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Plenary: Integration of Services Panel Discussion PEPFAR; the Global Fund to Fight AIDS, Tuberculosis and Malaria; UNAIDS; UNICEF; the World Bank and the World Health Organization June 6, 2008

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MALE SPEAKER: — brave enough to talk about the difference between rewarding success and rewarding failure. I am curious in the rapid scale up of your program which is very impressive, whether there were times when you felt that integrating a service actually turned out not to be successful. What did you mean when you were talking about rewarding failure and do you have an example from your own experience?

ELIODA TUMWESIGYE: You can reward success in so many ways by recognizing [inaudible] what or in public forums you can get recognition from politicians, which are done so many times.

At the same time, we have an experience where integration has failed before, not as we integrate one of a program into what we are doing now, but because of having many donors with

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different policies this could not work. And so we realize that that was almost going nowhere.

MALE SPEAKER: But there are specific service integration which you thought was a good idea but turned out to be a good idea that did not work.

ELIODA TUMWESIGYE: We had one problem but we wanted to introduce within the mobile fertility, with a family from Geneva Global in prisons. We wanted to start VCT by that time within our own existing mobile facility in the prison. But it did not work because of resistance from prison wardens and we did not get all the necessary documentation needed. But later on it came out to work.

MALE SPEAKER: Very much. We have a very distinguished panel of responders and the first one is Heidi Jugenitz who is the country manager in Tanznia for Phones for Health Voxiva. Heidi.

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HEIDI JUGENITZ: Thanks. I will be directing my comments this morning -

MALE SPEAKER: And they each have three minutes. [Laughter]

HEIDI JUGENITZ: My brief comments to the role of information technology and more specifically to mobile infrastructure in integrating care and services.

So as most of you I think have already seen, information technology offers a lot of opportunities for integrating care and services. I think from different countries we have seen examples of smart cars being deployed. I think we will also be seeing soon other technologies, like biometrics, that are applied to this problem.

But I do want to focus on something that is a more commercially available and accessible solution today. And that is the mobile

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infrastructure that is rapidly expanding throughout Africa and obviously the world.

The unique strength of the mobile network industry, focusing specifically here on Africa, are that it is arguably the most sustainable and thriving industry on the continent at the point in time. It has been extremely successful. There is a high demand throughout the entire region.

There is also unprecedented and increasing network coverage as a result of this that reaches into remote areas that are not currently reached by heavier infrastructures such as computers, land lines, etc.

With the increasing mobile phone coverage, this also means that we can reach beyond the health facility worker increasingly to the actual patient and use the phone as a tool for conveying information to, and collecting information from,

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the patients that are enrolled in different HIV services.

The latest figures I think are that there are three billion phones currently in the developing world and that one million are being added each and every day.

And lastly, the mobile operators themselves have expressed a great willingness to collaborate with health and development programs in Africa. And their major incentive at this point seems to be corporate social responsibility. But I think that they also enjoy the opportunity to add new users to their user-base. And so in every country in which the Phones for Health partnership has worked, for instance, we found that we have great reception from them.

Moving quickly, basically when you combine this mobile infrastructure with a powerful platform that is capable of storing, organizing,

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displaying and analyzing data, these mobile technologies can actually be used to integrate data from multiple programs. So you can actually have one unified systems that is collecting data not only on your care treatment program but on your other HIV services, and even on malaria, TB and other health programs.

And this is basically the Phones for Health vision in a nutshell. Some examples of how the mobile infrastructure can be leveraged to provide integrated care, I would provide one example that is related to what we heard this morning from Pablo, and that is for integrated care for pregnant HIV-positive mothers.

Basically, with the SMS technologies as they are, we have the ability to send out a number of messages to mothers. Some of which would, I have not - sorry.

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MALE SPEAKER: Okay. Thanks Heidi. I guess my question to you on what you just said is, is the industry interested in giving free phones to HIV pregnant mothers and would that work?

