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**Plenary: Integration of Services  
PEPFAR; 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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[START RECORDING]

**JIMMY KOLKER:** Ladies and gentlemen, we are hoping to award punctuality today. So those of you who arrived here on time, thank you very much and congratulations. My name is Jimmy Kolker. I am the head of the HIV and AIDS section at UNICEF in the New York Headquarters. And I am the moderator today of a very distinguished but also very full panel of speakers and respondents.

So I am hoping very much that the audience will give the rap the attention that is deserved and we, on our part, will try to keep this lively and moving quickly. I did put on the screen one slide that I think illustrates the need for integration.

Many of the sessions that we have been listening and learning from, over this week, have talked to the necessity of integrating services. Certainly from the point of view of UNICEF, the very success of prevention mother/child transmission has illuminated the need for great improvements in and integration of other maternal and child health interventions that help the very people that we are helping through PMPCT.

And the slide on the screen which is from the total universal access report that was just released by WHO in collaboration with UNICEF and UN Aids is a perfect example of

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how there are some obvious opportunities that would save lives that we are not ceasing because we are not appropriately integrating services.

So with that brief challenge to all of us, it is a delight to introduce the first plenary speaker who is Pablo Montoya. Who is a native of Colombia, worked for five years in the Amazon region of his country in the primary healthcare system.

He has Master of Public Health from the University of Washington in Seattle and he is now working in Mozambique with Health Alliance International where he also completed his thesis on performance of a rapid test for detection of syphilis during pregnancy. He has been with HAI as a staff member since 2004. He is also clinical assistant professor in the Department of Health, Science Services and School of Public Health and Community Medicine at the University of Washington.

His professional interests include primary healthcare strengthening, cultural adaptation of health services and control of infectious diseases such as HIV, malaria and TB. He is also a researcher and it is a pleasure to introduce Pablo Montoya. [Applause]

**PABLO MONTOYA, M.D., Ph.D.:** Well, good morning. I want to thank you for giving me the opportunity to talk about the partnership between Health Alliance International that I am

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going to call HAI and the Ministry of Health of Mozambique in this plenary session of integration. More so, I am glad to see this topic has become a theme in this conference. I am going to focus on how this partnership has allowed the strengthening international health system by improving HIV care in central Mozambique.

So, Mozambique has approximately 20 million inhabitants. A high proportion of them are living in poverty with a low healthy life expectancy, very low human resources and low budget for health. According to a results of the 2007, [inaudible] surveillance round, the HIV prevalence in Mozambique is 16-percent among adults. It is estimated that there are 2 million people presently living with HIV and approximately 300,000 to 400,000 requiring treatment.

However, HIV is not the only problem. There are many other problems and I am just mentioning here syphilis, malaria, tuberculosis and malnutrition that are highly prevalent and the prevalence vary from depending on the population that you are looking at. The red circles show the provinces where we are working. [Inaudible] are the provinces where we have worked for approximately 20 years. And we recently started working in [inaudible] and [inaudible] and Bhutan.

And so I am going to take some time to talk about the Health Alliance International approach. We are a nonprofit

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organization created in 1987 and since then working in Mozambique. This organization has associated with the University of Washington and currently working in Mozambique is [inaudible] Sudan and Ivory Coast.

And so I want to stress that we work within the health system with health managers of the national provincial district and health facility levels providing broad support for MOH priorities. Trying to strengthen the monitoring capacity to drive an integrated and SK [misspelled?] level health level system.

Our offices are located in the Ministry of Health at the provincial level with most provinces allowing for constant interaction with MOH management and programmatic staff. So the entire staff is frequently seen as part of the system. At the provincial level, we have technical advisors working side to side with MOH program managers and we have all disciplinary teams of clinical advisors, MCH, monitoring and integration laboratory, home based care community, mobilization facility, assistance who are responsible for providing technical support [inaudible] both provinces and the integrated supervision provide technical support, clinical mentoring and continuing education onsite.

And we also provide financial and logistic support to a national health system. So these things are frequently

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accompanied by a Ministry of Health and staff to ensure that we are building capacities rather than [inaudible] the Ministry of Health.

And we are planning to further decentralize our teams and include all of their staff including administrative, human resources and staff to provide a broader and substantial support to the districts.

So we do joint planning exercises with the provincial directorates of health so that our plans respond to their priorities. We are currently planning to increase our support [inaudible], implementation and financing of district health plans to facilitate a more accelerated development of the health system and to have a more comprehensive public health approach.

