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Rapporteurs Wrap-Up 2008 HIV/AIDS Implementers' Meeting June 7, 2008

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[START RECORDING]

DAVID KAPULI, M.D.: Ladies and gentlemen, the time has come; everything that is good has come to an end. And, this is our last session and our last day; we have had four grueling days of hard work and very, very interesting discussions and presentations. I welcome you this morning to this last session which is in two parts; the first part will be shared by Tiffany Hamm, and I will introduce her and the second part, when we have the guest of honor closing after 10:45, will be shared by myself.

Let me introduce myself once again, my name is Dr. David Kapuli; I am the Director of Uganda Commission and we have worked very hard in the [inaudible] in Washington and I have been a member of the International [inaudible] Committee preparing for this very important implemental meeting in Kampala. I hope you go and go with nice memories that will bring you back. I know that you have learned a lot. I know that what you have seen and heard here will change the course of the response in this world of ours.

Tiffany, who I am going to introduce, will be telling you about some of the housekeeping issues. It is now my pleasure to introduce Tiffany Hamm, and I promise I will not do the same thing that happened on the first day with introductions that took more time than the presentation.

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Tiffany is the Chief of the Department of International HIV Prevention Care and Treatment for the division of retro- biology in the U.S HIV program under the Walter Reed Army Institute of Research. In this position, she manages the implementation of comprehensive HIV Service programs in committees surrounding HIV [inaudible] research sites that Walter Reed has concerned in Kenya, Nigeria, Tanzania, and Uganda.

She has over 10 years of experience in HIV Research as well as nine years in International Development and Program Management. Tiffany, if you can just put your hand up because there are so many people here. They can not see you. There she is. [Applause] She subs on the Care and Support Technical Working Group as well as the core team members for the country of Kenya, Nigeria and Tanzania.

It is now my honor and pleasure, Tiffany, to hand over to you, for you to steer this morning session and I thank you very much. You are welcome, please take over. [Applause]

TIFFANY HAMM, PH.D.: Excuse me. Thank you, Dr. Kapuli for the introduction. I would also like to take this opportunity to add my thank you to the many who have voiced gratitude to the government and people of Uganda for their hospitality in hosting this meeting. What I would like to do quickly is start off with some housekeeping notes; the event

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organizers would like to remind you to please arrange your airport transfer with your hotel; the exhibition fair including crafts located in the Serena Car Park will still continue today from 8:30 until— Is that correct? 8:30 in the evening? The Imperial Royal guest room rates excludes the 18-percent charge and 5-percent service charge; so, guests at the hotel should not be charged a 5-percent credit card fee either. Abstract books are available at the Registration Desk, so please feel free to go by and take extras if you would like.

Also, you will find evaluations on your chairs, please take time to fill out these evaluations as they are helpful in making improvements. You can then drop the evaluations in any of the boxes right outside this meeting room either in the Primrose Lobby or upstairs near the balcony. Also, please remember to turn off your cell phone ringers in respect for our speakers as well as the First Lady who will be making the closing remarks later this morning.

So, back to our regularly scheduled program; dear distinguished guests, ladies and gentlemen, colleagues and friends, it has been an honor for me to coordinate the Rapporteur Session for this 2008 HIV/AIDS Implementer Meeting. I have had the joy of working with approximately 30 to 40 individuals from co-sponsoring organizations and implementing partners who have been working tirelessly over

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the past three days, noting highlights, key findings, and innovative approaches, approaches which have been presented during both oral and post-recessions. This culminated this year, as in years in the past with a late night marathon session last night, putting together the presentations, placing such sessions in one of four categories, prevention, care, treatment and cross-cutting and policy.

Now, as we only have 30 minutes for each presentation to which I am sure our Rapporteurs will strictly adhere to. I would like to introduce our first presenter. The Rapporteur for the prevention session is Dr. Rene Ekpini. He is the Senior Advisor and Chief of the PMTCT in Pediatric HIV care treatment in the health section for UNICEF. From 2002 to 2007, he was a Medical Officer and PMTCT team leader for WHO. From 1999 to 2002, Rene was the Deputy Director of Project Retro in Kosovo for CDC. And, from 2000 to 2002, he was a coordinator of the CDC for global AIDS program in Kosovo. Ladies and gentlemen, Dr. Rene Ekpini.

[Interposing] [Applause]

As you can tell, we are all working off of very little sleep, sorry. Okay. We are going to have a little switch in our schedule. We are actually going to skip to treatment because we do know that that one is loaded on the computer. So, a quick introduction of Dr. Francois Venter; he is currently cluster head of the HIV Management Cluster,

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Reproductive Health and HIV Research Unit and lecturer in the Department of Medicine at the University of Witwatersrand. He is the head of infectious disease at the Johannesburg Academic Hospital and is currently President of the South African HIV Clinician Society which has over 10,000 members throughout Africa; so, now for your treatment Rapporteur presentation, Dr. Venter.

FRANCOIS VENTER, M.D.: Thanks everyone and thanks for the invitation. The first time I have been a Rapporteur so forgive me if I make mistakes; any of the interpretation or sort of clinical mistakes I have made in terms of this is probably my own fault but my team put together, despite chaotic leadership, an amazing overview of the entire program. If there is anyone who was omitted, it was not deliberate.

So, moving straight into it, for us treaters, when and what to start is one of the major debates and one of the most provocative and content-fold sessions was actually one of the [inaudible] which actually discussed these areas and it raises reviewed Adult National ALT guidelines amongst PEPFAR partners, reference them against the WHO 2006 guidelines and analyze how whether or not the PEPFAR partners was actually conformed to these guidelines. And, interestingly enough, it was a detailed analysis and these are the major findings that most of the countries do actually

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conform to guidelines and follow the guidelines largely throughout the WHO points.

Thirty of the 15 countries initiate anti-retroviral below a 200 to 250 cells per millimeter cubed threshold which is not strictly in keeping with the WHO recent recommendations around 350 but as noted throughout the conference, starting to CD4 counts are very, very low.

So, in fact, increasing the threshold is unlikely to make a huge impact in terms of numbers of people or what CD4 counts are actually initiated as. What also changed that D40 is not a first-line recommended drug and several countries have actually made the move towards using [inaudible] and tenofovir and switching across to that. The dose of setia [misspelled?] has been reduced in many countries although not in all countries, strangely enough.

So, the recommendation at the moment is to move all patients to 30 milligrams twice daily. The second line anti-retroviral recommendations are generally consistent with WHO guidelines and 10 countries are recommending virological confirmation of the second-line failures; sorry about the typo.

Of the remaining seven countries, first line regimens continue to— Six out of seven countries, first-line regimen continued to include stebidine [misspelled?] and it must be just— Remember that the majority of patients in developing

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countries are still starting on stebidine based regimens. TDF and 3TC is recommended in five countries for those who have documented hepatitis B and after the presentation later looking at hepatitis B; TDF also included as second-line in eight countries; so, making a big appearance in the last two years. Botswana there is an interesting discussion looking at the policy cost and programmatic implementations of increasing the CD4 count to 250 which is what the recommendation of Botswana in the last two months have actually been. And, the estimated number of new people injected into the system is about 20,000.

Now, Botswana is a small country so 20,000 additional patients is a lot. There were concerns in about the cost; the other major recommendation that changed in Botswana was that they had moved from a D40 AZT-based first-line regimen, it is marked between the two, to a tenofovir based once daily regimen.

Tenofovir has also been rolled out in Zambia which is also actually [inaudible] from the front. The presentation here looked at a lot of the programmatic issues of switching drugs and I think it was- I was not at the presentation but just the report back I had was very interesting as there was a lot of concern about lab capacity, renal monitoring in particular, the issues around procurement, forecasting and the training healthcare workers.

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The fact that switching drugs is always such a big deal and I think what the presenter already knows is an incredible and unanticipated popularity of this regimen which is quite on the one end, quite reassuring because it means that we can adapt systems quite frequently to changes in our drug regimens, if both the provider and the patients actually believe in the drugs.

From Namibia, we have interesting data from concerning a regimen change. They have also switched across to AZT from a stavudine based regimen. The CD4 counts threshold is 250 and they are considering 350, although they worry about the cost. When they switched to AZT, fairly predictably they have had all the problems associated, the common problem of serious toxicity associated with AZT anemia and there was concern in this presentation about the cost of transfusion and erythropoietin. Although, I must say I think then it is a question of training, especially should be switched and dealt with a switch of the AZT. And, as I said this issue of switching to 350, there is some angst about cost of moving across to that.

Charlie Gillis finalized with the final [inaudible] very good presentation and looked at some of the changes in WHO policy in terms of the policy guidelines for woman pregnant, pregnant women, adult adolescence in children. And, I think the major move is this move towards teaching all

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children diagnosed below the age of 12. This has massive programmatic implications particularly for laboratories and for our testing programs. And, based largely on the results of the SURE study, this move towards treating all children diagnosed obviously by PCR and is a major move forward.

He also then looked at WHO's move towards the CD4 count 350 as well as some programmatic redefinition of numbers noted that this would mean that our coverage rates which would actually drop just by the fact that they are nominated around treatment have increased. I actually caution people around the fact that people might feel depressed about the fact that there were not any targets, even though the programs had been improving. You also notice this contra indication around the Nevirapine for women above CD4 count 250 and pretty much said, we do not really know what to do with women by the CD4 count at 250 if we start on combination therapy.

The idea that we treat all pregnant women with combination therapy, in light of a SMART study which documented an increase in non-AIDS events as well as AIDS events in patients who were stop started. It is just unknown the question that I was made aware [inaudible] that there are studies that are going to look at this.

Tenofovir, obviously, there is still a lot of data outstanding and at this point is not recommending children in

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adolescence because of the issues around bone and there is concern around its role in pregnancy and breastfeeding. It is obviously a concern that it is not at the moment being approximately eight to tenfold more expensive than stebidine.

So, we had an excellent session on the first day after the opening on side-effects and toxicity and one of the most provocative studies I thought was the one on renal dysfunction, presented by Karen Bolton which showed very high-risk of renal dysfunction in patients and initiating entry for anti-retroviral.

This was a study where they actually had creatinine clearance on a large cohort of patients and even though they found that renal dysfunction and mortality were related to the usual suspects, age, WHO24, and the low hemoglobin, it also found links in woman. And, this Captain MyerGroff [misspelled?] showed this mortality data even in patients with very mild dysfunction. And, I think we are going to have to think hard about what we are going to do about renal disease in Africa and developing countries going forward.

