

**2007 HIV/AIDS Implementers Meeting:  
Closing Sessions  
PEPFAR, The Global Fund to Fight AIDS, Tuberculosis  
And Malaria, UNAIDS, UNICEF, The World Bank, WHO, GNP+  
June 19, 2007**

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**CAROLINE:** Your Excellence, The First Lady; honorable, distinguished participants; after three wonderful days with each session getting if not as good, better than the other. Who would expect that the last day would get any better? I would like to join my colleagues to thank the other [inaudible] of this conference for a very well thought out program. We cannot think of any better way that – for the agenda of the final day of the conference. The room is still packed, normally plenary sessions, early morning, and people are filtering in, but every single day has been very, very well attended.

Now I kindly ask the Ambassador Dybul, the co-chair of the meeting, to introduce speaker Her Excellency, The First Lady. Thank you.

**AMBASSADOR MARK DYBUL:** Good morning. Your Excellency, Madame First Lady of the Republic of Rwanda, Honorable Minister of Health, Honorable Minister of State, Honorable Ministers and other leaders of the Rwandan government, good morning.

The leadership of the Rwandan government was on clear display at the opening of the meeting when His Excellency President Paul Kagame officially opened the meeting with

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eloquent words on the fight against HIV/AIDS, not only in Rwanda but around the world.

It's fitting that we open the final day of the meeting with Her Excellency, Mrs. Kagame. It is equally important that on this the last day, the closing of meeting we look to the future in this plenary session and our future as we all know is our children. So it's important that we focus on our future this morning as we close the meeting.

Her Excellency, The First Lady has been one of the strongest voices in Africa and throughout the world for families and children. She is past chair and one of the current leaders in The Organization of First Ladies of Africa committed to fighting HIV/AIDS, poverty, and empowering families, women, and children. Something she has continued to do actively in that organization. Her own organization I think the title of it says it all, Protection and Care of Families Against HIV/AIDS.

Her passion for these issues no doubt comes from many pieces of her past and present but perhaps one of the most significant contributors has been but that while doing so much for her country and for her nation, she has done so much for her own family and is a mother of four.

With the increasing feminization of this epidemic, young girls and women have no better friend than Her

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Excellency, Mrs. Kagame. Her strength of will and pushing for the rights of women and children and families is well known and her strength of will is the reason we are all here. As many of you know we were scheduled to be in another city in Africa until I fortuitously ran into Mrs. Kagame in Washington and she said Rwanda can do it. [Applause]

I think that we all know that if Mrs. Kagame says it will be done, it will be done and that is all it took to move the meeting to Rwanda.

In many cultures and traditions we are called to be a light atop the mountain. This week we have seen both in the extraordinary hospitality and warmth of our hosts here in Rwanda but also in what we have seen presented of the extraordinary success of the Rwanda HIV/AIDS program. That Rwanda is a light atop a hill, in fact a light atop a thousand hills for Africa and for the world.

It is my great privilege to introduce one of the brightest of those lights atop the hills, Her Excellency, The First Lady of the Republic of Rwanda, Mrs. Jeanette Kagame.

[Applause]

**HER EXCELLENCY, MRS. JEANETTE KAGAME:** Thank you Ambassador Dybul for the kind words. To the ministers on both sides of my table, the Mayor, ambassadors, and development partners, brothers and sisters unified against

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HIV and AIDS. I must begin by thanking you for the days you have spent in Rwanda, the worthy attention to one of the most challenging social and medical issues of our times.

As you pack your bags to go back home, I hope you will do so with renewed determination to continue to search for sustainable solutions in the fight against AIDS. I'm honored to be with you today as we continue to reflect on our common fight against this pandemic and share with each other seeds of thought that may one day germinate into strong trees of incentives that we can lean for support, answers, and results.

There is an urgent need to ask ourselves some tough questions like what are we as Africans and our governments doing to bring the barriers of taboos down? Are we going to just talk about fighting HIV and AIDS or are we prepared to change to fight HIV/AIDS? How ready are we to challenge those what we are suppose to be seeking short-term, selfish pleasure to cause long-term pain? Are we going to sit back and allow the children to be orphaned, exposed to, and affected by the virus? Can we co-pay or at least ensure they taught their children or ensure they receive the information in life skills needed to navigate an increasingly complex and fast changing world? Do we who are seated here feel that there is nothing more important today than the fight against

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diseases that tear at the fabric of our society, reverse development, and destroy some many young lives? Don't we feel we can and have to give up so little to gain so much success in the fight against HIV/AIDS?

