

**2008 HIV/AIDS Implementers' Meeting
Plenary Discussion: Monitoring and Evaluation
for Impact Improvement
Government of Uganda; PEPFAR;
Global Fund to Fight AIDS, Tuberculosis, and Malaria;
UNAIDS; UNICEF; World Bank; and WHO
June 6, 2008**

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DR. RUFARO CHATORA: Thank you, Kevin, for that presentation, for sharing with us information showing what progress has been made, but also showing us how far we still have to go.

We now move to the second section of this session, where we are going to have the panel discussion. We have five panelists. Starting from my extreme left, we have an NGO representative, Munira Khan, who is a Research Clinician from CAPRISA in South Africa. Next is our private sector representative, who is Sandra Ngwena. She is the Program Manager at ABMP. I believe this is African Broadcasting and Media Partnership. Then, we have a representative of the People Living with HIV/AIDS. His name is David Barr. He is not in his seat. He is the Director, Collaborative Fund for HIV Treatment Preparedness. Next, from WHO, is Haileyesus Getahun. He is a Medical Officer at WHO. On my immediate right is the FBO/CBO representative, Stephen Baguma. He is the Program Manager, Samaritan's Purse.

Each panelist [inaudible] is given two to three minutes to remark on the overall theme in the plenary presentation. Panelists [inaudible] are invited to direct questions to the plenary speakers or, of course, to other panelists. I hope we

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will have enough time to cover this. Who would like to go first? Okay. Sandra?

SANDRA NGWENA: Thank you, Chair. Good afternoon, everyone. As the Chairman shared, my name is Sandra Ngwena. I am with the African Broadcast and Media Partnership Against HIV and AIDS. So, really, in terms of a private sector perspective, I am also representing a subsection of that sector in terms of the media.

I think really in terms of talking about monitoring and evaluation for impact, where the media comes in is that the media has an important role to play, but as a bridge between information seeking and then services and outreach. But at the end of the day the success of media's role is, as mentioned by Daniel, that those services and underground level reach are accessible. Otherwise, media's role can get very, very limited. But, at the end of the day there is no denying the power and the impact of the media platform as a tool.

In terms of where media fits in into monitoring and evaluation, as you all know, when you look at kind of communications from a media perspective, they often focus on behavioral issues, and those kind of things take time to measure. But that does not exclude the sector from playing a role towards looking at what impact are they having.

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The ABMP itself is still in its infancy, but what we are looking at is as we start to look at impact around implementation of the work of the partners, all the broadcasters in the partnership commit 5 percent of their daily airtime schedule free of charge towards HIV/AIDS messaging and content. One of the ways that we follow up on this is they have to fill in an annual scorecard to say what percentage of that time have they given and what content is actually airing in that time.

And the success of the partnership rests on HIV and AIDS becoming a core part of company strategy, so that it is not seen as something you do on the side or as an extra thing or an extra burden, but something that you inculcate into the culture of your business and organization. So, that is a big, big way and way to do that, and one of the things that we ask the broadcasters is to say, in terms of what you are doing as a company around HIV or AIDS, whether that is your interaction with government, with agencies, with NGOs, what are you doing, and how do we know about that?

And as part of impact evaluation, the ABMP has now taken on two courses where, one, as there is a Commission on Independent Studies with the broadcasters in nine of the countries that we work in, speaking with agencies, with local government authorities, with national AIDS councils, to find

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out about the media's role, and also partnering with technical experts around M&E like the WHO to do more extensive surveillance. So, I guess that is really where the media fits in and where also media feels they could play a part, so that where there is M&E information, whether it is result or targets, is that being communicated to the media, are they translating it correctly and how do they play a role in also holding government agencies, implementers, accountable to the execution of those targets?

Thank you.

DR. RUFARO CHATORA: Thank you, Sandra. I do hope that all the players, all the implementers, are aware of this opportunity to partner with the media to put across our messages. Maybe you will have an opportunity to say a bit more about that later. Who would like to-yes, David.

DAVID BARR: Hello. Good afternoon. Thank you. Those were great presentations. A couple of thoughts. You know, I think that we failed to set really measurable targets when the notion of universal access was agreed upon in 2005. We know we are not going to achieve full access in 2010, so how do we really measure when we have not set realistic goals and targets?

The report cites a shortfall, a 2007 shortfall in funding of \$8.1 billion. That is what, less than one day of

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funding for the war in Iraq. Are the African governments following through on their 15 percent commitments? No. So, what we really face, still face, is a shortfall in political will that results in a lack of funding.