In resistance, there was a study from Nigeria which documented, I think, fairly predictable data that showed a higher- This study was a cross-sectional study of people entering a peer part program and had been treated by private sector in a very unregulated manner. I mean a very unmonitored manner for approximately two years and in viral

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loads in people who were clinically or immunologically not documented to be failing. And, as you would expect there were lots and lots of [inaudible] inhibitor mutations and [inaudible] mutations.

Though reassuring, it is quite nice to see this presentation actually because it has such a profound implication for our program but following on Dr. McConnell presented study on looking at responses in [inaudible] and based regimen responses in women you were exposed to single dose Nevirapine.

And, again documented it, quite reassuring data. The doctor between six months in a year, the resistance tends to wane and that we can pretty safely initiate a woman who has been exposed to a single dose Nevirapine on triple therapy. There are some concerns about [inaudible] and particularly in women who had a very advanced disease, you did not receive anti-retroviral but I think this is programmatically good news.

There is a lot of interest in the hepatitis; I think all the conditions which can actually roll up their sleeves in presentation, demonstrating that it is very hard to find hepatitis B. Now, hepatitis B, in particular in southern Africa is a huge problem but this study demonstrated that in fact, the vast majority of patients, had, in fact all the patients who were seen in this cross-sectional study and did

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not have significantly raised liver functions tests. About half the patients had slightly raised liver functions but not significantly.

And, that actually using liver function screening to find hepatitis B is not a good way to go. Well, if there is much more worrying with the patients, they looked at patients with hepatitis B core antibody and demonstrated in fact only core antibodies positive and found a large number of them were positive using hepatitis B DNA testing which is not available even in academic senses throughout Africa.

And, I think to take message from the presenter was very interesting; she just said that do not rely on [inaudible] testing. We have to recognize that there is this high rate of occult hepatitis B and the only real way to deal with this to have tenofovir in the first-line regimen [inaudible] with [inaudible] analog. And, then we really need to expand vaccination against hepatitis B as one of our most effective vaccines.

Bob Farris went to the physician in documenting how to support patients in terms of adherence and trying to decrease the default rate which is obviously been shown to be anything between 20 and 40-percent over two years within our programs. And, large numbers of interventions came into us; a lot of them using AIDS workers, community workers, lay people. The first one looked at using trained ALV clients

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and community members and documented that it is very important that around the issue of consistency. That if you are going to do home visits, that it needs to be planned and it needs to be consistent but you can educate for default tracking very successfully.

Pharmacy refill, I found the issue of pharmacy refills which is much easier to do than issues such as poor counting or Mems capsule or any of the more sophisticated mechanisms we have available to us. And, actually echoes several studies from Capetown and a recent study of [inaudible] demonstrating that this is probably quite an easy way to track defaulters and rather to track adherence rates.

Looking further at community based adherence models, using community health volunteers and local religious leaders and community volunteers and again saying that these people need support. You can not simply fire and forget; you can not simply send these people into the community and just tell them to get on with it. You need to have some sort of assurance program and accompany support program going with them.

And, finally using the fact that there is actually very good penetration of cell phones into Africa and into developing countries, there is an interesting presentation looking at using this to actually track defaulting. And, I am aware of other programs across Africa which are actually

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using this technology to start [inaudible] a new system. The issue of most interest populations was covered in detail in various presentations but in terms of the treatment track these were the two; first, going to Indonesia where more than half of the HIV infections are found in injecting drug users.

And, this session actually addressed the issue of detained injection drug users. And, interestingly, documented the role of the non-government civil society in terms of dealing with sort of unpalatable things government have to deal with and injecting drug users are probably amongst the most stigmatized groups, both in terms of health and the legal fraternity, and were actually used as an interface to deal with this difficult to reach group.

Looking at sex workers, a particularly interesting group, the boyfriends of sex workers and in this case in Mali, and documenting obviously, again, that this is quite a contained epidemic within high-risk groups; and, in this study, where they went to ask men, the boyfriends of commercial sex workers whether they were prepared to get tested and they said yes and, sort of said that they actually did not have access to the testing as much as they would like; so, again an intervention that is crying out to be done within this group.

In the Ukraine, again, where injecting drug users are— There is a very concentrated epidemic within this group

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as well as commercial sex workers and men who have sex with men and they documented it particularly amongst injecting drug users there; they make up a tiny minority of this proportion of minority of the patients actually accessing anti-retroviral while being very high-risk for actually [inaudible]. Again, suggesting that this group needs a very focused intervention to try and get them into care and to keep them there.

From India, we had an interesting scale-up experience where— I mean, India is huge and there is this population spread across a massive geographic part of the country and where they have managed to scale up rapidly to turn in 280,000 people and again targeting female sex workers and many of them sex injecting drug users.

In Uganda, again, noting that the men who have sex with men population is not well studied and obviously judging just by the newspapers over the last few days, it is very modulized and very stigmatized. The same goes for commercial sex workers which I think probably applies to all our countries.

Ethiopia, an interesting study, looking at retention and mortality, during the six months of anti-retroviral but just over 300 patients; the majority of them female as we see in most of Africa; again, the average age, again, consistent

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with most of our programs with quite a high death rate, 18-percent.

Again, no surprises linked to CD4 count whether they were bed bound or what their weight was and interestingly enough found that the distance from the site was correlated with being male, being more sick and of being older; and, making the point that we really have to decentralize these services. Ethiopia is another country with a very big land mass and that people have to travel vast distances to access care. And, this is actually correlated with poorer outcomes.

A study from South Africa, from Johannesburg, probably I would not be surprised probably the largest clinic in the world; over 15,000 patients are on anti-retrovirals in a single site and they looked at patients, six and half thousand of the patients, who had finished three years. Two thirds of these patients were female and they looked at the gender outcomes of these patients and within the cohort, women were found to be slightly younger, slightly higher CD4 count.

So, although you can question whether this is clinically relevant, the average CD4 count was 95 versus 80 amongst the men. But, they did have a better BMI and a lower WHO score on entry. And, there was a slight survival benefit which was statistically significant amongst the women. It is a very complex study and is going to be hopefully tackled in

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more detail. But, women appear to regain themselves faster and more consistently than men.

They are also more likely to get viral load suppression at 10 months. However, there was no gender difference at four months; so, essentially what they were saying is that men were getting access to treatment slightly later and were definitely sicker and seemed to have slightly worse biological outcomes.

And, the context of men has been a vulnerable group was raised and issues such as trying to promote work place PCT so that people actually tested earlier; innovative design, particularly at this clinic, paid a lot of attention and thought to the issue of trying to get male friendly clinics going. And, then issues such as delivery where you cannot pick stuff up at the pharmacy or the clinic is having the drugs actually delivered to the local post offices had high uptake amongst this group.

In a very complex study, somebody told me just before I presented this that it could only be understood by epidemiologists. It was from the ARTLINK program which looked at the issue of propomoxycol [misspelled?] use before at the point of initiation anti-retrovirals and after anti-retrovirals and I am not going to try to analyze that. I think if people are interested, it is actually better to talk

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[inaudible] themselves. But, did not find a mortality difference and I mean the multi-variable analysis.

An interesting study from Ruanda, looking at children this time, and looked at the clinical and immunological outcomes and demonstrated that if children were not started on anti-retrovirals, an interesting thing because we see this often in adults that they were last to follow up and the observation for this was 3.3. They followed them with 2,000 patients on anti-retrovirals; more than half of them were over the age of five years and documented this.

In Uganda, another interesting study compared rural and urban populations in terms of outcomes. And, while the rural children were sicker when they followed these children over 24 to 48 weeks and while the children who were based in rural areas were sicker, they did just as well as the urban children. And, as you can see the outcomes were pretty good in both.

In a Tanzanian study, that looked at strengthening and training of the various points of entry for children and they documented improved recruitment better propomoxetal [misspelled?] coverage. And, this very key thing that we know took in the adult population but I suspect is equally true for pediatrics, is that the delay in anti-retroviral initiation was actually decreased and there was improved [inaudible]. And, if you look at this graph you will see as

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the program evolved that the delay to starting anti-retrovirals was decreased and I was pleased to see that this is obviously going to translate into significantly decreased mortality and morbidity.

From Vietnam, they had lessons on rapidly scaling up pediatric care to 1,000 children and the session finished with looking at the new pediatric guidelines. And, the fact that there is a huge laboratory challenge in terms of getting children into care. We know that children die in the first year of life before they can be diagnosed with cheap and easy ELIZA based mechanisms, that we are going to have to improve our laboratory infrastructure and follow-up with children, in general, with PCR testing if we are going to make any significant impact. That was treatment.

I am now going to deal with laboratory data. There is a lot of focus in terms of leadership, as well as capacity issues in the laboratory and there is little bit of overlap between the various slides that I am going through, as well as some very interesting stuff looking at improving CD diagnostics.

So, laboratories are not simply things, as doctor's order blood and get results from. They are obviously critical in terms of prevention both in terms of clinical trials as well as surveillance and often provide the most rigorous data that we have in the most resource areas. For

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the commissions, obviously, they as a clinical staging diagnosis and for HIV and TB we rely upon them. It also enters the blood safety screening outbreak investigation by security so they are not simply there to send us the results.

Earlier this year, the [inaudible] declaration called on National Governments to develop national laboratory policy in the national strategic plan around laboratories. I think again and again through this conference, there was calls for leadership around the issues of laboratories and they often had afterthought in terms of how they dealt with [inaudible] scenario. And, we need to integrate laboratory support for the major diseases of public health importance and focus on those diagnostics and monitoring systems.

Some of the major challenges which I am sure are absolutely no surprise to anyone in the audience but the things that were raised is the issue of human capacity, the lack of eloquent training programs, the fact that there is a limited number of personnel and they tend to move on very quickly. The issue of infrastructure, the things that were taken for granted in developed worlds or even developing worlds, urban settings such as electricity and water. And, physical infrastructure, the fact that you have to maintain this equipment and even if you manage to get it out there as well as provide the consumable and the [inaudible] agents that need to go with it.

