n=3). From all the available drugs in mobile clinic, non-opioid analgesic is the most prescribed drugs (26.2%, n=852), followed by supplements (11.8%, n=383), NSAIDs (10.8%, n=351), anti-histamine (6.9%, n=223) and cough preparation (6.6%, n=216).

Conclusion: We would like to highlight our experiences on running this clinic which hopefully be of benefit to other organization providing health services to refugees in Africa.

Keywords: Rohingya, Refugees, Mobile Clinic, Health Determinant

Role of Doctors Without Borders Organization in Africa: Realities and Perspectives

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In general, non-governmental organizations that were established and based in developed countries aim to help by their nonprofit activities the weak and fragile countries of the South, which have been witnessing structural an complicated crisis in ample aspects. Over the past decades, Africa has been an essential continent for work of several non-governmental organizations that differ in terms of their roles depending on activities, sizes and purposes of each organization.. Among those ones, Doctors Without Borders (in French Médecins Sans Frontières MSF) represents one the most active non-governmental organizations in the questions of health in Africa, where it participates in delivering emergency medical aid to people affected mainly by epidemics, natural disasters, or exclusion from health care. Moreover, the humanitarian role of Doctors Without Borders has emerged in many armed conflicts the African states have witnessed since the seventies of the last century, Where MSF has played a big role in providing medical aid for local people affected by the scourge of conflict.

This study aims to provide an overview on Doctors Without Borders, as well as the role and activities of this organization in the African continent in the health sector. It will also highlight the humanitarian intervention of this non-governmental organization, especially during the violent armed conflicts, taking Rwanda and Darfur as cases of study. The study will discuss in its last part the new challenges that are facing MSF in light of the current crisis that the African states have been dealing with over the past years.

Keywords: Africa, Health, Humanitarian Aid Organizations, Doctors without Borders

Aid Campaigns for Africa: The Humanitarian Communication Ethical Dilemma

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Aim: The aim of this study is to analyze the ethical dilemma of the aid campaigns and activities held by aid agencies for Africa in accordance with the humanitarian and media codes of conducts.

Methodology: The methodology of this research depends on reviewing previous literature relevant to the topic to evaluate the aid campaigns and their influence.

Results: Previous literature mostly studied the ethical perspective of the representation of suffering bodies in aid campaigns yet, very few referred to the campaigns that were designed to aid the African continent and their influence.

Discussion and Conclusion: Humanitarian NGOs work to organize awareness and aid campaigns to support vulnerable people living under hard circumstances. Compared to other advertising campaigns, these campaigns have both more advantages and disadvantages. First and foremost, the elements of these campaigns depend on directly reflecting the reality with minor editing. Among these elements are images reflecting the bare truth or a sentence uttered by a child or an adult vulnerable to death. These elements are used to bring the distant victim to donor publics to bridge distance, yet this task is a hard one. On one hand, there are those who are vulnerable to all types of danger and you are obliged to reflect the reality, and on the other hand, there are donors who do not want to be exploited and aim at only helping others. Ethically, it is an obligation to protect the rights and dignity of others while seeking the maximum profit. In this regard, we conclude that these aid campaigns require not only the representation of reality but also following the media and humanitarian codes of ethics. However, in cases of crises and emergencies, to what extent is it possible to maintain these codes or carry out a campaign which does not involve any emotional exploitation, nevertheless successful?

Keywords: Africa; Aid Campaigns; Media Ethics; Humanitarian Ethics; Non-governmental organizations

10:15-11:30 Session-C5

Stigma from Psychoactive Substance Use: Sociodemographic Correlates of the Perceiver

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Introduction: Psychoactive substance use and abuse have been identified as the most stigmatized health condition. This often arises from 'public', 'self' and 'courtesy' stigmas and biases. In Nigeria, studies on stigma of psychoactive substance use and abuse are few and mainly from the perception of medical service providers. No previous Nigerian study according to search by the authors had published on stigma of psychoactive substance use from the perspectives of non-medical persons. This research is therefore aimed to study the prevalence and associated sociodemographic variables of public stigma meted out to users of psychoactive substances.

Methodology: The study instruments were filled by 480 members of staff of Kaduna refinery after obtaining their informed consents. Information on age, gender, educational characteristics and scores on Perceived Stigma of Addiction Scale (PSAS) were collected and analysed with IBM-SPSS version 21.

Result: Participants with no formal education significantly contribute to high stigma. The internal reliability of PSAS is relatively low (α=0.558) but acceptable. Belonging to middle age group and male gender are the two demographics that have non-significant low stigma mean scores.

Conclusion: Participants with no formal education are noted to have high public stigma against substance abusers. It is hoped that this study do provide a platform for interventional guide in reducing and preventing public stigma towards people with psychoactive substance use disorder.

Keywords: Stigma, Substance Use, Perceivers' Variables

The Sociological Cause-and-Effect Relationship of "Female Genital Mutilation" Applied in Africa

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The fact that FGM is an application which began in ancient times and is still being done today is a question that needs to be answered. FGM is practiced in warm countries in the southern hemisphere, but not in the cold countries in the northern hemisphere. According to functional anatomy studies, the labia minus of the women who live in warm climates are longer. These longer labia minus completely cover the clitoris and block sexual pleasure. At the same time, they block labia major which are close to the vagina by dangling from the cleft. They can reduce the quality of life for women apart from having sex because of esthetical and comfort concerns.

If FGM was done purely for sexual pleasure concerns, only the labium minus would be shortened. However, the cut of the clitoris is a pure torture. It is clear that infibulation, which poses a life-threating risk from the time it is performed until the woman's death, is also a savage act. By doing these interventions, sexual pleasure becomes no longer available and painful sexual intercourse is replaced with sexual pleasure, however the continued generation still be maintained. Why?

FGM began in ancient times and continues. This situation should make us deal with this phenomenon more consistently and more realistically, and look for a cause -and- effect relationship.

In order to stop sexual relationships from occurring outside of marriage in warm climates such as Africa, people came to consider the concept of preventing sexual relationships through a painful, disturbing and repellant situation, by cutting men's or women's sexual organs. If men had cut their own sexual organ, it would not be possible to continue one's bloodline. Therefore, it leads us to believe that they came up with the idea of blocking women's sexual pleasure through FGM.

Women in cold countries have to wear layers of clothing to be protected from cold weather. Also, cold weather can have an effect on hormones and sexual attraction, thus out of marriage sexual relationships may not occur so frequently, and there is no need for FGM.

Keywords: Africa, Female Genital Mutilation, Functional Anatomy, Sociology

Recommended Measures to Prevent Female Genital Mutilation and its Harmful Consequences

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We know that it is impossible to eradicate ancient traditions (Pediatrics 1998; 102; 153) that have been practiced for centuries in a short time. Moreover, a prejudice caused by the imperialist countries leads to a negative reaction to taking part in this eradication. All positive actions taken for female genital mutilation (FMG) by the imperialist countries, which gained a negative image in the eyes of the ingenuous and harmless African people, like American Indians, by initially enslaving and then economically, socially and psychologically damaging them. African people think that the actions of the imperialist countries against FGM are a continuation of these countries' cruelty, which they have encountered in every aspect, and rightfully react negatively.

