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**2007 HIV/AIDS Implementers' Meeting  
Workshops  
IMAI Implementation Tools and Country Examples  
PEPFAR, The Global Fund to Fight AIDS, Tuberculosis  
and Malaria, UNAIDS, UNICEF, The World Bank, WHO, GNP+  
June 18, 2007**

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[START RECORDING]

**SANDY GOVE, MD, M.P.H.:** And just to add, we're going to go through all of the presentations first, and then have a long period for discussion afterwards, because I think there's a lot of people in the room with substantial experience with IMAI and other tools for decentralization.

**BWIJO BWIJO:** Good evening, everybody. I hope you have been introduced, although I am coming from the W2, but I have been working very closely with the care treatment unit of the NACP National Controls Program. So what I'm going to give you is more or less of the same quality, what work that we do, that we would have given you. Next, please.

So my talk will cover, we will go through the introduction for measure of care treatment teams, scale up of care treatment services, to primary health care facilities, adaptation of a tool, also challenges, and the key recommendations for Tanzania. Next.

So Tanzania began to provide the care and treatment services for [inaudible] including free areas, in October, to provenance four. And there currently are 200 health facilities providing care and treatment services. And these included local hospitals, regional hospitals, district hospitals, private FGOs [misspelled?] and NGOs, so it's a mix

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of private, public. And those are the sites, how they have been distributed in the country.

The red ones were the very first sites to provide ART services in the first year of the program. That is the year starting from October 2005 for to the end of December 2005. And the ones in green, the 104 sites which were added in the second year, that's the whole of last year. And the graph shows you the number of patients who have been enrolled, and those who are on treatment at the moment.

So that gives you the total, and then the adults and the children. You can see that children are still quite a few, it's close to 10-percent of the all enrolled, and those in the area is now, totaled we are close to 80,000. And you can see there that in the pediatric, there are quite a few. It's a [inaudible] who have been not testing and who we have been discussing all morning.

And as we started the National Care and Treatment Plan, we had to prepare the National Care and Treatment curriculum, we had to go over the guidelines. And our training curriculum consists of those six modules: The general module, whereby all the teams sit together for the first three days, they cover the same sessions, the doctors, the nurses, the counselors and those who are going to provide the home-based care services, the pharmacists, as well as the

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lab people. They all sit together to go through module A. And then after they break out, they are put into their professionals, so there's a model for the clinicians, a model for nurses, and for laboratory personnel, for pharmacists, for counselors and for the home-based care providers. And the reason we will present the module for those who are involved in the management of decisions, to orient them to the issues related to care and treatment.

And you can see how much we have trained so far using that national training curriculum. The various who have trained, so in total today to have got more than 1,427 of different partners [misspelled?].

And for the year 2007, the National Care and Treatment Plan intends to roll out care and treatment services closer to the community. To achieve that, 500 primary health care facilities - and this would include health centers and the dispensaries - and we intend to get the number of patients in ARVs to 150,000 by the end of this year. And the rollout approach will be some of the sites, they have centers, and the dispensaries will be initiating sites, some of them will be just the refilling sites, and some of them will be the outreach sites, depending on the existing capacity in terms of the infrastructure, human

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resources, laboratory services, record and reporting system available to the infrastructure.

So for the primary health care facilities, we are not going to use the National Care training curriculum. We have adopted the IMAI tool, which is to be used for scaling up services to the primary health care facilities. And the process in Tanzania started in the year, early in January 2005, and to achieve that, we got all the technical support from WHO in Geneva, from the Uganda [inaudible], and to achieve the graphic designer with the support from Geneva, and later on from India. And then currently, we have got an IT person from Tanzania, but originally from Kenya.

So I am presenting that for you tonight, the challenges around it, our adaptation process. And from January to October 2005, we went into our cities of workshops and started initiating meetings and then the processes of the guidelines, and later of the training package, and we did the first training for field test of materials in November 2005. And in September 2005, we did the social cultural adaptation of the patient flip chart and the caregiver booklet. In October we adopted the TB/HIV common [inaudible] again last for Tanzania to minimize the number of documents who decided to integrate the TB/HIV [inaudible] to get us into chronic

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HIV care. So the two documents now for Tanzania, they appear as one document.

And in March to November, we started involving the human resources department of the Ministry of Health for specific reasons because initially, it was mainly the people from the clinical perspectives, the various colors and from the program. But we didn't involve the training institutions, and we noted that we needed their support as well to put the training materials according to the perspective of the training documents in Tanzania, and also to get the technical input for those who are involved in the training. So that was an excellent move to get them on board.

And in March this year, there was a wide scale-up of national training of the trainers for all the 21 regions in Tanzania. So we have money to clear facilitators for all the regions, so we are now preparing to start trainings in all the regions to get the number of 500 health care facilities at permanent level.

So you can see in the first field testing - that is the one which happened in November 2005, and the second one which occurred in July 2006 - and that's when the second one, it was done in collaboration, in partnership, with the Clinton Foundation. So we started enjoying the partnership right from the beginning. So you can see what we have

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achieved in terms of training for field testing. We were able to establish the teams of national participators, and those are part of them which trained with certain expectations, and the clinical teams from the health centers, which were about 23 health centers back then, so those are the numbers.

But during the March of this year, the national TOT [inaudible] trainers for the whole country, you will notice you don't see the expert patients. So this time, the expert patients were not involved. So you see the medical doctor, the assistant medical officers, the clinical officers, nurses and the pharmacists. So this is the number of the facilitators for the 21 regions in Tanzania, and the expert questions were not included in that.

So what are the challenges we have experienced? The logistical difficulties, working with much documents during the training. This has been a consistent complaint from the health care workers and, actually, as provided for those trainings are for them to be able to carry all the IMAI guidelines and their training packages. And then there has been a challenge of language and the ability to read in English, because the [inaudible] mode of training in IMAI, it needs them to read the materials. In Tanzania, our national language, our first language is Swahili. So when you go to the primary health care facilities, we find language becomes

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a barrier. And we noted the passage of technical expertise to edit the end design for us, and acceptability of the task shifts, and also experience a challenge for meaningful and greater involvement of EPTs, and quality monitoring of widespread IMAI trainings, and the establishment of clinical mentoring program. Those are the challenges to achieve quality.

So what are the lessons learned? IMAI is a very quick approach for scaling up the HIV prevention care and treatment and support. Health care workers very much appreciate the skills and interaction with the expert patients, an advocacy and partnership which was very much needed, and we have adopted great positive initiatives implemented by expert patients, trainings that are not recognized.

So what are we recommending? In my approach, the model for scaling up access of HIV related services, throughout partnership at three levels. We need that partnership from the community level, at the district level, for them to be able to include it into their program, to achieve their sustainability, and even at the international level.

And since we are talking and we are advocating positive prevention, and this can only be achieved by holding

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the expert patients, who will take care of the message to the rest of the caring team. And countries should create policies, integrated into the national human resources, for health strategy plan. This is much great important to facilitate meaningful and greater involvement of the expert patients as a clinical team. And the end design needed to be considered to change, so that to simplify, IMAI is adopted all over the countries. And we need to share the best practices, this needs to be encouraged. Thank you for your attention.