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Again, the lack of policies, advocacy and leadership and around issues of laboratories in the developing countries; and, finally, the need for better coordination and partner support and I think, again, we are going to have to think harder to integrate laboratories more, in a more focused and give them sort of the importance they deserve in terms of voices when we start to design programs. On a set in South Africa, they tend to be an afterthought in terms of being involved in the consultation processes.

So, the need to integrate laboratory services instead of having programs, specific laboratory services was highlighted in one presentation and again this issue of laboratory coordinating mechanisms being seen as important.

The leadership of lab managers in the bind of health directors; this issue of leadership again and again that there is the lack of leadership and it seems to me that firstly that the laboratory is being seen as an add-on, the fact that there is not a [inaudible] of health care directors. It is often quite an instructive process in terms of top-down processes to laboratories and you will do the following.

The critical elements of all this is continual infrastructure and equipment upgrades which are obviously going to be critical as we scale up. Appropriate human resource

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allocation and education and not seeing lab technicians or the training of clinical starters as being the be-all and end-all of program.

And, again those quality assurance programs; I have worked with a lot of laboratory people and they are very rude about the fact that clinicians tend not to think about the things; they just take quality for granted and that assurance of quality in the countries of laboratories is phenomenally important. And, in just the issue again, the strategic planning for all aspects of laboratory services and continual order of what is going on in terms of how they interface with the clinicians and with the programmers.

So, [inaudible] that was very interesting in terms of TB and as you all know TB is a nightmare in terms of diagnostics and probably the vast majority of people who are started on TB treatment have never had it actually documented. And, we know that HIV positive people, in particular, are often sputum negative which is our major diagnostic tool which we have available.

And, there were several presentations on TBs that focused around on this. The issue of trying to do TB screening using— There were other presentations which I think are going to be reported upon using simplified TB screening triggering a more focused laboratory intervention and was looked at. And, then the issue again of maintaining quality

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that you can not simply rely on the quality of marketable culture; if you are going to use this expensive technique to confirm and to support your commissions, you do need to focus on the quality.

A more mundane sort of concentration technique showed that you can improve the detection of market material in TB samples by 31-percent and that moving across fluorescence microscopy can reduce your reading time by fourfold and one of the major problems faced by laboratories in terms of TB diagnostics is the incredibly routine large volume nature of TB sputum analysis.

So, and, then we have had a lot of talk about knowing your epidemic and about incidence data. And, obviously, laboratories need to be included in this and countries should strict this for recommendation which I think all of us would agree with in terms of knowing your epidemic. Countries should strongly consider application of instance essays in HIV surveillance systems to monitor instance in populations at a time.

Now, this is often not recognized by politicians serving in my country. It is the difference between incidence and prevalence and I think that as this trying to focus on the epidemic, dealing more intelligently with prevention which I am sure that is going to be tackled. The role of the laboratory in terms of supporting [inaudible] as

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accurate data; this concept of knowing where your last 1,000 infections came from is going to be critical. However, we need to make sure that we use the tests that are useful and we need to adapt those tests particularly BDSA, appropriately.

Management trainees, again, came under the spotlight and that is policy support, policy maker support at facility level is nationally needed to be concluded in this training. And, development of all these mundane things which we are not what we enjoy talking about, things like standard operating procedures need to be part of it.

Early infant diagnosis, I think that I have touched on and if we are going to have to integrate the service into existing health care services and it is going to be hard. I think it is a massive challenge for laboratories to in terms of it but we have to do it if we are going to make an impact on, obviously, this very high mortality in the first 18-months and with this goes a quality assurance program and that is going to give us results that we can rely upon.

And, there was a presentation here just documenting the need for this and the fact that testing areas can be a real problem and particularly in this, you do not want to be starting children unnecessarily on anti-retrovirals; you also do not want to be missing children you know are infected. And, that data capture we need the endorsements and consensus

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from [inaudible] polls. What are we collecting and why and how we are going to act upon it? I am not going to relay the quality assurance issue again, just to say that we just need to make sure that this is somebody's job and that it gets taken seriously.

My final slide is on reference ranges and the issue of the fact that we rely often on developed countries reference ranges and we are fairly certain that this does need to be looked at. It is crying out for operational research. People need to go in and tackle these various populations and actually start providing reference ranges which are appropriate for the local population. We need to have them, obviously, look at issues such as race, gender, age, stage of disease even, potentially and start adapting our reference ranges at that point appropriately.

So, that was a whirlwind tour through a huge amount of data, a lot of work and some amazing stuff and I would just like to thank everyone who was involved. Everyone who participated in the conference and the various sponsors, all those people who sent me these amazing slides and I hope I have presented them correctly. And, just finally just to thank Tiffany and her team who were endlessly cheerful through the chaotic proceedings of last night. Thank you very much. [Applause]

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TIFFANY HAMM, PH.D.: Thank you, Francois. And, I believe we have the prevalent- excuse me, goodness. The presentation now for Dr. Ekpini on- So, we will go now to prevention and again, Dr. Ekpini, who is the Senior Advisor and Chief of the PMTCT and Pediatric HIV Care and Treatment in the health section for UNICEF. [Interposing]

RENE EKPINI, M.D.: Thank you very much. I was trying to figure out exactly how to start this presentation. And, I think, initially, I was supposed to be the first but now I am just the second but I think- It does not [inaudible], but anyway. [Laughing]

Prevention, so we all know that in terms of HIV, it is very important to provide your package of services but trying to find out exactly out exactly how to introduce this, I go back to the first day where we have his excellence, the President of Uganda here, and he put it very simply, prevention is the first choice of life. Yes, prevention is the first choice for life. For us, I felt so full of [inaudible] innovations. I would first like to thank all the members of my team. They have all worked very hard and I think we left his place at around two or four yesterday. [Laughing] And Edward, I would like to thank Edward, Aaron, Shanty, Beverly, MaryAnn, Rochelle, John, Shawn, and Karen [misspelled?].

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Through this presentation, we had several sessions and it is a very long list but I can briefly mention this for [inaudible] sessions, in terms of [inaudible] epidemic, coordinating and organizing national programs, behavior change including ABC marked by trace population, positive prevention, male circumcision, prevention of mother-to-child transmission and then I will try to conclude with sending some messages.

The great commitment of the international community as a result, we have [inaudible] in our progress and [inaudible] treatment care and support for treatment. Okay. Even in support for people living with HIV/AIDS, especially in under civilized countries. Although, some achievements have been made in the area of prevention and [inaudible] work, our collective legacy seems questionable, especially in resources of limited countries. A lot of effort still needed in this area compared with what we have already achieved in some other treatments. We have reached the point where we should aptly question ourselves. Do we really have a full understanding of the economic, social and cultural, and scientific dimensional of the epidemic? Do we know what works? Are we doing things right or are we doing the right thing? Do we focus on the priorities?

We do have some good examples and Uganda is one of these countries where prevalence of HIV has declined,

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including in some generalized countries, as I mentioned as Uganda, where a reduction in sexual partners play an important role. This has been achieved through the combined efforts of some and good political leadership on HIV/AIDS, community mobilization, social network, promotion of ABC, involvement of network with persons living with HIV, and look surveillance and analysis.

I will start by the first session which is on you're your epidemic by someone who does not have English as his first language [inaudible] be in this session because we need to question ourselves in this session. Try to ask some questions in terms of what do we know about what we call a global epidemic?

And, the point was, in fact, we do not have a global epidemic. We do have a multitude of epidemics and one epidemic in the Americas, Europe, Asia and Middle East will always remain concentrated. We need to be understanding with mixed epidemic in the Caribbean, West Africa, [inaudible] and [inaudible]. [Inaudible] epidemic driven by the [inaudible] population are preventable.

But, in the face of complex challenging environments, prevention in force in of this population has not been taken to scale. In a generalized epidemic, countries have been slow to respond to remain known drivers including lack of male circumcision and [inaudible] concurrence partners. The

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new challenges are among the need to reallocate efforts and resources from what has not been proven to be effective, to what has been shown to be effective, namely partner reduction and male circumcision that need to be applied at scale.

We do need to ask some basic questions. First, where are we in terms of new infection occurring at [inaudible] level at the original level? We [inaudible] the populations are targeted in which a direct areas, we do have the most important prevalence or incidence of disease. What does behavioral data say about priority groups? What should we be focusing on for HIV prevention intervention? Where should we be reaching them? What are we doing at the moment, where and with what resources? We are actively trying to address the issue. What is the degree of alignment between what we are spending and what we should be doing?

The development of evidence, there is national strategies but address key drivers and coordination of country response is critical. Some countries have established mechanisms to develop national prevention strategy and ensure coordination, monitoring and evaluation. National prevention reference groups to avoid de-population and analysis, identify priorities and make recommendations to improve prevention programs in Mozambique, for example; national behavioral change strategy involving prevention levels and addressing mutual and concurrent partners as key

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drivers in Zimbabwe. Multiple concurrent partnership is among, if not, the main driver of the HIV epidemic worldwide; concurrent sexual partnerships is a practice of having long-term sexual partners that overlap in time, often for months or years.

In general, several reasons can explain this behavior which includes [inaudible], infection, in emotional relationships, social and cultural norms and practices, alcohol consumption, looking for money, or material possession, and look at sessions of risk. Multiple and concurrent partnerships are especially common among both adults and young people in Southern Africa. They are associated to low rates of marriage and coordination in terms of [inaudible] sex often associated with [inaudible] sex, casual sex often associated with alcohol use and gender and [inaudible] in cohesive sex. Imagine mothers for reducing much of the population includes mass media communications, interpersonal communications, and community mobilization, special programs and curriculum for [inaudible], [inaudible], such as successfulness training of couples, involving religious leaders and tests [inaudible] especially for young people. These strategies should be integrated into existing programs, including prevention outreach with peer education, PMTCT testing and counseling, and life skills programs.

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Some key issues need to be addressed when we are talking of prevention in this area. We should have good evaluation of program motive intervention, clearly defining the messages to avoid any ambiguity, how to [inaudible] of concurrence partner's, involvement or communities carrying messages to their partners or type of partnership, using multi-level support to change social norms and behavior. We saw some key questions which should aptly be taken into consideration. Looking at the [inaudible] intervention and what should be the messages, for example, have only one partner, reduce numbers that overlap to avoid any ambiguity.