I would wish to hear all you say aloud yes. Thank you. I think we have the problem but we need to recommit ourselves and to give up some of our traditional values and yet we absolutely must, if we are to win this fight. Too often we are we are elaborating our efforts to protect the reputation of the wealthy and say they died or are suffering from ailments other than AIDS but at the same time we are quick to judge the poor as irresponsible when they become victims of this scourge.

AIDS does not make social judgement. So why do we? AIDS does not affect families based on their economic wealth, so why should we? All that is required is little love and understanding. Surely that is not too much to give. However as long as people do not go for testing, as long as people continue to engage in risky sexual behavior in an infected environment, we all have deprived ourself of the wonderful dream of a HIV-free generation in the future.

All we will have achieved is to leave behind the legacy of a deadly virus. Let us be true to ourselves and send a clear message that whether you are rich or poor, young

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or old, big or small, man or woman, boy or girl, the AIDS is a real and present danger in all of our lives.

How can we the mothers and fathers of Africa and the world shy away when the life of a generation can be saved? We cannot be caught saying if only I had. Our generation may be the victims of this plague but we cannot pass it on to the next generation. We must be remembered as the generation that gave it's all so that those who can have to rise, as spared the anguish of stigma, disease, and despair.

Many times we find the answers to our problems to hit us in the face. I want you to think for a moment about an example as silly as the motor vehicle. A combination of factors is required to keep us safe on the road as we drive every day of our lives. We must have good and road worthy tires. We must wear our seat belts. The newer models even have air bags. We must have safe and functioning brakes. And we have a clear and sober mind before we drive.

It's interesting to note how much attention we pay to these details but rarely do the same to our health. Let us take this approach in our fight against AIDS and go for the combination of strategies that really ensure that we succeed. The AIDS pandemic is truly [inaudible] , too complex to leave anything to chance. We must use the following education, prevention, behavioral change, protection, circumcision, care

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and treatment and others and even more strategies if we can find them.

Distinguished ladies and gentlemen, dear friends, I want to reach out in gratitude to the people living with AIDS and praise you for the courage to fight the stigma society places on you. I appeal for your support. As you work to be in a culture of understanding and responsibility together we can show our brothers and sisters that the world can only be one if we have no infections. Your story will send a strong message and your courage will help change attitudes. We want to work with you to educate and sensitize our youth and the change of AIDS, all of the damage of AIDS. We must work together to unite families in care and support, therefore I appeal to you all gathered here today as you get into the planes, buses and cars that will take you home pause for a moment and think about which seed you can plant. Think about what satisfaction we can bring to the world if use our courage to change.

In our case in Rwanda you all know that barely 15 years ago we lost over a million lives in just a 100 days. We see picking a lot of food [misspelled?] to lose any more lives and a picture we can do something about.

To our development partners and international policy makers I'm proud to say that the government of Rwanda is

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determined to stay the course in leading this change for the betterment for it's people and I hope that you will continue along with, along this path with us, Ambassador Dybul, and all the good people who have been involved in organizing this meeting in Rwanda, I must going to grateful for the owner and confidence you have given Rwanda by being here this week and working with such a concert of talents to bring a symphony of solutions in the fight against AIDS.

Thank you for your generosity and support for the home grown incentives that will help us find lasting and effective solutions. Be assured that in the heart of Africa there is a country called Rwanda that is determined to fight every battle, engage every incentive, and embrace every solution in the fight against AIDS.

All the best to you all and safe journey back home.

Thank you.

[Applause]

**CAROLINE KAYONGA:** Your Excellency I think the applause speaks for itself. Indeed we would like to assure you that we do feel very much in a daze. And now I have the pleasure to introduce to you the next speaker, Mary Fisher.

She is an artist, author, and speaker who travels the world advocating for those who share HIV positive status. She serves as an ambassador for the Joint United Nations

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Program on HIV/AIDS and on the leadership council of The Global Coalition on Women and AIDS.