To overcome the challenge of the strengthening the human resources that most of us agreed that probably the most [inaudible] improve coverage and quality of services. We are [inaudible] working free service training of NCA [misspelled?] nurses, pharmacy and our laboratory technicians and medical officers.

We support task shifting and use lay workers, many of which are people living with HIV/AIDS to improve adherence, counseling, improve linkages with communities and do active

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search of patients who needs a collection of their medications improve adherence.

We also provide financial resources to the provincial directorates of health to hire recently graduated staff until they absorbed by the system. And we are also supporting a strategist to improve staff location.

So, the infrastructure is another key piece and we have rehabilitated and now are building various health facilities especially focusing on outpatient services, laboratory and maternity ward. We also have rehabilitated and now are building housing for staff. This is a creative [inaudible] factor to improve the allocation of human resources and improve the staff integration. And we will also be on classrooms in one critical health training center to improve its capacity to respond to a mounting demand for new staff.

Our teams support program and [inaudible] evaluation strengthening, the routine data collection and analysis for quality improvement. HAI also promotes and supports the development of corporations research to respond to local problems and allow with the Ministry of Health and the National Institute of Health in Mozambique with PEPFAR and World Bank Support we recently created an operations research in Beira. We also support [inaudible] strengthen the existing supply and

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chain management to grant medication and laboratory agents and consumer levels in place on time.

We have worked actively in the integration of vertical programs into comprehensive and primary health care expanding on this [inaudible] service factors that include the effected integration of opportunities in patient management and ART for adults and children in routine outpatient services.

The integration of PMPTC [misspelled?] into [inaudible] healthcare with integration of counseling and testing into routine health services over the [inaudible] HIV programs, the creation of linkages with the communities through community counsels, community raised, faith-based and home-based care organizations.

We also provide nutritional support in partnership with World Food Program and implement malaria prevention strategies such as the expiration of long lasting period of [inaudible], HIV and anti-natal care in partnership with BSI and malaria consortium.

So this is what we are going to be doing to support vertical and parallel programs that provide direct service delivery and that create parallel or [inaudible] and monetary evaluation systems that employ [inaudible] and some procedures that differ from national health systems and fail to foster a strong contacts to wider health systems.

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So now I present some of the results of our experience with the implementation and the scaling of our activities in [inaudible] provinces. These two provinces have approximately three million inhabitants. And the next slide shows the development of our antiretroviral treatment programs [inaudible] situation in 2003. This treatment is 2004 when free ART was incorporated in the public health sector. For 2005, there was some expansion to some sites mainly located along transportation corridors in the most highly populated areas.

And then in 2006 we had started decentralizing to more rural sites. This situation was [inaudible] in 2007 and our goal for 2009 is to have 87 health facilities providing out most of which are health centers. You can see those in yellow dots with 45,000 people receiving care and treatment. And by March 2008, we already have 55 sites providing treatment with 22,000 patients who started in treatment.

It is important to notice that for each of those points and the duration of sites in their respective catchment [misspelled?] area that are good opportunistic infection management and we are aiming to reel the capacity in every health facility to actively provide [inaudible] access to patients who need it and by improving the technical capacities of all business staff to treat infectious diseases as well as

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by improving their working conditions and the supervision of field support.

We think that the whole system is gaining from this intervention for which the support of various donors, PEPFAR, and the World Bank and others have been instrumental. So here we show the number of HIV positive women referred from PMPCT and registered for HIV care less than 30 days after getting tested. Comparing the sites within our health care services and antiretroviral treatment onsite and with a health facility that do not have an antiretroviral care onsite.

We see or series, that do not have an antiretroviral treatment onsite and implemental care onsite. So that we see that there is a huge loss of woman here on the health facilities that do not have the service onsite. And we see that their [inaudible] is much, much better in the sites that provide both services in the same place. This is just trending the importance of providing all services in the same place.

And so this graph shows a proportion of [inaudible] patients sustaining treatment comparing the total number of that are not, those bluish columns and those starting treatment less than 90 days after their registration in HIV care that are [inaudible] and like [inaudible] bars.

Here we compare data from two provinces, Sofala and Monaco, here what we really want to show is the comparison

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between a standalone based hospitals and integrated sites. So we that the proportionate patients who are starting treatment is much higher in the integrated sites. And this happens much faster in the standalone based hospitals.