[Applause]

**SANDY GOVE, MD, M.P.H.:** Thank you very much. And now we'll go on to Damien de Walque from World Bank, presenting "A Baseline Survey of the Quality of ART in HIV and AIDS Service Delivery in Rwanda."

**DAMIEN DE WALQUE, Ph.D.:** Good evening and thank you for coming to such a late session. One point, I shouldn't be too long because I'm just told I have 10 minutes, but I was told previously by email that I had five minutes, and that I had maximum five slides, I cheated a little bit, I had six, including this one. So we should have time to go without rushing through my slides, but I will probably take 10 minutes.

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So I am going to talk about a baseline survey of the quality of ART in HIV service delivery in Rwanda that was collected, the survey was implemented at the end of 2006, and now I am going to show some initial results. And I would like to stress that this has been a very collective effort. The survey is part of our larger impact [inaudible], which I will describe in a minute, but which is done under the guidance and leadership of the [inaudible] commission, that's the [inaudible] here in Rwanda. And it's also work which is done in close collaboration with the School of Public Health here in Kigali, and with many of my colleagues at the World Bank, both in the Washington office, as well as the Kigali office. And many of the cultures which are on that slide are actually present in the room.

So first, I would tell a few about what we call a QSDS - that is, a Quantitative Service Delivery Survey. That's an instrument that has been developed by the Development Research Group at the World Bank, in the last, I would say, five to seven years. It has been applied both to health facilities in many countries, as well as to schools, and the idea is to - and that's a little bit of a paradox, but we claim that we are doing a decent job by doing it - and measuring quality in a quantitative way so that we can have

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large sample and draw conclusion which are nationally represented.

What we have done in our team is try to adapt this tool that was existing for health facilities to health facilities that deliver HIV/AIDS services. And in addition to run them, we are also implementing such surveys in [inaudible], in Mozambique, in the Free State province of South Africa, and we ought to be able to do the same in Ghana soon.

Now, what I want to stress is that this QSDS of health facilities, it's really a small part in a much larger impact evaluation at fault. I think on the first day of the conference, [inaudible] presented the fault that was all partners and run that for scaling up performance contracting, the approach contract in French in Rwanda, which is scaled up not only for HIV/AIDS services, but actually for other general health services. I'm not going to go into detail into that, but basically the idea, and that was building on previous experience in Rwanda, is that the health facility will get additional funding per medical act done, or for ACT done, or for PMTCT, or for vaccination for general health services. And so that's really what performance-based contracting, so that basically there is a contract between the government and the facility. And the better they

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perform, the more they will receive at the end. If we can still go back. Thank you.

Now, how are we doing this impact evaluation? We are, it's a prospective impact evaluation so that means there are baseline surveys and follow-up surveys. The baseline surveys were done in 2006, the follow-up surveys are scheduled for early 2008. And what we have done is four baseline surveys, two health facilities survey one that I'm going to describe in detail about the feasibility in health HIV/AIDS services one, in lower-level health facilities delivering general health services. Then also, we are doing [inaudible] survey because at the end of the day, we want to be able to say that the impact of performance-based contracting is not only visible or detectable at the level of the health facility, but also, which is the ultimate goal, at the level of the person, that it doesn't impact of the health of the population. Okay?

So we have done these four baseline surveys or health facility for general services, health facility for HIV/AIDS, also survey in the catchment [misspelled?] area for the health services, as well as health survey of HIV/AIDS patients and their families. And finally, we have allocated the different districts in two groups: a phase one group which started implementing the performance-based contracting

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in 2006, and the phase two group, which will start implementing early 2008.

Now, as I said, I am going to show you just a few results about the health facility survey of facilities delivering HIV services. The sample is 64 health facilities, and we are going to do 735 patients at these interviews, as well as 187 provider vignettes, and I'm going to describe that. Well, we can go to the next slide. Thank you.

So first, let's say we are trying to assess the skills of the staff working in HIV/AIDS care. And first, obviously, they are former training, and so staff working on HIV/AIDS care, 11.5-percent of them are doctors. The big majority is trained nurse, 69.7-percent, then you have a little bit more than 12-percent of social workers, and the rest are [inaudible]. What are the main responsibilities? For 35-percent, its PMTCT, close to 30-percent is VCT, ART for adults is 17.5-percent, and 7-percent are working for in laboratory services.

On the graph, we looked whether for PMTCT and VCT, the providers were delivering the service had received in the last five years specific training for that. And you see that it's fairly good. Since 80.3-percent of PMTCT service provider, if received this specific training, and it goes to 88.7-percent for VCT. The other bar chart is for the gender

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of the provider, because we thought it was important to assess that, because it could be a barrier, and we see that for PMTCT, which is to be expected, that more than 90-percent of the provider are female, and for VCT there is more of a balance in 67.2-percent are female.

Now, I want to talk briefly about something which is inevitable in this survey, it's provider vignette. So it's basically a small case that is given to the provider, where basically we ask what they would be, what they would do in that particular case of Mr. X, that age, coming in with fever, this symptom and this medical history. And it's been giving you a flavor of what we can find in the survey, I focused on whether the provider discussed the problems of HIV status, both the knowledge, and also if they are planning to or have done VCT. So in PMTCT we see that in the patient history, the provider will ask if she knows in her partner status in 77-percent of the cases. And in the consultation [misspelled?], it would recommend 83.3-percent that the partner be tested. So that's a fairly high levels. In terms of VCT, it's somewhat lower. We see that in the patient's history, the provider would ask if he or she knows his partner status, only 37.7-percent, and if the test result comes positive, then you would recommend that the partner be tested in just over 50-percent.

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Now, the last two slides comes from the exit interview of patient. And the first thing we are asking is about what they are paying. So we talk to patient, basically we see two messages from there is that the other costs, which are everything, medication cost, as well as transportations costs, et cetera, are fairly low and, actually, transportation costs are more important. So I think it's good that the main costs are low, but we certainly need to think about transportation as a potential barrier for access to PMTCT and VCT services.

And the last slide, and so we, in this exit interview, we also ask patient satisfaction. And so here you have the results for VCT, and there are four variables. So blue is for not satisfied, red for satisfied, and green for very satisfied. So time to be seen generates satisfied, privacy even more, staff issues as well, and overall is high as well. So I think we have a high satisfaction level.

So let me finish to say that we are going to combine this data at the health facility level with data at the hospital level, where we are actually going to interview the patients and their families, and we will, by that, look to address three sets of questions. First, we are going to look at the determinants of adherence to treatment, both from the facility level, as well as from the hospital level. We are

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going to look at the socioeconomic benefits of treatment, we are going to follow patients over time, and see all their labor participation, all their schooling of their children, for example, evolved over time, and also we are going to ask questions between treatment and availability of treatment and prevention both for ART patients, as well as the rest of the community. Thank you.