Her artwork has been featured in one woman group shows and is found in distinguished private and public collections including the prominent collection of UNAIDS in Geneva, Switzerland. She established the Mary Fisher Care that is standing for clinical AIDS research and education fund to support long-term outcome based research for the care of people living with HIV especially women.

Her Excellency, distinguished participants please welcome Mary Fisher.

[Applause]

**MARY FISHER:** Thank you, Caroline for that generous introduction. I'm grateful to you and your nation for hosting this splendid conference. On to the sponsoring agencies that have done so much in the global fight against AIDS. It's a great joy to be reunited with First Lady Jeanette Kagame this morning.

Mrs. Kagame she is known in the AIDS communities around the world for her dignity and her compassion. She is Rwanda's living proof that communities of hope can rise and villages once haunted by desperation and death. We are in your debt Madame Kagame and we thank you. [Applause]

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When you arrived at the conference and when the conference began you received a special gift. Bracelets made by Rwandan and Zambian women. When I designed these bracelets my intention was to create fine jewelry but my deeper motivation was to create employment and the reason is clear. Women who share poverty and AIDS can be empowered only by employment. And without empowerment [Applause], without empowerment there is no reason to live.

The bracelet project was done with my friend Willow Shored [misspelled?]. She is the founder of the Fair Winds Trading. Willow had been deeply moved by women who survived the terror and torture of genocide and needed now to make a choice. They could go mad with grief and die or they could embrace across the violent divide and live. They choose life. And they celebrated that choice through art by weaving together their extraordinary pieced baskets. In service to the women of Rwanda, Willow brought their stories and their baskets to America and used basket sales to generate employment and income for African suppliers and artists.

Then Willow saw some of my jewelry. And I saw some of her women at work. From that miraculous day grew the bracelet project employing women in both Rwanda and Zambia. When a generous donator purchased 2000 bracelets as gifts for

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this conference, we were able to keep women in Rwanda and Zambia earning a living wage a bit longer.

I have never been involved in anything that has so raised my hopes and my fears. Given me such pride and such panic. This is not a story of simple economics or guaranteed success. And the story is far from over. But let me tell you the story as a woman who represents UNAIDS and as an artist and as a woman with AIDS, I'm honored to be a special representative and goodwill ambassador if UNAIDS.

The leadership offered by Peter Poit and Michele Kazatchkine [misspelled?], the joy I have with my sisters in the Global Coalition of Women and AIDS. These are privileges. UNAIDS support for our training of women in Rwanda and Zambia was critical to our beginnings. The character and wisdom of Elizabeth Mactacka [misspelled?], the power of PEPFAR, the friendship of Ambassador Mark Dybul, and Mark's passionate devotion to this cause all inspire me.

Having recognized all of these gifts, the struggle remains. We know the truth of Nelson Mandela's great proclamation that poverty and inequality rank with slavery and the partied is social evils. And AIDS within poverty is the AIDS we know best. Millions of people he reminded remain imprisoned, enslaved, trapped in the prison of poverty. Overcoming poverty is not a gesture of charity. It is an act

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of justice. And the first step toward economic freedoms say Mandala is ensuring trade justice. I agree. The key to freedom is trade, not aide. [Applause]

I was in the U.S. earlier this year when an e-mail arrived from Retegona Newgrewu [misspelled?]. She leads PACVA, Madame Kagame's model program for women and families living with AIDS. Women from PACVA were recruited and trained to create the bracelets in Rwanda. The previous week rather than go on the road, the women had sent her to thank the World Food Program for their previous support. And tell them their food wouldn't be needed any longer. They were earning income now and the World Food Program should to quote them, "give their food to a more needy group". [Applause]

The World Food Program officer said that the best of her knowledge this had never happened before anywhere. But history can be rewritten. Aide recipients can become aide providers when employment is married to fair trade. We've seen it.

So what do I fear? I fear that we may put women to work sporadically but not consistently. I worry that we will not keep them working and proud, feeding their families and clothing their children, motivated to hope and to live. The record of income generating projects of this type is spotty at best. And we have no right to raise hopes only to dash

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them. Single economic interventions are not enough. What's needed is sustainable interventions. Businesses that can succeed year after year after year. As the West colonized Africa and other great cultures, the West depreciated the great art of those we colonized or economic interventions are based on indigenous art.

