

**2007 HIV/AIDS Implementers' Meeting
Community Mobilization: CBOs, FBOs, Innovative
Partnerships and Programs
PEPFAR, The Global Fund to Fight AIDS, Tuberculosis
and Malaria, UNAIDS, UNICEF, The World Bank, WHO, GNP+
June 18, 2007**

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

[START RECORDING]

MALE SPEAKER: Presenters today are kind of like, it's kind of like the lottery, some show, some don't show, some have names. So these that I know that are here, I think there might be one or two that come at the end. There airplane is still circling around Kigali airport.

But what we will do, because I think there is, we have abstracts submitted all the way through number 581, though I think there might be a presenter from either Malawi or someplace else, I saw someone loading something up, but if not. So we're going to start, we're going to ask each presenter to give their presentation. You'll have a chance for asking a few questions, and then after the completion of a few presentations we're going to open up to a general discussion.

And I think if you looked at the abstracts, and you look at the presentations, you're going to see a multiplicity of different models, different styles of working within the communities. From one, from the first presenter, from the cluster model, which is really on following the road patterns out of Mombasa, Kenya, up through the other countries with northeast Africa, I think it comes all the way over here to Rwanda. We look at a different methodology coming from using culture within the Indian tradition, we'll see an example from Tanzania how the Tanzanian environment they're doing something

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

on pure education. Get an experience from the orient with an Asia culture and Asian environment, how they're trying to respond in a way in the community. And then we're looking at a very large scale program that's being done by World Vision in Zambia.

So with that I would invite Gail Goodridge from Family Health International, if she would lead us off this morning. And the title of her paper is "The Cluster Model: Networking Indigenous Volunteer Groups into a Comprehensive Community Response to HIV and AIDS".

GAIL GOODRIDGE: Good morning. My name is Gail Goodridge, I'm the Director of the ROADS Project [misspelled?] based in Nairobi. I'm going to share with you today our custom model program for working with community based groups in HIV and AIDS programming.

Before talking about the cluster concept, let me share just a bit of the context of the ROADS Project for you. Regional outreach addressing AIDS through development strategies is a five year project funded by USAID East Africa, and increasingly by USAID bilateral missions across the region. The program has three major objectives, today we're going to focus primarily on one component within the first objective, our work with hotspot communities along the transport corridor.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

We hope, however, over time that our approach will become an innovative best practice.

ROADS is working in eight countries across east and central Africa and we're introducing programming in Ethiopia in just a few months. ROADS is designed to work in towns that host large numbers of truck drivers each night. These towns average between 30 thousand to 50 thousand residents generally, although our site in Bocavu [misspelled?] is significantly larger than that. While truck drivers are an important group for us along the transport corridor, ROADS is actually a whole, working with the whole community with women, with youth, with people living with HIV and AIDS, with orphans and vulnerable children. And also, importantly, the indigenous resources in each of those communities, whether that's local government, health and social services, FBOs, business leaders, all of them helping to develop each site.

To create an identifiable network along this long transport corridor that you see on the slide, we have branded these sites safety stops. This reflects the objective of the communities we're working to stop the spread of AIDS in their community. The communities drive our design. They define the extent of the AIDS epidemic in their community, what they think is driving the epidemic, and, importantly, what they think the solutions are. The stakeholder meeting involves

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

representatives of each of the target groups and the community resources that we've talked with, and it's an opportunity for us to review, validate, and correct what we've gleaned from our conversations with the community. And then to work with them to actually prioritize the next steps, and their innovations for the response. When we follow this process, the resulting programs truly reflect the priorities of each community and the ownership is solid and genuine.

From our experience to date, this slide presents the key components of a safety stop site. As you can see, the components include classic HIV/AIDS prevention, care and mitigation services. But safety stop communities also identify often overlooked but severe barriers to applying the learned information and accessing services. These include gender based violence, substance abuse, and economic vulnerability. For example, we know that ART patients who abuse alcohol will often miss their evening dose, thereby fueling drug resistance. And women who fear violence from partners if they get a positive HIV test are less likely to visit PMTCTs.

ROADS works with the usual suspects of national, regional, and international government and NGO partners. We also work with the private sector at all levels. This is not in the context of developing workplace programs however, but rather they serve as implementing partners in our various

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

initiatives, including one we call Life Works, which is a job creation program.

Now with that background, let me look explicitly with you at our cluster model. Through the cluster methodology, if the community prioritizes low income women, for example, as an important target group, we invite all community women's groups in the community to come together. This includes both large and small, some groups with as few as six or eight members, these are women's groups, church groups, women's associations, neighborhood groups, merry-go-round financing groups with women, any women's group in the community self-identified.

We facilitate a dialogue with, and among, all of those groups together, learning what they're already doing in the area of HIV and AIDS, and why they're interested in getting involved in this work in their community. This dialogue session is often the first time these groups in these communities have ever sat together to compare notes. They don't know what each other is doing and they don't know how they can learn from each other.

We ask them whether there might be activities that they could do together, things in a coordinated fashion that would increase the effectiveness and the reach of their work. Based on these discussions, the groups will identify a common agenda they can work on together. This might include for example,

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

skills development, community mobilization, advocacy for improved health services, and regular meetings of the groups where they can support and learn from one another. In Bocavu [misspelled?], we are working, as an example, with 50 women's groups who are all working together in HIV and AIDS for women.

This slide shows the governance structure. Each participating group sends one or two representatives to sit on a steering committee that provides ongoing leadership for the cluster. Now, FHI needs to provide the funding to one legally registered organization that has the capacity to manage the funds. So the steering will define a set criteria for selecting that anchor group, and they vote to decide which organization will serve as the anchor. The anchor signs the grant agreement on behalf of the cluster and is responsible for ensuring that funding is available for those joint activities that I mentioned a minute ago. FHI will provide funding for program materials, for training, for coordinating meetings. I want to emphasize that it's the steering committee and not the anchor that provides the leadership to the cluster. Over the first 18 months in following this methodology, we've established 32 clusters over our safety stop sites and we have over 450 small and large community groups participating together.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

This slide shows the results from our first 18 months of programming. Oh, I think I've missed a slide, oops. Here we go. A typical safety stop community might look like this when it all comes together. Low income women's groups will be formed into a cluster, all the PLHA support groups in that area will come together, youth groups, etcetera. And they're conducting joint activities. And as you can see from this slide, often there is overlap between clusters, so low income women might also be older OVCs, or PLHAs might also be low income women. These clusters will be supported by and linked with the indigenous services in the community. The local healthcare clinic, for example, for testing and counseling outreach, drug shop owners that have been trained to provide information to their customers on ART adherence and sexually transmitted infections. Churches that are now offering Alcoholics Anonymous like programs, or business leaders who might be coordinating a food drive for PLHA or orphans.

The cluster model has a number of advantages and challenges. I'm going to begin by briefly discussing the challenges. First, because we're working with indigenous truly grassroots groups, their level of management, organizational, and technical development, and skills are often very low. That requires a sizable commitment from us to build their capacity and to provide facilitated oversight.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Second, encouraging groups to work together can be challenging. Initially, everyone wants their own grant, they want their own office space, they want to provide salaries for their volunteer network. But our program is trying to actually leave a very small footprint in these communities to affirm that communities existing volunteer ethos, and their volunteer groups not to create bureaucracies that won't be sustained after the influx of donor funds is gone, that they are learning that there's strength in numbers in working together.

The third major challenge is being aware of, and managing local politics. There are lots of agendas in the communities, we like to talk about communities as if they were one organization, but in fact there are lots of things going on in communities, lots of agendas, lots of alliances, lots of old scores, lots of extended family members working in different places. And all of these things influence how people work together and whether they can work together. It's difficult to ascertain these, and where they exist, it's even more difficult sometimes to learn how to manage or work around them.

Fortunately, the advantage outweigh the challenges for us. Our experience suggest that the cluster model can result in identifying the most acceptable, locally responsive, community approaches and create a lot of synergy and excitement around this work. Bringing like groups together motivates

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

volunteer workers and results in very rapid coverage. And it also creates a buzz in the community that something's really happening because of all of the involvement.