Already one year, yes, one year's disease finding for frequent for clinical trials reveals that male circumcision reduced risk transmission and infection. Since then, very few countries have been able to implement male circumcision as a public health approach. Despite the global slowness in ruling out male circumcision, some countries such as [inaudible] and Zambia have made significant efforts.

In general, male circumcision is recommended for HIV negative people. That is countries assure that complication rates are lower in medical settings as compared to non-medical and traditional settings, rapid scale of male circumcision requires strong political support. A serious delivery level puts [inaudible] in high demand that

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[inaudible] with human resource constraints might require additional forces such as task shifting.

Male circumcision should not be seen as a magic bullet. It should rather be implemented as part of a comprehensive prevention package. In this regard, WHO recommends the following minimum package of male circumcision services which includes— I think this is gone but [inaudible] training of couples involving reduced— This slide is lost. [Inaudible] recommends a package of intervention which aptly includes HIV testing and counseling and some specific intervention to avoid transmission from infectious people to those HIV negative. This includes also screening for STIs as well as some intervention in the area of sexual public health. The most important and the end which is important and I would like to highlight the structure, is as I point out meets the condition should not be seen as a magic bullet. So, it is very important to send the right message.

In the men of HIV/AIDS, the role of the social society, in terms of prevention, in terms of care and treatment, of people living with HIV has been instrumental. That is why in all intervention, especially in the domain of prevention, it is very important to broaden the area of prevention providers by involving both living with HIV/AIDS but also committee workers. Different approaches are being used. We have peer educators and mentor models such as

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[inaudible] is doing; [inaudible], local residents provide comprehensive behavior counseling to committees in the proper control of epidemic strategy 24 plans to serve others.

[Inaudible] is doing part in Uganda, training of [inaudible] and ensure leaders to conduct participatory workshops, deliver sermons and provide peer support and counseling to church members on mutual monogamy and HIV prevention.

It is very important, in this area, to make sure that we have some [inaudible] monitoring of truths, we can aptly help to a system of guys and ensure quality in peer education programs and integrate them with the message that we are sending. Global care education tools can be adapted to look at realities. Look on the patient, in turn, can be informed global truths to become more practical at country and regional level.

In evaluating peer education programs, it is important to find a population who are not being reached, in terms of analysis, and why the population is not reached. The social dimension of HIV epidemic and the preponderant role of persons living with HIV/AIDS has led to requisitioning communities as an underpinning entity of HIV prevention, care, treatment and support programs. Various approaches and motives are being implemented. This includes peer education, educator or mentor model, as I mentioned a

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few moments ago and also all of the approaches that we have been using, peers, including in the young people population.

In this area, several approaches have been represented during these conferences; in Ruanda, we have the multi-sectoral committee ensuring coordination that refugees can access a full-range of HIV services and come. In Kenya, a national technical working group and drug users, injecting drug users and presenters coordinates for [inaudible] HIV and drug-related services.

In South Africa, [inaudible] separate workers is provided to [inaudible] services. In Russia, there is a demand for risk reduction in HIV. STINTB services increase improves through caseworkers and training to reduce discrimination by medical professionals.

I, personally, was in this session and the thing you should keep in mind is in this area again, the words are not the same; when we are talking of knowing our epidemic in recessions we are about [inaudible] the enemy [inaudible] and [inaudible].

Military represents a special population; experience from Uganda, during this conference, Benin and LaSoto, showed that [inaudible] can run highly innovative responses to a risk specific situation and culture of the military committee such as deployment in conflict area which has high prevalence of HIV, specific responses have been built around behavioral

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and theological surveillance, comprehensive decentralized to for prevention. Pre-force and during deployment including mobile testing and peace keeping pay after post-deployment health check. Major challenges include the role of confidentiality in military guest setting, in the area of ARV and compensatory disclosure of HIV [inaudible] to commanders and spouses.

This is a different population but the new generation. We are talking about the young people. Young people represent a special and vulnerable population often neglected or not properly addressed in terms of risk, intervention for risk reduction by national programs. This population has particular needs and therefore requires specific approaches with critical roles of peers. Approaches presented during this conference include mass media campaign, addressing gender norms and HIV prevention among young people in Kosovo. Partnership with street youth in Kenya, participation of youth and peer educators in a review of [inaudible] Haiti, support through help of school for boys and girls with HIV education and referrals, non-formal education, that would [inaudible] Utopia and addressing cross-universal and convectional sex in Uganda. The situation of people living with HIV emphasizes the need to involve people living with HIV in development and implementation or prevention programs to understand the

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experience and in order to develop meaningful prevention programs and integration of prevention into HIV care and treatment need to be accelerated.

Key prevention programs targeting persons living with HIV or with around sexual prevention of HIV support for disclosure and counseling around discordant couples, sexual and predictive health, services including family planning, STI management and treatment and stigma determination intervention. More importantly, it is essential for us to understand and keep in mind that the fight against HIV is not seen by people living with HIV in terms of prevalence or incidence, in terms of 'P' value, or confidence in [inaudible], even not in terms of human rights but it is simply in terms of right for life, even right for survive.

We have few presentation abstracts on blood safety and injection safety. Here we do have a couple of slides in this area focused on how to strengthen country capacity in terms of management or supplies, training and when it is contained to ensure involvement of the private sector and collaboration and awareness building with medical training school in Kenya to support the national program. PMTCT represents the main entry points to HIV/AIDS prevention, current and support services for women, their infants, and children in resource limited countries.

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During this conference, several topics were aptly addressed, starting with the need to move for more education and interview regimen for PMTCT; the need to integrate HPMTCT in maternal and newborn and childhood services, the need to address issues around optimal infant feeding and also issues around HIV testing and counseling in the context of PMTCT. In South Africa, in LaSotho, a recession of pregnant women was shown to be feasible, safe and effective with lower infection rates among infants whose mother received treatment.

In general, shorter duration of HAART and lower CD4 cell counts were associated with infant HIV infection. HIV monitored transmission rates among women who received less, more than seven weeks of HAART treatment was 23-percent. In LaSotho, transmission rates were different when you compare women on HAART and women receiving combination prophylaxis therapy and using as a combination group, women receiving a single dose of Nevirapine with transmission rates varying from two points to 5-percent, 2-percent and in the combination group around 55.3-percent.

In Malawi, Mozambique [inaudible] access to CD4 in the organization for services in medical clinical staff significantly increased the number of eligible women enrolled prophylaxis in AFT. In Rwanda, the proportion of women with CD4 testing increased from 43-percent to 80-percent with a

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concomitant increase involving and associating use of drug regimen from 52-percent to 99-percent.

In Malawi, the proportion of women who qualified for ART, those on WHO clinical staging stage three and four, on other words 2-percent went 54-percent of the same group of women was eligible for treatment when we used CD4 cell count less than 250 for initiation of treatment. What are the lesson learned, that shorter duration of ART during pregnancy is also showing to have higher transmission rates, keep [inaudible] to challenges includes adventures, gestational age and a treatment initiation and loss to follow-up.

Early infant diagnosis of HIV is critical to ensure early access to care and treatment for HIV infected infants. CD4 cell counts should be integrated as part of primary care for HIV infected pregnant women. Mentoring of clinical staff is essential to ensure integration of PMTCT into maternal, newborn and childcare services. Exclusive breastfeeding up to six-months carries a lower rate of HIV transmission than mixed feeding; providing free infant formula from birth does not lead to better HIV free survival compared to exclusive breastfeeding. Breastfeeding promotion on a scale is possible as evidence by improvement in Madagascar, in Bolivia, and Ghana. In Uganda, HIV free survival did not defer by feeding options when you compare formula feeding

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with breastfeeding. However, mortality was significantly higher in the formula fed group.

The main points here is to recognize that countries are using different strategies but now we have good, good evidence in terms of the protective role of exclusive breastfeeding. The recommendation and national policy should be on this recommendation made recently revised by WHO taking in accounts the fact that if replacement feeding could considered if that is affordable, feasible, acceptable, sustainable and safe. But, in areas with high prevalence and where access to clean water is difficult, it is very important to look at the promotion of exclusive breastfeeding at population level especially with focus on HIV infected women.

In terms of specific action, we found out through this presentation, during the conference, there is an urgent need to send capacity of physician policy makers to train healthcare workers and committee service providers living with community service providers of the guidelines in lack of WHO guidelines and the recommendation will realize resources for integration of infant feeding processes for nutritionists, supervisors and senior health workers at facility as well as community level. There is a need to simplify all consensus statements made by WHO and union agency. There is a systematic important communication for

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behavioral and social change approach in support of optimal infant feeding involving many partners and other family members.

Early cessation of breastfeeding seems challenging; 70-percent of breastfeeding mothers were through breast feeding by 12 months. We did have a session on best practices in the area of PMTCT and as presented during this conference, yes, we still have a way to go in terms of improving and increasing the coverage of and recession of the provision of ARV to pregnant women for prevention of mother-to-child transmission but recent data produced, released a few days ago, in University of this report shows that, the world-wide coverage of ARV prophylaxis for PMTCT in middle and low-income countries is at about 34-percent. Even in some regions such as east and southern Africa, this coverage is higher and is about 43-percent.

We found in the presentation at different sessions that we do have some good examples in maternal testing counseling in Zambia for example, all were introduction of HIV testing counseling; labor was of women with a known HIV status increased population coverage by 16-percent. There was also an increase in services in terms of focusing on improvement of facility quality control in intervention including involvement of male partners in Tanzani, a introduction of CD4 cell count and also later we have ART

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centers supported by training, monitoring, and modern living, community advocacy mobilization, mother-to-mother support groups and provision of delivery in Nigeria help also to improve optimal services. The same observation was made in Zambia where [inaudible]. I am sorry. This is the same slide. The relation of HIV testing and counseling of pregnant women with known HIV testing, as I mentioned here in the labor and delivery services in Kenya, show that most women, 80-percent knew of their HIV status on arrival of labor and deliver delivery wards.

Most women of a known HIV status were offered testing in labor and delivery wards. And, this women accepted at this moment. Average ANC and PMTCT are the motive to increase coverage in Ethiopia including specific activities targeting very hard to reach population; we linked it to ART training to CD4 and ART raises rates of prenatal HIV screening of population with low access to facility based ANC.