We must overcome the stereotype that Africa products are inferior because they are not. [Applause] We need products of great quality and we can have them to support prices high enough to give women a livable wage. First we need to defeat the myth of cheap crafts. To achieve Mandala's vision of freedom through trade justice, we will need to challenge all models of government aide, philanthropic grants, and missionary zeal. These models all assume that the donors infusing indigenous cultures with money and know how and after a few years indigenous businesses will grow strong and independent. Then folks from donor agencies or nations can go home. Sometimes this model works but not often.

The secret to sustainability to ending my fears and keeping my women working is a different model, a sustainable model, a partnership model. This model assumes that Africa and donor nations are equally important to one another. That we share a single goal and are like it or not codependent.

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Partnership has no room for paternalism. This model also sees communities of poverty as communities of potential. The Western partner first assures sell of a product and only then comes to Africa to produce it.

In short, we bring the market to Africa rather than bringing Africa to the market. There is no other way to assure that goods produced will be goods sold and for a fair price. And sustainability demands no time line for separation, no going home ten years from now, or 20 if I'm still alive, I will still be designing jewelry, still seeing it produced by my business partners, sisters.

A sustainable model is built on continued relationships not the illusion of independence. When global corporations are going to emulate this model, they too will become partners in communities. When poverty enslaves but employment liberates, they too will accept the challenge of employing a fair share of people with AIDS. They too will see themselves neither as rescuers nor as raiders but as partners in the long haul, creators of justice, and sustainability.

I have seen the power of economic intervention and the urgency of building a sustainable model. But I have something else as well because I too am a woman with AIDS. I would not be here today were it not for Dr. Agnes. Dr. Agnes

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as you all know and will hear from shortly is the, leads the Rwanda National AIDS Control Commission, serves dozens of global boards and initiatives, and is driven, not by professional ambition but by a passion for justice. When I, a woman with AIDS, see Dr. Agnes I'm moved both to tears and to hope. And I see you before me, heroes in the global war on AIDS. You lift the weary and you carry the orphans, rescue the dying, and protect those not yet infected. You've shown bravery in the face of criticism, courage in the face of disappointment, compassion in the face of brutal oppression. It is you that we celebrate with a gift of the bracelet. [Applause]

I am a woman with AIDS. After years preparing to die, you have kept me alive with miracle drugs but life without hope, without honor, is not life. It is slavery. My sisters are weary of charity. We want work. We do not want medications that keep us breathing but enslaved. We want the dignity that comes with proving that we matter. The power that accompanies a just wage. Drugs give us the capacity to live but employment gives us a reason.

We are weary of being victims, objects, numbers, even patients. We want to graduate from slavery to partnership and we want it now. [Applause]

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Until we have created sustainable businesses in every community touched by AIDS, I will wear the bracelet in tribute to you. You are the ones who can redeem our lives from slavery. And I will wear it with this prayer for you and for the marvelous women who created it. Grace to you all and peace.

[Applause]

**CAROLINE:** Thank you very much Mary Fisher. We are truly humbled by your words. And hers is a very innovative example of inventive intervention for HIV and the strength that goes with the people who continue to fight, who are examples of people living with AIDS who are leaders as well and continue to struggle and gives us even more hope and more strength to go on. Thank you.

It is my pleasure to introduce to you the chair of the next session Douglas Webb who works for UNICEF in the eastern and southern Africa region with children and AIDS. He has previously worked for UNICEF in Zambia and Save the Children, UK in London. Douglas Webb, please.

[Applause]

**DOUGLAS WEBB:** Thank you, Caroline. Good morning everybody. Madame First Lady, honorable ministers, Ambassador Mark Dybul, colleagues, and friends it's my pleasure to introduce somebody to you this morning who has

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been a complete inspiration in the fight against AIDS in Rwanda and has proved to be real agent of change in bringing together a host of people such as those in the room today.

Dr. Agnes Binagwaho is the executive secretary of Rwanda National AIDS Control Commission, the national body which oversees the planning, evaluation of the activities in the fight against AIDS. Dr. Agnes is also a member of the country coordination mechanism in Rwanda for The Global Fund is chair of PEPFAR steering committee and is responsible for the management of the MAP program, The World Bank. All that sounds like an extremely busy day in the office as far as I can see.