This slide shows the strengthening of the lower three network. In the last three years, we have improved infrastructure and equipment in 22 laboratories including the recent [inaudible] trialization [misspelled?] for testing capacity with provincials support. Currently there are 55 ART and PMPCT sites that are recurring samples for testing. And we have 20 additional hard to reach sites with our other equipment with hemoglobin monitors for the initiation of follow-up of women they are starting HTP [misspelled?] [inaudible] healthcare. And we also support the referral system for early infant diagnosis.

So this graph shows the number of health facilities offering different components of [inaudible] healthcare and ultimately offering an integrated package of anti-natal health care services. The first bar shows the number of health facilities of 180 plus or minus along the years that we are comparing. And these represents an 70-percent health facilities of both provinces. The remaining health facilities do not have the human resources of a level to perform this

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service. The [inaudible] each of the [inaudible] is different service.

There are key issues to show here. And in between 2003, 2004 we piloted them as [inaudible] rapid syphilis test. And the results and doing advocacy at the national level was between - the use of these tests became a national policy in 2007. It was a huge increase in the coverage of syphilis screening because of that.

In between 2003 and 2004 those piloted the intermediate [misspelled?] preventative treatment of malaria and with the results, this also became a national policy in 2005. And we rapidly scaled up the services, also the centralization of ART and I already talked about. And here these bars show the expansion of PMPCT. So there was a huge increase in the coverage of PMPCT because the Ministry of Health acquired a leadership over the program and we also expanded the coaching to guarantee the conservation of tests.

So by March 2008, 96-percent of the health facilities providing anti-natal care were doing syphilis and congenital syphilis prevention, IPT, 86-percent PMPCT and 30-percent antiretroviral treatment and [inaudible] testing.

So here we show the effect of the scale up of those programs in the number of woman receiving those services. And this line represents the estimated number of pregnant women

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though in both provinces. And the next one is the number of anti-natal care basics that are helping in these two provinces.

There is over 120,000 and of those consultations, 94-percent of these women were screened for syphilis and 81-percent was given at least one dose of sofalshin [misspelled?] prophylaxis as IPT and 72-percent with a PMPCT. So we can say that at least 22-percent of the anti-natal care [inaudible] integrated practical [misspelled?] health services.

Here we show the proportion of women receiving [inaudible] AZT or antiretroviral treatment for PMPCT. We see increasing proportion of women who are getting antiretroviral treatment to aid centralization and integration of treatment and the rapidly growing proportion of women getting AZT. Fortunately decreasing the proportion of women getting only single dose [inaudible]

So here, we can see the number of people that have been counseled and tested for HIV during the year, during the last year. And we are supporting the progressive integration of VCT to routine clinical services inpatient, outpatient services and we expect to see this year a triple in the number of people tested because of this integration.

Here we see the effect of tuberculosis on HIV integration in the number of patients who registered for HIV care it is this blue line. And we get a couple of

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interventions that changed dramatically the HIV diagnosis in few patients, it was the training of the staff in HIV [inaudible] infection and the integration of counseling and testing as a routine in the TB program.

So we saw a huge increase in the referral of TB patients to HIV care. And these interventions are now implemented in all TB sites. And as you see here, data from the first quarter of 2008 and approximately 80-percent of the TB patients were tested for HIV and high prevalence of HIV. Most of them receiving prophylaxis with cotrimoxical [misspelled?] and more than a few receiving antiretroviral treatment.

And this graph shows the [inaudible] number of home based care clients and the linkages with the community. And I want to say that as a part of our strategy we try to have one to three home-based care organizations linked with each treatment site in order to improve adherence and patient flow as well as to improve the linkages with the community. So currently in approximately 60-percent of these beneficiaries of home-based care are receiving - are registered in HIV services and 48-percent are getting treatments.

So in summary, an integrated approach and improved linkages between services and with communities decrease loss of treatment services in a greater efficiency in the flow of

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patients from test to [inaudible] and improve the geographic coverage and the overall service delivery.

So lessons learned and recommendations from this experience is that they support fairly strong leadership by Ministry of Health officials is key to granting integration, expansion and sustainability through a definition of clear policies, targets [inaudible] strategies for implementation.

That is very important to build on existing Ministry of Health structure. And, well it is important to advocate for international and national level toward integration for simple coherent norms and monitoring and evaluation systems. For the definition of clear targets for integrated programs -

**JIMMY KOLKER:** I promised you would not be able to go over time. So do your other slides right now show them. Your 20 minutes is up, thank you.