**SANDY GOVE, MD, M.P.H.:** Thank you very much, and we look forward to further results for this survey. Next, I'm going to ask my colleague from WHO, Eyerusalem Negussie, to present on "TB/HIV Co-Management with Co-Supervision and Co-Sponsorship by TB and HIV Control Programs."

**EYERUSALEM NEGUSSIE, MD, M.P.H.:** Thank you very much. Good afternoon, ladies and gentlemen. I will be presenting on TB-HIV co-management with co-sponsorship and co-supervision by TB and HIV District Teams, focusing on district teams. And I will be presenting also on behalf of [inaudible]. Next slide, please.

And my presentation will be a brief background Sandy, Rose, K.J. [misspelled?] and [inaudible] for HIV care, treatment, and prevention, and also an introduction of a new tool related to TB care in TB-HIV, and also I will be describing country adaptation status of this material and also some key changes and recommendation.

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The IMAI [inaudible] tools for TB care and ART prevention are in difficult in support of integrated management, family related, public health approach to rapid scale-up, and also to contain [inaudible] service based on decentralization and simplified, operationalized guidelines in training materials for ART or HIV program managers. And it is a mode of integrated materials and also it supports clinical team building. Next slide, please.

When we look at the TB-HIV areas, there are existing IMAI guideline modules. Our acute care contains when to suspect TB, describing some of the common symptoms and signs related to TB, and when to send and also respond to sputum results [inaudible] to get counseling. The chronic HIV care and prevention includes clean color review, this module focuses on chronic HIV care after one is tested HIV-positive, it focuses on clean color review and assessment of HIV positive individuals, TB screening during each visit, and if you have a positive person, IMAI prophylaxis, when to refer a TB patient for the ARV treatment, and also response to new signs and symptoms, which can include development of TB after initiation of ART, or follow-up on priority, otherwise responds to immunodeficiency syndrome and also side effects.

That said, guideline module which focuses on quality of care, and symptom management in end-of-life care, it also

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contains when to suspect TB during home-based care, and caregiver booklets, and TB treatment supports, TB treatments [inaudible]. Next slide, please.

The new six IMAI Clinical Guideline module is called "TB Care with TB-HIV Co-Management Guidelines." This slide shows us on the six IMAI clinical guidelines and modules. They are acute care, chronic HIV care and prevention, and quality of care, symptom management in end-of-life care, principles of good chronic care, the IMAC for high HIV settings, and the current one, TB care with TB-HIV co-management. Next slide, please.

This guideline is developed jointly by the virtual stock TB and HIV departments. This doubles up to meet the needs of clinical TB-HIV co-management and primary care laborers. This is our care centers and district outpatient departments in the hospital. This material is useful in terms of it can be used as a job pick by service providers and clinicians, and also it can be used for training purposes. It focuses on training, on TB training of TB care providers [inaudible]. It also assumes that the trainees are already trained on basic TB care. Next slide, please.

This guideline supports an expanded capacity to provide HIV care at primary care level by preparing TB stock to provide chronic HIV care and ART, and also it supports

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decentralization. This, however, its implementation requires co-management, co-supervision and co-sponsorship between the TB and HIV programs. Next slide, please.

This guideline has also, like the other IMAI guidelines, has also a training material with it. Just to highlight what the contents are, it contains integrated TB and HIV care, patient education, adherence preparation and support, and monitoring both TB and the treatment, and these are the main areas. And patient education, adherence preparation and support focuses on both adherence preparation for TB care and HIV care, and also the patient education also focuses on TB and HIV, and it also includes TB infection control within the health care sector.

And country adaptation, adaptation has been completed in Ethiopia and Tanzania, who structured to adopt it out here, while [inaudible]. The other countries with the longer list are countries who waited for the module to be finalized, and they are in the process of finalizing that. Next slide, please.

The company trained material is under development, it has been presented in Ethiopia, and is currently in the finalization process. Next slide, please.

What are the challenges to integrate the care? I'm thinking about TB and HIV integrated care. Providing TB and

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HIV care at one stop really simplifies some of the care-related processes to the patient. If the patient who is on TB-HIV co-management receives both the TB care and HIV care at one stop, that really simplifies things nice for the patient. But this requires training and human capacity building, including - and I'm also focusing on TB care providers, and also it requires a close coordination between the TB and HIV control program, which means co-management, it means co-planning, co-whatever and also co-sponsorship, in terms of funding - both programs need to sponsor it - and also close supervision is required by both the TB and HIV control programs at the district level.

The key recommendations are building the capacity of health care workers who are professional TB care providers, by training, clinical mentoring and co-supportive supervision is essential to also be part of the study care provider team, and also co-management, close supervision, and co-sponsorship by TB and HIV national programs and district teams are also essential for this implementation. Thank you very much.

[Applause]

**SANDY GOVE, MD, M.P.H.:** Thank you very much, Eyerusalem. And I'm going to give the last talk and then we'll have plenty of time for discussion. I'm going to talk about the IMAI district strategy for scale-up overall,

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introducing some of the new and expanding package of IMAI and IMCI tools, and also go on to talk a little bit about the new operations manual, it's still in development.

So I'm giving this presentation on behalf of the whole IMAI team, both WHO and the broader IMAI Alliance and Technical Resource Network that's growing around the world, of which I think some of you in the room are a part of. I think we're all aware that a huge implementation gap still exists. In lower-middle-resource countries, only 20-percent still have access to basic prevention interventions. The majority of those who need ART still do not receive it. We know the essential interventions for HIV prevention care and treatment and how to deliver them in a public health approach is necessary to go to scale. There has been a large increase in the number of sites delivering HIV prevention care and treatment, we've seen that in many of the presentations at this meeting, but many, many more sites are needed, and more community delivery of interventions to really head towards universal access. Next slide.

And so the IMAI and IMCI tools have been designed to support decentralization of HIV prevention, treatment, and care, with tools both for the district hospital, for primary care delivery at the health center closer to home, and for community-based care. And the reasons for that are obviously

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equity access, and also improved adherence. We saw in an earlier presentation today the high cost of transportation as a very significant part of care and I think it's one reason we are now at a stage where many of us are thinking about moving down to the health center. So the IMAI and IMCI tools really emphasize rebuilding a district network, establish good chronic HIV care with clinical teams, working with them in network. And that district network model, I think you call these tools in a facility community hybrid, it's the hospital plus satellite health centers, plus community-based care, with careful attention to linking facility and community interventions, building the clinical teams for chronic care, building a communication system at minimum, the ability to use cell phone and communication or radio or a land line in some circumstances, and a strong patient monitoring system, which we really considered to be the backbone of treatment and care.

We also quite firmly believe there shouldn't be parallel systems and, from the start, we should think of ways particularly as we're decentralizing, that HIV services are integrated. So in this pyramid, where often care is started and is still backed up by central and regional university specialized referral facilities, we've been concentrating on the district hospital health centers community, with an

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emphasis on the community-facility link, and with building the referral, back referral linkages, having a national clinical mentoring system, which many countries are still trying to develop, and assuring supervision by both the district HIV management team and the other cooperating management teams. Next.