And, once again, there is a raging debate regarding whether to fund AIDS or to fund healthcare systems. And it is a false dichotomy. And DPD's [misspelled?] new positioning on this issue shows a really, I think, significant lack of understanding of AIDS and how we all got here in the first place. And it relates to Daniel's point on engagement, and David Wilson's points at the opening on the need to address directly affected communities, a point which directly affected communities have been making for over 20 years.

I guess, unlike Dr. Wilson, I think that the real miracle of HIV intervention has been the engagement and mobilization of communities to respond to AIDS in the face of overwhelming obstacles, and that is where the greatest impact has been seen. If individual and community engagement is the linchpin around which success of public health efforts hinge, then AIDS is the greatest example of this in our history. The commitment to provide treatment and care and prevention came from people with AIDS and people affected by AIDS. It did not come from public health officials. It did not come from governments. They responded to our demands. Community

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responded before government, with TASO, of course, being the prime example, since we are here in Uganda, when they created services where none others existed.

The history of AIDS is a history of sex workers, youth, drug users, gay men and the poor demanding their rights to healthcare, creating services where none were available, and facing constant life-threatening stigma in order to engage in healthcare. To have people seeking so hard to engage in healthcare, that should be any public health official's wet dream. And the most poignant example of that took place here over the last couple of days, when three gay activists from Uganda tried to come into this room to demand healthcare, to engage in healthcare and were arrested for it. And let us pray for those people after we all go home, what will happen to them. Fortunately, they are out of jail right now.

And I think that any time public health officials see this kind of engagement from communities and individuals in health-seeking behavior, you should seize upon it. Right? You should nurture it. You should find out what we need, what is needed to sustain it. So, if you are truly interested in strengthening healthcare systems, then you invest in those areas where communities are mobilizing for help. And there is no better place to do that than in HIV.

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And just one final point, and I say this not without recognition of the tremendous hard work and effort that all the constituents make in this, healthcare providers, donors, government officials, public health representatives, etc. But people living with AIDS and those affected by AIDS are at the heart of the success of any effort for impact. Without the engagement of people living with AIDS, nothing else matters. We take the pills. We use the condoms. We do not use dirty needles. We change our behaviors, or we do not. We are not on the periphery of this discussion. We are not an add-on to this discussion. We lead this discussion, and we always have, and you work for us. Thanks.

DR. RUFARO CHATORA: Thank you, David, and thank you for reminding us how the community responses and contribution to this work has contributed to the realization of the progress that we see today. Who would like to go next?

DR. HAILEYESUS GETAHUN: I am speaking from the HIV/TB perspective. I work in the Stop TB department of WHO, and I am speaking also on behalf of the HIV department of WHO, which is directed by Kevin, as we are closely and collaboratively working on the issue.

And I want to give two brief remarks. One, as Kevin mentioned earlier, WHO monitors the implementation of TB/HIV activity since 2002, using the well-established TB monitoring

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system, and the latest data came from more than 200 countries and territories. And that data shows, especially in the last two, three years, the rapid scale-up of collaborative TB/HIV activities, particularly those intended to reduce the burden of HIV for TB patients, like HIV testing for TB patients, providing them with antiretroviral and Cotrimoxazole prophylaxis.

However, when we see those interventions that are intended to reduce the burden of TB for people living with HIV, intensified TB case finding, TB infection control and isoniazid preventive therapy, the coverage is very dismal. And these interventions that are crucial to the livelihood of and the care of HIV people as part of universal access should be prioritized in any HIV/AIDS care and treatment services. And that is why now WHO, both the TB and HIV departments, are branding these interventions as three I's for HIV TB, and stepping up our efforts to ensure they are part of integral HIV services care for the people living with HIV in the context of universal access. And I believe HIV implementers have a crucial role in this.

The other point I would like to touch is on monitoring and evaluation and the ownership and the standardization of indicators. We heard many times from countries about who owns the TB/HIV monitoring and evaluation. Is it the national TB

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program or the national AIDS program? I think our position here should be clear. This has to be decided by countries through dialog, collaboration and also based on what is useful for that country's situation. And we also know that different agencies, including WHO, UNAIDS and PEPFAR, were using different parameters to measure the monitoring of HIV/TB activities.

And I am happy to announce that we acknowledged that deficiency and corrected it recently, that now we have harmonized monitoring and evaluation indicators for TB/HIV. And this has already been feeding the monitoring and evaluation revision of the Global Fund. So, we are much hopeful that this will be crucial step for you, HIV implementers, to take up this activity.

