

Personal Perspective



By: *Harriet Mayanja-Kizza*

It was in April 2000, when a note was pushed under my office door inviting me to a meeting to discuss an interesting proposition. This was during the *AIDS in Africa Meeting* held at the Sheraton Hotel in Kampala, at a time when the Global Fund had just been launched and the main area of focus was how to provide ART for as many people in Africa as possible. The proposed satellite meeting included a group of Ugandans and North Americans who had been working on HIV-related research in Uganda: Merle Sande and Moses Kamywa from the MU-UCSF collaboration; Tom Quinn, Nelson Sewankambo, Fred Wabwire and David Serwadda from the Rakai Programme; Roy Mugerwa, Jerry Ellner, Edward Mbidde and myself from the Uganda-CWRU Research Collaboration; Allan Ronald, who had conducted research in neighboring Kenya; and Mike Scheld from IDSA. The question at hand was very concise: a lot of research on various aspects of HIV/AIDS had been conducted in Uganda; a lot had been learnt; but what could we as researchers offer to actual care and treatment of patients with HIV/AIDS?

Frenzied e-mail communication and a number of meetings followed over the ensuing months, as we grappled with this challenge. Finally a grand plan was hatched: we would initiate an HIV/AIDS treatment programme that would treat **all** Africans with AIDS, would train **all** health providers in Africa, and would control the **entire** HIV/AIDS pandemic through prevention. About six months later, it was agreed that “babies are also important and that they too definitely had to benefit from this grand plan of ARVs for all Africans.” Thus Phillipa Musoke was invited to join the group, which she gladly did; this brought the group to the “five plus nine” that would be responsible for control of AIDS in Africa.

The problem was that we still had no name and no funds. The one thing that we were able to agree on were some key words that might eventually constitute a name: “academic” and “alliance,” since all members were academicians and researchers and known to each other; “AIDS care,” as this was the main area of focus; and to accommodate the important roll of continued prevention, “and prevention” was added. We also agreed that this would be an all-Africa venture (not just a Uganda venture). After a lot of debate, a name eventually emerged: “Academic Alliance for AIDS Care and Prevention in Africa”—otherwise known as the “Academic Alliance.”

Funds were the next major issue. Merle strongly believed in international philanthropy, and was very clear in his vision: we needed to treat everyone who needed ARVs; the world out there would be willing to assist; and there is a lot of philanthropic will which we just need to harness. Within a short time Merle had come up with a winning card: Pfizer, Inc. and the Pfizer Foundation had agreed to make a significant donation which could make our dreams a reality. The grant would cover a building as well as start up care, prevention and training services.

We began meeting with architects and engineers, and gave them our wish list. Sketches were drawn, which we pored over as we discussed number of rooms, size of labs, etc. We did not realize that we were working with professionals but using a very amateurish approach: soon, to our great surprise, the bills started flowing in—one from the architect; one from the structural engineer; one from the electrical engineer; one from the water engineer; and, to our alarm, one from the lawyers of the engineers. These bills amounted to almost 25% of our total building budget, and we had not yet even agreed on what kind of building we were going to have! We cried foul as the engineers sent more bills, and we felt very naïve and incompetent not to have planned better.

Pfizer realized that we were way out of our comfort zone and quickly intervened. It took a lot of skillful negotiation from Barbara Lawson of the San Francisco AIDS Foundation (later Pangaea) to un-do the financial mess we had created during our first foray into the construction industry. So after that we decided to stick to our areas of expertise—patient care and clinical research—and we were grateful to have experts in the field take over the building planning.

We were very fortunate to be offered the services of Julia Martin and Chuck Wilson. They had an excellent knack for turning our exciting and poorly planned ideas into what they called a business plan (the first time many of us had even heard this term). Julia listened to our excited discussions on how we hoped to train 100 African physicians in ARV care, who would train 1,000 who in turn would train 10,000—leading to a domino effect that would train every health worker in Africa. Within a couple of days she had written up a coherent (and perhaps more achievable) training plan. Chuck listened to our plans for the building, the laboratory and the treatment of multitudes, and managed to make them into a building plan and a patient care strategy.



The site for IDI before building began

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also obtained, which became our “training office.” We sent out announcements for training courses, sourced trainers from the IDSA (we had to have the best), and started training—12 physicians at a time, six times a year...and by the end of the first year we had met 0.7% of our training goal, and about 0.1% of our treatment goal. We could see that we were going to need to revise our programmatic planning process, as well.

The building process finally started, and we all held our breath. Would it be completed? Would funds be sufficient? Would it be what we had planned? The only downside was the thought of the wonderful 50-100 year old trees that had to come down to make space for the building. We were hoping that the engineers would find a way of at least saving a few of them (maybe through building around them), but unfortunately this was not possible. However our guilt at contributing to the extinction of trees gave way to excitement as we looked out the window of the Dean’s office at our regular Tuesday morning Alliance meetings and saw the bricks and mortar going up, slowly and steadily.

As the building process continued, the over meticulous and ever cautious Pangaea was not building as fast as we wanted them to (or as fast as we could have built ourselves, no doubt, had we ventured back into the part-time building technology industry). Our building was supposed to be done in six months, but it was taking more than 18 months just to see the bricks above the fence. “Be patient...we have to move carefully...” said Chuck continually—but patient was something we did not want to be. There were also other complications, from our perspective. For example, Pfizer would not have a building without adequate wheel chair access. And although we did not want to waste limited funds on a fire water sprinkler system, Pfizer would not accept a building that was not at a US standard—so there had to be a water sprinkler system installed and a ramp built in lieu of a lift.

Then the ominous e-mail came from Chuck: “It fell last night!” We ran to the window but saw nothing wrong, until Chuck informed us that a section of the mortar had fallen in the middle of the site. Thankfully it was just a small section, and the engineers were able to work out what had gone wrong, and nobody was hurt; but it made us realize that this building planning process was actually important. Next we formed a sub-committee to select the colors and finishes.

Back to all the patients and trainees...we couldn’t wait to start! We received temporary use of some Mulago hospital space, which we soon made into a temporary clinic, treating about 200 patients a week. A small room in physiology department was

Fast forward to May, 2003; at last the beautiful red brick building was complete, and the final date for moving in was set. (This date had been changed at least four times, with each postponement significantly increasing our anxiety levels.) The Alliance had to open a new chapter, and IDI had to be nurtured to grow. The unit obviously needed a full-time leader. We started by looking within the Alliance, but no one was ready, willing, able or keen to take up this challenge. So a search committee was formed to scour the world and find the best person available. This person should be a Ugandan, or at least an African, of high esteem; a senior researcher; active in the area of HIV and infectious diseases care and research; and an excellent fundraiser. Many people were found and considered, but nobody met all of our needs...until Keith McAdam was unearthed. He was perfect—a quarter Ugandan, a quarter African, a quarter American and a quarter British; he knew more Swahili than all of the Alliance members put together; he was a son of the soil, “home grown” here in Uganda; he was a Professor of Tropical Medicine from LSHTM, and had led a large MRC unit in The Gambia; and most importantly, he was willing to take the job.

During this past three years, Keith has been both pitied and envied. Funds have been uncertain; expectations have remained high (thanks mostly to the Alliance members); and the patients have been many. At times there have been no ARVs, and yet patients have continued to hope for treatment. Many skeptics had warned of the “long expected collapse of this grandiose group.” However it has not happened; Keith has weathered it all, and the Alliance members have happily moved back stage...back to their research programmes, where they are experts...experts who, through this experience, learnt a lot and achieved their dream.