HEIDI JUGENITZ: Everything that we have seen would certainly indicate that the answer to that is yes. The mobile operators themselves, or in other cases actually handset providers such as Motorola, which is the Phones for Health partners, or some of the other headset providers, certainly we have seen a huge interest from both of those industries.

MALE SPEAKER: Terrific. Thanks. Representing Concentrated Epidemics from Russia is Victor Boguslavsky who is the country director for University Research Company and their representative offices in the Russian Federation. Victor.

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VICTOR BOGUSLAVSKY: Thanks. Good morning. In my three minutes time I wanted to touch on integration from the point of view of the country that has a concentrated stage with the epidemic and I am from Russia. And when I think about integration of services I first of all think or integrated care, I think about the system of care that is accessible, that is coordinated, that provides services that a majority of the patients' requirements and need and the system that provides good quality services.

When we look at the situation in our country right now, we do have a large number of patients with HIV who are not in care. It is about 50-percent of the patients who are not receiving care. And we are talking about 70-percent of those HIV-positive patients who are injecting drug users. And when we look at those people then the

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number of those patients even less in care than of the percentage.

So the question becomes essential, how do you develop this integration because it sort of makes a common sense. How do you bring the system together? All those fragments of the system that provides adequate care and that is a lot of key questions right now that we could try to deal with Russia.

We do have some good examples, actually, of the integration and again I think the integration can be used in many ways. Referrals and harmonization and alignment of services, but we do have some good examples from we shifted care for testing for TB of HIV patients to the primary care centers like Polo [misspelled?] Clinics down in Russia in the health care system.

And we do have pretty good results in increase of coverage for instance over the last

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four years I would say and it is on pilots, pilot regions where we worked, we have increased coverage from 20-percent to 40-percent and then later to 75-percent of those patients who are with HIV are tested for TB.

And those patients now receive IPT and those patients are receiving treatment for TB. I think this is a whole issue of the system transformation into the integration. And there are some good examples of referrals to substance abuse treatments, for instance. Those patients who are now getting the rehabilitation services the substance abuse clinics are being referred by providers from general health care systems. I think this is a very good example of the system that can be transformed into integration.

One question I wanted to pose is yesterday's session was about, one of the break-out sessions was about integration of services.

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And the question was, does integration of HIV services increase or improve quality of other clinical services. And it seems to me the answer is yes, I think we need to look at this more carefully.

But on this last example of the substance abuse treatment and rehabilitation services, the patients who account for substance abuse in treatment need to get good quality of care on substance abuse and treatment. Otherwise they will not count.

I think more referrals, more bringing patients in the system, or requiring the system to be more responding. Thanks.

MALE SPEAKER: Good. Thanks very much Victor. The question for you is that in the Russian Federation the largest number of HIV-positive people appear to be among injecting drug users.

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VICTOR BOGUSLAVSKY: Yes.

MALE SPEAKER: Why is the state not doing more to integrate responses to the injecting drug use problem and HIV?

VICTOR BOGUSLAVSKY: Why is it important.

MALE SPEAKER: Why are they not doing it? Why is the integration not more widespread, if at all. There are very few examples.

VICTOR BOGUSLAVSKY: Well, why is because the traditionally the HIV/AIDS care in Russia provided by through the AID centers, specialized clinics or facilities and with the growing needs of patients numbers the center is just simply incapable of addressing the needs of its patients.

So someone has to look more holistically in terms of how these [inaudible] with the system that exists into being engaged with it. But it has to be purpose oriented.

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You have to have a purpose of, and measure this purpose, of making sure the patients who are getting care are measured then you really know why you do this. I think you need to convey this message to decision makers and providers. And NGO as well, actually NGOs play a key role in this particular issue of integration.

MALE SPEAKER: Thank you very much. The next speaker is the Honorable Elioda Tumwesigye is the chairman of the first ever parliamentary AIDS Committee and member of the Parliament of Uganda and is also the chair of the International Parliamentary Union Committee on HIV and AIDS. Elioda, also a medical doctor and a leader of a very effective NGO in Bushenyi Province in Uganda.