As demonstrated in my earlier slide, we've already seen lots of synergy between clusters. The PLHA cluster, for example, will send representatives to work with the low income women's cluster to talk about stigma discrimination. The youth cluster, the bicycle taxi bota-bota [misspelled?] drivers will provide free taxi rides to health clinics for people living with HIV and AIDS and people on treatment who otherwise could not afford to get the transportation bus to go to the clinic. And again, I think this helps to create a lot of visibility in the community, it creates a lot of shared common purpose.

In sum, I would say that communities have realized that important resources exist right in their midst to address the epidemic in a local and sustainable manner. These resources have existed for many years and will continue to exist long into the future long after we're gone. They won't disappear with the under project funding. By linking and strengthening indigenous volunteer groups by experienced and the nascent, those who may have seen some level of donor funding in the past and those who are so small will never be on the radar screen for a donor. This cluster member is helping to ensure a

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

vibrant, relevant, community wide, long term, last buzz word,
and sustainable response.

Lastly, I would like to acknowledge my colleagues who
are here today, Dorothy Morothy [misspelled?], and Rob
Ritzenthal [misspelled?] who are co-architects of this cluster
concept. Thank you. [Applause]

MALE SPEAKER: Alright. We have plenty of time, I
think the first thing is that, does anybody have some questions
for Gail before we move on to the next speaker? If so, people
with the microphones, there's a question back there, I see a
hand back there, there's a hand there, microphones. Get your
roller skates on, who has those rolling microphones? I think
they're all having tea. Who has microphones? Microphones, no
microphones? Why don't we all come to one place then, I don't,
does anyone have a microphone here or do you all have to come
up here? They, today is technical problem day I think. There
we go, a nice young lady coming up with microphones. Why don't
we all just come to the middle whoever wants to talk. These
gentlemen here are first, there's a young lady here, I think it
will make it easier. Hop up. Why don't we take all the
questions and then Gail can answer them back and stuff. That
will be better. Go ahead.

BILL PHILBRICK: Hi Gail. My name's Bill Philbrick and
I'm with CARE USA. Phenomenal presentation, I found it

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

fascinating and I couldn't help but to think, as I was listening to your presentation, seeing a lot of parallels with the Hope for Africa Children Initiative, something with them. And I had a specific question about the anchors. I want to understand, you mentioned that the steering committee makes the decisions, and it's not the anchor, but does the anchor organization have any accountability? Because one of the things that we encountered was, and the former hockey star to us like this, is that in a lot of cases there was one prime on a grant which had all the accountability to use aid, or to whatever the donor was, but supposedly in theory it would be like the partners or the other people who are not accountable to the donor making this decision. I'd be curious to hear how the anchor operates in the accountability, if it ever has.

MALE SPEAKER: Take each one of these. Go ahead, answer that. Why don't you answer that one, I think it would be easier.

GAIL GOODRIDGE: Do you want me to answer it?

MALE SPEAKER: Yes, I think it would be easier for you.

GAIL GOODRIDGE: Sure. The, that's a great question and I would say that this process is still evolving so there are lots of different responses but we really are making an effort to make sure it is not the anchor that's the lead. We really, really, really want people to work together as a team.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

So in various clusters people will form subgroups to handle different parts of the program and the responsibility, and in the anchor does, that is the organization that receives the funding, all of the groups are mentioned in that agreement, and we're really encouraging them through their monthly meetings to proactively make joint decisions. I have to say, just anecdotally that in one of our clusters, it was an OVC cluster in one of our sites, that we actually, the community, that cluster group asked a very large NGO that was working in the region to be the anchor. And our experience was that that large NGO could not understand this cluster concept of how there would be joint decision making. And after the first year of the cluster, when we got the cluster in a meeting to plan the next years activities, one of the first thing we asked everyone was how's the membership of the cluster going, do you need to bring new groups in, are there groups that maybe need to take a backseat for while, that maybe their busy on other things. And then how's the anchor doing. And in this one community, the cluster actually asked the anchor to step down because they felt the anchor was taking too much control over the cluster and not allowing the community to really drive the process. We were very excited about that. Not getting rid of the large organization, but because the community had taken so

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

much ownership of the process that cluster really said that we want to drive this.

MALE SPEAKER: Okay, thanks because we have other presentations. Next question please. Sorry to cut it a little bit. We can't take a lot because we have other people, so this time I'd only ask for one, if we have more time at the end I'll reopen it, but everyone has to have the chance. So I'll ask for the next question behind the person behind you because we have all these people to present, but at the end any open time we're just going to go into discussion. So the young lady from Coptic Hospital, she can ask her question now. So I only want, I have all these folks after 11 o'clock. So I'm going to ask the next person afterwards you can talk and if we have more time at the end you can talk, but everyone else you can sit down, you can ask another question, then everyone else decided they wanted to sit down, so I guess you get to ask another question.

LUFT COCOR: Yes, Luft Cocor [misspelled?], International Federation of Red Cross and Red Cross Societies. Thank you very much for a very nice presentation. Would you be so kind to clarify how formal the registration of these clusters is, is it something of CPOs or what the whole thing is about. Second question, when it comes to empowering the community, what concretely does cluster receive?

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

GAIL GOODRIDGE: Sorry, can you speak into the microphone?

LUFT COCOR: Concretely, how the clusters have been empowered. And number three, when it comes to management of the volunteers you had mentioned that they are receiving salary incentives, or something, can you clarify that a little bit? Thank you.

GAIL GOODRIDGE: Thank you very much. Well, just to, at present the clusters are very, very informal groups and so there are not, in most instances, the organizations that comprise the cluster are in many cases not registered CBOs, it depends on the site and countries, all CBOs have to be registered. But we have groups that are not even registered CBOs. We want to keep this as grassroots as possible.

In terms of formalities though, there is one of the clusters has already decided to form a combined group and to register as a combined group. This is Mariet Conti [misspelled?], Kenya, and it's a low income women's cluster of 56 small groups and they formed an organization themselves called Lugania, which in their language means to knit together. We think that a potential evolution of this process will be following that Lugania model, and if they follow that course it will be possible and more likely for them to actually open up more donor funding.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

In terms of paying for volunteers, you know, as I mentioned, we're working with really tiny groups, these are church groups for example. And if you're a church women's group and you're providing home based care to parishoners as part of your church ministry, we really don't think that it's appropriate to pay those women to do that work. That's part of their volunteer church ministry. Or other community groups the same thing. We do try to make sure that when we work with volunteers that we are very mindful and respectful that they are volunteers and to do lots of different things that I don't have time to tell you right now that will both maximize their involvement, the benefit they get from it themselves, but minimize the amount of time that we require from them. Thank you.

MALE SPEAKER: Thank you very much Gail and hopefully at the end of this all these presentations we're hoping there's more time so that people who didn't ask questions or we'll get into a discussion of the different presentations. But, since we're talking about community is very often answers become much longer than in the more scientific where they can give it right back.

Okay, at this time I'd like to, as we move from the ROAD Network out of Mombasa over through one of the eight countries, now more off the continent of Africa and we're

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

looking at a model, which is really built on the culture model from India, making providers of judicial systems and medicine suitable for HIV, STD prevention and experience of intervention project in India, and the presenter will be Papiya Mazumdar, I apologize if I said your last name wrong.

PAPIYA MAZUMDAR: Good morning everybody. This is Papiya from India and I'm going to tell you something about an indigent project that we did in the International Institution. That International Institution has for the first time waiting to action this project and we hope that sharing our own experiences will really make some sense.

Now, as you already know that in India is a very ancient civilization and it can also boast about its medical tradition. So, not only the folk medicine that is largely prevailing in the country, we have very well defined systematic traditional systems [inaudible] our country. As you know about, diabetic, [inaudible] and many others.