One of the presentations in this session was about what we have learned in terms of the key elements for success, for PMTCT in resource limited countries. And, this element was aptly described in the guidance book skill of PMTCT with the AIDS specific direction including demonstrative government leadership and commitment. This has driven delivery of a standard package comprehensive services

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and to the realization of provider initiated testing and counseling in labor, delivery and postnatal settings and to the realization of [inaudible] HIV care and management in maternal, newborn and child services increasing access to AFT for pregnant women, mothers, and their children and families in the context of PMTCT strengthening infant feeding and nutrition advice, counseling and support for women and their children and their families in the context of PMTCT and HIV care for children; operations realizing the linkages between PMTCT and sexual predictive health and finally empowering and linking with communities. The issue intervention is also very important and the prevention, we have several presentations on integration of PMTCT into maternal, newborn and child health services.

A presentation from Swaziland from South Africa, Tanzania, Rwanda, and Mozambique; the men listen and learn from this intervention and the average services from [inaudible] to health centers is [inaudible] of PMTCT services and allows more women to access full ART in Swaziland where policy environment is key to increasing access.

In South Africa, the PMTCT policy still uses VCT which limits the number of women accessing PMTCT services; after the first ANC visit is impacted by lack of trained personnel and the policy of VCT. Integration of PMTCT in NCH

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and ANC clinics is key for follow-up of plans. Breastfeeding replacement is possible in the rural settings of Africa but requires a great deal of input in terms of food, formula and clean water support. How to scale this up is an issue.

The discussion of full AFT and exclusive breastfeeding compared to replacement feeding is key but we still need more evidence to actually discuss the comparison of benefits of providing the AFT to all pregnant women as providing from the current recommendation of WHO which states clearly that women with education and treatment should receive AFT; white women with no indication should receive combination prophylaxis, combining AZT and single dose Nevirapine.

What are the remaining challenges for PMTCT? It is very important to strengthen coordination and collaboration among national programs implementing partners in the private sector and civil society in support of the implementation of national scale-up plans. To strengthen sub-national planning, coordination and supervision, support the resource mobilization, liberation and allocation for implementation of national sub-national plans; support systems strengthening to increase access and uptake of CTX prophylaxis in early diagnosis and early initiation of infant AFT; supporting operational research to inform the implementation of optimum infant and young child feeding within the health facility and

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of community level; paradigm shift toward improving maternal and child health and survival focusing on improving ANC and delivery care and linking with child survival programs. Yes, PMTCT is about infection of averted but PMTCT is ultimately about improving maternal and child survival and health.

Let me finish with a answering a couple of questions. Getting back to the exercise of understanding how epidemic and taking the right action. It is very important to focus on key priorities. When we learn new things, we have difficulty changing what we do but this should not be a barrier to moving forward in terms of implementing, putting to scale what we know in terms of prevention which is aptly working. There is no one magic bullet and sometimes we need much of a component prevention package to move to scale. It is important to know what to do especially in terms of the area of behavioral change.

HIV is not very infectious and is preventable. Again, as you can see I am getting back towards the first day and courting his excellence, the President of Uganda, when you know the enemy and how it operates, you know how to respond. You know your enemy, you know your response.

Finally, the title of this conference is scaling up through partnerships which are key. The time has come for us as country players; the time has come for us as partners to put our hands together. There is no more time for

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attribution. It is time for contribution. Thank you very much. [Applause]

TIFFANY HAMM, PH.D.: Thank you, Dr. Ekpini for a very excellent presentation on a subject area covering very target populations as well as transmission routes requiring multiple approaches IN achieving the same end, prevention of HIV infection.

So, we would like to move onto our third presenter today and that will be Dr. Donna Kabatesi, who is the director of programs at CDC Uganda and she will be presenting on care and care and support. Dr. Kabetesi is also the co-chair of Uganda's PEPFAR palliative care and policy in system strengthening or systems technical working group. Before joining CDC Uganda, she worked with the industry of health STD control unit in [inaudible] Hospital for 12 years.

In addition to her work with the national STD AIDS control program, Dr. Kabetesi founded and directed the NGO beta [misspelled?] which has successfully engaged traditional health practitioners as active players in Uganda's HIV/AIDS response. She received her medical training from Mackrory University and her master's degree in Public Health from the University of California at Berkeley. She has extensive postdoctoral training, expertise and experience in management and leadership for Public Health programs and HIV/AIDS programs management in particular. Dr. Kabetesi, thank you.

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DONNA KABATESI, M.D.: Thank you and good morning. I would like to thank the great team of Rapporteurs that put together the care and support session's summaries. Let me start this presentation with the exciting news of a name change from Palliative Care to Care and Support. For many of us, this more accurately reflects broad categories of service, services provided to HIV infected and infected persons in communities and home-based settings which include clinical services, psychological, social, spiritual, and preventive services.

This name change is still under going review at OGAC; most empathetically, PEPFAR continues to support Palliative Care as defined by WHO as the component of care and support with a focus and detection of management of pain and symptom control. Clarifications of definitions will hopefully reduce confusion and enhance visibility, support and implementation of Palliative Care. My presentation will summarize what we will have to do this week in adult care; Palliative Care, pediatric care, counseling and testing, TB, HIV, food and nutrition, orphans and vulnerable children, and summarize some key organizations.

In the adult care section, we learned that one of the key programs that we are testing as programs is retention of patient care but very little attention as evidenced by the number of abstract on presentation on this matter was

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observed. In Rwanda, for example, 119 HIV positive patients were enrolled in five health centers, 99-percent were referred to an ART site for staging and only 33 patients of the 119 were able to go three months later. Piloted clinical staging and CD4 testing at onsite at three health centers in 2007 was able to show that 39 patients were enrolled and only three were ART-eligible and were successfully referred.

We are going to emphasize that when services are provided onsite, you are more likely to get people in care and treatment programs. This slide goes onto demonstrate that when you have services onsite, particularly for pregnant women, when a CD4 test was able to be conducted at the ANC site where this pregnant women were seen, many more women were able to get into ART treatment programs over time. As you can see in the first quarter in this study, only a tiny portion of women were able to be enrolled because their CD4 testing service was not available onsite and increasingly, the same number of patients that had a CD4 count done almost were able to get enrolled into ART when the service was onsite.

Let me turn to another important area in care and support programs and this is the area of quality improvement. As we scale-up our programs, we are aware that quality is likely to suffer. And, many programs, particularly this example, from Thailand have instituted quality improvement,

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activities within care and support services and as you can see, over time, the quality of service provision as evidenced by the percentage of eligible patients receiving these services increased when this current improvement program was instituted. And, the lesson to take from here is that if quality improvement interventions are implemented in our programs, collective activities can be undertaken but it is never too late to institute quality improvement activities within our care and treatment programs.

Let me turn to another initiative that is a collaboration of the world health organization and PEPFAR. That is developing documents and manuals that will help us rule out HIV prevention care in ART programs to primary healthcare centers. These documents are available in the email indicated in this slide and your comments and input are kept; so, when you have time, please go to that website and contribute to this process. During this meeting, an example of a successful program in Uganda that provides HIV positive patients basic preventive care package was presented.

Over the past three years, this program was able to demonstrate that you can distribute preventive HIV packages to patients and use multiple approaches through various outlets. In the past three years, as of March this year, this study showed that 188,000 basic care kits were distributed to over 134 outlets at the end of March this

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year. And, as we speak, the basic care package is part and parcel of the comprehensive care services provided to HIV patients in Uganda. And, as I understand, this program is being scaled up in other countries as well.

During this week, this study was able to share some of their practical challenges including the maintenance of commodities and ensuring that there is a logistics system to track commodities, ensuring that there is ongoing support and training for programs involved in distribution of these packages and they did indicate that identification of more than one supplier ensures that there is continuity of these commodities and instituting every service at the same time a social marketed service ensures that there is availability and the options.

Another interesting study during this week that looked at the impact of discontinuing cotrimoxazole to most in patients who were on ART, did show that actually it was harmful to discontinue cotrimoxazole prophylaxis in HIV patients while on ART. In patients in this study, in eastern Uganda, showed that episodes of malaria in patients who had discontinued cotrimoxazole in three months increased significantly and other morbidities as well associated with cotrimoxazole prophylaxis were observed to have increased. What we do not know in this study is whether these HIV positive patients on ART who have discontinued cotrimoxazole

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had any more episodes of malaria than their neighbors who are HIV negative.

Unfortunately, this study, they were not able to tell this but it was a very interesting observation that cotrimoxazole is beneficial in patients on ART in places where malaria and other opportunities to infection that are known to be- Cotrimoxazole is known to be effective in preventing them.

This study from Thailand did demonstrate to us that for a quality improvement program to be brought to scale, you need partnerships with critical scale-up and for you to be able to succeed, you need the national healthcare system to participate. You need hospitals to be involved and their staff to be involved in this process. Capacity building and training is an ongoing process and there is peer learning of motivated staff that increases quality by sharing successful practices. And, it is very important to continue to monitor the quality of implementation during national scale-up and ensure that there are corrective interventions to improve the program.

Let me now turn to Palliative Care Services. In the Palliative Care Services section during this meeting, I will focus on two areas. I will focus on the availability of the basic care package and access to pain management medication. In this study, undertaken in Kenya by Heidi and others- The

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slides may not be very clear but what this study demonstrates is that as you go lower in our health facilities towards home-based care services, the availability of basic care competence becomes fewer; so, home-based care have fewer companies of basic care packages. And, indeed, as a general observation, there are very few study sites that provide a combination of these services that have a more effective intervention.

What we saw during the week is that for Palliative Care, for to be successfully scaled up, there are efforts that need to be in place, permission of government and non-governmental collaborative work group with ministerial of health, Narcotics Control Authorities, the regulatory and professional counsels and some of the three examples that were presented during the week showed that this was an important component of successful scale-up of [inaudible] of our national programs. Situation analysis are important and conservation for special populations such as children, injection drug users, people in prisons, and people using in rural areas is important.

And most importantly, we learn in this session that the four pillars of successful Palliative Care Programs still stand and we should continue to uphold and promote them and this includes the showing that the national policies and guidelines and insuring that the medications are available,

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the pain medications are available. Making sure that training and capacity building of health care service providers is ongoing and implementation of these activities.