ELIODA TUMWESIGYE: Yes. Thanks. I look at the integration at various levels and the bad experience at various levels to head us in to [inaudible]. I am sure the clinics that they have

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progressed very [inaudible] out patient care. Integrated VCT, integrated PMTCT [misspelled?] and diverted ART [misspelled?] now.

And also integrated school [inaudible] programs with the integration of [inaudible] academic excellence in HIV prevention and now we have integrated INB [misspelled?] [inaudible] clinical trial of research on discordant couples.

[Inaudible] of the adjusted groups are to problems that attend to take the integration of services affirmative [inaudible] where we use what we called the [inaudible] just coming [inaudible] able to go into the home and provide HIV/AIDS education, prepare for HIV counseling and testing, provide best care kits, [inaudible] nutrition, and others.

And at the parliamentary level, we have also [inaudible] taskforces on HIV/AIDS, TB,

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Malaria, [inaudible] STIs, [inaudible] high level [inaudible] in looking at all of these diseases.

The challenges of the [inaudible] as a parliamentarian was with respect for and other funding agencies, one is that if you are to integrate services, you need proper infrastructure and [inaudible] you cannot construct, you can only remodel, you can only extend, but you can't construct.

The second issue is that of human resources, a lot of brain-drain [inaudible] countries going to the north. We need see how to be able to improve training in the south and also look what the bucket is innovative ways of recruitments, innovative ways of retaining staff at the health centers.

The other challenge or the other issue is to be able to use the HIV resources that are available to strengthen our head of systems for

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care, for other diseases. Especially I am very excited about how you can use funds for circumcision to be able to increase our abilities for surgical procedures in our health units.

And finally, the big, very big challenge that I think we need to look at carrying out this integration and that is the challenge of being able to harmonize our systems, our human resource systems with the systems that are being — coming from like the U.S.

You find in the [inaudible] facility for example, the government with conditional programs, you want to find somebody to work on this project and another one working on this project and like at break time, one project provides tea, one gets paid in Duras [misspelled?], another gets paid in Grena [misspelled?] shillings.

These are challenges of integration [inaudible] deliver then there is [inaudible] time

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shifts like in the government facility. If you are working on the government, [inaudible] in the project these are challenges that are facing us in the developing world but they still need to be addressed at which I discuss this later. Thank you. [Applause]

MALE SPEAKER: Thanks, Elioda. As you can see the very effective presentation. You have rightly raised the question of human resources, though. You are a parliamentarian, you vote these budgets. You can help raise health worker salaries, eliminate the brain drain and so on. What are the chief obstacles to that in Uganda? Why is there a health resources problem?

ELIODA TUMWESIGYE: Well, as you know, most of these countries the basket or their available funding is very limited. And in a country like Uganda you have a small budget and that budget they are competing in needs for this

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particular budget. You have [inaudible], you have good [inaudible], you have good defense and like Uganda, living in this geopolitical atmosphere, with two huge countries surrounded [inaudible] which are very complicated you have to invest in security.

So there are many, many things, yet the income, the tax base is very, very little, the incomes are very little, the budget is very little and therefore as you try to give out resources you find you cannot pay enough to health workers to be able to retain them.

MALE SPEAKER: Thanks very much. There will be more discussion among the panel when we have time. Representing faith-based and community-based organizations is Jed Hoffman the chief of [inaudible] for Catholic Relief Services AIDS Relief Program, which as you know is one of the sponsors of the project that Fred described. Jed?

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JED HOFFMAN: I do not want to put the flowers in the lap of our moderator. I hope to make just a few brief comments that refer to both Pablo's and Fred's presentations and I thank them for the information they shared with us.

My first point is actually made most eloquently by Fred's CD which is that the faith-based organizations and the community-based organizations really have integration in our DNA. This is the way we approach life. Our tradition is really all about integration and our work has always been based on the community and building on holistic care and support, and on existing community capacities and priorities.