So our intervention was basically the broad objective of intervention, was to reduce the overall sexual health risk of the men, we focused on men, with many partners that may be found as the key of many problems and we tried to invoke this private community based health providers who were providing, who were at least and registered and know [inaudible] such as

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

[inaudible] Ministry of Health. And we tried to make their skills [inaudible]. Now, I go to the next slide.

So our project is popularly known as parishta [misspelled?], which is actually the short for [inaudible] and sexual health. I'm sorry you cannot see the first slide. So, it is centered on intervention and sexual health adhering to action. So intervention project was based on research that we did. It was founded by National Institute of Mental Health USA, and our partners, and I come from International Institute for Population Sciences, that's a government body and our partners were the University of Connecticut, and the Institute of Community Medicine.

So it was truly a team of disciplinary research you can see since we have psychologists within our crew, we had demographers, statisticians, and anthropologists, physicians, to name a few. Then the project was basically developed in the backdrop, there was research of some of the normative approach of how we can add these, this risky section of behavior of the men and to provide them a kind of guideline, which is really good health in terms of reduction, at risk reduction. And this rational was a part of, you can say, a research that was done in the first five years and we found there were a lot of [inaudible], like [inaudible] connotation of the problem. And people in India do share and many of the literacy say that all

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

over the world do share the men basically a lot of needs around their sexual health. So, [inaudible] focus on this sexual needs and the cultural context.

So my presentation will be like this, as you can see, I can definitely tell you as you go. Now we actually focused on Mumbai, why just so? Because Mumbai, as you know, is the epicenter of AIDS capital, you can say in India. That statistics showed that during the span of eight years that HIV zero positive rate of the clients live like visiting institute clinics rose too high, like 1.62 to 64 percent. And [inaudible] AIDS prevalence rate as shown right here in this column that had rose from one percent level to three percent level. And I already had mentioned on why we focused on men, we found that there is a lot of need, that we really catch them and reduce the risk. And when our pilot understand which we did, showed that there's a very clear [inaudible] that is used for STDs, you can see that's called goopthrog [misspelled?]. Goopthrog basically means that if you translated it into English it comes the same as. So why the secrecy? Because the section here all together share a lot of secrecy, like people don't want to go for treatment, people have a lot of stigma attached to it, and other things.

Now we thought that really it was [inaudible] that men's lifestyle was associated with non-sexual health problems

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

do it not like become the sexual health problems, it does not come through contact. Even that was very much disturbing, like people have need about their sexual health problem. And treatment from goopthrog are from community based, trained or not so trained health providers. Many times men go for these kind of community based small doctors because they find that they will not share this client information with somebody else. So as I have already mentioned of a secretive list, that's completely served their purpose.

Now, as a reason we focused on this and community based providers. Now [inaudible] actually had other objectives too, what I'm going to present here is basically restating the use of all that I have already mentioned. And that's basically our objective of this traditional providers we already had, that we developed a model calling [inaudible] Intervention Model. The model I showed the model after the slide, the model took care of all sexual health problems including contact problems, like STD, and non-contact problems at these not related to this contact. And this model gadget for the entire diagnosis, treatment, and counseling. So as I go ahead you will be able to understand. And after that it was training that we provided to these traditional providers coming into providers. And we evaluated this result.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Now, I'm going to show that this idea is actually we took care of three large communities, as you know that India is the second largest populated country in the world, having a population of 1.16 billion and this Mumbai is having 11.6 million population. So this large, three large communities which we took care of actually was that inhabited by more than a lack population. Now that study was conducted on three phases, this first one was [inaudible] research, second was intervention and third was evaluation. So it had one controlled community and two case communities. And there's a concept model that we focused on. As you can see down the slide that is masculinity, that is say of maleness, you can say. That we found that is a kind of core like feature of men's risky behavior and they're [inaudible]. So, this is the model I was talking about, about this narrative intervention model.

So in our baseline research we found that are many, there are many components. All sexual health problems that the men were classed into three groups, that was [inaudible], these are all [inaudible] concept, and this model, at the symptom was actually about what they feel. We had trained the doctors about what they feel about this component, like what the patients coming to them feel about their symptoms. Patients perceived archeology and their risky lifestyle, so this is the

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

model which [inaudible]. The interaction between provider and client, and finally the treatment and counsel that was provided. I can talk more about it if time prohibits.

So what we did is a formal training, there was a four days training, we had defined it on 46 partners from these three [inaudible] communities. And we trained them, and we give them some [inaudible] management chart, we give them knowledge about this management intervention model, we provide them the clinical [inaudible] which was very much important to maintain them, but used to keep records. And then intermediate training just some time, we tried to increase their knowledge. So this intermediate training was actually raised. So all we provided them nine training, including this first and foremost training. And then patient training of course.

Now a political states [inaudible] of knowledge of providers based on willingness of information, like informed consent, they had already told that they are going to get involved in this kind of project, I mean this kind of activities, are you really willing or not, so there are a lot of critical states and tools being used as you can see, and lectures, activities, various other processes and partners. We had [inaudible] partners also. At the provider level they took an election tool was done at the evaluation and also at the patients' level.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

So, in all it provided one side view of this evaluation view of this training, but also from the patient side. Now what we found is after the training, after this [inaudible] training, is the providers, communities providers engaging, treating STD and HIV clients, they could increase their assessment label like the good, it says the need of their clients, they could understand what exactly has led them to this risky sexual behavior. Or, in another hand, it is not known, or I mean, if it is a non-contact problem they've been to, building up their sexual need, and then there was a reconstruction that providers themselves took a proactive road to kind of deconstruct these needs or any other misconceptions that they had, and finally deconstruct it, along with their providers.

So, lessons learned is we found that earlier through our training there is no clinical examination done that lead to later on, and that there is one thing like ineffective management like that patient had non-contact sexual problems when ineffective management [inaudible] they were able to understand what their patients were talking about, so we lead them a little bit [inaudible] sensitive and we found that there was many things that we should not be defeated if this kind of activities is done. And just rushing through that is what mass defeated physically is that based on that we need to, like make

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

a homogenous group of these providers and training. Like we cannot make everybody and anybody, there should be a systematic approach for their training and contact, evaluation, and interaction with them should be necessary from all sides. Or anybody-

MALE SPEAKER: Thank you very much Papiya. I think we'll go for questions now, because we do have to move on and we did have times for everybody, so just, any questions for Papiya? Anyone? Questions? Microphones again please. They have a microphone and they're all sitting in the back, so it's exercise time for.

ROSALYNA: Thank you very much, my name's Rosalyna. I come from Uganda, and I work for an organization that delivers to encourage collaboration between the traditional and the modern. Now in Uganda we have this showing where the modern health team, or the biomedical do not find it very easy to collaborate with the traditional in any kind of intervention like this. Now my question is how easy have you found it to bring together the allopathic side and the traditional to come up with such an intervention. Thank you.

PAPIYA MAZUMDAR: Should I answer it now sir?

MALE SPEAKER: Yes please.

PAPIYA MAZUMDAR: Yes, so actually the [inaudible] very brief mother, like this traditional providers, the [inaudible],

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

they're grant to be using allopathic medicines to [inaudible], if not, I think it is illegal, even if it is not illegal they are using it. So, we just wanted to make sure that they don't make any harms to their clients, like prescribing some drug which is not suitable. So, they had a need, they found themselves valued when they [inaudible] and they had physicians from allopathic known, at that famous institutions, so they feel [inaudible] in thinking with us.

MALE SPEAKER: Alright. Any other questions for Papiya at this time? Hopefully at the end we will have a further chance to ask everybody. As we move into the next speaker I would like to remind the speakers that we have a young lady sitting over here that will tell you how much time there is, and then when you see me stand up with the time, after that the microphone is going to have to be shut off. [Applause] So, we ask you all, and thank you again Papiya for your presentation, and I do hope that there will be time afterwards for people to ask more questions of you.

Right now we're moving back from the continent of India back onto the continent of Africa, and to the tropical environment of Daversalom, Tanzania where we're going to hear about issues around stigma, within reduction of stigma in the community program. The presenter is Pfiriael Kiwia, and she'll

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

be talking about Kimara Peer Education and training trust.
Welcome.