She is a member of several boards and foundations and journals combatting AIDS and infant mortality and is on the Health Advisory Board for *Time Magazine*, which I didn't know. She co-coordinates the task force of the Millennium Development Goal Project for HIV/AIDS and access to essential medicines and is currently the co-chair of the Joint Lending Initiative on Children and AIDS, an initiative which I am proudly involved in.

She is an active mobilizer in pushing the agenda in favor of children and women in Rwanda and in the world. She is a wonderful person to work with and shows incredible energy, leadership, and tenacity. Dr. Agnes.

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[Applause]

**DR. AGNES BINAGWAHO:** Your Excellency, Madame First Lady, and all other ministers, excellencies present here in this conference, Madame Mayor of Kigali City, colleagues and friends it's an honor and a pleasure for me to share with you in this session Rwanda experience in implementation of our National OVC framework in the world of AIDS and compare it to the global response.

Waiting the presentation I can tell you that the structure of my presentation will include children and AIDS in the global picture, [inaudible] strong globally and locally, and the Rwanda case study and some conclusions.

Next please, next. As you can see here in the ten worse HIV infected countries in Africa more than 15-percent of children were orphaned in 2006. Those are AIDS victim. And the proportion range from 15 to 20-percent but as you can see in countries with prevalence of AIDS the proportion of orphans due to AIDS is also high. There is Zambia was prevalence of 20-percent. There is Botswana [misspelled?] with a prevalence of 24-percent.

In most regions of the world the added [inaudible] is the crazy. That means that orphan's numbers are also the crazy. Changes in population strict to also implied that since fewer children are being born the number of orphan will

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decline in most case however it's not the case in Africa.  
Only in Africa there is an increase of number of orphan.

As you are all aware and our First Lady has just mentioned it, there is not only one cause of child [inaudible]. We need to consider the AIDS dimension with the rest of factors relate to [inaudible]. We need to consider the child, the high school, the community challenges that makes you [inaudible] and among them there is poverty. There is other disease. There is short, there is in some area conflict. There are challenges and those challenges interact each other and make perhaps the children and their family unable to cope. This indicates the need to focus on realistic approach even when and certainly when you talk about HIV/AIDS.

I selected to show milestone [misspelled?] for children globally and at national level. We remember in '97 the first big victim children on the brink, at that time first actions, first that we were putting together and first action were taken. Over the year, globally we have seen increasing commitments to children and AIDS and many partners, researchers, implementers, donors, are all coming together to address all the facets of the children and AIDS issues.

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Here I would like to recognize new [inaudible] like John [inaudible] for children and AIDS which was established to ensure that in the future we will plan based on evidence and inform better. As a global response unfold in Rwanda we see a time that was high level [inaudible] to companies and now First Lady is a champion because she has led a big company at continental level and she always support other companies who benefits children.

Doing so we create a dialogue at national level and we give instruments and many months for holistic care, for orphan and [inaudible] children. We have in this country a very high level of commitment from overseas and it was demonstrated with the food integration of overseas intervention in the economic development and public distribution strategy.

Rwanda can be a useful case study in understanding the mechanism of the national OVC response. The country was acknowledged before to have the highest orphan prevalence rate in the world. But this is rapidly changing now due to good framework and policies. According to the census in 2002, 30-percent of children in Rwanda were orphaned and only a small proportion was due to AIDS, most being due to the genocide. The orphan profile is very dramatic and age

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sensitive. Orphan numbers are projected now to drop from 1,300,000 in 2006 to around 800,000 in year 2012.

Why? Because we assume that with access to care and treatment for parents, the number of children due to AIDS are going to drop down. We assume also that orphans due to genocide will have grown up and the proportion of orphans for AIDS was supposed to be before 52-percent will be dropped down and the one due to genocide will be dropped down too.

Overwhelmed, there is a projection using spectrum [inaudible]. We documented those changes. Parents are surviving due to a good anti program and the rate of [inaudible] and parent's death due to other disease like malaria will also drop down just due to a better management of those disease. The variability profile will also change due to the intervention that the government has put in place as safety nets and also due to the intervention tackled by the antiretrovirals.