Nonetheless, the faith-based and community-based organizations, like everyone, we are challenged by the advent of this unprecedented level of funding and support with the scale up of HIV prevention, care and treatment. Not only

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because of the scale and the mammoth logistical issues that capacities that they have demanded, but also because of the initial vertical nature of these donor initiatives.

The challenge right from the beginning, at least from the faith-based organizations, community-based organizations perspectives were, not only have them meet the targets and performance standards, but also how to link these programs into the ongoing work that we are already doing in a holistic way, and with community organization and initiatives.

As Fred described in his presentation, Chreso is an example of a faith-based organization that took on this challenge in successfully integrating into existing community initiatives on first VCT and then treatment and then family-based testing and other things as he described. And Chreso is also typical of most faith-based

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organizations in its capacity to mobilize and empower local groups around health care service delivery and which he pointed out is an essential component of the sustainability of these services over time.

All right. I would also like to point out that we need to think, recall that faith-based organizations do provide between 30 and 70-percent of all health care in developing countries and is therefore necessary to expand our definition of integration beyond the linking of individual components of the continuum of care, but also how to better link the faith-based organizations into the public health care systems as they are both strengthened and their capacities increased with support by PEPFAR and other initiatives, including the public sector, the government initiatives.

A strong national health care system should be a robust combination of both public and

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private, link both in policy and operational levels.

And finally, particularly from the perspectives of organizations like CRS who are developing relief organizations. We need to take integration a further step by incorporating sectoral activities into HRD programs to address the full range of needs of HIV-affected communities and families.

MALE SPEAKER: Great. Thank you very much Jed. My question for you follows up on what you just said. Are there good examples of cross-referral a genuine integration between faith-based systems such as capital accostable [misspelled?] systems which are expensive in many high prevalence countries and the state systems? I think you mentioned the challenge of PEPFAR trying to establish this. Are there some success that we can point to?

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JED HOFFMAN: Fred mentioned that the support that he has received in I think supply chain and other issues, I think also there is in our experiences, there has been through PEPFAR initiation of a policy dialogue about national policies and how to better tailor them to the realities on the ground.

My experience is that in some countries the integration is fairly strong. In fact, the faith-based organizations are actually linked on both operational of course policy levels, they have to be linked because they are operating in the national policy environment.

There are some countries, and I think Pablo might be able to comment on this, where the faith-based capacities have been fully integrated and in fact taken over by the public sector and that perhaps has not been as successful as it might have been. But in many countries and I think

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Kenya is one of them, the Ministry actually supports salaries and provide material and financial support to the faith-based organizations because they seem them as part of the overall national capacity to deliver health care.

MALE SPEAKER: Thanks very much. Representing People Living with HIV and AIDS is Fanny Kaunda [misspelled(?) 20:57] who is a youth peer educator with NAPHAM in Malawi. Fannie?

FANNY KAUNDA: Thank you very much. I am Fanny Kaunda from Malawi and I am a volunteer with NAPHAM, the national organization for people living with HIV/AIDS in Malawi. Is provider following services [inaudible] which is [inaudible] group [inaudible] children care stations where children of parents with HIV/AIDS talk about the virus and how to live with AIDS.

Income generating activities for our members. I am working as a volunteer for young

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people. We are organizing outreach programs, in schools, communities, in companies. In classes to teach our values.

There are challenges in our [inaudible] for example, we are letting skills, information and counseling at HBC. We [inaudible] for children of activities. We do not have [inaudible] and uniforms. We also lack provisional skills which can help us generating income.

Youth have special needs, social [inaudible] as well as physical needs. Youth can be organized and can implement programs as long as they are assisted in capacity buildings in care given the money from donors for this.

There is need for our government donors and other implementers to recognize that there is a generation for youth living with HIV. We need special attention. Do not group us together with others living with HIV/AIDS. Thank you. [Applause]

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MALE SPEAKER: Thank you, Fanny. My question for you is whether your peer education and outreach to youth actually has resulted in behavior change?

FANNY KAUNDA: Thank you. Yes. Because after our [inaudible] with [inaudible] youth, they are able to know the benefits of visiting kids VCT centers. Disclosing their, behavior [inaudible] is taking place [inaudible] is the [inaudible] because they better understand HIV and AIDS.