So really, we need to emphasize now completing that district network. At the beginning, many of us have focused on facility-based interventions, gradually adding more community-based interventions, and then interventions through outreach to most at-risk populations. Why an integrated approach? We all know the number of interventions. If you look through the number of different presentations at this meeting, there's multiple interventions that need to go down to the primary health care facility. If we do all this separately, it's very, very hard for the health worker and the district management team. Next.

So we think that in an integrated approach is efficient, that once scale-up of HIV services needs to happen at district level. When we started doing district coordinator training, we were met by district coordinating center in Zambia saying, how can we do both HIV care and ART scale-up, and PMTCT scale-up, and BCT scale-up, and TB-HIV? We've got a lot to manage and sometimes I have to look in the

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mirror in order to meet the other district management team members because there's not that many of us. And so we've really emphasized compatible materials, working with partners and countries to really develop one scale-up of HIV services at a district level so that we can do together chronic HIV care, ART, testing and counseling, PMTCT and TB-HIV, and finding a way that we address children, adolescents, and both pregnant and non-pregnant adults.

And we really do feel that all adult HIV care in ART sites should integrate. In fact, I'm not sure any of these sites started out saying they were adult ART sites, they just emphasized adults more than children and failed to get pregnant women onto ART treatment. We think they all should be able to deliver PMTCT and I think that's caused a readjustment in many places for more facilities targeted for PMTCT than there were at the beginning of 3x5. And also that for really achieving higher levels of pediatric HIV care in ART, we think the most rapid way to scale-up is integrated, that family-based care is the model, and that we can build on basic IMCI for the most common conditions. Next one.

So starting out in many places with HIV in ART, sometimes not even at the district hospital, just moving down to the district hospital, we need to move down to health centers for HIV care, ART, and prevention, TB-HIV co-

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management, supported by the guideline module that was just talked about, and then really moving laterally, also, to be able to deliver ART and anti-natal/PMTCT clinics. So this integrated approach, again, is based on clinical co-management, co-supervision by the district teams, and co-sponsorship. And I think that it's almost harder at the national program level than at the district level.

But we do have to find ways to think more about shared programs of work so that when the district team is receiving the various support for delivery of interventions, there is a very rational way that they can deliver that shared program of work. And we all know from that TB-HIV, as presented, can be more efficient for the patient for a single clinic visit. This also applies for IDU, having an integrated approach, being able to deliver all primary care with HIV care and ART in one place, including, where permitted, opiates as substitution therapy, is advantageous. And there's more and more experience in the current global strategy for PNTCT, also calls for PNTCT integration with anti-natal care. And now with the new guidelines, that really means being able to deliver ART, or ARV prophylaxis AZT from 28 weeks within anti-natal services.

So basically, the IMAI approach to scaling up HIV prevention, care and treatment is based on integrated

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services. And it's not just integrated HIV services, it's HIV services integrated within basic primary care, a public health approach, all this achieved through standardized, simplified tools to support decentralization. Overall, aiming throughout to strengthen the district network and using several human resource strategies that I think you've heard a lot about in other presentations this week. Task shifting, taking advantage of the fact that there actually are ample human resources if you're able to hire and train and pay PLHIV, or expert patients, to actually serve on the clinical team and to be community health workers, and also by emphasizing health worker safety and support through clinical mentoring. Next one.

And this is what we developed since about 2001 for the approach to task shifting for clinical co-management. There's other cascades for other types of management for lab work for data monitoring. Clearly, we've moved from physicians and pediatricians, which are very, very few in these countries, to HIV care and ART delivered, some parts of it, by doctors, medical officers and GPs, shifting down to health officers and clinical officers, and then not only shifting some tasks to nurses, but also laterally to TB clinic nurses and midwives, or MCH services. This lateral task shifting at a district hospital level, or a large health

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center level, can provide multiple sites for HIV care and ART, and further task shifts to nursing assistants, counselors or lay counselors, with the aim more possible to include trained and paid PL HIV on the clinical teams. Also task shifts then to the community health workers and other community-based practitioners, community volunteers, both PL HIV and others. And probably the most important task shift, actually moving a lot of services and sub-management, to PL HIV and their family care givers. So, next one.

Again, the support by the family and self-management are key task shifts, and in the community, there is growing evidence about the effectiveness of case detection, treatment support, home based care, and simple monitoring. Next slide. All designed to build functional clinical teams linked to the community within a district system.

And just, we are asked by a few, to try to say something about task shifting and how it relates to some of the other task shifting presentations at this meeting. The task shifting to support HIV prevention, care, and treatment, really builds on the task shifting to nurses that's happened for many years, for actually even decades, in order to deliver primary care. This is an essential base for HIV care. We don't feel that we can put in care in ART without being able to deliver basic services for children for

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diarrheal disease, pneumonia, malaria, malnutrition, infant feeding support. Those were integrated in 1995, and to IMCI. TB case management has obviously been around with a lot of task shifting for decades, other lung and health problems in adults was added in 1998, and syndromic STI management has been around for some time.

In terms of task shifting for HIV care and ART scale-up, the guideline modules that we've shown you were developed from 2001, and published in 2003, and then as the 3x5 was launched, as well as PEPFAR, there was an important consultation in Zambia in 2003 that, even at that time in November, called for decentralization and task shifting to nurses, as the only way to possibly achieve three million on ART. And since we're still not there, I think the lesson is still true. There also was an important meeting in 2004 on core competencies for HIV service training and certification, that really emphasized the need for task shifting. And then we've talked about TB care with TB-HIV co-management. There is also now the important TTR task shifting, research study, and policy work, which began in earnest in 2006, and there's many important obstacles that remain.

Many ministries of health and finance are still reluctant to have trained and paid PL HIV on clinical teams, and working in the community. And that's a key task shift

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that we hope to get results from this policy work in order, and regulatory work, in order to move forward. So just to reiterate that one advantage of an integrated approach, even though it does have a pile of documents and guideline modules, is that we're able to strengthen basic health services at the same time. And we really do believe you can't do this if they're weak. So the integrated approach can draw from its strength and management of other common illnesses, pneumonia, diarrhea, malaria, STIs, and anemia, not just OITBN-ART. And HIV in children needs to address other leading causes of mortality and IMCI, the HIV version of that, for high HIV settings can do so. The challenge, really, is in instructional design and country adaptation to determine the mix and emphasis, and how to stage these in over time. Next.

And so when we started in 2003, we had a lesser number of modules than what Eros just showed you, next slide. We've added the TB-HIV, and we're now going into a third revision of acute care, where actually we cover some other conditions and some simple surveillance efforts. Next one. There's also now reproductive choices and family planning tool for PL HIV that's totally integrated with the two day course. And then a whole series of harmonized modular short courses, of which we told you about some.