In this country there is only one key element. The great political commitment. And this gathering can ensure you how, the gathering we have here with the Mayor of the city, with five ministers show you how, what the support we can come from. [Applause] the opening of those, this conference by His Excellency, the President Paul Kagame, is also something to show you the support we have. The presence in the room of the good, of the national control commission

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is another indicator. But what is most important is that all together institution of the country involved in care of overseas have come with a strategy and plan for obviously [inaudible] and that mean the government is committed to find the resources.

In 2006, implemented the design transition the government have bring the decision and the services closer to population. And this and other [inaudible] indicators that have action plan focused on children and AIDS, two dimension were taken have a cross cutting issues and it was originated in [inaudible] Paris. There is also [inaudible] intervention place such community housing strengths which will do something. Education district funds and free primary education, micro freelance project supported families and parents and help them to have a better life and also [inaudible] societies were encouraged for communities to access grants and loans. [Inaudible] system strengthening to improve quality of services for all and many other various [inaudible] strategies in place by the government. All those are aligned to our region 2020 and Rwanda commitment to the MDGs, to the Ugandans [misspelled?] and all others international framework we involve the welfare of children.

In 2003, our country adopt the OVC policy. And this policy has got all of us in [inaudible] development of our

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strategies and action plan among them all the AIDS response as far as AIDS is concerned and OVCs. Over the period of 2003 and 2006, the National Action Plan for OVC was also adopted. And this year, this month in fact, in June 2007 the National Strategy Plan for OVC was adopted. All this was led by the [inaudible] and owner of the minister is here in this room. And all those document gathers went in plan. In the health sector we have, the truncate is used to track infected children and give them a better access to care. But there are other tools. We have now the [inaudible] Minister of Health accommodate an information system and this system will capture community information. We have also in the national Control Commission a web-based database, A Life Online. It will capture also information when AIDS is concerned.

Rwanda is a very strong and effective, the big, the core of this is a very strong technical working group shared by a Minister of Gender that put all of us together to work around those issues.

So, what is important and I'm happy to tell you that the success of HIV carrier and transmittal [inaudible] reduce the number of orphan. The success of the malaria program reduced the number of orphan. And all the government action taken to reduce mother and child mortality reduce the infant mortality. This has specific implication as far as it

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changed all our projection. Before it was assumed that AIDS orphan will be 52-percent of the total OVC in 2010. This was the projection done in 2005. And now remember that in 2005 the rate of OVCs was, sorry, the rate of all orphans due to AIDS was 26-percent. That mean it was assumed that the number will double. But it is the contrary, thanks to all those strategies, policies, and activities put in place by the government and I have to tell you that when the government do such a policy that brings on board the citizen society it will implement with us. Thanks to all those things now with respect to Rwanda the projection is that by the year 2012 the rate of AIDS orphans will be 17-percent. This has been made possible because of how we have fight against HIV/AIDS and also other disease.

Ladies and gentlemen, we have to acknowledge that we still face a general rational impact of the orphan of genocide. Those children of yesterday are going to have children themselves today and tomorrow. Children made orphan due to genocide, will pass definitely into the next generation. This is taken in account in the strategies and that's why if all those strategies, policies succeed we will see this drop out. These gains will assure that the proportion of orphan children reduced overall not just the proportion of orphan due to AIDS, but all orphans, all

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[inaudible] children. This gain will assure that the proportion of well average children with this overall not only AIDS one. And this is an important message I give to you on behalf of the Minister of Gender in charge of OVC in this country. In this slide, you can see the blue line shows the projection of orphan. We use for that the dashes and we adjusted the figure with The Institute of Studies, and you see the line is declining. The pink line is the proportion of orphan due to AIDS. It's also declining. The yellow line is the proportion of orphan due, all orphan. You can see that it is declining. Sorry, the dark blue is all orphans. And you can see that it's declining very seriously. And thanks to the work of the Minister of Gender who has put all us together to work around these issues.

The success of that is due to only one thing. The government has done it's job of coordination. The military, the NGOs, and all institutions. This have made the money world as far as OVCs is concerned and the principle of the [inaudible] was used to reach a resist.