Sometimes in some countries, they have good policies and guidelines, we may not have constant supply of medications and again if any of these four pillars is missing, we can not have a successful Palliative Care Program. In Vietnam, this is one the examples in Vietnam, trainees received mentoring to gradually take over Palliative Care as a teaching responsibility and what this example shows is that the availability of training materials in the core team of people who have been trained and who are able to train others in a cascade mechanism ensures that there is successful.

And, now there are several people in various parts of Vietnam that were able to provide Palliative Care services through this successful training program. Let me turn my attention to issues of children. In two examples during the week, one from Rwanda and the other from Uganda, we were able to learn that children in pre-ART care are more likely to be lost to follow-up than those on ART especially for younger children. We also heard that expansion of care treatment services with emphasis on early diagnosis and identification of those who need ART for children is key.

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In the Ugandan study, we learned that HIV infection; infected children in rural areas start ART very late, when they have more advanced disease but they responded favorably the same way their other counterparts did. And, we also have that community mobilization is working to get more young children get into testing programs and eventually into care and treatment.

In Tanzania, we are told that pediatric HIV and HIV program, a pediatric HIV program in Tanzania was very successful as the results of prevent implementing some interventions that included instituting child friendly services and showing that there are some people focused on pediatric services in this site. And, the same observation was made in Vietnam, where there was a specific focus on children and provisional treatment to 1,000 children was able to be scaled up as a result of having all the pieces in place. For partners who are involved in pediatrics and those who are studying, UNICEF has produced good documentation that are available that can be used to help the scale-up of pediatric services.

In summary, for pediatric care issues, linkages between PMTCT, maternal child health, care and treatment services is vital to ensure that the child receives as many services as possible over time. Children respond well to ART in both urban and rural areas when it is provided despite

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lower levels of staffing and support in the rural site. HIV positive children who are not eligible for ART are more likely to get lost to follow-up. And, we have heard about the UNICEF programming framework that is available.

Let me turn my attention to HIV and counseling and testing experiences that were shared during the week. Key observations included the fact that focus on counseling and testing had been made to link HIV positive people in care and treatment with very little emphasis on preventive aspects of HIV counseling and testing. The other operation we had about was that counseling and testing could benefit from being viewed as part of a larger intervention strategy rather than a one-time intervention and an end in itself. There are several examples in several sessions. We also heard that strategic information and program data can be used to identify gaps in access to and utilization of counseling and testing services in order to better services.

Uptake of counseling testing remains high when services are most convenient to clients. We had a very interesting example from Botswana where innovative opportunities of assessing men for visiting services did yield very positive results with over 233-percent increase in the numbers seeking this service over the regular efforts for counseling and testing. This example was able to show that through creative and innovative operations, you can get to

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the most difficult people to reach and these individuals accept testing much more than you would expect in the regular operation used and through this example, they were able to identify newly identified HIV positive persons close to over 16,000 individuals were identified in this effort.

Lessons learned in this section of our meeting was of large scale counseling and testing activities such as national HIV testing events require a significant amount of planning and foresight and we had examples from Tanzania; we had an example from LaSotho and a couple of others.

Let me turn my attention to TB and HIV. This slide demonstrates the fact that we are moving; we are getting there in terms of HIV and TB services for people who are currently infected. As you can see in this slide, the general trend over the three years, 2004 through to 2006, was an increase in the proportion of people accessing services; TB patients accessing HIV testing services. Other examples during this week included progress that has been made in scaling up HIV testing of TB patients through provider initiated testing and counseling. One challenge that was mentioned was the need to link TB patients to HIV care and treatment and to try out one stop shop types of interventions where services to TB and HIV are provided in this same site as where it is feasible.

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We also had that a variation of routine TB surveillance systems had been used to improve programming implementation and documentation of scale-up was a very successful activity in Zambia and several other places. Examples of implementation of TB screening and diagnosis in select sites were shared during this meeting. However, we had that national scale-up effort has been very painfully slow.

International agencies have recently made efforts to harmonize reporting indicators to measure progress and TB, HIV progressive activities and hopefully, these efforts will increase national scale-up of TB and HIV programs. The follow-up for TB will continue to be the three eyes including intensified TB case findings among people who are HIV positive, insuring [inaudible] preventive therapy in patients who would benefit from it and infection control to prevent TB transmission. WHO has recently branded this policy and collaborative guideline upward and hopefully this will help to increase and scale-up TB, HIV services.

One example from Mozambique did demonstrate that with a little more effort you can have many more people with HIV screened for TB and those who are TB suspects diagnosed on getting those who are TB infected into treatment. In Kenya, we had one example of [inaudible] preventive therapy presented here and very interestingly, the only predictor

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that was significant for people completing their IPT prophylaxis was their resident's; urban and rural residents, there was a significant difference between patients coming from these two situations. Otherwise, all the other factors were not important.

I will turn my attention to the sometimes a forgotten subjects, food and nutrition. During the week we heard that there is urgent need to strengthen nutritional support as a critical component of comprehensive care and treatment of HIV patients, as well as for women, in PMTCT programs and orphans and vulnerable children from birth to after 18 years. We heard from some presentations that nutrition has been generally under prioritized and under funded and strong national commitment by government and partners including PEPFAR is imperative.

Clinical service providers provide the platform for nutritional assessment counseling and support for patients as well as provide an entry point to link with other services. The food crises will increase the vulnerability of HIV/AIDS patients and their families including OVC and making clinical and community linkages to people who need food and nutrition support is imperative. We heard of an example in Kenya where food by prescription was successfully implemented. This program provides nutritional assessment counseling and points of use, water treatment as well as fortified branded food by

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prescription as part of a comprehensive care service in comprehensive care centers.

They target clinical malnourished adults with a body mass index below 18.5, pregnant and lactating women in PMTCT programs or OVC's from weaning to two years of age; they were able to enroll over 36,000 patients by the end of December and they graduated those who improved, those who reached a body mass index of more than 20 within a period of four to six months; reasons for us to follow up included poor access to facilities, changes in plans, circumstances, inadequate resources for transport stigma and mortality. They observed a critical need to improve integration of food by prescription within comprehensive care services.

Although the service centers are already over stretched, the group did feel that quality improvement operatives including adequate staffing, establishing roles and responsibilities, performance standards for all staff, test shifting where some of the interventions that could address this critical challenge; partners in health was another example presented at this meeting. Food commodities provide 20-percent of daily energy requirements for a family of four. They were able to show that preliminary analysis of outcomes for others following six to 12 months following of food assistance included decreased in food insecurities as well as improved body mass index. There is a need for final

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evaluation to determine program cost changes in treatment adherence and clinical outcomes and longer terms for security for targeted families.

In Rwanda, a program to working with network of people living with HIV and AIDS in Rwanda was able to show that integrated competence support established PHA agricultural cooperatives and some of the key recommendations from this program include replication of these agricultural cooperatives, land and focus in partnership with local governments, training in sustainable farming among others.

And, now I will turn my attention to orphans and vulnerable children. There are several studies during this meeting providing enriching experiences and examples of OVC programs. One study that conducted in my variate analysis on DHS data from 11 countries showed that other factors other than [inaudible] were very important and these included gender, region, work, wealth rather than orphan status itself in terms of affecting school attendance.

And, one lesson we learned from this is that policies and programs should offer a single minded focus in the open states of this child and target based on the context in which this child lives and combined HIV/AIDS specific activities within the broader sectoral policies including issues related to gender, geography and work among others.

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We had a about an interesting planning too that could be used to map OVC activities using GI as marking and in this example, both high and low tech tools were introduced to help illustrate the relative size proximity and relationships among vulnerable sub-populations. During this week, we also heard about a range economic interventions that are provided to OVC and their caregivers and a variation of a range of economic strengthening products and the line that needs to tailor interventions to arrange different groups especially elderly, orphans, children care givers such as grandmothers and showed that some states, some countries are ready to take over the responsibility of cash transfers palliated by others.

We also heard about examples of some front line services delivery models including one in Tanzania where a training project between Tanzania and Illinois based schools of social work resulted in the development of the cadre of social workers to address the needs of offices throughout the country. We heard about another example of operation of mentors in Rwanda and which underlined the importance of the racial volunteers to household to achieve positive outcomes for children. We are also heard in multiple sessions the reiterated the need for better research and expanded programs to address highly vulnerable girls in urban, orphan or living

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outside family care and the need for both prevention and protection.

Some of the lessons learned include the significant progress in this session overall in care and support. Some of the significant observations we would take to that significant progress has been made in all points of HIV care and support services. However, integration and linkage prevention still needs strengthening. We also learned that care and support intervention are most effective when implemented as a package. And, programs should move towards more comprehensive approaches to be more efficient and effective.

During this week, we have learned that we continue to need special consideration for pediatric populations; we need to be paying more attention to our children and the children of people who are implementing programs, need to be paying attention to children populations. We also heard and we launched through various examples that we need to continue to build a [inaudible]. Program implementation can often feed into the process of developing and finalizing policy guidelines and tools.

So, in the absence of guidelines and tools we still need to continue doing something. We learned during the week that obviously policies and programs should not just target singular factors such as orphans in childhood but instead use

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comprehensive ability factors and aim to balance AIDS specific activities within broader sectors of policies and programs for vulnerable children.

I want to thank all these people who enabled this meeting to be a good success that it is. I thank you for listening to me. [Applause]

TIFFANY HAMM, PH.D.: Thank you very much, Dr. Kabetesi, to you and your team for a very compromise review of the sessions under Care and Treatment to include, identify the four pillars of Palliative care and policy, medication, education, and implementation and the need for comprehensive or coordinated programming across care and support. So, for our final presentation will be Dr. Carl Stecker and he will be presenting on cross-cutting and policy. Dr. Carl Stecker has nearly 30 years of international health and HIV and AIDS experience in Africa. He is based in Baltimore, Maryland with Catholic Relief Services and he has been there since 2002 where he is a senior technical advisor for HIV/AIDS helping to provide technical assistance to the agencies 250 plus HIV projects in 52 countries.

In addition to promoting and helping to ensure the technical excellence of these projects, the bulk of his time is spent on policy, advocacy, and resource development for faith-based organizations working in HIV and AIDS. He is also the agency's chief spokesperson on HIV related issues.

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From February 2004 through June 2006, he was the initial chief of the party for AIDS relief. The CRS lead consortium for the rapid expansion of anti-retroviral therapy, a five-year PEPFAR supported ART project in nine countries. As the end of March 2008, over 330,000 HIV positive individuals were receiving ART and other supportive services of which 112,000 are receiving ARVs. So, for our final presentation, Dr. Carl Stecker.