Eradication of any kind of negative situation can only be achieved through a cause and effect relationship. The results cannot be changed without changing the reasons. The reasons for FGM were explained in the previous papers.

The recommended measures are: Long-term education programs should be organized and made widespread to correct false information about FGM and disseminate accurate information. The power of Islamic sanction within the scope of the commands and prohibitions of Islam should be brought into force against FGM. The eradication of FGM should be attempted within the scope of faith, which is more effective, by indicating that FGM is both HARAM (forbidden) and BID'AH as clearly and definitely indicated in both the QUR'AN and in Muhammad the Prophet's hadiths and in FAREWELL SERMON(VEDA HUTBESİ).

CIRCUMCISION (SUNNE) which is crucial to increase sexual health and pleasure required for a sexual intercourse, should be substituted for FGM.

FGM, which is HARAM and BID'AH, should be eradicated and replaced with obedience to Allah and His Prophet Muhammad who leads people to heaven.

A long-term information and implementation program should be initiated with the Islamic scholars in Islamic countries and in Africa. Sustainable education projects should be rganized in Islamic countries and in sister African countries.

Keywords: Africa, Female Genital Mutilation, Education, Eradication

Adolescent Health Analysis of the African Region

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World Health Organization (WHO) defines adolescents as those aged 10-19 years. Adolescents have significant health problems in Africa. Early unwanted pregnancies, septic abortions, sexual abuse, HIV, alcohol and substance use and abuse and vulnerability to risks associated with early sexual activity and child marriage, and limited access to family planning services are the leading problems of adolescent health in Africa. The health indicators are the worst in Africa. There is a high adolescent pregnancy rate in the Region. Adolescent fertility rate (per 1000 girls aged 15-19 years) in the African Region, 2008-2012 at 116 per 1000 in (Figure 1). Girls who do become adolescent pregnant need access to quality antenatal care. Adolescents who opt to terminate their pregnancies should have access to safe abortion. Reducing the number of unplanned births among adolescents allows younger women to continue to study, which in turn improves women's social status and economic output. In 18 African countries have that women and males are allowed to marry below 18 years of age. The prevalence of child marriage in Africa varies across countries, with the highest (75%) in Niger. Access to family planning is very important for young people. However, access to services is very limited owing to the lack of health-care services, the lack of information and counselling, and the financial and psychosocial barriers. Unmet need for family planning, among girls aged 15-19 (%) in the African Region, 2004-2011 is 27. About 41% of new annual HIV infections are occurring in this population. HIV is now the leading cause of adolescent death in sub-Saharan Africa. Adolescent for health and development should be adopted a holistic approach. Early diagnosis and appropriate treatment in adolescents may improve the results of future health. About adolescent and youth health issues, must developed youth-friendly quality health-care services and laws males and females to be 18 years of age or older before marriage.
Keywords: Adolescent, Adolescent Health, Africa

Health and Nutrition Problems in Sub-Saharan Africa

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Introduction: of the most important factors underlying health problems in Africa is nutritional deficiencies. The health care organizations that we have organized in these regions have examined the diseases that the malnutrition also plays a role in the etiology and which can be treated by surgical treatment. We aimed to discuss the policy of food and health aid for sub-Saharan Africa as public and non-governmental organizations of Turkey.

Material-Method: Between 2006 and 2017, a total of 24 health-aid travels were organized in cooperation with civil society and public institutions in Niger, Chad and Mali from sub-Saharan African countries. While providing health services as voluntary organizations, "Goat Brother Family Project" and "Water Wells Projects" which we made for the solution of nutritional problems such as hunger and thirst which affect the health negatively were examined. Nutritional deficiencies also play an important role in etiology; the cases of inguinal hernia, sistolitiasis and uterine prolapse were examined in terms of frequency and grade.

Results: All trips; General surgery 1516, urology 1068, gynecology 689, total of 3273 operations were performed, respectively. 849 of the general surgery operations were inguinal hernioraphy, 147 of the urology operations were systolithotomy, and 463 of the gynecologic operations were uterine prolapse surgery. The incidence of malnutrition in the etiology of the disease was 1459 and the rate of all operations was 44.57 %. 20,571 goats were distributed under the "Goat Brother Family Project". In the scope of "Water Well Project", 486 drilling wells were opened.

Conclusion: In Sub-Saharan Africa, hunger and health problems have been intertwined and the development of agriculture and livestock sector which is based on economic development and growth, the ending of internal and external conflicts, the regulation of immigration, efficient use of underground and overhead sources of the country, should be one of the priority issues for the treatment of nutritional deficiencies and related health problems. Thus, we believe that common cases like inguinal hernia, sistolithiasis and uterine prolapse will decrease.
Keywords: Nutritional Deficiencies, Health Problems, Sub-Saharan Africa

Iron Deficiency: The Greatest Nutritional Challenge in Africa

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Iron deficiency and Anemia are major public health issus that Africa still suffering from; 50 of women in childbearing and 74 of children aged 6 – 59 months suffer from this disease according to a study that included 11 African countries (2015). It kills also 273000 person in the world which Africans make 30 of them according to statistics of the world organisation of health (2004).

Poor physical health, hypoimmunity and morbidity rate increase especially recurrent infections, cognitive delay and poor concentration are the most serious complications and the most common for children and infants.

For pregnant women it can cause weight loss, birth defects abortion and death of the fetus in his last months.

Adults suffer from a lack of endurance, concentration and poor productivity by 10 to 15 which leads to 15 of Gross National Product decrease according to the World Food Organization (2002).

The statistics confirm that the first cause of iron deficiency and other micronutrients such as Vitamin A, Iodine, Zinc or what is known today as "hidden hunger", is malnutrition, poverty and epidemics such as Malaria and intestinal worms that causes inflammations which causes iron malabsorption.

Encouraging and extending breastfeeding, improving infant and supplementary feeding, providing daily doses of Iron to children in need, and making a nationwide programs of iron fortification of flour and local food are the most important ways to control this deficiency that presents the biggest nutritional challenge for Africa.

Keywords: Iron deficiency, Nutrition, Africa, Anemia

Potential Drug-Drug Interaction Occurrence in Adult Patients on Antiretroviral Therapy in Lagos, Nigeria

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Objective: Drug–drug interactions are an important therapeutic challenge among human immunodeficiency virus-infected patients. Early recognition of drug–drug interactions is important to prevent potentially adverse outcomes. The study documented the commonly used antiretroviral therapy (ART) regimens and their co-prescribed non-antiretroviral drugs (CPD) and evaluated potential clinically significant drug interactions (CSDIs) occurring between them.

Design: A retrospective 10 year open cohort study

Settings: A large HIV treatment centre (APIN clinic) in a federal teaching hospital, in Lagos Nigeria, caring for over 20,000 registered HIV-infected patients.