**PABLO MONTOYA, M.D., Ph.D.:** Okay.

**JIMMY KOLKER:** Show then the slides and stop talking [inaudible].

**PABLO MONTOYA, M.D., Ph.D.:** Okay.

**JIMMY KOLKER:** We have got to keep with time.

**PABLO MONTOYA, M.D., Ph.D.:** Okay. So more challenges.

**JIMMY KOLKER:** Time is up really. You had 20 minutes, show the slides and [inaudible].

**PABLO MONTOYA, M.D., Ph.D.:** I can [inaudible].

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**JIMMY KOLKER:** Okay thank you. [Applause] Rather than summarize at this point I am going to ask a question of each speaker to a little bit more challenging. And for Pablo, the increase in coverage is very impressive, what is happened in those two provinces in Mozambique. I am interested, have you also judged outcomes? Are there actually fewer children being born HIV positive? Are there more orphans averted because of the coverage of mothers and children in the program?

**PABLO MONTOYA, M.D., Ph.D.:** This is a good question. So we are trying to improve the early , well the follow-up of these mothers. Follow-up of mothers and children is a huge challenge. As most of the people working in the field would know and it is obvious the statistics show that.

So we are trying to create a strategy in the system to tracking province follow-up and to try to catch those children and mothers in different services in the health facilities. , like for example, mothers may not come for follow-up visit for anti-natal care or postpartum visits, but these mothers may bring their children for vaccination or consultations for their children.

So we need to guarantee that there is a full integration of all this maternal and child health services in the health facilities to try to improve the follow-up. Measuring the impact, well I think, at least extrapolating from

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the data, we know that we are preventing several vertical infections.

But we know that it is not enough and that well we still need to improve the performance of the program and especially do better at guaranteeing that the mothers get antiretroviral treatment on time because this is their best way to prevent mother/child transmission. And also to guarantee that the mothers are - that we are doing something for the mothers and at just trying to do something for their babies.

And these mothers are not going to realize to care for their children, well it does not make a huge difference when you see a condition in the field. These babies are born without HIV but they are not going to have their mothers which is very important to guarantee how the cohesion of the programs and these view of family.

**JIMMY KOLKER:** Thanks very much. And I had warned people in advance that this was - we were going to keep the time very, very strictly and that they had to put their most important slides first.

So I hope that our next speaker has also heeded that message; is Fred Chitangala. He serves as Program Director for Chreso Zambia. He has been in that position since 2000 when he was the very first employee of that organization which started with volunteer counseling and testing and vocational trainings.

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Fred has a B.A. in psychology, a Master of Public Health and post-graduate degree in monitoring and evaluation.

In 2003, together with board members, he worked very hard to win funding from PEPFAR and because of this funding there is now a team of professional and qualified individuals who include medics, paramedics, scientific and social experts. Fred is actively involved in home-based patient counseling and providing inspirational talks to the support group.

He has done many TV programs. He is an amateur actor and he is also a trained high school geography teacher. So living the integration of services provider, Fred Chitangala.  
[Applause]

**FREDERICK MULENGA CHITANGALA:** Thank you very much, Mr. Chairman. I am looking forward for the time when my introduction of quite long.

Okay so we are Chreso Ministries where I am coming from. And to a lot of you who have been to Zambia you know the building definitely looks different from this one.

Cluso [misspelled?] is a Greek word that means the needy. And it was established by a church in order to take care of all the social needs of the population together with the church members in 1996. Especially to provide community health and training programs.

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As I am talking right now, Bhutan [misspelled?] College, a guest house and three treatment centers across Zambia, the biggest one - the one that you just saw in Lusaka and Rubudwan [misspelled?] in the Livingstone town of southern province where the [inaudible] is and another one up north.

Other change - I told this is a change from the Chreso. We have been running a mobile clinic for 20 years now. With other support drives and [inaudible] and coming now from the government of Zambia. And in 2000, we thought of making Chreso professional. That is employing professional staff and having to be the first person that was employed by them. And because we have not [inaudible], we had just started making proposal to the German government to ask for funding to build that building that you saw.