CARL STECKER, ED.D., M.P.H.: We have decide that in order to provide an evidence base for good programming and improving the programming of our conferences that we are going to do a study on subliminal capture and retention of critical information. We are going to do this by dividing into three groups.

In one group we are going to flip through all these slides, 60 slides in one minute. The second group is going to have to sit here for 30 minutes and the third group can select to either be part of the first group or the second group but can do it with their eyelids closed. And, there will be a self-test at the end in which we will see what your short-term recall is in retention and then we will be asking if the organizers of the conference can provide arrangements for free registration for next year.

An additional factor in trying to make this go a little bit faster, the presenter has intentionally not used

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the restroom since getting up this morning and had only an hour and a half for sleep. Thank you very much. [Applause]

I have the privilege of having worked with a large team that has 17 people who have looked over 12 subcategories that have been lumped together into one presentation. I think this is a good picture of partnership, a group of people holding their hands together, we are not going to sing Kumbaya but we are going to look at integration. The first five of the 12 subcategories are looking at things where we need to work together. While some progress has been made towards strengthening coordination, there is still a lot required to resolve issues raised in Rome and in Paris; the driving force of U.N. such as the three ones, the global technical teams, the universal access and it has ensured donors improvement to a grading between 'C' and 'B' this year as we heard in the conference.

Major development partners are not regularly using NSPs and national reporting mechanisms. Turf competition and duplication is rife especially in provision of technical support. It was suggested that a web-based data service for technical assistance should be explored. While total funding for AIDS has increased, there is uncertainty of the amount actually reaching beneficiaries. These particular slide shows, from a presentation by the World Bank multi-country AIDS program, an overview of coordination harmonization;

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where a map shows the funding was catalytic to the U.S. government's involvement in PEPFAR initiative, the global fund amongst other initiatives.

Some of the critical messages include the fact that coordination will only serve its purpose if it is aimed at strengthening sustainability. And, it is important to use national structures as much as feasible; government leadership and ownership is key. It was noted that coordination itself was not cheap and required long-term funding, a lot of time and commitment. It is important to clearly establish whose agenda was being addressed when translating global coordination initiatives and actions particularly at country level. This, of course, should be informed at country level by country level priorities. Effective coordination that results in leverage of resources requires an enabling of environment, both at the global and at national levels. Some of the lessons that were learned in this area, that coordination is not cheap but it is an essential ingredient for success and for leverage of resources.

The importance of predictable, adequate and consistent funding, formal divisions of labor of various partners that acknowledges comparative advantage of partners results in efficiency gains. Both financial and non-

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financial resources are required to strengthen national structures and systems.

Under performance of any one partner, negatively impacts total performance and concluding this category, there is still no clear indicator for measuring efficiency gains from strengthened coordination; these have yet to be developed. Also, no clarity around country priorities of those of donors or on how to harmonize different procedures has been done. And, there is an urgent need to ensure the largest donors coordinate within country led frameworks and this calls for stronger government leadership. And finally, there is a need to coordinate technical support, a plan based on country's national strategic plans and identified obstacles.

The next area on the global fund for AIDS, tuberculosis and malaria and the goals of the CCMS were presented around monitoring for the implementation of grants including the performance of principle recipients as managers, timely execution of work plans, technical results compared to targets on a quarterly basis, coordination, and harmonization with other funding streams. Three areas for country coordinating mechanism oversight were also elucidated around finance program and performance.

There were five key questions that were posed. They include, where is the money, looking at the global fund,

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primary recipients and lead recipients, where are the drugs, and looking at commodities because that accounts for about 50-percent of all current global fund grants. Are the recipients receiving the resources and the technical assistance that are planned? Are the grants being implemented as planned, and are the results meeting the performance targets agreed upon? They also looked at what does a CCM need to perform oversight role and included this list.

Another presentation dealt with becoming a direct funding recipient and the session discussed presentations and experience from Tanzania, the churches health association of Zambia, Co_Devore [misspelled?] and a project in Namibia. The churches health association of Zambia made several presentations and I apologize for the typo here it is not Tanzania; it is the church's health association of Zambia. And, have been a multiple prime recipient for three global fund grants in Zambia managing 28-percent of the global fund for HIV and AIDS in Zambia. They showed that a program facilitated rapid scale-up of services in civil society of faith-based organizations through mobilization of NGOs and rapid capacity building. Success was linked to their willingness and their willingness to the government to share responsibility independent of country coordinating mechanism and this was prior to the global fund as well. Challenge

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coordinated, the challenge was- It is coordinated oversight by the coordinated mechanism, the government and the LFA.

Similarly, in Tanzania, Pat showed some of their work with regarding requests for application announcements that they placed in newspapers, simple guidelines that were developed for NGO applications to make it easier, compliance review for those who have been passed into reception of funds. There was a bidder's conference that they set up before with technical review with local authorities and donor references. They also included pre-award visits to the applicants to the RFA that passed a certain level and then they tied capacity building to all of their sub-grants and part of their success was in allowing enough lead time for the NGOs to hire and train staff.

Some of the obstacles that they encountered in Tanzania with Pact were grant making limitations and it was really around the lack of capacity of many of the non-governmental organizations. Lack of human resources, lack of knowledge and understanding of children's rights and national plan of action and poor systems for financial management and that the budgets were not based on assessments of the actual children's needs. They also had several tools and approaches were developed and presented, the interagency task team on children and HIV/AIDS have a draft paper that was presented

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and is an operational assessment of programs for orphans and vulnerable children.

In Namibia, they discussed the transition of independent nongovernmental organizations status and compared the institutional and legal implications of nongovernmental organizations versus private voluntary organizations status. We are going to move onto the public/private partnership which is the last in the category that I put into integration and some of the key findings and lessons learned; first, there was involvement of the private sector and service delivery that has been shown to increase the number reached with HIV/AIDS services. This was reported for partnerships in different countries and settings including projects in Uganda working with a private foundation, a partnership in Ethiopia with a private hospital, services that are provided in partnership with the corporate sector in India and partnership between the private and public sector in Vietnam.

Secondly, capacity building and ongoing training, support of supervision, follow-up and technical updates are coordination and regular reporting mechanisms are essential components of all projects to strengthen technical capability. Community ownership, project management and sustainability; these processes are described more detail in the project abstracts that you have.

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This slide illustrates the increased uptake of HIV counseling and testing services in a project in Uganda resulting from the contribution of the private sector. The percentage of civil society organizations contribution, minimal in 2004, has grown by 52-percent of the total uptake of availability in 2007. And, this next slide shows the increase in gains of the number of persons receiving ART as a result of adding antirectral viral service delivery in Addis Ababa Hospitals [misspelled?] in Ethiopia.

Critical obstacles and issues that were raised around partnership to deliver HIV services may not be perceived as a priority by the private sector. While the public sector may have reservations about the ability of the private sector to deliver such services, long term commitment and ongoing advocacy is therefore essential. Challenges in the private sector included the opportunity cost of time spent in training and the tradeoff between in depth training for quality services and reaching a larger target audience.

In India, where global funds under a global fund project, the Confederation of Indian Industry had committed to setting up ART centers at private health facilities. It took time to change the corporate mind set from focusing only on awareness programs to identify those companies who would support the development of infrastructure. And, then thirdly in Vietnam, where the development of civil society is still

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in its early stages, challenges included little government experience with private sector, legal barriers, the lack of an in-service training institution, a strong distrust between the public and private sectors. The project therefore focused on prevention, mixed public and private health care providers in the same classroom for training, and work to sensitize central and provincial government.

This situation is now changing in Vietnam with the development of a new legal framework and the emergence of professional medical associations. Some of the new tools and approaches that works word and presented, for project assessment supported evidence based project assign including those that were detailed mapping of health services, health facility assessments, analysis of data from national health accountants, DHS and AIDS indicator surveys. These approaches provided data on such issues as the number and use of private and public facilities, the percentage of resources spent on public and private providers and the extent of which providers delivered services in accordance with national protocols and guidelines. A study of the financing and utilization of private sector services in 15 African countries is pending and more information is available on the website that is shown there for this particular project.

Now, switching again from private-public partnership we move into human resources. Some of the key observations

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from the presentation that were made in this category include one by Angela Bower [misspelled?] from the capacity project in Tanzania, in which she described a decline in health workers by 68-percent from 1994 to 2002. Mussalla [misspelled?] in her presentation talked about trained community youth serve critical roles in global funds, proposal development in finance reporting and monitoring of activities and then human resources inadequacies are key constraints to HIV care and treatment from those three different authors.

Some of the lessons learned in this category in critical messages that were presented there is a two year cycle a 22 trained and placed multi-sectorial action team coordinators that were needed for work with formal fund projects in Cape Town, South Africa. These coordinators were lesser trained personnel and needed closer mentoring but they did find that replication would be able to be done at a relatively low cost. These two year cycle would put the 22 trained in place coordinators was less than \$6000 over a two year period. Donor and NGR inducted internal brain gain is also a serious problem threatening sustainability of HIV programs in primary health care in general. The code of conduct of NGOs is being developed by a group of NGOs to help reduce the inequities and underlie the brain drain.

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Finally, PO HIV persons living with HIV are important human resources but it can be difficult to harness because of stigma and discrimination and lack of support systems available to them. Concluding this section, King Horn and a study of human resource needs in mapped out to 20 to 16 showed that systematically human resource planning for HIV and AIDS services based on the defensible projections and consultative processes have important benefits in defining country resources and capacity development needs as well as helping with prioritization and policy decisions for long term implications. The code of conduct for health systems strengthening developed for non-governmental organizations to help reduce the inequities underlie internal brain drain is also an important contribution.

Moving into work place programs, some of the key observations in critical messages that we observed here, public-private partnerships that include the private for-profit are a feasible mechanism for delivery of effective workplace programs. However, this may require additional technical and financial support, particularly for the public sector. Public services coverage service procedural requirements are always in sync with the projects demands, thus occasioning delays and rescheduling. Policy and management buy in is an essential prerequisite. Stigma,

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discrimination and fear of loss of employment hamper uptake of workplace interventions.