Participants: Electronic case files of 500 participants who received treatment between 2005 and 2015, were randomly selected and reviewed retrospectively.

Main outcome measures: All ART regimens and CPD prescribed within the 10 years study period were extracted from the case files of the patients and evaluated for potential CSDIs using drug interaction checker of the Liverpool HIV Pharmacology group.

Results: Of the 500 cases reviewed, 421 (84%) patients were at risk of CSDIs most of which were moderate (410, 82%) and frequently involved co-trimoxazole + zidovudine (or stavudine) /lamivudine (386, 77.2%) and artemisinin-based combination therapies (ACTs) + NNRTIs or PIs [296, 59.2%]. The NRTIs and the NNRTIs were significantly associated with CSDIs ($p<0.05$) while age ($p = 0.969$), sex ($p=0.789$) and the PIs ($p = 0.365$) were not.

Conclusion: There is potential for CSDIs between ART and CPDs with co-trimoxazole and artemisinin combination therapies being most commonly involved. Further studies are required to evaluate the pharmacokinetic and clinical relevance of these interactions.

Keywords: Drug Interaction, Antiretrovirals, Non-antiretrovirals, PLWHA, LUTH

11:45-13:00 Session-C6

Predictive Score of Severe Acute Malnutrition in Children under 5 Years in Developing Countries

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Introduction: The nutritional status is the best indicator of the well-being of the child. Inadequate feeding practices are the main factors that affect physical growth and mental development. The aim of this study was to develop a predictive score of severe acute malnutrition (SAM) in children 6 to 59 months.

Materials and methods: It was a case-control study. Cases were children 6 to 59 months admitted to hospital for SAM which was defined by a z-score weight / height <-3 SD or <-2 SD with presence of edema; the control were children of the same age admitted to the same hospital for another condition other than the SAM. The number of subjects included in the study was 263 cases and 263 controls. We performed a univariate and multivariate analysis. Discrimination score was assessed using the ROC curve and the calibration of the score by Hosmer-Lemeshow test.

Results: After logistic modeling, new criteria emerge as predictive factors of SAM: low birth weight, repeated or chronic diarrhea, daily meal's number <3, age of breastfeeding cessation <6 months, age of introduction of complementary diet <6 months, age of mother <25 years, parity <5, family history of malnutrition, and number of children aged less than 5 years in the house ≥3. To each of these criteria, it was assigned a coefficient to determine the predictive score of MAS. The area under the ROC curve of this score was 0.9685, his sensitivity was 93.5%, and his specificity 93.1%. The positive predictive value and the positive likelihood ratio were 93.2% and 6.8% respectively.

Conclusion: We propose a simple and efficient score predictive of the risk of SAM risk of occurrence of SAM in a population of less than 5 years in developing countries. This predictive score of SAM would be a useful and simple clinical tool to identify people at risk, limit high rates of malnutrition and reduce disease and child mortality registered in developing countries.

Keywords: Severe Acute Malnutrition, Predictive Score, Risk Factors, Children

National Program of Newborn Screening for Congenital Hypothyroidism in Morocco Situation and Prospects

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Context: Congenital hypothyroidism can cause mental impairment and growth retardation in newborns. Early diagnosis through newborn screening and treatment of hypothyroidism can prevent the complications of this disorder.

In Morocco, since 2012, National Newborn Screening Program for congenital hypothyroidism has been established by the ministry of public health in order to reduce the prevalence of mental handicap.

To implement the NNBS for congenital hypothyroidism, three main phases were defined: pilot phase, Expansion Phase, Nationwide

Results: The pilot phase was launched from March 05, 2012 to March 19, 2014.in seven public health care structures all of which represented 80% of expected births in the pilot site. Health professionals and laboratory technicians were trained in sampling techniques, routine analysis and diagnosis confirmation. Equipment and reagents have been acquired, a manual guide in support of newborn screening activities directed at health care professionals has been developed. Educational materials have been developed. A monitoring system has been set up with monthly records and reports by professionals at the different health care level involved in the program. Monitoring indicators for the processes and the results were defined.

Data analysis of the pilot phase established a prevalence of 1 births with congenital hypothyroidism over 1,613 live births. The implication of greatly motivated multidisciplinary team resulted in a clear improvement in the quality of the NBS program with progressively reduced time transfer of samples between the health delivery unit and the analytical laboratory. Involvement of careers was increasing progressively and effectively. Diagnosed cases had subsequently a hormone replacement therapy, medical monitoring. Parental awareness about neonatal hypothyroidism increased as well.

Conclusion: To date the program has been expanded to three new sites and an action plan has been established to subsequently implement the programnation wide and equip all regional laboratories.

Keywords: Neonatal Screening, Congenital Hypothyroidism, Prevention, Substitution Therapy.

The Status of Early Initiation of Nutritional Suppliments and Its Influencing Factors among Babies in Uganda

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Introduction and Purpose: Early initiation of supplementary nutrition refers to introduction of non-breastmilk nutrients to babies within the first six months after birth. This study was to identify the underlying situation of the early onset of supplementary nutrition in children under the age of five and the factors affecting initiation of supplementary nutrition in the first three days of birth between 2006 and 2011 in Uganda

Materials-Methods: This was a cross-sectional study. Researchers used the 2011 Uganda Demographic and Health Survey (UDHS) micro-data with permission from the Demographic and Health Surveys (DHS) Program. The study involved women in the 15-49 age group participating in the 2011 UDHS, which was a total of 8,674 women. 4,774 women with their under-five children from the 2011 UDHS micro-data who had sufficient data were used for this research. The dependent variable was the early initiation of supplementary nutrition (first three days of birth). Independent variables were; maternal socio-demographic factors, economic and fertility characteristics, prenatal and birth care and characteristics, baby's gender, birth weight and initiation of breastfeeding. Chi-square and logistic regression analysis were performed.

Results: 40.3% of women initiated supplementary nutrition in their children earlier (first three days). It was found that economic level (moderate), assisted by non-health profes-

sional and unassisted-deliveries and babies who started late to breastfeed increased the risk of early supplementary nutrition initiation (p <0.05). Early initiation of supplementary nutrition was also 2.15 times more for economically moderate mothers, 2.02 times for rich mothers, 1.73 times for mothers delivering without health staff assistance, 4.35 times for unassisted delivering mothers, 2.49 times for mothers delivering twins, whereas 5.08 times mothers initiating breastfeeding in the first day of birth.

Conclusion and Recommendations: Mothers in good economic status, more educated, unassisted births and late breastfeeding initiation were more likely to early initiation of supplementary nutrition. This result shows that like developed countries, mothers with high education and economic status in developing countries gave less importance to exclusive breastfeeding. Initiatives should be taken to prevent this situation which is risky for the child's health.

Keywords: Breastfeeding, Breastmilk, Child, Early Initiation of Supplementary Nutrition

Risk Factors of Low Birth Weight in Lubumbashi, Democratic Republic of Congo

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Objective: The aim of this study was to identify risk factors for occurrence of low birth weight (LBW) in the city of Lubumbashi.