PFIRIAEL KIWIA: Good morning everyone. I'll be presenting our experiences on dealing with stigma and as I do move into what I'd like to share with you, I wish to see everyone in their programs looking at and visualizing how stigma and discrimination does put challenges on what they're doing and what we've done and what our approach has reached to, can be of use to awake and for scaling up for visiting what we are doing.

Again, my name is Pfiriael Kiwia, I'm from this organization, Kimara Peer Education, and has promoters, and I would like to begin with acknowledging the people who have worked together with me to put up this presentation and to put up our lessons on stigma. And these are the co-anchors of the organization Kimara [inaudible] International Center for Research on Women, ICRW. The [inaudible] says [inaudible] family health international, but USAID be, in my case, global funds.

The background of our organization, we are founded in 1992, and we've been function in a high HIV prevalence [inaudible] community, and that is surround Tanzania where the initial HIV prevalence stands at seven percent and that is alarmed as the big 10.9 percents. And this is based on these

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

reports 2003 and 2004. Looking at what we are doing is an organization, we are doing HIV prevention, information dissemination, care and support to people with HIV and AIDS, and should I say at least to that, our organization is a mixed group of people living with HIV and HIV-free group. We are doing capacity building for local and imaging organizations, countries who are doing HIV prevention, AIDS programs. We are participating in a lot of research, including the research on stigma, and leaking the research results to communities where we are waiting for effective HIV responses. We are also going to networking in collaborations.

And as I said, we started way back in 1992, and down to year, 2000, we said we needed to make a stop and asses our wake in the community and impact that is had to our people. It look like stigma was compromising all our way, and despite all the efforts that we are putting into the program and all the other efforts that we are coming out, and opening new opportunities for people to improve qualities of life, we could see there wasn't much that we would say, there's a big change in the trend of HIV.

And between the year 2001-2003 in cooperation with the International Center for Research for Women and the University College for Health Sciences we participated in a [inaudible] study that was a cross country study that was conducted in

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Tanzania, Zambia and Ethiopia. And this did contain causes the stigma being one of the hinders to the progress that we wanted, and it did also confirm an existence on the funds causes and the effects to stigma to our way. And this study also helped us to understand more of the whole epidemic of HIV and we as an organization wanted to do something and we did work with our collaborators to stand up again if we could do something on stigma.

And with the research results we could see we did see things but we had no tools to work with. And Kimara was one of the 50 stakeholders involved in trying to develop a tool, and these were the two keys that we said we could use instead of doing something against the stigma. And the tools that we did develop were a package of two key facilitators guide and an accompanying features cause, that way we thought and we found out that they are very useful to start us move ahead.

How did we then start? We solicited for funding based on the research and designing and a program that was 18 months old. Got funding from the Community Reach Grant that was funded by USAID and we started an intervention in [inaudible]. This is where we have been working for the past ten years and this is an area that has a population of about 1.8 million by then, it's now growing to around two million people.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Let's look at the approach that we did use. It had two levels. One was focusing on ourselves, the staff, and volunteers within the organization, but also because you are working in a community where the structure are already there, we also looked at the key community leaders, at the gate keepers to the community people in our community. But at this level had to think of a training tool using the two keys and we did an initial work of translating the materials to the national language that would make it more user friendly. And the second level was to look at how do we go back to the community to implement the mobilization and systemization using outreach programs, and promoting non-tolerance of stigmas.

At that first level we had 56 staff within the organization and we had 24 PLHAs and we selected a core team of ten community leaders. And at that, with that team we conducted training. This was, the training was for the purpose of empowering the team and building their capacity as the key implementers and the key gate keepers for our program. And then we also did at level two building this community support using the trainers who had now a bigger knowledge of what stigma did look like, the causes, the effects, and what it was with the impact it had to our people, to our programs.

At this level all the trainers were now ready to go out to the community using the original approaches, but now with

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

more stigma messages than they had before. And for the home based care they had more skills now to go into the homes not only to visit the sick people, but also to convene meetings with the members of the family, and in some cases they could also invite neighbors. The [inaudible], the community leaders that we did, I did mention in there, and these were the [inaudible] missing their residents and discussing the same with their co-peer [inaudible]. We also were enabled with a Reach Grant to produce more brochures in addition to their tool kits to keep more sense and to keep it more simple for the people to understand.

Immediate results of the all of those programs was that, we could at first even within the training seeing a better perception of all the participants having better perception of PLHAs and there was a real high level of self esteem within themselves to go out and talk to other people and we could see even within themselves more decline of stigma within themselves. Training the tool kits, materials being more useful for them to use and move out of the trainings in a better position to do their work.

What did we learn from all this intervention? Lesson one was increased awareness of the HIV related stigma, in a relatively short time using the exercises within their tool kit. Although we could also see for ourselves that if the

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

intervention was longer we would have better results than what we did. And so we are saying time and space is needed for reflection, you see you need more people to sit down and conceptualize what it looks like and how do they start with their own. And then there was, it's true that social change requires building on change of individuals and the community leaders and looking at the, how the local leaders, the [inaudible] and faith based leaders could help in our process. And we see with the trainings we are slowly building up our networks so one can stigma advocate within our community.

And I need to also share a few of the challenges that we met. It's like you would agree with me stigma is so deep routed, it's based on attitude, it's based on language, the paper and the body language, and it really requires time and time again to look at it. And we are seeing, there's no doubt, HIV creates fear. The more information you do give out, the more like we're building anxiety among people even with casual contacts with PLHAs being seen at the clinic wanting HIV tests, being seen at the shops wanting condoms, scared of children playing with children whose parents have died of AIDS, and all this.

So, for sustainable change we need more time and what we recommend is that for all people wanting to do stigma work, they need to start at home, start with your own selves, see how

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

you fit in the picture of stigma and what can you do to reverse it. And we need to put compliance in the training, work with, keep people in the community, including those that are working as our leaders, have to be champions in the reduction of stigma. And the use of the tool kit is what we are saying, it's very useful, they are simple exercises that can be used by cross-section of people, and this is the health material. And we are saying communities are ready to open and they are ready and open to challenge stigma and discrimination. And can you clap for me please. [Applause]

MALE SPEAKER: Thank you very much Pfiriael.

Questions? My microphone people now are much closer, I'm sure we have a few questions from the folks on her, question of her ideas on how to decrease stigma in the community and the tools used. Anyone have questions?

PFIRIAEL KIWIA: I think there's a person.

MALE SPEAKER: There's one way back there. While your walking way back there, I maybe can ask you a question Pfiriael while we're waiting for the other person. Have you been able to document through some type of a tool, the change I believe is really happening with the community, but with the tool you're using, but have you been able to create some type of a document or tool to show those outcomes. Because they very happen a lot in communities, we know it happens, but other

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

people say well how do you prove that it's happened. Or do you have in mind down the line to have kind of a document or questionnaire that would kind of show that type of an outcome?

PFIRIAEL KIWIA: At the end of our two year intervention, we did do an evaluation and this was done by two outstanding organizations, ICRW include [inaudible] moves in the horizon. Our reports on the, on what your asking will be our with Horizon and this did show a lot of change with people who had been exposed to our stigma processes.

MALE SPEAKER: Okay. Thank you. Question, I think there was one back there someplace? Go ahead.

JOHNA CALISTA: Thank you very much. Johna Calista, Journalist for Rwanda. Asking a question about to children. Why is it that children were known to [inaudible] their presence in this major conference? Because sometimes stigma is associated with prejudice, and children what, no matter the peak, they learn by imitation, what they see as they grow. That's what they practice at adult stage. So, I was of the view that children had at least to attend such conferences. However few they are, but they may represented. So why is it that children are not at such conferences? Thank you very much.