And finally the private sector requires quantifiable evidence of the impact of HIV and AIDS on productivity and return on an investment. So, the lessons that they learned and were presented included the following formalized agreements between partners ensuring clarity of roles and responsibilities, ownership of and commitment to programs, and sustainability of interventions. Workplace programs provide great potential for a multi-sectoral response. Workplace programs can be used to launch into other programs such as gender mainstreaming.

Existence of health facilities within the workplace provides entry points for the introduction of workplace programs. Well targeted workplace programs can be used to serve vulnerable population. Advocacy is key for promoting ownership and buying in at all levels and stages of engagement. This slide that is presented shows the elements that have to interact for quality HIV services to result in the workplace. The alafa [misspelled?] model serves the apparel workers of Lesotho; it serves to combat two key drivers of the epidemic in the country, gender and poverty in the country where the workforce HIV prevalence is 43-percent. By August of 2008, 72-percent of workers will have access to preventive services in the workplace and 50-percent to care

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and treatment. They have 21 factories adopted or are adopting and HIV workplace policy.

And, concluding this section, governments should create enabling environments by providing the policy and legislative framework for monitoring compliance by private sector firms. Partnership with business coalitions on AIDS is an avenue for supporting scale-up of workplace programs. Effective workplace intervention can ensure sustained productivity. Shifting again to capacity building and cash shifting no pun intended. Some of the key observations include that all the studies that were presented showed that cash shifting resulted in time saving for physicians, and measured in physician hours saved.

In this slide, Joyce Child presented a Rwanda's text shifting efforts where she acquired the findings from pilots to create estimates of demand for physician services in Rwanda. Assuming expansion of up to 59,000 people on treatment by the end of 2008, they estimated that it will require approximately 9,300 hours of physician consultation time per month or roughly 77 physicians providing direct care for 30 hours per week.

Since only about 150 physicians providing patient care in the public sector, this is going to be extremely difficult. This means that HIV care and treatment will absorb about 51-percent of the total physician capacity of

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the government of Rwanda by the end of 2008. The application of tax shifting on nationwide, over the course of the year would result in a 78-percent decrease in physician demand to just 17 physicians working 30 hours per week or just 11-percent of the total public physician capacity. The amount of physician capacity available for complicated cases or non HIV care is then increased by 183-percent with this task shifting scheme.

Again Shugushu [misspelled?] showed in this particular slide that he was looking at results from all patients evaluated in their study to see among those who started treatment, how many met the criteria and eligibility and how many did not. And they also looked at those who did not start therapy to see how many were effectively were not eligible and how many met the criteria. The first thing to note in this slide is no ineligible patients was put on therapy. And secondly, that among those who did not start therapy 19 cases were found to be eligible to start ART which is only 4.2-percent of all the eligible patients. So, except in two cases of delayed start of therapy, the overall determination of eligibility to start ART by nurses was very satisfactory.

Concluding this section on fact shifting, we note that task shifting is part of the response to the health care work force and part of the long term solution. Task shifting

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is here to stay, but more workers both clinical and non clinical staff must be added into the system for it to succeed. In a zero sum game, there is cost to shifting results or responsibilities and providers can still be quite stretched. Supervision and mentoring is critical to ensure as tax shifting is implemented into the systems and among those of health care workers and salary workers and the community members.

In service for task shifting needs to be moved into the pre-service training where appropriate and creating sustainable systems; a cautionary note was made that task shifting cannot solve all problems because you cannot task shift all clinical items to non clinical workers. In the area of strategic information special thanks I want to give to the team of U.S. government aid of my members reporting team. We are already organized before they even got here. And, then Paul Bouie [misspelled?] stayed up till 4:30 in the morning with me as well. The key observations from this section include the lessons from this conference.

The systems include at a minimum, a consideration of coverage of facility, community up to national, international levels, human resources in capacity, stay colder participation and ownership, information system and tools, business models, policy, advocacy, politics, surveys, surveillance, monitoring, evaluation, operational research,

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dissemination, data quality in use, epidemic character, local to national to regional comparatively, program and service, quality and improvement, and feedback and cost. The following slides attempt to summarize a few of these key themes that emerged over the course of the last three days, specific abstracts are sighted but this should not be interpreted as a full representation of all that was presented over the three days.

So, the critical messages that we see, there was an attempt to deal with this complexity, attempts to deal with this complexity can take various forms but we see countries and partners taking more strategically and focusing on the future. This prospectively leads to careful planning as well as more organized methods to develop these plans.

Available tools have been used by countries in the development of the plans, helping to organize processes and products of this exercise. Plans need to be focused on the issues at hand and must be adequately resourced implementation is to be successful. These national plans need a coherent response to the needs down complexity of monitoring and evaluation, they need to be appropriately focused designed and resourced. And, stay colder participation ownership of the process and results is imperative. Some of the critical messages well more data are

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available to guide the planning processes, planning must take into account all levels of decision making that will occur.

Continuing a second major theme of these presentations can be described most simply as data use. How one approaches and works with data, conducts analyses and interpretations and uses this information to guide future actions. Data use is a really broad term. It includes a diversity of issues that contribute to more informed decision making and we take inspiration from one of the presentations which created two subcategories, one is situation analysis and the other is response analysis.

No single epidemics are unique in their situation, now we must recognize this quality to fully understand how to design responses. Online use data to guide the design of programs, identify direct causes rather than generic ones. Synthesis use data from different sources to triangulate to strengthen inferences and do this often, lack of data creates obvious problems but we need to make the most of limited data and make cautious inferences. The response analysis section just to say a few more things about this here we are looking at how programs are functioning and how these data can be used to further our understanding of local circumstances and some of the problems that we face.

Within this same arena we have seen a concerted effort to explore the issues of quality of program and level

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and performance based funding at the national level. We also note the development of service scanners for peer education programs and platform by which is to monitor service quality. The third thing within this response category pertains to capacity development to work with the data. Community involvement is key to start with a simple collection; use data even if it is questionable quality, develop support systems, and make relevant appropriate end users. These conclusions I need to move along, but we have known these things all along but only as we are in the process of using this information do we really appreciate where we stand. Okay everyone we have got four more sections to go and I will try to just get into the critical messages.

This one on procurement there are quite a few presentations about pharmacy as supply management need to link the procurement team with program team, coordinate with all stake holders, principal recipients should work closely with their country coordinating mechanisms. And when they are applying for global fund procurement to follow the policies outlined in the global fund TSM policies. This particular slide shows covariance to consider in procurement and the steps in pharmacies supply management cycle. And, this next slide shows another good central importance of management support and the steps and the procurement cycle. The lessons that are learned we want to present today as a

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good example, well planned procurement in pharmaceutical supply management.

Country coordinating mechanisms should be more utilized for country questions, logistics and other questions when development their pharmaceutical supply management. An important aspect on narcotics that can be procured with a well-documented description of use, storage and safety, and that leads into the next section which is on integrated access to opiate analgesics. Pain is a frequent complaint among persons living with HIV/AIDS and should be viewed as a medical emergency. Indeed pain relief is best scene as a patient right that is all too often violated. Healthcare staff often do not ask questions if they suffer from pain or access it thoroughly. Also, because of many settings, drugs for adequate pain management are not available.

This sort of leaves pain management in most developing countries under recognized and underutilized. Opiates and effective drug for pain control to this day is often not available. The first step to provide a framework for adequate pain management is the development of national guidelines and policies. Such guidelines have recently been issued by the governments of Ethiopia and Vietnam, and there was also a presentation of Uganda's guidelines that have been available since 2001.

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Such guidelines have been, these guidelines provide a legal framework and broaden access for the use of opiates in management of pain. The challenges that are faced then in this is that including the expansion of opiate availability in rural areas is difficult, meaning that more peripheral healthcare centers are out of reach and outpatient care settings in home based care setting for institutional groups such as prisoners have limited access to opiates or none.

Further prescription policies ideally should be modified so that certified clinical officers and nurses are allowed to prescribe opiates. Other challenges include fears about the use of strong analgesics among both healthcare staff and patients as well as misperceptions about medical opiate use among law enforcement officers and healthcare staff. Almost done.

People living with HIV and AIDS are preeminent partners and stake holders in all of our efforts. Their involvement should be mandatory in all steps of program development from advocacy to planning to implementation to monitoring and evaluations. Contributions that were sighted by David Daisey [misspelled?] made an interesting presentation about the Indian network for people living with HIV/AIDS. That example supplies this principle of greater involvement of people living with AIDS. INP plus is a large national PLHA network in 166 districts in 22 states that

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bought together a team of persons living with HIV/AIDS in non PLHA members under a U.S.A. funded project developed a national greater involvement of people living with AIDS strategy and which was indorsed by the Indian government.

A large number of PLHA members in state and district levels were also trained in public speaking and have many policy advocacy sessions with government and other stake holders in their respective places. And, as a result they insured representation of IMP plus members in steering committees and national and state programs as well as on the country coordinating mechanism the global fund to fight AIDS to be in malaria. And, finally I can skip over this last one and have two slides on military but since Dr. Rene Ekpini already covered it, I think I can just go on with only to note that I really appreciated having been in this one myself to credo of the means. Anyone who does not have it will never get it.

Anyone who does not know he has it will know and anyone who has it must be treated. And, the pictures of us solider, peace keeping officer, with a kit that. Again, thanks to the people of Uganda, all the persons living with HIV from whom we always learn so much, all of the participants, the organizers and sponsors, the team of Roth Werturst [misspelled?] that we work for, all of our patients and the tiffany for helping us till 4:30 in the morning.

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TIFFANY HAMM, PH.D.: Thank you very much, Dr. Stecker for providing this or indentifying the tools and possible operations or instructions on how to install our kitchen sinks. So, please everyone for remain seated as we are expecting the First Lady to arrive any moment but before that I would just like to extend a special thank you to our Rapporteurs as well as the Rapporteur teams who put in countless hours in getting these presentations together for you.

I would also like to thank personally Rebecca Minendorf [misspelled?] for with a gag could have provided us our logistics as well as Amy Bolustein [misspelled?] of Courtesy Associates for insuring we had access to all of the resources we needed and a special thank you to CJ Emanuel who is a worker here at the hotel, who made sure our working environment was comfortable every night and we had refreshments last night. Again, please remain seated as we are expecting the First Lady to arrive. Thank you again.

[END RECORDING]

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