Methodology: It was a case-control study of births (singleton pregnancies) from July to December 2014 in 3 referral maternity in the city of Lubumbashi (DR Congo). Sociodemographic characteristics, maternal history and sex of the newborn in the study group (<2500 grams) were compared to those of the comparison group (2500-3999 grams). The usual statistics and logistic regression were used to analyze the results. The significance level was set at p <0.05.

Results: We observed that the low level of education (aOR=2.5 [1.5-4.0]), having an occupation (aOR=2.0 [1.3-3.1]), no prenatal care (aOR=2.5 [1.5-4.2]), maternal anemia (aOR=7.6 [2.3-24.8]), malaria during the pregnancy (aOR=1.5 [1.0-2.3]), urogenital infections during pregnancy (aOR=1.6 [1.1-2.5]), gestational hypertension (aOR=2.7 [1.5-4.9]), maternal malnutrition (aOR=8.3 [2.4-28.5]) were significantly associated with LBW.

Conclusion: The present study shows that certain demographics and maternal medical and obstetrical history have a great influence on the birth of a LBW. Since some of these

factors can be addressed and treated, the reduction of neonatal morbidity and mortality related to LBW through accessibility and improving the health care system in our city.

Keywords: Low Birth Weight, Risk Factors, Childbirth, Lubumbashi, Democratic Republic of Congo

Maternal Mortality Related Factors in The WHO African Region

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Background: Maternal mortality shows a wide varity in the WHO African Region, ranging fron 140 to 1360 (per 100.000 live). Our aim is to determine some of the factors related with maternal mortality and to measure the strength of the relations in the WHO African Region Countries.

Methods: An ecological-multigroup study has been designed comparing rates in the WHO African Region using recently available data from 2005 to 2015 WHO Data Bank. The maternal mortality rates is the dependent variable. Health system related factors, economic indicators and female literacy are the independent variables.

Results: In bi-variate analysis, inverse relationship is observed between maternal mortality and General Government Health Expenditure as % of Total Health Expenditure, births attended by skilled health personel ratio, health personnel density, female literacy. In contrast, Out of Pocket Expenditure as % of Total Health Expenditure has a positive correlation with maternal mortality ratio.

Conclusion: Not only health system related indicators but also economic indicators and other factors like female literacy have relationship with the maternal mortality ratio. In African region, health system should be strengthen to be effective without the requirement of out of pocket costs.

Keywords: WHO, Africa, Factors, Maternal, Mortality,

14:15-15:30 Session-C7

Study on the Barriers to Use Magnesium Sulfate by Health Professionals in Morocco

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Objectives: Determine the barriers to the use of Magnesium Sulfate by health professionals; Evaluate the procedures for its implementation.

Methodology: As part of the accelerated reduction in maternal and neonatal mortality and morbidity, the Ministry of Health has adopted the use of Magnesium Sulfate as the treatment of choice for eclampsia and pre- severe eclampsia.

Thus, this drug and its antidote were acquired, its protocol was developed and disseminated, and training sessions were organized for midwives, general practitioners, gynecologists and resuscitation anaesthesiologists from different regions in the region. To educate them about her job.

An exploratory study focused on the representativeness of the types of delivery structures and the user and manager profiles of Magnesium Sulfate was conducted by the national program managers.

Results: Almost 75% of childbirth structures report that the use of Magnesium Sulfate has become a common practice for the treatment of severe preeclampsia and eclampsia. The product is known in more than 40% of cases (contraindications, adverse effects, signs of overdose). The product is available and the protocols for use are displayed in all delivery structures. The regional directorates and provincial delegations of the Ministry of Health were involved in the introduction stages of Mg Sulfate However, some health professionals do not adhere to the protocol for the use of this drug and claim to have a phobia caused by the introduction of this treatment for fear of side effects such as respiratory arrest.
Keywords: Magnesium sulfate, Eclampsia, Brakes, Barriers, Availability

Health Professions Gap in Somaliland: Challenges and the Way Forward

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Background: Despite the implementation of multifaceted interventions by the government and development partners to address the challenges facing human resource for health in Somaliland, profound deficiencies in quality and quantity of health professionals continue to plague the healthcare system of Somaliland.. As a result the key health indicators rapidly declined to being among the worst in the world. For instance, under five mortality rate is 225 per 1000 live births, Maternal Mortality Ratio 732 per 100,000 live births, and 61 per 1,000 infants die within their first month of life. No progress has been made to lower this in the last 20 years partly due to inadequate health staff. Aim: The aim of this report is to highlight the gaps in health professions in Somaliland and to offer recommendations that can be adapted for the ultimate goal of improved healthcare.

Methods: Mixed methods using qualitative designs and secondary quantitative data were employed to conduct the assessment. The primary source for qualitative data was key informant interviews with relevant Ministry of Health officials sampled purposively while quantitative data was extracted from relevant secondary sources including MoH Findings: Two dominant themes out (1) The need to offer new health programs in medical schools to meet the health needs of the population and (2) Increasing in-service training opportunities for health professionals. As such, the assessment indicated the need to establish new health programs in medical schools to reduce the acute shortage of key health cadres. The health programs include: Postgraduate for medicine dental and surgery, Bachelors in Pharmacy, Imaging Science and Dentistry. The interviews emphasis the post-graduate programs than undergraduate due to limited specialists. This can be addressed by increasing in-service training opportunities for healthcare workers.The health training institutions can take the initiative to continuously provide in-service trainings and continuous professional development to health professionals especially in teaching hospitals to improve the quality of practice and inter professional collaboration.

Conclusion: There is need to employ novel strategies to overcome the two gaps existing in health professions. Addressing these gaps will meet the health needs of the citizens in Somaliland.-

Keywords: Somaliland Medical Association, Ministry of Health, Health Information Management System

Health Workforce in Somalia: a Policy Analysis

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The Somali human resource for health (HRH) crisis is of a highly significant magnitude, ranking among the worst in the world. Considering the global thresholds set by WHO for the collective density of doctors, qualified nurses and qualified midwives of 23 per 10,000 population. The purpose of this study is to analyse the health workforce and to demonstrate the current situation of human resources for health in Somalia. To analyse the policy of human resource for health in Somalia, heuristic model of policy making process is used to look back the health workforce specially the last 6 years. In addition that, retrospective study is flowed to inspect the policy of the health workforce particularly the available documents including government reports and international articles published on the internet for the last dedicates. According to the study findings the health systems of sub-Saharan Africa have been badly damaged by the migration of their health professionals which is entirely related to the "Brain Drain" of the global south. The lessons learned from the study also indicates that there is a big gap in Somali health workforce. In addition that, the issue

of workforce insufficiencies in healthcare has become a global concern and one of major policy agendas. Lack of a comprehensive evidence of this study is the major limitation particularly in Somalia. There is also a need for developing new policies and strategies to highlight the HRH crisis in Somalia.

Keywords: Africa, Health, Human Resources, Migration, Somalia.