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So IMAI often comes in a second phase, you know, countries and often it's the most expert clinicians at the university and central and regional hospitals, need to get competent in using ART. It often starts and builds up in large number at centers of excellence, but we're finding in many places, I think that many of you are familiar with very large patient numbers, mega sites, where the ability to actually provide adequate counseling and continue to do high levels of adherence, can be difficult. So often in countries, Ministries of Health want to expand to district hospitals at health center level so there can be more sites, get more patients on treatment closer to home, greater equity in adherence, we hope, in the long term.

So we've seen now, we had an example in the first talk, Tanzania wanting to go to 500 health centers this year, so many are looking towards rapid decentralization in several countries. And that's what we're trying to help with these standardized tools and technical support.

And just to say, in terms of the rapidity of training, we thought at the beginning that training would be the bottleneck. But, in fact, we don't find that because we're able to train back to back with what we call continuous training, so we can go to a region and train in this manner by having several different cadres of health workers from

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even 10 clinical teams trained at the same time. We also use, as Stella was saying, skill stations where we use PLHA expert patient trainers, so it's very active and interactive training. We're also working now on ways to make it even more efficient with clinical training with videos and counseling training videos. So it's an evolving strategy with continued innovation based on country experience.

There's new quality assurance and clinical mentoring tools, some of which are on the back table to pick up. We're working on the second level learning program. We're working, again, on how to improve efficiency to support scale-up, because going to this number of sites and to be able to do this volume of follow-up after training, is really the challenge. We're now starting working on IMAI content for pre service education, evaluating program effectiveness and impact, and expanding the integrated approach actually beyond HIV. Acute care has always been for both HIV positive and negative adults, and the general principles of good chronic care are now actually helping apply to other chronic illnesses, such as diabetes.

And the goal is that in this standardization is to get these guidelines, training and management tools, shared so there is shared training, shared mentors, and patient monitoring systems within a district, so that even within a

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district between the government sites, work place, HIV services, private providers, military services, NGOs, FBOs, et cetera, we can try to share some of these things as we scale up and try to move into a sustainable system.

Just to say briefly, because Ramsey wasn't able to come, that we have about 60 partners involved one way or the other, in contributing to an ongoing second-level learning program. We've realized that the target of this really is the district hospital clinician, that's the medical officer, clinical officer, a basic multipurpose doctor, a GP. We realized many of these people don't have a full MD and yet they're carrying the brunt of clinical responsibilities at the district hospital level. So we've had to get very directed materials that really support and improve clinical reasoning, differential diagnostic tables, et cetera. There have been already to do this for children, a child hospital pocketbook, and we're adding to that in addendum to updated for current HIV care and ART, but also developing a comparable adult HIV clinical manual, an initial training course that's already been used for a couple years, but is being improved, casebooks, other tools for clinical mentoring and CME.

We call it a learning program because we feel this needs to continue over time and since there's always, we're

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fortunate to have, always new innovations and new interventions in HIV, to have a process that we can continue to update it and to update the clinicians at the hospital. There is increasing emphasis on management, both district management through out district coordinators course, national and regional management, and quality assurance.

And all of these IMAI and IMCI tools are now being complemented by an operations manual. And this operations manual for delivery of HIV prevention, care and treatment at primary health centers and high prevalence resource constraint settings, is aimed at these clinical care teams at the health center, as well as their supervising district coordinators. The goal is to provide standard operational guidance for implementation of quality, HIV services, and everything needed to provide these services at primary health centers. So these are not clinical guidelines. These are designed to complement either the IMAI, IMCI clinical guidelines, or other national primary health care guidelines. So these are practical tools to improve the rate of scale-up at health center level, and the efficiency quality and sustainability of services.

So there's 10 chapters, this is adult services and pediatric services, lists out a consensus view on what are the basic essential services for country adaptation

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infrastructure, human resources at the health center level, lab, service linkage and integration, and patient monitoring, supply management, quality management, and leadership fiscal and facility management. So this is based on normative guidelines and patient monitoring tools, developed by WHO, USG, and other partners, and it's all part of a new WHO USG scale-up collaboration, aiming at the health center level. And we feel this is a powerful combination, providing joint support or implementation by USG agencies, their implementing partners, WHO, Ministries of Health, and other partners, to support decentralization to the health center.

Already in trying to produce the drafts of these guidelines, we have almost 200 people on 13 expert panels from more than 72 partners. So already we know that in one way or the other, 12 out of 15 PEPFAR focus countries are using IMAI, IMCI tools, and there's many countries now rapidly expanding.

You heard in an earlier presentation yesterday, Ethiopia has already gone to about 120 health centers, Tanzania 500 this year. So we're hoping to have this draft operation manual by mid-July for a second phase review, and for initial country adaptation by mid-July, and then moving onward to other countries. And we really do welcome suggestions and volunteers for the second phase review once

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we have a complete draft and at the end, there are little cards, we'll show you how to send those in.

And just to give you some idea - I won't read through all of this because my time is almost up - the infrastructure manual, which I will talk about, facility design, space, how to reconfigure for integrated services, design and ventilation to prevent TB infection, privacy, furnishings, waste disposal. So it's a very practical how-to manual that we hope the clinical team will find very, very useful.

Laboratory services, it has both SOPs and quality assurance procedures for what are considered and agreed to be essential laboratory services, how to collect specimens and transport them, space, biosafety, recordkeeping.

For patient monitoring, there is actually now three simplified and linked patient monitoring systems. The one that many of you are familiar with for HIV care, ART. There's now a newly revised TB system to incorporate HIV variables, and a new paper based PMTCT system. All of these have been worked on now to make them completely intra linked, guidance on roles, how to use data, what to send to the national level.

And then leadership, fiscal and facility management, something that many people now with the experience of overseeing multiple sites have said has got to be some of the

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highest importance in terms of delivering quality care. How to be a good manager, how to manage finances, how do I add services. We list many new services, there's many things descending on the health center, how do you actually look at what services you have now and add new services? How to develop and use an implementation plan, time management, work planning, and clinical team meetings. We're working with the community and district level authorities.

And this operations manual collaboration is a broad collaboration. Mary Lou Lindegren misspelled?] has joined the panel here so that when we get questions on this, she is from CDC gap, we also have strong collaborations with USA and many of the other USG agencies and implementing partners in developing the operations manual.

And so briefly, on the back table we have many of the IMAI site materials. To access them, you can go to this website, you can pick up a little card and it will put the share point drive where you can even get all the draft materials, the e-mails are on this card, and if you want to make a suggestion for a second-phase review of the operations manual, either suggest yourself, we're really looking for people that will work at district level, and know what the needs, the practical needs, of a clinical team are to give us some real feedback on is this operations manual going to be

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useful? Please use the IMAI mail e-mail address, and it would be nice, as you're proposing someone, to indicate the experience and current work of the person proposed. Thank you very much.

And now we have quite a bit of time, I think, still to take both questions and comments. And if there's people from countries that are using IMAI, if they want to make a short comment about the experience with IMAI, also questions about the operations manual. I think there's two microphones, one on the left and one on the right, and you can come up to the mike, and I'll sit down and take the questions from there. Thank you. Martha?