I also encourage them to work hard on school. I am not encouraging them to use their condoms a man use because they work hard as opposed to — and encourage them to work hard on the school so that they have a good future and to have good marriages in the future. Thank you. [Applause]

MALE SPEAKER: Thanks. Talk about integration. She gave a marvelous presentation

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yesterday at the break-out session on integration. But today specifically representing the question of TB and HIV is Wafaa El-Sadr the Director of the ICAP Program at Columbia University.

WAFAA EL-SADR: Good morning and thank you very much. I have a few comments. The word integration slides very easily off the tongue and I think it is a complex word and I think we have to be cautious as to what we mean by integration. And to reflect and think about where we want to truly integrate and where we want it really battle the tough work that is involved in establishing effective linkages.

So I go back to the first talk at this conference was about knowing your academics. Knowing your academic. I call it knowing your academics, when it comes to TB and HIV. We also need to know, not just the academics but we need to know what are our priorities. We need to know

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the strength and the weaknesses of the various services we are thinking of integrating.

We need to develop a strategy that is going to assist us in accomplishing our goals, whether that includes integration or includes other strategies.

And then we need to work on these strategies and be able to evaluate the outcomes of the various strategies.

For various settings, integration may be the answer. For other settings, it is not the answer. So I believe that before embarking on efforts to integrate, whether they be at various levels that we talked about today, that one needs to think about our patients, the community and what are we trying to accomplish for the people we are serving. And then step back from that and think about what are the kinds of programs and the

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shapes of those programs that will accomplish the goals for these patients.

In some settings it might mean integration of two services like TB and HIV completely at a service delivery site. And in other settings it may be through linkages and effective linkages between the different types of services.

I believe that integration or total integration is the answer in some situations. But I also feel that integration may not be the answer in other settings. And before we walk out of here, all of us, I had this vision of all of us walking out of here chanting integration, integration, integration and using that as our mantra in everything we do is that we need to think carefully about what we mean what level we are talking about integration.

Is it at the level of the funders, is it at the level of the services, the people of

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policy, the policy makers of the country, is it at the level of the program, is it at the level of the facilities and really try to define very carefully what we mean by integration. And also try to define very carefully the outcomes we want through whatever strategy we use and be able to evaluate that. So in the end we can deliver high-quality services.

Integration of lesser quality services is not going to accomplish very much. So I think there are two challenges. The challenge is really truly about the quality of the services, whether they are integrated or not. And the other challenge is the availability of the services, so that people can get access to these services. Thank you. [Applause]

MALE SPEAKER: Thanks very much Wafaa. Very useful corrective. I remember the U.S. civil rights movement. It talked both about integration

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as the goal but de-segregation sometimes is a step toward that goal. And it sounds like that is what you are mentioning. That we should be alert to the danger of vertical programs. That does not mean that everything needs to be integrated at one time.

I am curious from what you said. Are there examples of vertical programs which actually at this stage of our fight against AIDS and the integration with fights against other diseases and [inaudible] system strengthening. Are there programs that you see as actually doing well because they are vertical programs?

WAFAA EL-SADR: I can think of actually examples within the TB/HIV arena which is the focus that I was asked to talk about this morning. If there always seems the situations where there may be TB facilities and HIV facilities within HIV

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services and TB services, with the same facilities or very close to each other.

And in that situation, integration may not be the way to go, its effective linkages between the two services, cross-training of the staff at the two service sides. Enabling the patients with both TB and HIV to access the services across the two different sides and also ensuring that there is continuity and quality care at both service sites is very important.

So this is a situation where true integration may not be necessary and actually may not be advantageous.

On the other hand, there are other situation where the services may not be conveniently located for a patient for example. Where you need to bring those services to where the patients are at. You cannot expect them to access services at varied settings where they are

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very far apart. What you need to integrate the services for the patients. Where the patient is at.

So even within the context of the two diseases TB/HIV we can think of models where integration is the goal. And other models within the same country, where the model could be effective linkages rather than integration.