Public Private Partnership in Healthcare Sector: A SWOT Analysis for Africa

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This article explores the public–private partnerships (PPPs) phenomena, a short background, assessment and definitions of public-private partnership, the reasons which contribute to increasing demand of PPPs, worldwide Implementation in various sectors. This article further focuses on the application and evaluation of Health PPPs in African perspective. Presented with vivid examples below, Health PPPs in Africa exists as both tradition PPP (western) and collaborative efforts by various actors, funding institutions, donors and other actors in the world which support interventions necessary to save lives, treat and protect the population from diseases; in terms of strengthening health services, improving advocacy and health education, improving health regulation, quality and standards and achieving global health financing coordination. This enables the smooth implementation various health projects via public and private cooperation. Lastly, A SWOT Analysis is made to assess the public-private partnership in Africa, along with suggestions to overcoming the weakness.

Keywords: Health Policy, Health PPPs, Africa, SWOT analysis.

Utility of a Biomedical Inventory: Case of Benin

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Introduction and Context: Improving access to health services is one of the main lines of action of the Ministry of Health. Following the elaboration of standards and standards for infrastructures and equipment of health facilities at all levels, an inventory is needed to determine the deficiencies to be corrected. This led to a complete inventory of infra-

structure and equipment across the country, beginning with 4 departments of Benin's 12. Objective: Have a database for decision-making.

Methods: The methodology used for this work is the mobilization of financial and human resources made up of biomedical technicians and engineers, the preparation of data collection sheets and the analysis and sharing of data.

Infrastructure data relate to premises, biomedical waste management, excreta management, drinking water, energy sources and administrative securitization of estates. 15000 biomedical equipment, refrigeration equipment and medical furniture are listed. The inventory enabled some equipment which had been declared inoperative to be switched on but which was not.

Results: 75% of the equipment is functional and used, 12% is in good condition but not used, 11% is down and 6% equipment is discarded. 38% of the equipment inoperative is biomedical equipment, 28% of non-functional equipment is donated.

12% of the equipment is switched on by the technicians by training or connection.

Conclusion: The biomedical inventory is an important phase which has led to the development of a maintenance plan and will be useful for the multi-year equipment plan. It is more important than a gross inventory carried out within the framework of administrative management

Keywords: Inventory, Biomedical, Equipment, Benin

The Views of Key Stakeholders in Zimbabwe on the Introduction of Family Medicine: A Qualitative Study

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Background: Strengthening primary health care (PHC) is a priority for all effective health systems and family physicians are seen as a key member of the PHC team. African family physicians, however, have different roles in the team when compared to those from high income countries. Zimbabwe has joined a number of African countries that are seriously considering the introduction of family medicine training. Implementation of training, however, has not yet happened.

Aim: To explore the views of key stakeholders on family medicine

Setting: Key stakeholders in the Zimbabwean health and higher education systems.

Method: Twelve semi-structured interviews were conducted with purposively selected key stakeholders. Data were recorded, transcribed and analysed using the framework method.

Results: Anticipated benefits: More effective functioning of PHC and district health services with reduced referrals, improved access to more comprehensive services and improved clinical outcomes. Opportunities: International trend towards family medicine training, government support, availability of a small group of local trainers, need to revise PHC policy. Anticipated barriers: Family medicine is unattractive as a career choice because it is largely unknown and may not be recognised in private sector. There is concern that advocacy is mainly coming from the private sector. Threats: Economic conditions, poor remuneration, lack of funding for resources and new initiatives, resistance from other specialists in private sector.

Conclusion: Stakeholders anticipated significant benefits from the introduction of family medicine training and identified a number of opportunities that support this, but also recognised the existence of major barriers and threats to successful implementation.

Keywords: Family Medicine, Primary Care, Zimbabwe, Africa

15:30-16:45 Session-A-B-C-8

From Emergency Aid to Integrated Community Development – the Benefits of a Holistic Approach to Health

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Protecting life and improving health is at the very root of Islamic Relief's work as an international aid agency. Our organisation was established in 1984 by a group of medical students in the UK who were horrified by the human cost of famine in Sudan and were determined to help save lives.

Since then Islamic Relief has grown into the world's leading Muslim faith-based humanitarian aid agency, with over 100 offices in more than 40 countries. We have assisted over 110 million people around the world, and the generosity of our donors means we deliver over $130 million worth of aid each year.

It is tragic to reflect that we have come full circle in our 33-year history. Today South Sudan is once again in the grip of famine, and there is a real threat that severe drought will turn into famine in Kenya, Somalia and Ethiopia too. Islamic Relief is there on the ground in all four countries, providing life-saving food, water and other emergency aid.

Emergency response for those affected by natural disasters and conflict still accounts for over 70% of our programme spending globally. Alongside this, however, we are finding that the best prospect for long-term community health and well-being is to promote and

support integrated community development. Ultimately it is poverty that makes people so desperately vulnerable to the ravages of disease and climate change, and it is investment across the board in all areas of poverty alleviation and community development – such as livelihoods programmes, water and sanitation, education and disaster risk reduction – that holds the key to breaking the cycle of poverty.

In the areas where Islamic Relief works, the lack of clean water and adequate sanitation and hygiene account for disease and death on a significant scale. In the current drought 60,000 people have been affected by acute watery diarrhoea and cholera in Somalia and south-eastern Ethiopia alone. The health of women and girls is affected not only by water-borne disease but also by the gruelling task of fetching water over long distances each day – typically as far as 10-15km.

In addition to a severe lack of health facilities, millions in sub-Saharan Africa are unable to access the basic health care available because their income is inadequate. The poorest households cannot even afford to buy a treated mosquito net, which costs just a few dollars. Pregnant women are often malnourished due to a lack of nutritious food. Babies are born underweight and continue to suffer from malnutrition throughout their formative years. Where education provision for both children and illiterate adults is lacking, and where families cannot afford to send their children to school, there is very low awareness around nutrition, health and sanitation – reinforcing vulnerability to ill health.

Islamic Relief's development programmes are generating a wealth of ideas that can help break the cycle of poverty. These include highly effective disaster risk reduction projects in Kenya and Niger, delivering solutions such as drought-resistant crops, irrigated horticulture in place of unsustainable livestock farming, and building community microdams that not only provide clean water but also sustain vegetable cultivation through much of the dry season – improving livelihoods and nutrition and reducing migration. In Ethiopia simple and cost-effective mother-to-mother mentoring is showing the potential for a transformative impact on women's empowerment, education and health.

From policy makers and funders what we need to see is an increasingly holistic approach to the design and delivery of development programmes. Our grassroots experience is that better access to clean water and better livelihoods can translate into better school enrolment, better education, better health and better long-term prospects for all. Flexible and innovative approaches need to be embraced, including forward-looking disaster risk reduction and resilience building; the recruitment and training of frontline health workers from within local communities; mother-to-mother dissemination of health messages; and basic health insurance for the most vulnerable.