So we thought of integrating the visitor services that we had planned into the already existing cheaper mobile perma health care clinic and this from the beginning quite promising except for one thing. We made the mistake and we did not do a very good take hold analysis, we did not go to the people that have been beneficiaries of the mobile clinic to ask them if they needed VCT. We did not go to them to tell them what a VCT entails and how the testing entails. We just assumed because we had seen a lot of AIDS related complexes that the people needed VCT.

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And so we rolled out what are we told. We were told that if you asking for blood for testing then you are [inaudible]. And that needles spread HIVs are not going to test us. We did not have time to explain to them that now we have disposable needles. This one lesson learned that all of you must take hold. You have to do a very good stakeholder analysis. So that is just a picture of mobile clinic at work.

At this particular time we have just gotten our funding to build our building and we had almost finished. But it was a time when it was almost impossible for a faith-based organization like ours to get external funding. We found ourselves in a situation where we were almost debating about what comes first between an egg and a chicken. In the sense that every donor you go to tells you shows us proof that you are accountable. Shows us proof that you have handled donor money before. How can I handle donor money when I have never had the opportunity to get one before?

So we found that we are not really in this debate. So what we started doing is to start being accountable and transparent. With the little that we were able to raise on our own, from our training department and our guest house. And so the testing we did was to define sustainability as ability to raise your own local resources - both human and financial. And so and get ourselves in serious income generation activities

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and we thought if we can prove to the whole world that we are able to account for our money; we can as well do for somebody else's money.

And the first step we did after that was to go to the government Zambia to ask for HIV testing kits which they started supplying us and from that time up until now they have been giving us HIV tests every month. And I am happy to say that we have been accountable to these.

But, of course, this was a time - this was an opportunity for us to prove to the whole world, to the whole donor community that we can be, even a church and be trusted with external money and we happen to [inaudible] opportunity.

PEPFAR program was knocking on our door. And it was a time in 2003, December, when the presence of Children's Aid Fund, CAF, which is a little [inaudible] met with the chairman of and that was the day that the doors opened to PEPFAR.

But the question is, could a simple, small HIV testing center with three members of staff, one is a counselor, one nurse and myself turn into a HIV mobile, HIV treatment center? Well, yes, it happened.

The possibility that we got from [inaudible] coordinating committee, the consortium that was led by CRS with, of course, Dr. Hahn Morine [misspelled?] who I believe is in this country now waiting on CRS was very helpful. And of

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course, we identified our inadequacies as [inaudible]. We identified our gaps and we opened our doors to get this help. And we got the help that we needed from this consortium.

And more importantly, Children Aids Fund, one of the members of the consortium went even as far as getting private funds from GSK to receipt the VCT center into a treatment center and that was very, very helpful indeed.

This is a just a testament of what has happened from 2004 in December when we had four people on our care. I think one of which was in treatment already and now, the end of April 2008, we have 6,000 people in our care out of which 3,600 are already receiving treatment.

This comes with the art of lending, in other words feed ourselves and we have got an opportunity to share these best practices with other implementing network partners in the country doing what we call partner forums. This is an opportunity when we have been able to learn from other people and they have been able to learn from us as well. And of course, these best practices that have put us on the world map. It is these best practices that have gained us significant attention from both politicians and philanthropists.

And this picture you are seeing here is just but one of these examples. You have Mrs. Bush coming to Chreso June 2007. She couldn't just resist the temptation of coming and seeing

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what is happening at Chreso after hearing a lot of good news from our country. So there is Mrs. Bush with First Lady of Uganda, Mrs. Mwanawasa and myself in the middle, of course. And Ambassador Mike Dyke [misspelled?]. [Laughter]. It was one of the best moments that any employee can ever experience.

Things are going along well. We have donor support. From one of the biggest donors we would want but still did not go to sleep. We are innovative, more of thinking. So we noticed that within our program parents are not bringing their children for visiting. Why do they think that children do not deserve - children cannot get HIV? And we also noticed that most of the health promotion activities in the country are packaging at others.

And we launched a child VCT campaign. And be mindful of two challenges. The first one being that children cannot bring themselves in for HIV test and the second one being that if parents that have never taken a HIV test cannot take his or her child for a HIV test because the result would definitely imply he is on.

So our targets were [inaudible], were are others, parents, guardians and orphanages that were taking care of these children. And more especially those patients of ours who were in treatment but did not bring their children for testing

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even if they knew that their children were the result of their sexual act and that was our entry point.