**MARTHA ROGERS [misspelled?]:** Martha Rogers, Kenya work force project. I'd like to ask if you have developed any sort of minimum or ideal staffing standards for these health centers, perhaps based on HIV prevalence in terms of what you recommend for staffing, if you're going to suddenly add lots more patients, needing a lot of services. Thank you.

**FEMALE SPEAKER:** I think we're going to take five, we've got three more people, we'll take those four questions and then we'll answer from there.

**FEMALE SPEAKER:** I want to thank the speakers for good presentations. My question goes to Stella. I picked on

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the lesson that you gave that IMAI is a practical, indeed a practical approach, to increasing or scaling-up HIV services. I wish that you probably didn't have some practical demonstrations, not really demonstrations, but elaboration on how you have translated the trainings, because the presentation elaborated on the training that you have done, but how has this been translated into practical aspects of it, and to what extent is it then effective in actually increasing the HIV services?

**FEMALE SPEAKER:** My question is more related to the clinical content of the IMAI. The experience we have in the PMTCT program is that one of the challenge to get more women in the HIV clinical, that the clinician asks when he comes to give AIT to the pregnant women, and also at health center level. I feel that all the minor or major conditions related to pregnancy or to HIV, is difficult to treat at the health center level due to reluctance or ignorance about what drug can be used. So I was wanting to know if in these new manual you have a specific module for the pregnant woman and HIV.

**MALE SPEAKER:** [Inaudible] from in Rwanda. My question goes to the WHO presenters. We both know where HIV8 is a problem, and the infant/child mortality rate is very high, as well. And I was really interested by the integration of services, of HIV services that you presented,

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and I was just wondering how confident you are now that these integration will help the NCH and child help services to get attention, even for HIV negative persons? Because we all know that all the evidence-based intervention available since like 20 years, but despite all the advocacy, that field seems to not move. Thank you.

**BWIJO BWIJO:** To answer that question in how effective my training has been in Tanzania, as you realize, I told you we have done two or three testing trainings and we have done the National Clinic of Trainers. And also I told you that before the IMY, there was also the National Curriculum, which is basically the PowerPoint slides training materials. So what happened in those areas as well, we tested the materials, some of the people who had previously trained using the previous materials one day saw this, they really felt that they need another training through the IMAI approach.

And another thing we noticed, some of the health centers' clinicians, when they went back to their care and treatment clinics at the district level, when we visited them what they told us when they went to these places, instead of them learning from the institute level, they were to share the experiences they gained from the IMAI trainings to their teams at the district level. So they felt as if they were

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not learning, but they were actually training the teams at the district level for the IMAI trainings.

And also another practical thing is that the IMAI training, they really tell you not only how to do and when to do, clear instructions. So when you go out there you feel you know how and where to start. And that interaction with the patients, they really get the skills and the courage to use their services straightaway, without wondering where to start because they get that practical experience as they go through their school sessions, they interact with the expert patients, and later on they go to the wards. It's very practical and it gives them confidence to start their services.

**FEMALE SPEAKER:** [Inaudible].

**BWIJO BWIJO:** As I told you, we have still been in the field testing, but the few centers which have trained, the 23, and especially in the two regions where we put our [inaudible], they could provide services immediately and they are doing very well. And actually, when they come in they have support from the district level, they went and then later on felt as if they were managing. So we have seen what happens in those health centers, which has started providing the services after their training. We expected them to spend quite some time [inaudible] after studying, providing the

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services, but they could provide the services a short time thereafter. Even before these 500 health primary facilities, which are going to provide it now, they have started to provide it now.

**SANDY GOVE, M.D., M.P.H.:** I think on that question, perhaps Eyerusalem could add from Ethiopia, or someone from the floor.

**FEMALE SPEAKER:** I just wanted to comment on our country before I explain.

**SANDY GOVE, M.D., M.P.H.:** Ethiopia will come to the mic and comment, thank you.

**MALE SPEAKER:** Okay, thank you for the invitation. So in Ethiopia, when we started the decentralization process, it was for health and labor training, IMAI was the stand out training material used for the scale-up. Based on that, we have, currently we have 144 health workers who provide ART services with the IMAI training, the stand up training, [inaudible]. And as you have seen in my presentation yesterday or the day before yesterday, obviously, in areas where there is task shifting, the outcome of patients is fairly good, although we need to compare it with other sites, the rate of [inaudible], as well as [inaudible] data. So that is it.

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**FEMALE SPEAKER:** Sandy asked me to comment because I moved to Geneva very, very recently, and I used to work on the [inaudible] in Geneva. I had been working the [inaudible] for the implementation of IMAI, and I would like to add from what doctor said, when we do supported supervision and field visits and clinic, we have also seen, you know, the IMAI is not, I would like to say that this is not only a training approach, it also includes a service delivery approach, how is the clinic going to continue to be organized, how does the service need to be referred, when to refer, and what to do with the patients when referral is not possible.

Therefore, in supported supervisions, we also follow-up on whatever they have been, whatever have been learned in the classroom, is implemented and in the field. Who is involved with us, the clinical team [inaudible], care team, and so on. So it is very early to say, I think, what the findings we have doing supported supervisions. Where they are important. Thank you.

**MALE SPEAKER:** I'm [inaudible]. I'm in charge of National Capacity building for ART in Uganda, and I think I was recruited during the 3x5 scale-up, and in Uganda we used, actually, BMI. And my experience is that during the 3x5, during the process of achieving 3x5, we actually used two

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approaches. We used the traditional outreach of the far points, which my colleagues have been talking about. But also we used IMAI, because we wanted to include so many sites into the process, we took what [inaudible] provide us to the National School, and also we kept on doing it again, our training, so the IMAI. It was very surprising that those people we took to Makari to do an advanced, to go through the advanced course of one month, sometimes when we would go to the sites, they would not have started because they don't teach people as a clinical team, because the IMAI, as we have had already the power trainings, but train you to work as a clinical team. And after the other had failed health care providers at the sites to start, if they just went through the advanced course with the PowerPoint, and not training them as a team.

I think IMAI is supported with the patient monitoring package, so if you actually go back to the site, you start practicing what you learned in the class, but you also are prepared to train something in the patient monitoring tool, which is utterly based on the clinical review which you learned on the class. So you actually practice, and unlike somehow like, I am shy, because I am shy depended on the form, the review form, but they did have a patient monitoring

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presentation, so people would read, fill in the form, but they don't have anywhere how the patient is actually moving.

So the package of the patient monitoring is really a strong tool which supports the MI skills which people get in the class. And I think she has also talked about one thing. You know, it's basic, the simple way of imparting skills, and we test in the field, you are tested in the [inaudible], you are tested with the expert client, and when you go to the ward you are tested on the same, same, same thing, so every time you finish a topic, you go through those, so it imparts more knowledge, especially to the people who didn't have confidence.