Keywords: Aid, Health, Islamic Relief Worldwide

Defining a Regression Model for Performance of STMM (Short Term Medical Missions): Doctors Worldwide Case Studies

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Aim: Our aim was to evaluate and critique the performance of 80 short-term medical missions (STMM) conducted by Doctors Worldwide Turkey (DWWT) since 2013.

Materials and Methods: The study was conducted in 3 phases: 1) Reviewing literature about STMMs in order to determine critical factors to evaluate the performance of STMMs, 2) Designing a framework for missions to enable 360 degrees evaluation with respect to these factors, and 3) Evaluation of STMMs of DWWT since 2013 based on this framework.

Results: Articles describing the performance of STMMs a small minority of the literature, and the majority were descriptive and lacked contextual or theoretical analysis. With a large number of article writers urged the importance of cost, efficiency, impact, preparedness, education, sustainability and harmonization with local partners and existing government programming. Met local health needs by STMM will try to be shown by the performance evaluation of them in the dimensions indicated above.

Discussion and Conclusion: STMMs provide an easy solution to this significant crisis what would otherwise be the source of a significant headache to local governments by providing much-needed aid to these areas. However STMMs are not only difficult to sustain, they can also create a dependency relationship because of temporary solutions that do not address the main problem. In this regard, we conclude that STMM organizers and volunteers should pay attentions to mission planning, implementation, and reporting. Along with reporting on financial aspects of the mission, organizers should report the number of people treated, follow-up needed and how this will occur, cost per beneficiary, training of local counterparts conducted and challenges faced.

Keywords: Doctors Worldwide Turkey; DWWT; surgery; short-term medical missions; STMM; performance evaluation

How Important is Africa in the Altering/Transforming World?

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After the reconstruction of the African Union in 2002, the continent in fact headed towards a new domain that provides with a position in the global politics. Although the global attention towards Africa had been increased interestingly after the period between 1997 and

2007 that is called as the golden age of the African diplomacy; Africa has lost its position to be the leading actor. In the present study, especially the position of Africa in the face of global developments will be discussed from the viewpoints of military interventions, crisis, economic and political global transformations and Africa will be tried to be repositioned. The main question to be answered in this discussion is formularized as "How important Africa is in the global world or what does it need to pay attention to be an important actor?", and, in the framework of this question, the borders and problems of Africa's role on its own will be evaluated in multi-dimensionally from health to politics, from economics to the agriculture.

Keywords: Africa, World Politics, Globalization

The "Safewhere Initiative", a Malaysian Solution to Clean Drinking Water Problems in Rural Areas: A Pilot Study

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Introductıon: Globally, an estimated 768 million people did not use an improved source for drinking-water in 2011 and 185 million relied on surface water to meet their daily drinking-water needs (WHO 2011). The safety and accessibility of drinking-water are major concerns throughout the world. Health risks may arise from consumption of water contaminated with infectious agents, toxic chemicals, and radiological hazards. Improving access to safe drinking-water can result in tangible improvements to health. This study intends to study a «test and build approach» for field water treatment in rural areas in Malaysia.

Methodology: A single blinded Randomised Controlled Trial in 2 different rural locations in Malaysia with an untreated fresh water sources. Intervention in the form of a custom built field water treatment system installations based on raw water test results. Wide range of water treatment from Chemical, Physical (Bio Filtration), Ultrafiltration and RO treatment were considered. Outcomes were measured in the form of water quality and safety as well as Cost Benefit/ Cost Utility Analysis.

Results: The " Test and Build" approach has proven to be a cost effective solution to field water treatment in rural areas. This approach has helped to reduce the use of unneces-

sary water treatment methods while producing a comparable drinking water quality. The findings from this study can be used to provide solution to Africa's drinking water quality issues.

Keywords: Water Purification, Waterborne Disease, Malnutrition

Immunization For All in Africa

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The WHO Offices for Africa and the Eastern Mediterranean Regions recent report showed that Africa has made considerable progress in immunizing against vaccine preventable diseases (VPD).

Immunization coverage for DTP3 (3rd dose Diphtheria, Tetanus, Polio) has increased from 57% in 2000 to 80% in 2014.

Measles deaths declined by 86% between 2000 and 2014. In 2014, while the coverage of one dose of MCV (Measles Containing Vaccine) in Africa was 74%, coverage of two doses of MCV was only 19%.

Many countries in Africa have introduced new vaccines, such as Pneumococcal Conjugate Vaccine (PCV) and Rotavirus (RV) vaccine.

Despite this improved access to vaccines, one in five children in Africa still do not receive life-saving immunizations. Africa's routine immunization coverage of 80% (DTP3) is the lowest of any region in the world. Measles, Rubella, and neonatal Tetanus which have been virtually eliminated in most regions of the world, remain widespread in Africa.

Many African countries have health systems that are not resilient to times of crises such as armed conflict or major disease outbreaks (HIV, Ebola). This must be immediately addressed to prioritize child survival strategies including immunization which save childrens' lives.

Only 15 African countries fund more than 50% of their National Immunization Programs (NIP). Donors have played an important role in supporting immunization programs. African countries need to increase investments in immunization, improving access to routine and new vaccines.

Apart from saving lives and preventing disabilities, there is growing evidence of the economic and social benefits of immunization.

The recent Assembly of African Head of States and Governments at the 26th Summit of the African Union in June 2016, honored the progress of recent years, while also commit-

ting to universal access to immunization and strengthening of vaccine delivery systems and overcoming challenges towards achieving immunization for all in Africa,

Keywords: Immunization, Africa, Children

Closing Session Health in Africa

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Health is a blessing from God. Africa has a good share of health components; safe environment and rich natural and human resources. However, Africa's burden of disease, death, disability and handicap is higher than expected. This is due to historical conditions and stealing of its resources and intellectual heritage.

The World Health Organization (WHO) has paid attention to Africa in collaboration with the ministries of health, civil society, international organizations and other non-governmental organizations involved in health and community development. In 2008, Dr. M. Chan, then WHO Director General elected, asked people to hold her accountable at the end of her mandate for health of African people and for the health of women. WHO took steps to situation analysis, identifying weaknesses and strengths, starting to improve health indicators and achieve the Millennium Development Goals (MDGs), such as eradicating poverty, hunger, disease, illiteracy and discrimination against woman.

There are important success stories in health in Africa; eradication of smallpox in 1980, approaching the end-stage of poliomyelitis eradication, the eradication of river blindness and the tsetse-borne sleep disease in 31 African countries, and alleviation of tuberculosis, malaria, schistosomiasis and elephantiasis. There are major initiatives implemented successfully in Africa; insecticide-treated nets, the availability of new and affordable anti-AIDS and hepatitis C medicines, meeting the basic needs initiatives, IMCI (Integrated Management of Child Illnesses), skills development in nursing, midwifery, obstetrics, and encouraging the establishment of medical schools.

The scene of health in Africa in future will be based on planning and joint actions. The main titles will be: psychosocial support to maintain the structure of society, safety of families and individuals and out-reach them with health services, utilization of the continent's heritage in traditional medicine and herbal medicine, investing in health workforce, and production of original research and studies and translating them to better health conditions.