PFIRIAEL KIWIA: Thank you for your question. Should I say children are part and possible the process, only that we

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

don't have enough time. But the tool kit does give a cross section of exercises and models targeting children, and as you see on that photograph, children are participating in the exercises. What we are saying is we have an exclusive section in model J within the tool kit that gives children as children the exercises to perform and the advocacy that they throw out to others, say what they want to see HIV looking like and how they would want the world without the HIV look like. So there's a lot of, to share with you models within the tool kit, if you have time please we can have a more talk on that, specific kits for faith based organizations, specific chapters living with HIV and AIDS and etcetera.

MALE SPEAKER: Thank you very much. Question over here please.

FEMALE SPEAKER: I just want to ask you that during your intervention did you feel that you need to change something, like say for example, you did some intermediate evaluation and you realize that some changes are to be done. Did you feel so?

PFIRIAEL KIWIA: We did an immediate intervention and that's why I said for the an intervention to make sense we need to do programs and not projects like what we did. We did a project for two years, by the so, it was like changing behavior in two years. It's not easy to see, but we could see the

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

immediate changes within the community for people who were exposed to our programs and we would see if we are really going to make sense in HIV programs, we need to mainstream stigma reduction processes otherwise we'll continue wasting our resources and not reaching out the people that we want to reach out. Even if we did, we do increase services, people who are scared to take the ARVs, women are taking the ARVs, putting them in their flower cans, they are, they can say they know all these options, men are scared to tell their women they are HIV positive, re-infections happens, so it's like a vicious cycle for programs that do not have a stigma reduction process.

MALE SPEAKER: Very good. Any other questions we'll hold till the end. And now we move again off the Africa continent over to Southeast Asia and I think probably very intriguing presentation of positive network, establishing linkages amongst people living with HIV/AIDS in Ho Chi Minh City, and I don't think I know from my own personal contact with that area of the world, to do aid work with Vietnam isn't that easy, so, and by the system itself. So it will be interesting to see this presentation by Enrico Caja.

ENRICO CAJA: Sin cho [misspelled?]. Good morning ladies and gentlemen. My name is Enrico Caja. I'm going to present Positive Networks establishing linkages between PLWHAs in Ho Chi Minh City.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

The socialist republic of Vietnam is one of Asia's fastest growing economies. It is actually the newest member of the WTO, and the fifteenth PEPFAR country site. It has a population of around 86 million and just on my way here I saw in the magazine it's considered at the 35th safest country in the world. So, safest.

I will be focusing on the south, which is Ho Chi Minh. The outline of my presentation will be a brief overview of the current AIDS situation in Vietnam. The situation in Ho Chi Minh, and again about GIPA, how we are able to carry out GIPA, our outcomes and challenges.

The first case of HIV/AIDS was detected in Ho Chi Minh City from 1992 to 1993. I believe the cases have gone from 122 thousand to 280 thousand, according to UNAIDS and the Ministry of Health. More than 100 Vietnamese are getting infected everyday and there is a high level of prevalence of injecting drug users and sex workers. HIV was detected in all 64 provinces in Vietnam.

Ho Chi Minh, or we call it Tanfo [misspelled?] Ho Chi Minh, was formerly called Saigon. It's located 1670 kilometers from the capital of Hanoi. It's across a population of over six million and it's considered to be an economic center of Vietnam. However, 20 percent of the entire HIV/AIDS cases is coming from Ho Chi Minh in that the prevalence rate is said to

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

be over one percent, if I'm not mistaken it's already 1.2 percent.

We are often, we are guided by the so called GIPA principle, we hope from GIPA to MIPA from MIPA to RIPA. But again, we are often identified as the GIPA project and every time you have to say that GIPA is not a project, it is a principle. Our objectives is to increase participation of PWHAs in HIV/AIDS activities, access to treatment and other health services, reduce stigma and discrimination from public towards PWHAs, increase understand support for GIPA, and promote volunteerism among PWHAs.

Our major partner is the Vietnam Women's Union. I'm happy posted at the Vietnam Women's Union, second women's union, which has around more than one million members, it is a massed based organization and for the project it's a bit very strategic to work them. In Ho Chi Minh they're located in all of the 26 districts. And [inaudible] provides us with easy access to the communities, the women's union is also recognized by the party.

The first activities that we did, please note that the project officially started sometimes January 2006, however, the budget came in only on August 2006. So the first thing that we did was to first conduct some awareness programs regarding the GIPA principle to the Central Women's Union in Hanoi. At the

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

local level we were collaborating with the Women's Union in developing activities for PWHAs. Of course, in the planning the PWHAs were consulted. Also during the early stages we had to identify PWA groups since we learned that there were a lot of PWA groups who were not part of the so called network. And some of these groups would opt to organize themselves based on need. We actually invited ourselves every time we learned there was going to be a PWA meeting. We often invited ourselves into that meeting and presented GIPA and later on we were already convening local PWA meetings.

For 2007, this is only up to May, we were able to advocate GIPA to over 350 active members from 60 PWA self help groups. Now the provincial AIDS counsel of Ho Chi Minh has a list of around 270 active PWA members. If you would look at the figure, we have actually more because we were able to focus on PWHAs who were not only part of the member network, but also part of other organizations, or no organization at all. So we had provided capacity buildings to PWHAs and the best example I could give probably is one of our volunteer who attends this training, said that before you could not even ask him to talk in public, now he's already able to discuss and share during meetings and he's also able to talk with the local press.

We are able to link also PWHAs through the GIP website. The team, the GIPA team in Ho Chi Minh is also composed of one

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

PLHA, and one recovering addict, and one of those, that guy who's working with us right now is the one who actually developed the GIPA website. He also runs the harrowing.com and will soon be starting the NA program within the GIPA office. One of our outputs is actually we provide a regular venue for different PWHAs to meet, sometimes it's quite hard because we focus not only on those who are a member of another group, of a network, usually this networks are organized by other international organizations, but there are some, or a lot of PWHAs who doesn't also want to be linked with that kind of network, but through GIPA we try to provide the venue for them to discuss. As I was saying we were supposed to be in the middle.

We were also the, able to refer 180 PWHAs to HIV/AIDS services. GIPA office is located inside the City Women's Union above is the VCT, in front is the legal clinic, inside is the Marriage Center, so you see, the VCTs FHI, and if we have clients whom have undergone counseling in the office whom may need such service, we are able to refer it directly on top. We also work with the legal clinic of the policy project. I think they're not called policy project anymore, they're called Health Policy Initiatives. And they also provide trainings, we also link with other organizations such as MDM, Medicines of the Month. We're not strictly stand alone project, and we

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

can't be a stand alone project. And we have to link with all these organizations.

Currently we have trained eight PWHAs to provide home based care and support, they also, we also have a group of around 45 volunteers who stays and provides administrative support to the staff. We are also able to strengthen the support of the Women's Union on the side you have the signature of more than 26 district women's union directors. We needed something to show them as proof that we needed their support so we had at least this document was signed by the members of the Women's Union at the district level.

Our challenges, well, there's a still a limited understanding of GIPA, considering that there's around 10 to 22 thousand PWHAs tested in Ho Chi Minh City alone. One of the biggest issues the PWHAs always would raise would be the lack of a legal framework. Though there is the Vietnamese National AIDS Law, please note that PWHAs are looking for a legal basis in terms of being recognized by the government. We also have participation of PWHAs remains very minimal, we have limited access to other resources. When I said limited access to other resources it is quite hard for PWHA groups to get funding from outside because usually the donor would ask for their legal personality, which of course they do not have. We have stigma and discrimination within, even with the PWHA community and

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

more outside. So, the challenges, we really have a lot but these are some of the major challenges which we had discussed with the team that actually prepared this presentation.

So, with that, I would like to end my presentation. Thank you very much and good morning. [Applause]

MALE SPEAKER: Any questions for this rather stimulating presentation of a country that's really kind of trying to get it going a bit.

HALE AQUILO: Thank you, and I appreciate highly your sharing but I have a question here which concerns the increasing [inaudible] of PLHA, is actually a very appealing idea. But please share with us the advantages you have experienced in working with them. Does working with them add value in terms of programs, response for the community. I'm Hale Aquilo, from Tanzania.