The last, but not least, point is really we have to make sure national authorities, national administrators of funds, take leadership in owning this information and this data, because we had sort of anecdotal evidence that many HIV/TB activities are going on, but this data is not captured by the national authorities, and not coming to WHO or help to monitor the global as well as the national and the local progress in implementation. Thank you.

DR. RUFARO CHATORA: Thank you for that intervention, especially sharing that information that the different partners

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are harmonizing the indicators that are used to monitor progress, and also the importance of national leadership as we work on this. Who wants to comment? Yes, Munira?

MUNIRA KHAN: Thank you for that presentation. The organization that I represent is five years into its development, and our focus has been obviously the treatment and prevention of HIV. We have our own internal monitoring and evaluation measures, and these look at three key areas, which include the process measures, quality measures and impact measures.

And rather simply put, the process measures essentially look at the clients that we have had for counseling and testing and the number of patients that have managed to access antiretrovirals at our site. The quality measures look at the levels of adherence amongst our patients, the number of patients that we have managed to offer family planning services to, as well as Pap smears. And, lastly, we have expanded this to include couple counseling, as well. The third measure looks at the impact measures, and, although rather limited, we look at the mortality within our population whilst on antiretroviral, and more importantly we look at quality of life, and we assess this by multiple behavioral questionnaires that are administered at every clinic contact.

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Our monitoring and evaluation measures are used largely on an internal basis for our weekly meetings, and they are used to redirect our own efforts toward our own concentrated population. However, we also have a central data collection point, and our data goes into our national data. And here is where I think some focus needs to be sent, because I think a number of organizations collect data, and all the data needs to be collected in a standardized format, validated and then used to redirect policy. Thank you.

DR. RUFARO CHATORA: Thank you, Munira. Next?

STEPHEN BAGUMA: Can you hear me? Okay. I am Baguma Stephen. Can you hear me? I am Baguma Stephen. I come from Samaritan's Purse. I am representing the FBO/CBO background. And I think monitoring and evaluation is really important. And from working with communities and small groups, it is a challenge. It is a challenge because collecting of data is an uphill task. Most of these groups already do not appreciate the importance of collecting data. They would like to get straight into the activities, but collecting the data is quite tricky. And sometimes it can be rigorous. You want to collect a number of maybe the youth they have outreached, or the number of orphans that they have given support, and then you want to categorize it into male or female and the age sets, and sometimes it can be very difficult to work with these small

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groups, which comprise of some people who do not know even how to read or write.

But we have seen this improve among the CBOs and FBOs as they have worked. We have seen capacity building. And in most of the evaluation and monitoring of outputs, we see them developing simple formats and recording some of this information. We see them creating synergies between those who know how to read and write, helping each other, and even implementing together. At the end of the day we find some of these CBOs having information or data collected at output level.

Sharing from the experience of Samaritan's Purse in our implementation of the HIV/AIDS program, when we work with communities we find that these are the same. We find we do not find a lot of capacity for monitoring and evaluating systems in our communities. So, we have to work at teaching people on how to record in information, formats that they can use. We spend time coaching them in some of the simple formats they can use.

And when we get through with collecting the outputs, we have to move to evaluating and monitoring our outcomes. And here we basically use a lot of quality actuary and sampling survey techniques, and we do that every six months. And it is because it is simple and it is cheap and time efficient. So, we find that we can easily monitor some of the outcome

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indicators over a period of time. And this kind of showed us that maybe we will make a contribution on the impact, because when we see some of these indicators over time, it informs programming to make necessary changes when we still have the time and the fund, and then we can do proper programming. And, finally, when the impact assessment is done, we are sure that we made a contribution. So, I think monitoring and evaluation is important, but for FBOs and CBOs, it is important to move beyond outputs towards monitoring and evaluating outcomes. Thank you.

DR. RUFARO CHATORA: Thank you. We have one more panelist who was not here when we introduced the others. This is Fulgence Afrika. I hope I pronounced your name correctly. He is Director, Planning, Coordination, Monitoring and Evaluation, National AIDS Control Commission in Rwanda. You have the floor.

FULGENCE AFRIKA: Thank you. Thank you. Do hear me? Okay. First of all, I apologize for delay. I was in another meeting I have with another appointment, but I tried to reach you. So, now I am going to speak about the importance of monitoring and evaluation at the government level, as I represent the government here in that panel, and I am going to give an example of my country, Rwanda.

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For us, the program was before the collection of data, but we see those data, we have two kinds of data, data from community and data from clinical, for clinical indicators. We set out a database which is online, and then we collected data by using our database, and clinical data are collected for another source [inaudible], which is the TRACnet, and we have harmonized those two so that we can capture clinical data from HMIS or TRAC Plus, and then we make a consolidated report for all those indicators.