Keywords: Health, Africa, Eradication, Millennium Development Goals

Access to Healthcare and the New Migration Policy in Morrocco

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Background: Migration is a global phenomenon. It links public health, health security, human rights and equity. In Morocco, according to the Royal guidelines, the Ministry of health developed a National Health Immigration Plan based on a participatory approach.
Methods: An in-depth analysis was conducted by the Ministry of Health, review of studies, and semi directive interviews with key national informants and workshops with stakeholders in Migration Health. The areas of interventions were defined and a migration health plan was developed.

Results: In 2013, the typical profile of migrants is a man, 25 years old, single and Christian. The frequent diseases presented (>50%) were: psychological disorders (21.3%), digestive disorders (19.2%), infectious diseases (15.34%). 56% of migrants have access to healthcare, >70% have access to public health programs in the Primary health care. The main barriers to healthcare were: lack of knowledge about the healthcare system, fear of being reported to the police, linguistic and cultural difficulties, lack of specific skills of health professionals and lack of funding mechanism for migrants care. Therefore many actions are undertaken, such as establishment of health insurance scheme for regular migrants, establishment of surveillance system, development of a capacity building plan, development of a comprehensive training package for the specific care of migrants and development of awareness-raising tools.

Conclusions: Reducing barriers to healthcare system requires innovative policies and guidelines, which in accordance with international human rights law, ensure access to healthcare for migrants and give clarity to healthcare professionals.

Keywords: Morocco, Access, Migrants, Health care.

Health Policy in Algeria Between Reality and Activation Requirements

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The Abstract is dedicated for the evaluation of the Algerian policy of health and its methods of governance by dealing with its results in hope for curing the problem of Healtht. This dissertation also deals with the obstacles and challenges that prevented the achievement

of practical results of that policy. Moreover, it tries to evaluate, whether negatively or positively, the health policy. By the end, it tries to suggest ways and methods for the Algerian health public policy's wise governance. This might be done with shedding light on each factor of wise governance in the framework of fostering a correct and active public policy of health.

Keywords: Public Policy, Health, Governance.

Pulmonary Tuberculosis in Children: Our Experience with 717 Patients and Analysis of Risk Factors Affecting Mortality in Lubumbashi (DRC)

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Introduction: Tuberculosis remains a major public health problem in the world and particularly in the Democratic Republic of Congo (DRC). Our country is among the 22 countries on the planet most affected by tuberculosis. It occupies the third place in Africa.

Aim: In this study we aimed to share our experience in the management of pulmonary tuberculosis and to identify risk factors that affect mortality. The DRC has notified 119,000 cases of all forms of TB in 2015.

Methods: The medical records of 717 children under 15 years with pulmonary tuberculosis who presented at the Centers for the detection and treatment of tuberculosis in Lubumbashi from January 2013 to December 2015 were reviewed retrospectively to analyze the outcome and identify the risk factors of mortality.

Results: 377 were males and 340 were females. The mean age was 8.3 years (range: 6 months-14 years). The evolution was known for 674 children of whom 157 died (mortality rate 23.3%). In multivariate analysis, age ≤5 years (aOR=7.03 [4.36-11.35]), emaciation (aOR=2.95 [1.82-4.78]), HIV seropositivity (aOR=5.25 [3.20-8.62]), negativity by direct microscopy (aOR=2.04 [1.13-3.68]) and hyperleukocytosis 12000/mm3 (aOR=1.99 [1.28-3.09]) are independent predictors of mortality.

Conclusion: TB is still a very severe disease with high mortality rates in children. Early recognition of infection associated with correct early treatment, systematic entourage investigation and chemoprophylaxis by isoniazide in all children under 5 years of age is essential for attempting to reduce these prognostic indices.

Keywords: Pulmonary Tuberculosis, Children, Mortality, Lubumbashi

Use of Calcium Hypochlorite to Improve Quality of Pit Latrines in Uganda

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Introduction: Pit latrines are the commonest method of waste disposal in Uganda with 79% of Ugandan households having a latrine. Pit latrines are a breeding ground for houseflies, cockroaches and mosquitoes all of which are vectors for the common infectious diseases. Conventional pit latrines use biological methods for decomposing the faecal matter but newer environmentally friendly and viable chemical methods have been introduced. Clean Habitat Uganda (CHU) funded by Lonza South Africa through the Sanitation for Africa Campaign is implementing a three year project in two districts to pilot the use of calcium hypochlorite sanitizers to kill vectors and eliminates bad smell making latrines more convenient for use.

Methodology: Communities are mobilised through their local council, Religious and Opinion leaders and public announcements. Training/Sensitisation about the sanitizer is carried out. Each client avails 20 litres of water per stance before dosing which is done monthly supervised by CHU officers, Village Health Member or local leader for compliance and ownership. The project targets latrines at households, Schools, Health Centres, Police Stations, Prisons, Town Council Public toilets and religious institutions.

Findings: So far 1309 clients have been served and 92% of these have expressed satisfaction. These have mobilised other residents by word of mouth and encouraged clean living.

Conclusion: Dosed latrines are odour free, more pleasant to visit and have a longer lifespan than those untreated. There is increasing acceptability for the sanitizers.

Keywords: Calcium Hypochlorite, Latrines, Uganda

Palliative Care in Africa

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According to World Health Organisation (WHO) definition; palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

Palliative care is a form of care that focuses on eliminating patient suffering and increasing quality of life. This care is a service offered to reduce and eliminate the symptoms of cancer or other chronic diseases and their treatment. "Supportive care" is also commonly used for palliative care in public and health professionals. Palliative care is given to patients at every stage of cancer.

Worldwide Palliative Care Alliance (WPCA), was founded in 2003 and is a network of national and regional hospice and palliative care organizations around the world. According to the report results of 2006 and 2011, the most progress in palliative care occurred in Africa, but, after the Princes Diana's founding foundation in 2012 has announced that it has withdrawn its support, it is estimated that this progress can not be sustained anymore. The African Palliative Care Association was established in 2004 and has launched palliative care training programs in Africa. with the support of the World Health Organization, in Botswana, Ethiopia, Tanzania, Uganda and Zimbabwe, studies are being made within the context of "Palliative Care Project for HIV and Cancer Patients in Africa". National health policies are still inadequate and only supportive care can be provided with primitive health and social care infrastructures and rural health services. There is a lack of understanding about palliative care in the community and also trained professionals are required.

Keywords: Africa, Palliative Care, Nursing

Contributions of Private Wing Set up in Public Hospitals: Medical Professionals and Users Perspective

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Migration of qualified health professionals alongside with very low funding of health services and deterioration of health service infrastructure is one of the main factors behind African countries' health crises. Migration of health professionals, specifically medical doctors, from public hospital is due to attractive remuneration elsewhere. In an attempt to solve this problem, the Ethiopian Ministry of Health launched successive health financing reforms that was endorsed by the Council of Ministers and became a very important policy document for introduction of health financing reforms. The reform comprised the scheme of private wings inside the premises of public hospitals. This scheme was designed primarily to improving health workers' retention, providing alternatives and choices to private health service users, and generating additional income for health facilities. Based on document analysis and primary data collection from Medical doctors and users of St. Paul's Hospital Millennium Medical College, this study reports the extent to which private wings in public hospitals help tackle turnover of highly qualified medical profes-

sionals in public hospitals and the extent to which the system provides alternatives and choices to private health service users.