This was during our campaign launch. These are the results of child VCT campaign. We compare one and a half years before the launch of the campaign and one and a half years after the launch of the campaign. Before the launch of the campaign, one and a half years before, we had untested 120 children. Of which were put on treatment and a total of 95 were on care. One and a half years after the launch of the campaign we have tested 700 children and that put 14 people or children on [inaudible] and we have 306 on care.

Now, these look to be very small numbers but ladies and gentlemen, if you compare what was happening before the launch and now. You will definitely understand what I am talking about and we were targeting other communities. And who are intelligent people to go to, we showed the nearing testing center they could go to. So if this was operating out of Chreso then definitely the same might have been at other treatment centers.

We also noticed that there is an increased amount - increased but especially on TV and radio programs on child VCT and ART and that generally [inaudible] now started taking an interest into publicizing the benefits of taking children for VCT.

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We also noticed an increased in the door to door community [inaudible] about the benefits of taking children to VCT and of course, we have seen a lot of interest from both politicians and philanthropists.

So what lessons have we learned in these integration programs. Well, the three programs that I have talked about, integrating, VCT to a mobile clinic, integrating treatment into a VCT center and integrating child VCT into adult dominated programs.

The first one is to learn to humble and empty yourself. Without being a know it all. We acknowledged our inadequacies and this is why we got help for integration programs. Then to be transparent and accountability, you are talking about your own resources. This is another way to open the doors to public support. Program visibility begins with willingness the best practices for a broader reach. If you want to be recognized of what you are doing lend to [inaudible] best practices.

When we began our programs, it was time - there was a time when [inaudible] were hiding their best practices because they knew that if you knew what they were doing then you would compete for the little donor money available. Okay, so this [inaudible] support we have. It is utterly important to be creative. Do not depend on yesterday.

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We also learned that the key to program survival and success lies in the commitment too difficult to measure things like people, quality, client service and most importantly, ladies and gentlemen and distinguished guests, developing the flexibility to meet changing conditions. Integration involves change. And the first test in service integration begins with learning to be flexible and accepting change knowing that all management especially [inaudible] agree with me resistance to change has a downside effect to it.

The beginning point in learning from your success is recognizing it first. Recognize your own success, then reward it otherwise you are most likely rewarding failure.

Continuous, integration is continuous because it leads to more comprehensive services - provision and this saves people a lot of time and money to start looking for other things elsewhere. It is also cost effective less repercussion of delivery service functions, you can just imagine the integrating of treatment into VCT and how much this serves the [inaudible] looking of where to refer these people.

Location [inaudible] clinical [inaudible] from our services just as the cost. Nice [inaudible] is access and encourages stigma and discrimination. I'm going to [inaudible] I will explain why. What are the cost cutting challenges with integration? The initial costs can be very high. And this is

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quite tough have to go outside of their box to ask for funding to receipt the visiting centers so that we could the visiting center into a mobile treatment center.

It would be very expensive to start integration in the beginning. Although later it only becomes [inaudible]. Overburden - with little funding and no infrastructure expansion it is tough end up being overburdened and this may compromise on quality of the service that you are providing.

A long waiting time, it may lead to overcrowding and may adversely affect treatment at adherence, so got to be mindful of that. Partnerships, as I said, to convince every relief that we are ready to integrate [inaudible] it was very difficult especially on the partnership involved [inaudible] area in which we have no experience at all.

The key lesson. I have got two key lessons, although I am only able to indicate one. Lend to the most [inaudible] results. This is a starting point for support. Number two, ladies and gentlemen you agree with me that it is sweets. When you put sweet in your mouth it will dissolve and disappear. Sweet things never last. So the question I have for you is what is your sustainability plan?

Finally other key issues. These are issues available for research. I am planning on picking one for my Ph.D. When is the best time to integrate and how do you tell integration

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is necessary? Do you just go about because you feel like doing another problem.

Even when successful models of integration are identified, how do they fit in the different government and donor policies? You have so many donors. How do you impress them with integration programs? Does integration improve product or services? Or is it just to increase the burden on health services?

If it is true that service integration is able to stimulate [inaudible]. How about those people that come for VCT but they are uncomfortable to be on the same queue with people that coming to pick up their relatives?

Okay, I hope you have good answers to those questions and I believe on top that you have learned one or two lessons from that. And indeed we thank the following people and all of you for listening. Thank you very much. [Applause]

**JIMMY KOLKER:** Thank you Fred for keeping time. I do have one question for you.

[END RECORDING]