So that's, I think, that's the strength because it's not very easy to measure. Of course, for us, we have almost 290 sites, and all we have been using is mainly MI, and we only take maybe people to go for advanced training, the clinicians and other people, but we use MI. We have already now the capacity and the authority, we used MI, we got support from ectop [misspelled?], and we said, okay, [inaudible], so we use MI for the 20 districts, and utterly, at one time, the big announcement was asked to open up their own section in their maternity ward, so that when the mothers they can assist them and start treatment there. We kept on

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resisting but said, let's fight. So in integration with PMTCT is utterly a very strong tool.

I don't know, I've been in the countries, I've been in many countries, I think one of the countries wants to speak here, but let me first finish, and they find it useful compared to the systems they have been having, because people hesitate. Even then they read a textbook, it is so difficult for them to put that into practice. The PowerPoints here, like you have seen, but when they go home, trying to put that in practice, is a big different. And it's done, they tried to put the IMCI in PowerPoint, they did actually, because when they came back to be retrained, it was difficult, so we said no, let's leave, this stinks, and not use PowerPoint. But you can change your mind, but like I said, it's difficult. So for us, when you come to study basic [inaudible] in Uganda, you utterly will be trained in EMI. Okay, thank you.

**MALE SPEAKER:** Good evening, everybody. I'd just like to share the experience that I, we had, in Nigeria. Unfortunately, I think some people may be in a better position to share their experience in this audience, but maybe they are coming out, so I will just say the little I know. Now the challenges I see with IMAI, because I feel this is an opportunity for people that want to use IMAI to

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scale-up, to know what kind of challenges people face in their different countries. Nigeria is a [inaudible] country, one of the challenges I realized was convincing those who are used to the usual high tech training, working in institution, which is a way in which HIV programs usually come into a country, so the challenge is for them to even accept that something HIV, can be made simple. I think, even before I also attended the IMAI training, I felt similarly to that. How is it possible for somebody at the primary health care level to actually provide HIV care, provide ARV, to still avoid resistance, so I think that's one challenge that people are likely to face.

The second challenge is that IMAI training will last about three weeks, if you had the complementary IMC course, and for god's sake, if you're going to take a complete team of a doctor, a nurse, a doctor, maybe two nurses, counselors, and all that from your facility, how much of the staff do they actually have in that facility for you to take all that number of staff from the facility? That is another challenge. Three weeks, and they're going to spend three weeks outside of where they are working. So that is the second challenge.

The third challenge actually is the cost, having to take a number of people like that to somewhere, you host

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them, and with a lot of facilitators, I think that is another challenge, that one is likely. But from my experience, I have had to participate in the training in Nigeria, where consultants and physicians have been treating patients for HIV for a very long time. Mention as part of their comment that this is the best training I ever attended on HIV.

So I feel it is necessary for those who are the big players in this to ensure that those who are in the big institutions actually understand what IMAI is all about. I think it's actually due to ignorance. IMAI is an excellent tool and, for example, in my program now, we are planning to ensure that everybody on the program, who is working on the clinical team, at the next available opportunity to train people in IMAI in Nigeria, all members of our clinic, we have very top, top people, will have to attend this training. Thank you.

**FEMALE SPEAKER:** Thank you very much.

**FEMALE SPEAKER:** I'm Dr. [inaudible] from the African [inaudible] Association in Uganda, and we've been hearing quite a bit about IMAI and the scale-up of ALT and HIV services, and I'm just interested a bit to hear about Tanzania and Ethiopia, whether you've been using the IMAI positive care module, and within that it looks as many essential drugs you need for palliative care, and some of

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those are not available throughout Tanzania and Ethiopia. So I'd like to hear a bit about that, but I also would like to challenge people, we've come across people using IMAI, but using it just for the acute care for the ALT care. We need to be making sure if it's going to be integrated, that the palliative care module is included, and all aspects of palliative care are included when we're talking about IMAI. Thank you.

**FEMALE SPEAKER:** Thank you for that question. But before I go to that one, the practicality is not only for health care workers, even for the expert patients, essentially it will assume that reports when those expert patients they went back, they did a marvelous job in the communities, you can't believe. And even for some of the doctors who are supervising the care and treatment clinics at the regional level, they want now to partner with these expert patients, to track the patients, to even modernize, to my surprise, they even used the expert patients to sensitize the regional health management teams, and they used the health management teams to be able to support the sites which were not functioning well, about modernizing, using the expert patients, those that started performing very good job. And they are very useful in tracking the patients. They have so many patients, they are full up, they could follow them up

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into their houses and everywhere. And some of the expert patients who are clinical, they are actually here, they could use a witness themselves.

About the palliative care module, in the repetition process, we adopted the palliative care model as well. So those things which are not available in the country, they were removed. But right now, as we are reviewing the health sector strategy, we are advocating for some of those drugs to be included for wide-scale use in the country, and probably later they will also be included in the palliative care module. But to have adopted everything in those documents are being shared with the health care workers in the expert patients as it would seem. Thank you.

**FEMALE SPEAKER:** I just want to comment on that. Please, could we advocate for not taking stuff out of the palliative care module? Because the drugs aren't available, but for using the IMAI module as an advocacy tool so the Ministry of Health and the governments to get the drugs available. Thank you.

**SANDY GOVE, M.D., M.P.H.:** And I think that did happen some. In Ethiopia, we got a big stall for a while in the adaptation of IMAI because we had oral morphine in it. And that, I think, contributed to the discussion around the realization that there was hesitancy to adapt morphine

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because even some of the doctors and hospitals weren't well trained in it, and I think it contributed to that.

But I must say that in the midst of all of the HIV care and ART scale-up, although we're adapting and putting out the palliative care module, and we're also training in how to use it and cross reference it for all symptom management and pain control, that the specific palliative care training courses that we do have, have been under utilized.

And I think that, to me, what that calls for is that we need a multi-partner effort in countries as we're scaling up to be able to fill in those gaps and to have that amidst the training requirements and needs for a clinical team to be able to back up what's delivered in the home. And I think that's one of the advantages the operations manual, is that looking at human resources, it helps guide you to assess what the training needs are, and there we've really tried to emphasize symptom management for both adults and kids, and end of life care.

If I could quickly answer a couple of the other questions because we're getting a little late, and then we'll see how many more comments we can take up.

There was a question from Mozambique about, and a comment, about the difficulties of getting clinicians to want

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to start ART and pregnant women, because of the many major and minor conditions in pregnancies and concern about doing that. We do have specific training modules, both for anti-natal care, labor, and delivery, and postpartum care, and we worked with an expert women's health group to actually expand in the new version of chronic HIV care, the side effect and symptom table for ART, to actually go through and make specific mention of, in a pregnant woman, how to distinguish a common complaint in pregnancy from a side effect of ART or other possible complications on ART.

So we've really tried to simplify and then get very basic, and midwife or nurse, first take the basic ART course, and then take, if they're doing anti-natal care, the two-day course, so it really gives a lot of practice and helps gain confidence. And I think it's been both directions, it's been not only lack of confidence of the clinician, but we heard a couple years ago, up until recently, people saying, well, they can't do it, how can a midwife or even an obstetrician do ART?