MALE SPEAKER: Great, thanks very much. We do have about ten minutes for the panelists to enter into more lively discussion. It is a diverse and obviously very well-informed and experienced group, so I open the floor to the panelists to ask each other questions or make comments on other presentations.

VICTOR BOGUSLASKY: Actually, my question is to Pablo. I think you described very well of the integration of the work that you promote in Mozambique. How did you manage to get the

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agreements between the providers and the decision makers at the regional level and national level about the fact that integration is really necessary, and then to receive their support?

PABLO MONTOYA, M.D., PH.D.: Thank you. Well, you think, this is a big challenge. Well it is not very easy to integrate at national levels when services are disintegrated or programs are convertical like we have been able to achieve this through a long process, a continued process of advocacy.

I think that is one of the key issues. It is very important to [inaudible programs have good data collection and routine [misspelled?] data collection, and that you use data to inform policy makers and decision makers.

And I think that has been the key to guarantee buying of Ministry of Health officials. But this has taken years in many cases. For

example, to guarantee it, [inaudible] doctor services are provided as a comprehensive package of services. I think, I do not know, we have been working on this for at least 15 years and it is not yet a reality across the country. We have been advocating for the creation of a modern forum, a health care forum that integrates all those programs and this has taken a long time.

So, you to advocate at all levels. And, for example, the decisions that have been made at the provincial level have been also instrumental to be able to integrate at this level so you can see that in order to scale up the programs to a magnitude that I was from showing is key to work with the existing health instructors and support well, all the province, all the districts to guarantee it is happening. Thanks.

MALE SPEAKER: Elioda?

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ELIODA TUMWESIGYE: Yes. Thanks a lot. I think when we talk about integration; we need to focus on what is the ultimate objective. And I believe the ultimate objective is to have a prosperous [inaudible] population or innocent mankind..

And then I wanted to ask Wafaa from ICAP who seems to have a lot of experience on integration. Are there programs where you have countries with programs that specifically take an integrated package of services at the headess [misspelled?]. Because we know under what we call a house a concept of household production of headess. Headesses live in the home and owner repaired [misspelled?] in headess centers. And for [inaudible] you must go to home.

So there are countries where there are packages, where for example government can pay community worker a stipend [inaudible] train to go

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and take a package of integrated services [inaudible] parliamentary division of services AIDS care treatment and support, TB, malaria, [inaudible], nutrition and promotion of immunization. All of the package per household by a paid employee at level. Do you have that experience.

WAFAA EL-SADR: I think we heard earlier at this conference there are some countries that are attempting this. I think the example of in Ethiopia, for example, and I think it was discussed earlier in this meeting. There is an effort to establish a cadre of workers, community health workers that will exactly do what you just described.

That they would be trained and cross-trained to work at the most distal part of our system which is in the community and in the household. And to be able to bring a package of

health-related services that are pretty uniform but they are quite comprehensive. And that these individuals, these community health workers will be trained to deliver this package within the household, within very distant communities.

I think that is a very, and there is ongoing effort to train thousands of these individual to be able to deliver these services.

The programs are new and I think are in the process of being implemented. I think this will be a very interesting example to look at the outcomes of such an effort, which is really truly trying to deliver a package at the household level.

I think one of the, as I was saying, there are several levels of integration, but I think there is another word which is very important, which is coordination. And then it is very critical. And that is, I think where there is a

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very key role for the programs at a national level to coordinate their activities and to coordinate their programs and to develop joint strategies.

And I think that is very critical and is fundamental, really, at the service level you are going to integrate or not. At the national level and at the provincial level and district level, there needs to be coordination.

And that means bringing together the TB national program and the HIV national program to sit together and develop a joint strategy. That is very critical. That coordination is absolutely fundamental and applies to many other areas as well.

Whether it be HIV or reproductive health or HIV and you know, the PMCCT and treatment even within the HIV arena so the coordination is critical and then their coordination can manifest itself, either in an integrated services at the

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facility level or at well-coordinated and well-linked services at the facility level.