ENRICO CAJA: Yes, thank you very much for the question. The other value is actually gives more base to HIV/AIDS. But the biggest thing I saw working within the PWHA communities, they know rain better than I do, so they could actually link us with other PWHA groups or individuals then us just staying in the office and trying to come up with a very scientific type of mapping. They would refer us to organizations, newly organized, which are not linking themselves to the PAC, and I think they give very much valuable

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

inputs when it comes to program design, planning and implementation.

JENNIFER: Hi, this is Jennifer from the PEPFAR team in Nigeria. I was wondering what you've done in your office particularly if anything to make an effort to higher PWHAs within your office.

ENRICO CAJA: We actually have eight volunteers working with us. In the GIPA team we have one PWHA and one ex-addict. One recovering addict and one Shoshodidy [misspelled?] graduate. But we always try to emphasis, which is very hard, volunteerism because, well, I think, we have eight people working with us plus two other PWHAs joining the implementation. And one of the leaders of the network is actually part of the GIPA project team.

MALE SPEAKER: Are there any other questions at this time? Okay, let's move over to the last speaker this morning. Whose going to be Bruce Wilkinson from World Vision. He'll be talking about a rather large OVC care and support program in Uganda, and after Bruce finishes and then he questions you have for Bruce, then we're going to open it all up for question you might have for any of the other speakers that you didn't have a chance to ask before. I know there was some questions from the very first speaker, and I'm sure there's some more. So with that, welcome Bruce to talk about the experience in Zambia.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

BRUCE WILKINSON: Thanks Ed. Good morning and it's getting near lunchtime, I understand, so let's keep our, let's try to keep you awake a little bit.

I don't know how many of you struggle with logos, you think I can get more logos on the slide, what do you think? Let's a vote for more logos on slides, right? Alright, yes. We could put our private sector partners up there as well. I am based in Zambia, Ed, actually, and we're actually working in Zambia. I guess the reflections this morning, one of the reflections is, when you have that many partners, we're not practicing what PEPFAR tells us to avoid, multiple concurrent partners, so anyway, we're working on that. But we do need a ton of partners in the work, and especially when you're trying to go to scale in OVC work, but it's not just OVC, and that's what I want us to be aware of today. This is definitely being framed as an OVC community based program, but at the same time I want to expand that sort of thought.

We are what I would call community led. We have tons of community associates, just as we saw in the first presentation, they exist, there are many, many community organizations. And also we have lots of large NGOs which practice different methodologies for bringing those community organizations to the table, Salvation Army is different from CARE and CLS is different from World Vision, but they all are

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

community led, and that's basically get inside and mobilize those community led coalitions. Again, I want us to focus on its household approach, we are not just targeting OVC, I keep challenging my PEPFAR colleagues, when we start thinking about HBC and palliative care, when you're getting parents well, you're service OVC. So we need to count those, if you want to count them, I don't know, we need to be thinking when we're PMTCT programs, are we extending the PMTCT program right into the household caring for the children because they are definitely, definitely having a positive impact on that household approach. Are we working with youth within the household, let's not segment our resources OVC, HBC, or palliative care, and youth and then livelihoods. No, it needs to meet up at the household level then what you can do is aggregate those investments going into that household to produce enough of an investment that actually makes a difference. Because at the end of the day it's the household members who have to figure out how to deal with the disease burden, whether it's HIV, whether it's malaria, whether it's TB, it is at the household level, and again linked to the community associations. Because those community associations, as you will see, provide that umbrella for our 12 thousand trained and equipped community based volunteers. And these are the beautiful people, I love these people, these community

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

based volunteers are just, they're wonderful folks. And when 52 of the 72 districts of Zambia and then we have officially 210 thousand OVC within the program. And Zambia has what they call OVC burden of about 1.1 million of about 700 thousand, 750 thousand of those OVC are certainly as a result of the impact of the impact of HIV and AIDS.

This was supposed to be a map of Zambia, we just can't get this thing to come up, so we've tried three different sticks, but anyway that would have shown you a little bit of the where we're distributed. But what I wanted to emphasize here is the opportunity for 52 districts to be part of the National AIDS Councils, work with the data, the district AIDS task forces because the districts AIDS task forces are important instruments in helping those community based groups to have a voice in the districts. So the National Aids Council set up these District AIDS Task Forces at the community district to really empower district organizations to have a voice around the care for OVC, around HIV and AIDS work, so again, it gives us a chance to be part of that leadership work within those data's, those district AIDS task forces.

Now I'm going to take the OVC platform, and I'm going to say if we're not using the investment to PEPFAR in expanding on it, in building it out, I think we're missing a great opportunity. We need to leverage, we need to take that

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

resource that's invested and migrate it into child health. How can you work at OVC and not talk about child health, right? Well, child health has many manifestations, we had great child survival work in this world, right? How do we migrate child survival work into an VOC program? If we're not doing it we're not doing a good job, we're not connected, if we're not connected to the MOH, government services, district health management teams, and other actors in healthcare for children, we're not doing our job in the OVC world.

Again, one of the specific things that we do within the RAPIDSs program is we actually help with the Ministry of Health and the DHCMTs, the District Health Care Management Teams, to actually put albendazol, de-worming meds and vitamin supplementation at those levels and then our care givers mobilize the communities, not just the OVCs within our program, but they mobilize the entire communities on the child health weeks, which happen twice a year in Zambia and it's a wonderful time to mobilize for their vaccination routines. And we bring in the drug through the Ministry of Health, we actually outsource it through corporate donation, and we don't pay for it and we give it, and so now we have a million children who have been de-wormed. Want to talk about nutrition, it's not just about what kids eat, right? It's about making sure what they eat actually is beneficial to the child, you can actually

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

improve nutrition with albendazol by about 15, 20, 30 percent just by making sure children are de-wormed. And it has to happen as we know every six months and many vulnerable children really do have a problem with parasites.

So again, just simple things. Again, we moved in to malaria. We took the platform and moved it into malaria. Now we're distributing 500 thousand insecticide treated bed nets, those bed nets are going through the caregiver network directly to households, 154 thousand households are covered with three to four nets per household, whatever the need is there. So now you have these OVC children sleeping under, but again, it's community led. It's actual caregivers going into the household, opening up the net, hanging up the net, and talking about malaria, a little education program at the household level, around why the net is important and again, why you should be sleeping under it, and number three is if you do get malaria, these are the symptoms, go get treatment at the health facility.

And then the last part is taking that platform at community base and linking policy at national level with a community voice. What we're finding is that we need the communities, the District AIDS Task Force is to have a voice at the national level. So what we're doing is trying to translate that voice at that level for the issues these families are

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

facing in their communities, whether it's in school systems, health systems, on and on it goes so that it actually can be transferred within the policy. So we have two people who are within the RAPIDSs group that are succumbed to the ministries, Ministry of Youth, Sport and Child Development and other ministry which is community development and social services. They're inside the Ministry. They're working on these issues inside policy reform, inside with the government.

Sustainability. Yes, I'm getting to old to worry about sustainability anymore. I don't think anything's sustainable to be honest with you, let me talk about sustainability because that's our mandate right? Sorry, Ed, I'll behave. But, you know we're working with a target population of people who are highly impacted by disease burden. And friends, these are people who really are struggling. These people need assistance. Straight up. Now, okay, if we can migrate them through the system and to get the sustainability for economic impact, because we do a lot of livelihoods intervention at household level, then we're doing something, alright, we're building a platform. But even if we're not building that platform, are we going to deny that assistance? No. We need to do more in fact. Alright? So, anyway, sorry, I won't preach anymore, I'm sorry.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

But again, we really do need to integrate the work of OVC community based work into national frameworks and it's been quite successful, I can go into details here in terms of how we worked in national development plan, give you a lot of detail. But again, you're seeing these communities represented now in the shifts and policy in Zambia because they have voice, which is wonderful. And in Zambia government's wonderful receptor of that voice, it's a real positive environment. Again, having care givers trained in the community, 12 thousand of these caregivers, they remain resonant in the community rather RAPIDS or whatever project funds them in goals, these people are training and they're community based, they're there. They're resource people, they're people of good will, they're high esteem in the community because of what they can do for their communities. So again, they are actually, and then we do a lot on capacity building for the CDOs and FBOs. As we know they struggle with in terms of organizational development, in terms of finances, in terms of, so what we do is we have a whole CBO is you like capacity building model that we take them through, and we build the capacity of these community organizations. And that's because we have great partners who know how to do that. That's why you've got the big NGOs in there, right? The guys have been around this stuff for a while and then we've got 101 community based faith based organizations with small grants

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

to anywhere from five thousand to 50 thousand dollars. And we, through those grants we help them to build the community capacity and their own capacity, both at the same time, which is a bit of a challenge, but it works.