This is the kind of thing medical doctors and people in these clinics only do, and I think more and more, we need to emphasize that starting first line ART is quite doable, and the conditions, and actually right now, people have commented, starting AZT at 28 weeks and then the changes in

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regimen that that requires, is actually a little bit more complicated than ART if you've started at the appropriate time, and continue throughout that.

So we have CDs at the back and those training modules that are still in draft, and we want to get review on are actually included in those, and we'd appreciate any comments and collaboration and further testing of those modules.

Rwanda had a question about given the high child mortality, maternal mortality, how confident we are that integration will help MCH services to get attention. And I think nothing happens automatically, we have to put it in the planning. I think we have to be very firm about the fact that you really need strong basic services in order to have viable ongoing HIV care and ART. We have seen countries that this has meant a revival of IMCI training, and increasing demand for that training for basic child services. And I think that it's something that we have to include in our planning and get people behind.

A lot of places, also, we've found that, you know, there hasn't been a lot of recent anti-natal training, and that's why we have tried to integrate so that if you take one of these integrated courses, you have some updating of your anti-natal care services at the same time you learn PMTCT, same for labor and delivery and for postpartum care.

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In terms of, there was some request for some more comments on how opiate substitution therapy is integrated. When we started preparing the adaptation for China, and it's the same adaptation that's not being used in Myanmar, [misspelled?] it was felt that we really had to integrate more home reduction as part of a country adaptation, but also to be sure that we could use this primary care, chronic HIV care and ART training, as something that could be added at a site that was giving methadone.

So we're still in early days with experience with that. But I think if anyone needs one-stop shop and doesn't do well with being referred to four or five places in order to get primary care, it's an injecting drug user. And I think that that's been an experience and we're trying, as we evolve these materials, to contribute to that as possible. In most cases, it would be, obviously, adding those services into an accepted and licensed methadone maintenance clinic. And I think that was it.

Oh, the minimum ideal staffing, Martha's question. That's something that we're still developing as part of the operations manual, and we tried to lay out difference scenarios with the number of HIV patients, the number of ART patients, trying to limit ourselves, going only up to 750, otherwise it's in a whole other manual, and then trying to,

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from the best information we can get, try to estimate what are the relative requirements for that. And I think that's something that's going to need more review and input as we evolve and review the manual. But it's obviously essential for planning.

**FEMALE SPEAKER:** One other thing to think about it, is it really is for areas with high HIV prevalence and a generalized epidemic, so that kind of human resource needs is particular for those kinds of epidemic situations. And even in planning, we talked a great deal in development of not only the treatment that it would support, but also the needs for prevention and staffing for those needs, as well. So that is, we would welcome input on that level from countries, and we really hope that you bring your cards up, present your names, or your colleagues, to help us in the secondary review of these tools, to make them as useful as we possibly can.

I know there's a gentleman who would like to ask a question.

**MALE SPEAKER:** I am currently mostly used for service providers who are already on station. So how do we get, while we are doing that, while we are always behind the wave, are there any attempts currently to design useful training tools for the next generation, you know, in here, and my impression is while we are concentrating on those people and

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service, every year we get thousands of new people in the system, but they're still trained on either the old high-tech kind of a thing to learn how to do HIV and teaching hospitals, or they are not trained at all.

**SANDY GOVE, M.D., M.P.H.:** We've been trying to do early introduction of pre-service. We have two modes of approaching it, and this is really following on to the experience with IMCI and pre-service. One we call our emergency mode, and I think four countries now, they've actually taken the IMAI in service training, and made sure that either nurses or doctors, before they leave their pre-service or basic training, get the training so that they don't have to be called back once they're out in the facility.

And we're just starting, there's actually a meeting next week between about seven or eight partners, all of which have contracts in IMAI countries, that are using IMAI for in service, to actually do pre-service work. And we're trying to look at ways that we can then provide, in addition to the in service materials, some materials that faculty can use and integrate into their teaching plans for pre-service. Overall, the goal is that when you graduate, you are able to go into a public health system, and we know that can be done successfully. I know in Tanzania they can actually advertise

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for an IMCI-trained health worker. And I think that makes a huge difference in terms of the cost, and it's an important factor in sustainability.

So we're trying to shift some energy into doing that and taking advantage of the fact that we also understand that PEPFAR and some of the plus up funds has made a couple million dollars available, potentially, I think up to \$3 million, for any of the PEPFAR-focused countries on pre-service. And so we think this is really prime time that we bring together collaboratively, to have a strong set of materials that can also support curriculum change.

**MALE SPEAKER:** [Inaudible]

**SANDY GOVE, M.D., M.P.H.:** The training has both individually by cadre, but also these clinical team experiences. As health workers go out to an out patient clinic and get experience, I think they can join a team, you can do case discussions, have experience in reviewing cases in mock teams, but more and more I think in good pre-service, there's community rotations and linkages and attachments, I think, that can start to provide that, particularly when you have the basic services existing in more and more health centers and outpatients at district hospitals.

We really also, I think, need to emphasize that all lot of times we think everything is fine at the tertiary

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hospital or the university teaching hospital, and IMAI is just needed for a more decentralized and peripheral location, but we're really trying to emphasize that an individual provider, for instance, trying to be a solo provider in an infectious disease clinic with long lines, is probably not giving as good care as if he or she had a clinical team there. So we're hoping also in those faculty settings to also have these model clinical teams so people can experience them.

**FEMALE SPEAKER:** I just also wanted to add on the issue of invoking the pre-service. I know we already started discussing how do we take the trainings into the pre-service, because so far it's mainly for the in service. And then they started using the IMAI modules to see how they can incorporate them in their paradigms.

And when I was presenting, I told you that we had the human resource department before that, because those ones, they are the ones who are preparing the curriculum for the clinical officers, for the medical officers, and for the nurses. So after they have realized what is contained in the IMY, they can now start to strategize how to take it to their pre-service trainings. But we are still in the process stage to see how we can take it to both.

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**FEMALE SPEAKER:** I'd just like to say for PEPFAR, PEPFAR has been supporting the operations manual for implementation and for the development in countries, and we would like to work with countries who are interested in the COP development process to begin to use these tools and adapt them to the country contacts and work with stakeholders on the ground, and we have been working with, across all USG agencies in this effort, and with many of our implementing partners, so that's what we would invite you to, this is coming out of our adult technical working group where Ted Elrock and Bob Farris are the cochairs, so those are more contacts for you to work through in your countries.

**SANDY GOVE, M.D., M.P.H.:** I think we've reached time, but I know that there's quite a few people here that wanted to discuss further, so I think we might break now. We've talked mostly about IMAI, the World Bank presentation, though, brought up some really good quality assurance tools that I think we can try to bring you into the operations manual development process, I think they're highly relevant, you've really listed out patient accident interviews and some of the tools, so I think that it fits really actually very well with this new phase of going in to more evaluation and quality assurance work.

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So we'd like to thank you all for your comments and thank the panelists for their presentations, and I think if some of you want to stay, we're very happy to continue to discuss as a smaller group into the evening, even. Thank you very much.

[END RECORDING]

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