Keywords: Private Wing, Public Hospitals, Medical Professionals, Health Service Users

What Are We Doing in Africa?

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After a long period of unstable coalition governments in Turkey, a new vision has been adopted with the abandonment of reactive attitudes in the Turkish Foreign Policy from the beginning of the 2000s and the introduction of proactive policies to be preferred and implemented. The developments experienced in this new period have made the size of Tükiye almost as if it affected the relations with the world states and the international community. Thus, Turkish Foreign Policy has evolved into a qualified form prominent with its proactive, deterministic and originality by abandoning its role of acting in the manner of the hegemon power / powers and deeper reactionary approaches.

Turkey has stepped into the process of becoming a regional hegemonic power by acquiring new perspectives at the regional and global level, increasing its importance both in the region and in all nearby / remote areas with some steps and initiatives that determine the new form of foreign policy. The main steps of this step and opening are; Improvement of relations with the nearest (primary) environment and neighbors, development of relations with the countries in the region and interaction area, new openings in the intercontinental, relations with international organizations, studies in cooperation with civil society. The new period relations, which are developed and deepened with the African countries, which have high interaction potentials even when there is no close neighborhood relationship, should be evaluated in this framework.

It is necessary to look at these new period relations of African countries and Turkey as at least delayed openings in the neglected area. This is due to the fact that African countries have been left behind hundreds of years during the colonial period and besides the negativities such as poverty, hunger and civil wars brought about by this situation, Turkey has been very ineffective in the field of foreign policy by taking a long- It seemed to be effective until 2000 years with a visionless look.

Keywords: African Opening, New Turkish Foreign Policy, Regional Hegemony, Humanitarian Diplomacy

Establishment of Public Health Laboratory in Somalia

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Objective: Establishment of a public health laboratory where basic chemical and microbiological analyzes can be carried out in order to diagnose and identification water and foodborne diseases in Somalia.

Method: Public Health Laboratories are laboratories that examine the factors that affect individual and community health within the scope of public health protection and improvement. In addition to the health facilities opened in Mogadishu in order to serve the people of Somalia, a public health laboratory was established in 2017. The laboratory materials supplied by Public Health Institution of Turkey were transferred to the Turkish Red Crescent. Laboratory device, equipment and consumables sent via the Turkish Red Crescent have been operating in the public health laboratory in Mogadishu. A team of doctor, chemists and biologists is working in the laboratory. Chemists and biologists are tasked with designing laboratories, teaching staff working in Mogadishu and carrying out analyzes. The epidemiologist has been assigned with conducting epidemiological studies in Somalia to provide information to the Ministry of Health of Somalia.

Results: A public health laboratory was established within the Mogadishu Somalia-Turkey Education and Research Hospital in order to serve the people of Somalia. Basic chemical and microbiological analyzes for water and foodborne diseases are carried out in the public health laboratory.

Keywords: Public Health Laboratory, Analysis, Water, Food, Somalia

Eye Health Care Projects of Doctors Worldwide Turkey

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285 million people are estimated to be visually impaired worldwide: 39 million are blind and 246 have low vision. In African Region, there are total of 32.7 thousand blind and with low vision and visually impaired people per million population. Cataract is clouding of the lens of the eye which prevents clear vision. Globally, cataract stands responsible for 33% of visual impairment as the major cause.
Doctors Worldwide Turkey (DWW Turkey), have regularly organized eye health care programs and eye camps. In this work, experiences of DWW Turkey is illustrated. The aim of work is to contribute and encourage to share knowledge on different methods of eye health care projects.

Keywords: Doctors Worldwide Turkey; DWWT; Visual Impairment; Surgery; Short-term

Medical Missions; STMM; Humanitarian Assistance; Africa

Nutrition Projects Doctors Worldwide Turkey

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The vast majority of the world's hungry people live in developing countries, where 12.9 percent of the population is undernourished. Especially, Sub-Saharan Africa is the region with the highest prevalence (percentage of population) of hunger. One in four persons is undernourished.
According to the Food And Agriculture Organization of The United Nations (FAO), more than 795 million suffer from malnutrition around the world, this means that 1 out of every 9 people cannot access the required amount of nourishment to lead a healthy and productive life. 780 million of the people who suffer from malnutrition (nearly all of them) live in under-developed countries.

In this work, the operational experience of Doctors Worldwide Turkey is presented a case study of nutrition centers in Somalia, Yemen, Syria, and Niger with background information. The aim of this work is to emphasize the most under estimated perspective of the fight with hunger.

Keywords: Doctors Worldwide Turkey; DWWT; Hunger, Therapeutic; Nutrition Centers; Humanitarian Assistance; Development Assistance;

Water Well Projects of Doctors Worldwide Turkey

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According to World Health Organization (WHO), 10% of human population does not have any access to a clean water source. Moreover, At least 1.8 billion people globally used a source of drinking water that was faecally contaminated.

Access to clean water is among the most important preventive health care services and is often more important and effective than therapeutic services. In many parts of Africa, people have trouble reaching clean water although they have water resources. To illustrate, the diarrhea caused by use of contaminated water for sanitation claims lives of 842.000 people every year; tragically 361.000 of those people were children aged under age 5.

In this work, facts and importance of water well projects is emphasized.

Keywords: Doctors Worldwide Turkey; DWWT; Africa; Water Well; Sanitation; Humanitarian Assistance

From Humanitarian Aid to Capacity Development: Doctors Worldwide's Somalia Program

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Humanitarian assistance is defined as an aid that seeks to save lives and alleviate suffering of a crisis affected population. Humanitarian assistance may be divided into three categories - direct assistance, indirect assistance and infrastructure support, which have diminishing degrees of contact with the affected population. On the other hand, development assistance is a programming approach which aims to promote the inclusion of refugees and host communities in development agendas through additional development assistance to promote a better quality of life for refugees pending with emphasis on durable solutions.

With the dawn of the Horn of Africa Crisis, between July 2011 and mid-2012, a severe drought affected the entire East Africa region. It is said to be "the worst in 60 years", the drought caused a severe food crisis across Somalia, Djibouti, Ethiopia, and Kenya that threatened the livelihood of 9.5 million people.

In this work the programs and projects of Doctors Worldwide Turkey (DWW Turkey) committed in Somalia is discussed with the scope of operation models and generated values. The aim this work is to encourage an argument about suitable a strategy which is started with humanitarian aid evolved into capacity planning.

Keywords: Doctors Worldwide Turkey; DWWT; Somalia; Surgery; Short-term Medical Missions; STMM; Humanitarian Assistance; Capacity Planning; Horn of Africa Crisis