Okay, let's go, let's fly here, I'm going to get into trouble. Challenges to quality and scale. PEPFAR resources aren't enough, Global Fund resources aren't enough, National Level resources aren't enough, private sector resources aren't enough. How many OVC do we have in Africa friends? Let's talk the numbers here, alright? Twelve to fifteen million children and growing. We need all resources and all partners to come together. What was that? I'm sorry, oh man, alright, almost there. Alright. We've got to watch out for the, so we need all of these resources to come together and that's where I think we've got to engage more partners who aren't normally engaged in the fight on HIV and AIDS and that would be some of the corporate sector, some very interesting and we'll talk about that in the private partnership things, what I'm going to do later.

But, also volunteerism, how far can you take it? That's the big question. We equip our volunteers, we do not pay our volunteers they are equipped with bicycles 23 thousand bicycles we just got from a donor. The bed nets, the caregiver kits, and they get seed, we do seed to household distribution

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

to just before the rainy season for vulnerable households, the caregivers benefit from that, the benefit from the IT distribution, yes, we've got to get evidence based stuff here. And we're working with pop culture, we just finished our midterm evaluation, they're putting together the quantitative data, we will have the qualitative data very soon, it's coming together and then we will do the analysis and that should probably be out, if Katie is in here, it's probably going to be out by September. So we should have some good evidence, and then, yes. Alright, Ed, you're going to throw me out of here.

Just let me say that we're trying to create an OVC and caregiver data base. We're working with central statistics office in Zambia, because one thing, if we really know how many children are vulnerable, we can advocate with a national and international level on that. I'll skip the rest, and there's lots of those things. And then the last piece is you also, if you're going to do a fair amount of in kind distribution to encourage your volunteers, you only have a two to three percent drop out rate for our volunteers, our 12 thousand volunteers at this point. And it's because they're equipped and they're trained in their values. And we have to have a whole logistics platform underneath that to support those volunteers in terms of equipping them, because 52 districts, that's a huge operation. And I will stop there. [Applause]

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

MALE SPEAKER: So we've heard now from Bruce on a very wide scale community program, OVCs within Zambia, does anyone have any questions for Bruce? Anybody want to go to lunch? No, I'm just kidding. Alright if there are no questions for Bruce, does anyone have, I open the floor now for questions that can be asked of any of the speakers. I know the very first speaker I had to cut off some questions because I had to make sure we had some time. So, at this point in time does anybody have any questions for any of the other speakers? A question over there, there's a question there, we have plenty of time now folks, so as they say in Squahili, Poa [misspelled?].

MALE SPEAKER 2: Thank you so much for the presentations done. I have a question for the presentation on the cluster model. I wanted to find out what the attrition rate with your volunteers is and what you think is the main cause of that attrition? And I would also like to find out how you, the incentives that you have for them. Then I wanted also an explanation for the time you used where you said you wanted to respect their volunteering spirit. I wanted to find out if that was there expressed risk or it was assumption on the side of the program managers. Thank you.

GAIL GOODRIDGE: Yes, well I would say that within the clusters, again, the groups that we work with groups, so the

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

cluster itself doesn't have attrition rates, but the attrition might happen within the community groups themselves. And it's different in different clusters so I really can't give you a, but I can give you sort of a range, I can tell you that in most instances in the cluster concept it tends, people tend to stay together because they're working together, you've got three or four people, or maybe five people in a group, now they're working with another eighty people and they get a lot of motivation from that. That's been our experience again for about eighteen months.

The other thing I would like to say is that in terms of respecting volunteers, this again is still a work in progress, but these are some of the things we're trying to do. For example, we realized the volunteers in a community still have to make a living every day, still have to feed their kids. So we try, when we do trainings, we try number one not to pull people away from their community for a long times, in fact we try not to pull them away from their communities all together. When we have trainings in a community we work with the church group or a mosque, or something like that facility and the trainings are conducted onsite and it's the women's church group that provide the good. So we really try to use community resources. But we try not to do trainings that are very long, if we need to do trainings of a couple of days long we try to

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

break them up so they're not full three full day trainings but half day trainings.

The other things we're trying to do with volunteers is to use a strategy that we're calling the immediate network strategy. And what this means is when we train women to be peer educators, we don't expect them to take a whole community or a gigantic neighborhood and go door to door talking to those women, for example. But what we do is we ask them to look at the women they interact with every day. If they're a vegetable seller, who are the women in the vegetable stands next to them, who are the women who come to buy from them every day, who are the women that live next door to them, who are the women that go to their church or do other things, they're on the PTA with their kids. So, we ask them to use that network as their peer education network, and we find that if you can bring a lot of women together, or a lot of youth, or a lot of men, following that kind of a strategy that you can get really good coverage as well. But it's mindful of the fact that they're doing this in the day to day work that they do. So those are some of the things that we're trying to do.

MALE SPEAKER 3: Thank you very much and thank you indeed for all your insightful presentations every body else. My question goes to the cluster model again. Having seen that there are different clusters and the focal person from each

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

cluster forms a steering committee, I think is a very good idea. However, in the clusters we have also the cluster of truck drivers. And I was wonder how those truck drivers really play a critical role in the steering committee because they are always on the road and they have their own issues. The second question is, all those clusters have different issues of [inaudible] and in view of that, how can we actually reach a common ground, a common idea as far as consumer concern because the OVC class that we have an issue of it's own, while the cluster of youth we have another issue. So is it not an imposition if we are actually pushing them to really look into or refer to the issues that we are bringing forward.

The third one is I'm just wondering about the relationship between the anchors and the steering committee. The steering committee I believe is formed from the different clusters and the anchor is an NGO that is receiving resources, and therefore, I'm really wondering about the legal relationship between those two structures. Thank you very much.

GAIL GOODRIDGE: Thank you very much for your questions. We don't have a lot of clusters combined of truck drivers. I will say that we tend to be working through truck driver associations or truck driver unions. However, I will say that in Bocavu, we are working, we have a cluster of

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

transport workers and in that case, what we're doing is we're working with about nine different unions and associations along with long distance truck drivers, taxi drivers, bota-bota drivers, etcetera, and they've come together to try to look at the issues to reach men, high risk men. So that's how we're working with truck drivers.

I'm not quite sure I understood your second question about working with the various clusters, but let me see if I understood it. In terms of what they're doing it's the youth groups will work together and develop their agenda, but we want them where it happens, we don't encourage it, we don't insist on it, or direct it, but where it makes sense we see overlap. And where there's overlap we want that overlap to happen because we think it's an opportunity for growth and also for people to just make sure that they're working with other people in the community. Our whole model is designed to create cohesion in communities, that's the way we're working and the communities themselves know the best way to do that.

In terms of the role of the anchor in the steering committees, as I say, we're really trying to make it clear that the role of the anchor is to accept the funding on behalf of the cluster. We don't want them to be seen as the manager and that's why frankly, as I said earlier, it was exciting when the community groups came together and said, you know that big

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

anchor group that we thought we'd go with because they knew so much, we'll frankly they didn't understand the cluster concept and they didn't do a very good job of being the anchor. And so we don't, they're welcome to be a part of the cluster but they're not going to provide the leadership, they're not going to play a major role as the anchor because they don't know how to be collaborative.