What are now the challenges? The challenges were the capacity in terms of infrastructure. In my country, we had not Internet connection in all districts. But to solve that, we have mobilized fund for buying modems for all districts so that we can, and we have put people at the district level, and those people are collecting data and put the data directly in the database.

After that, there is another problem of using the data, which is really a challenge. But there is, for example, a study we did in the whole country. We call it the [inaudible] data. That study showed us the points where we have problems than other points, and then the data and results of that study were in there, but they were not used. And to solve that, we have organized during the planning process a meeting for all implementers and for all districts so that we can provide to

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each district the results for that study so that they can use during the planning process and make the right intervention for those points. Thank you.

DR. RUFARO CHATORA: Before I come back to the panelists, the presenters, I would ask a question of Sandra. Do you think that the implementers, the people who are doing the work out there, are aware of the services that ABMP provides? And then secondly, how else, what else do we need to do to improve our partnership with the media? I am asking this because I think it is critical to communicating what we are trying to do, what we are trying to achieve, to the general public. Sandra?

SANDRA NGWENA: Thank you, Chair. Well, the ABMP is still in its infancy, but this is the purpose for us being present at these kind of sessions and conferences, so that people become more aware of the role that the media is playing. In terms of the other side of the coin, in terms of what do implementers need to do, I think it is a question of coming alongside. Because one of the things that has come out from media players is government departments, NGOs or whoever will come forward and say, "Here you go. We have produced X amount of content for the purpose of our whatever direction our focus is on. Will you not air it?" But they have not involved the media in the planning process, in the conceptualization of that

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material. Because ultimately whilst medium are not HIV implementers, what their expertise lies in is in media content, is in their audiences, what plays well with what age and how to package that material. So, it is about a coming together of those two processes. So, that is really the purpose, I would like to believe, of these kind of sessions.

DR. RUFARO CHATORA: Thank you. I come to Daniel and Kevin. Any last thoughts on some of the issues raised by the panelists?

DANIEL LOW-BEER: Thank you. Okay. Thank you very much. I will make a few comments on the presentations by the panelists. First of all, I will start with David Barr's, that we certainly work for you and for them. I remember when I first went in WHO into the community to talk to a village chief in Uganda when we had WHO on our car, and he came out to speak to us, and then he came out with all the medical conditions that he had for us to treat, because he was clear that WHO was there to work for him.

But I also think it is important that we work together, and I see very much the public health response alongside the community engagement as some of the front line deliverers of service, engaged with people with HIV. And it is very important those two are scaled together, which was in some ways one of the points in my talk. As we scale up the services, we

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ensure that, as we have seen in some of the successful responses, some of the ones you have been involved with in the U.S. but also in Uganda and in Africa, those two are very close together.

Also, the media, I was very pleased to hear the role of the media. I do not always emphasize it, but it clearly has an important role in communications. It needs to be very focused, simple, persistent messages, which I think are important to get into communities. Some of the monitoring you are doing to ensure it gets onto networks is great. I also probably think it still needs that personal contact, that we look at the networks, we make that personal contact with networks and communities to get to be [inaudible].

The AIDS and the healthcare system, that was obviously a very important point raised there. The two for me are very, very closely related. In many of the hospitals here, 50 percent of patient cases can be AIDS, and malaria for outpatient cases. And as we have had strong disease programs, I am also beginning to hear some doctors saying hospitals are beginning to become hospitals again. They were certainly not perfect [misspelled?] before for AIDS and malaria.

The third point I have very strongly, getting straight into the activities is clearly one of the tensions alongside collecting the data. But I do think it is very important that

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our activities are delivered with this learning of the populations, their attitudes, where they are, where the epidemic is. And I know it is an effort for a lot of the interventions here, for the implementers here, but for me that is an important element.

And then, finally, which came out from some of the HIV/TB, who owns the M&E, the importance of a harmonized framework. I think the finer point to stress for me is we need accountability in each of the programs, but we also need this overall framework of impact in some of the collective goals of services and impact, and I think ensuring all the very good activities we are doing fit into an overall strategy, a plan towards impact is probably one of the important elements of monitoring and evaluation for impact.

KEVIN DE COCK, M.D.: Thank you. Let me make three or four different comments. Firstly, David's comment, which I appreciated, universal access was not introduced as a concept by an epidemiologist. It was a political slogan, a political target, and the responsibility of technical people is to translate that, what is a human concept, to translate that actually into technical elements and specific targets. Somewhat arbitrarily, we think that 80 percent antiretroviral therapy coverage is close to universal access. It is a bit unrealistic in the poorest of countries to expect better

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achievement than in the wealthiest on earth, but maybe there is an element to universal access that is a bit like WHO's definition of health. Nonetheless, I think it is a useful concept and that we have done better than we might have been expected in translating it into specific targets at individual country level. But we specifically avoided setting a global target for different reasons.