But I think that the fundamental need is for very close coordination at the national level and the provincial level and the district level.

MALE SPEAKER: Victor, you have the last comment and then I will try to summarize.

VICTOR BOGUSLASKY: Yes. Thanks. I think another question of the [inaudible] that seems to be one of the question we need to be thinking in the future of how do we achieve integration. And I wanted to share with you some of the examples that we have in Russia.

When we put together interdisciplinary teams of providers at the municipal level and those teams are providers or presenters of people living with HIV, NGOs, TB services, HIV services, substance abuse treatment services, general practitioners and [inaudible] disease doctors to

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work together on one purpose, to understand how we want to provide care for a patient because the [inaudible] and the focus.

And in order to facilitate the importance of this teamwork we have created also coordinated communities at the municipal level that facilitate and oversee the work of the teams and basically facilitate the decision making process in order to make those changes in permits institutionalized.

I think this is a very helpful approach and I can tell from our work over the last four years that this is really a successful approach and we need to test more about it but I think it will demonstrate to you results. Thank you.

MALE SPEAKER: Thanks very much, Victor. As one of the people who have for better or worse was involved in PEPFAR when it first was being implemented back in 2003, 2004. I think that the strategy was rapid scale-up. We talked about 2-7-

10, prevention care and treatment. And I think everyone in this room told us at that time and we all knew very well that it is not just about prevention, care and treatment.

It is not just a program that has specific quantitative goals, but that there are a whole lot of other things that are involved in fighting AIDS. And PEPFAR, to its credit, has been a learning organization.

And we have been listening to our customers. We also, I should say that I am now with UNICEF, but I still feel some ownership for PEPFAR. But we will say that the implementers also have clearly recognized all of the other issues that are involved in the fight against AIDS, and that includes as Wafaa just said very well, family planning, nutrition, violence against women, questions of health systems, questions of capacity, questions of human resources.

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Above all, the question of integrating the AIDS intervention AIDS services with other things that are going on and that the patients themselves are beneficiaries need for their own health and for their own wellbeing and their own prosperity.

So in terms of benefits, I think integration, we have learned at this session, Pablo made a very effective presentation on the much greater up-take of both anti-natal care and ART services when they are provided in the same facility.

Fred talked about starting small and establishing accountability procedures as a way to add additional services. Heidi talked about using technology to integrate. The new technologies are very conducive to trying to correlate, integrate and collaborate if we are able to master them.

There were a number of references, someone anecdotally to HIV integration improving the

quality of services, including non-HIV services. But I think one of the challenges we do not know enough about that. Clearly we need to do much more evaluation of how we are doing in measurement of the quality of the interventions.

Also, there is a clear benefit in patient convenience, which has been demonstrated by almost every speaker in trying to integrate services. At the same time we have not really measured that, and the question of health worker morale, which we also assume would be improved by integrations that are training more informed health workers. There was not much evidence presented on that question.

In terms of challenges, clearly one is measuring the impact as I have described. Another is, as Fred pointed out, we need to be sure the beneficiaries are being asked about these services. Whether - are these things that are entirely provider-initiated or is this something

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that people actually want and need and can take advantage of in response to their own geographic location and their own sense of their own needs.

As Fred said very wonderful metaphor that sweet things tend to dissolve in our mouths. And the sustainability question, how do we be sure that what gets off to a good start and if we are good at one thing, how do we sustain that one service while we are at the same time adding additional services and becoming more complicated as organizations.

Elioda mentioned limits of donor responsibility in terms of integration, the problem of facilities construction. The problem of human resources for health, which are very hard for international donors, international partners to help in local circumstances. Also the question of cross-referral of integrating the public and non-public providers. And finally, Fanny talked

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about youth-friendly services and how young people actually do not respond well to being integrated into adult centers, especially where it concerns HIV. Very unique problems of youth.

So I thank the audience for a very attendance and rapt attention. But particularly thank the presenters and the panelists for what I hope was an informative and stimulating time.

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