So we really, we really want to keep it community based. The other organizations that right now that are receiving funding as anchors are a little bit larger organizations but they really understand community mobilization and community capacity development. So we've found that's really worked very well. In terms of legal, they are a legal entity or not, the cluster anchors generally are legal entities because we do need somebody who can pass a USAID 133 audit. But even then there are community based groups, and I won't give their names but they're smaller organizations that know how to work with communities. We frankly don't have an agenda for whether these clusters should become formal, legal, independently registered institutions. We'd really like to keep communities mobilized and to find ways of reaching out to these tiny groups that nobody else really reaches out to.

Thanks.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

MALE SPEAKER: Okay, there's a question, we'll come back here, but we have Southeast Asia, over there by herself, we'd better get her before we forget about her. Please go right ahead.

MARTHA: Well, actually we're not from Southeast Asia, but I can make up a question about that, but just to say that Bruce, I know you ran out of time, Martha with World Vision, and I put a stash of CDs behind his chair there that I don't want to lug back to South Africa, so if you'd like to pick up a CD with all of World Visions core materials, they're behind Bruce there. Thanks.

MALE SPEAKER: Okay, the promo is over now we're back to the next question.

MARK: Thank you. My question is to Bruce and I just wanted to thank you for a superb presentation, just coming back to the issue of volunteerism, I think that is a big issues that we're all grappling with in terms of scale up. Could you speak a little bit more about what that equipping and training actually entails, is that standard across all the partners? And secondly, what is a volunteer's job description look like in terms of time, effort, what is expected of those volunteers, because I think that's something that we're also grappling with. I'm Mark from Hope World Wide. Thank you.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

BRUCE WILKINSON: Thanks Mark. It's, the training is standardized across our partners. The partners come together in what we call a technical working group around care giving, and that's OVC care giving, HBC care giving, youth work because we have a lot of youth peer educators, so the actual training modules are standardized across our partner agencies. We have had our technical people, we have technical assistance that we have in each, we have a technical advisor for OVC, a technical advisor for HBC, they go into the various organizations and train that higher level of trainers and then that cascades down in. So the training is fairly standardized and what's also nice is we can actually move the training along. We just incorporated about eight months ago a strong malaria component into our, we're actually right now tempted to pick up on TB and start to say could our care givers provide some kind of a buddy system and a dots system, and we're careful here because that entails a lot more work, and so we're a little careful. But each time you add a component, like bendazol, or albendazol, or— [audio gap] —I didn't, we didn't decide that, we give them five households, they are responsible for five households, so that's the caregiver load if you would like, and so the care givers are selected by the community, they're trained within the community frameworks and then they actually get the allocation of households by the communities themselves but we

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

say please limit that to five households. Now, we do find some that are going to six and seven, and you always get the people that want to do more and better, and then you also get the people who don't quite make it to some of the ones that they're responsible for.

But I think in limiting the number of household and expanding the type of care that they can provide to those households, whether it's OVC care in the household, HBC care, youth work on prevention and livelihoods I think you start, and also, somebody said the caregivers, I believe, are an essential ingredient right now in reconnecting families that are in distress back to government services. Many of these families just don't have the capacity or they're so overwhelmed by the disease burden that they're not getting the kids to school, they're not getting to the clinics, they're not actually taking advantage of added extended services or water. The caregiver kind of helps those families to reconnect if you would like the services that are available within their communities. So again, that's another role of the care giver and they become a big cheerleader and encourager, and we really do train them a lot on psychosocial support because the families just really need to be encouraged in that environment.

MALE SPEAKER 3: My question goes to Papiya from India. About the traditional medicine practice she has. How do you

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

deal with the issues of equality, [inaudible] and how do you integrate these in line with modern medicine practitioners?

PAPIYA MAZUMDAR: Thank you very much sir. Yes, quality assurance was one thing that we really were very much aware of, and that's the reason I could not stress in my presentation because it was like I took a lot of time. But we had a very specialized group of physicians with us with they ran into preventive and social medicine and they are practicing doctors and they were constantly in touch with these providers. So we monitored them almost every week, they were told to maintain case sheets that were coming back to us, they were evaluated by the partners of these physicians and we took all trouble to maintain the quality of these providers. Even after the intervention these providers, these trained providers in the community are with us, and even not so frequently but we are understanding their quality and assure that they are providing the real and true treatment. Thank you.

MALE SPEAKER: Just before we get the last question, because I know people are sneaking out for an early lunch, I'd like to remind everybody again if they would be kind enough to fill out the evaluation sheet before you sneak over for your lunch, and again, anybody from the Ministries, if they're involved in orphaned and vulnerable children, there will be a meeting this evening with the senior person of OGAK, overseeing

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

OVC care at 5:30 in the banquet hall, and that end the [inaudible], and with that I turn the microphone over to the questionnaire.

MALE SPEAKER: My question is to Bruce. Actually I would like to appreciate very much for your reading, particularly on sustainability. My question is on sustainability. What is your anticipation that the government has a common thing will take over your initiative to continue the support of OVCs. And secondly, do you liberate your resources from government and community, actually you mentioned about volunteers outside of what enters, what resources do you really liberate gradually to continue your initiative evaluative towards sustainability. Thank you.

BRUCE WILKINSON: Thanks, your asking the hard questions, I like the questions, I'm not sure I've got the best responses, but in terms of integrating with government. We have had really good success working through the District AIDS Task Forces because this brings together a cross section of civil society government leaders, business leaders at that district level. And they really become sensitized around the issues of OVC, of home based care, of reaching out to the youth and it provides them a forum where those discussions take place. So, in the national development plan, for example, and I have to be careful there because my Zambian colleagues will

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

not be nice to me later on, alright, but in the national development plan what we saw was the national development plan and the World Bank comes in and does its thing at helping each of the Ministries with a consultant. And so you have a consultant in health and a consultant in education and they started putting together the pieces in each of the Ministries, driving that process. But there was no overarching them of children in that, and especially vulnerable children and youth, in that development plan. So we worked with the Ministry that we were in and we said we can find some resources to get a consultant to help to pull together a cross section of youth and vulnerable children sort of activities and if you'd like to incorporate in the national development plan, because that's what Zambia does every five years, the big plan, and that makes the allocation of resources through the budgetary process. Well, that person then was doing such a great job the government said let's create a chapter on youth, children, and vulnerable children in that. So they, the government took that process over and just it's been fully integrated now into the national, UNICEF was part of that process, NACK [misspelled?] was part of that process. But then, now on an annual basis, you've really got to lean on the Ministry of Finance, because we all know where these decisions get made, friends, when you're going to get resources allocated. So that the Ministry

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

of Finance, now we have to make sure that we have services and activities that are built into each one of the Ministries budget, the Ministry of Health, Education, on and on it goes, that target vulnerable households and children and youth.

So again, that's a process that's ongoing and I think the national development plan in Zambia is increasing its budget allocation now, so that's part of the government thing. And the last question was, I've probably talked to long already, Ed, am I right? What was, the last, the last bit was, I'm sorry, I'm forgetting the last question. I'm very. Ed just reminded me how old I'm getting here, he's a great facilitator. Thanks Ed. [Laughter] But no, once again, I just think we're on the cusp of getting these community and government pieces working well together and I just congratulate all the Zambian government and all the partners that work in RAPIDS consorting, because they really are making a difference.

MALE SPEAKER: Very good. Why don't we give an applause, these people worked hard on they're presentation and they're work. [Applause] We thank them very much for that. Since we had one promo in the questions, someone's sent me a note and said can I do my promo? So, I'll give Gail two minutes to do her promo and then after that I wish everybody a bon appetite. But folks remember to fill out the evaluation

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

2007 HIV/AIDS Implementers' Meeting
PEPFAR, The Global Fund to Fight AIDS, Tuberculosis
and Malaria, UNAIDS, UNICEF, The World Bank, WHO, GNP+
6/18/2007

65

form and drop it back there. Have a great day, enjoy the rest
of the meeting.

[END RECORDING]