I am glad you raised the health systems issue. I was going to if I had time. There are three, I would say, there are sort of three malignant arguments that continually run together. One is this issue of we should be putting all our money into health systems, not into these disease-specific programs. Paradoxically, that very argument itself is the result of some of the successes of these programs and their evaluation, showing that health systems actually are a major obstacle. Secondly, the idea that AIDS is getting too much money, and thirdly, that you cannot trust any of the data anyway, because the numbers have been downsized and etc., etc. It certainly does reemphasize the importance of getting the data right and communicating it in a way that is intelligible to people and persuasive. And it ties up with the issue of the media nicely.

Having said that, I think I want to emphasize that we do not invest very much in all of this. I think with the Fund

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and with PEPFAR, clearly more has gone into monitoring and evaluation, but if you look at epidemiology capacity in Africa, it is woefully short. And if you look at the number of people who actually work full time to deliver the kinds of reports I described, it is very, very few. And we just cannot expect – I think we are just expecting too much from too little. And strengthening epidemiology and everything like that, including vital statistics at country level, is, I think, really critically important.

I think we in the U.N. do have the responsibility to harmonize our reporting better than we have done. This report has just come out. Next week there is a high-level meeting in New York, and there will be a Secretary General's report highlighted. At the Mexico conference there will be a global report, and ordinarily there would have been another epidemiology update at the end of this year, although there actually will not be. Then UNICEF has various previous reports, as well. I do think there is a need to try and pull this better together.

I think a responsibility in Africa is to do better with the descriptive epidemiology of HIV in groups at special risk, which also includes assessing the size of those populations, including men who have sex with men and injecting drug users,

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and I think that is actually an urgent priority to be addressed.

Let me finish with one comment, perhaps back to David's general comments. I do think we need to recognize the huge role that people affected, people living with HIV, have played, and the affected communities. I think what we also need from you, David, and from the community, is advocacy for prevention. How can we get prevention to matter to people as much as treatment access has done?

And, finally, in my – because I showed a picture of Jonathan, who died in September 10 years ago, I think we need to – it is time to think again about what we mean by human rights and health. And I would hope that we focus less on the negative rights, which were so emphasized in the earliest days of the epidemic, the right to be let alone, basically, and that we focus more on positive rights, which obviously include treatment, which include protection from drug-resistant tuberculosis if you happen to go into a healthcare setting, which include not being ill or dying from malaria and so on, and that we put the emphasis on positive rights and view this access as a fundamental global public good and a basic right. Let me stop there.

DR. RUFARO CHATORA: Thank you, Kevin, and thank you for summarizing. Two sentences on my part to summarize. First

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is that in partnership, we should use M&E systems and data so collected to manage the epidemic. We have different roles, but each one of us has a role to make it all work. And then, secondly, that there is some progress, progress in different technical areas, but also progress in different geographical areas. However, a lot more needs to be done.

I have a couple of announcements to make before we come to the end of this session. The first one is that the First Lady, Honorable Janet Museveni, will close the 2008 HIV/AIDS Implementers' Meeting. There will be increased security. It is imperative that you wear your badge tomorrow and bring some other type of photo ID on you.

Second, maintenance is occurring in Kampala tomorrow. Therefore, water service may be interrupted during the process beginning in the morning.

Third, the [inaudible] team will have access to the Daisy Room beginning 6:30 p.m. tonight.

Fourth, abstract books and program books are available at registration. Please stop by if you would like an extra set.

Fifth, please arrange your airport transfer with your worker.

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Sixth, if you are checking out of your hotel tomorrow, June 7, please review your hotel's checkout policy, as the closing ceremony ends at 12:30 p.m. tomorrow.

Next, all presentations will be available on the conference website in early August, after the International AIDS Society meeting. Attendees are kindly requested to refrain from asking for copies of the presentations.

Next, there is a poster session, Sunflower Room, on fourth floor of Imperial Royal, from 18:30 to 20:00 hours. All posters must be removed on Friday, June 6, that is today, at 8:30 p.m.

And then, last, Exhibition Fair, including crafts, is located in the [inaudible] car park today and tomorrow from 8:30 in the morning until 8:30 in the evening.

It only remains for me to thank you, the audience, the presenters, the panelists, for having participated in this session. We declare the session closed. Thank you.

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