What we have today in the field of money raised linked the HIV/AIDS, we have \$8 million for OVCs in the year '06. We have now proposal for '07. We will tackle the issues of OVCs and it's for \$28 million but as you know it's not predictable. We may win, we may not win. We have

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several director partners who commit themselves to support the program but this is also a challenge because it's short-time commitment. We have PEPFAR, the DISD, World Bank, and we have also the UN family. But there is saturation of the UN family in one UN is a challenge but it can also be turned in an opportunity.

Here are several indicators which show, I take this from the OVC plan and from Aid in Paris. Those indicators are available in [inaudible] so I'm not going to pass through all them but you can see that we have group plans in Rwanda and we have indicators to guide us in implement, in our implementation so that you can see if one good track or not.

We have also attached to all those strategy plan and [inaudible] plan a strong [inaudible] system and those, the money train and evaluation exists in the health system, in HIV/AIDS framework, in the all institution and all framework and action plan concerned by, while working for the welfare of OVC. There is also studies were planned. Every three years there will be a study to see where we stand. We are also [inaudible] on [inaudible] indicators because Uganda has indicators concerning OVC. We follow the [inaudible] and there are other indicators we use to track our actions.

In conclusion Your Excellency and ministers, we can say that if we reach those projections just because the

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partnership is good. Our partners have aligned them self to government plan and the government is the ultimate coordinator authority. We know that partnership is necessary because no one can do it alone. We need to be together to achieve those. Enhance in education, in social welfare, and we need to integrate everything we do in those sectors. We have challenges. We have opportunities and we are all going to deal with them all together. I thank you for your attention.

[Applause]

**DOUGLAS WEBB:** Thank you, Dr. Agnes. Just a couple of comments. I think the Rwandan situation has brought us into a new dimension of the leadership of the response. We in international community use to bemoan the lack of political leadership and what we are seeing in Rwanda is how the political leadership is actually managing a response and we are all learning about how to herd the cats, which is the three ones in action. It's nice to children and HIV/AIDS discussed in the context of poverty reduction and the context of national development planning. For too long AIDS and children has been a marginalized agenda and we are seeing in this context AIDS and children at the center of the development strategy where it is exactly where it belongs. AIDS is a driver of the response. We are recognizing that we

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are looking in this Rwanda situation of children with multiple vulnerabilities and a dynamic context of vulnerability. So how do we use AIDS as a driver of a much wider response?

So we are learning from Rwanda but while we have much optimism about the response as the figures have suggested we must realize that the task ahead of us is absolutely enormous. So thanks again Dr. Agnes.

[Applause]

**CAROLINE:** Thank you very much. And now it is my pleasure to introduce to you the speaker for the next session. Reverend Edward Philips.

He was born in Boston, United States and graduated from the Boston College in 1968. After completing his undergraduate degree he joined the Maryknoll Fathers where he did his graduate studies. Father Philips was ordained as a Roman Catholic Priest in 1974 and has since over 30 years in East Asia. He has many [inaudible] to rule and [inaudible] people in Tanzania and Kenya. In 1993, he established the East Deanery AIDS Relief Program as a risk opposed to slum dwellers suffering and dying from HIV/AIDS.

He is presently the managing director of the Eastern Deanery AIDS Relief Program. Her Excellency, distinguished guest please welcome Reverend Edward Philips. [Applause]

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**REV. EDWARD PHILIPS:** Good morning. As your final presenter this morning I'm, I don't think if I'm lucky or bad luck following out to the presentation of the President's wife which was extremely eloquent. She might have been a preacher in her earlier days in the way she presented. And then when I mentioned the Mary, my radical activist in kind of letting the world move a bit and challenge people, and then hearing what we heard from the head of the AIDS Control Program and the challenges, I'm going to take you to another part of the world which basically is talking about slums, health care services, and models which are basically radically different than almost every thing you have heard during these fast few days and which is basically different what we are seeing within most clinical care or intervention programs around the world.

So where we are and who is Eastern Deanery. Deanery in the Catholic Church is just a section of the city, the eastern side of the city in Nairobi is loaded with slum just from one area to the other. And before anyone was really speaking about HIV/AIDS in Africa and other parts of the world, we had seen in these slums in the eastern side of the city in Nairobi in the early '90s people were dying of AIDS. No one was saying anything. Poor people could not access

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care in the hospital because of cost sharing factors and other economic issues.

We ask ourselves a group of priests, how can we respond to the people in our area who we see as suffering and dying. No one is caring for them. And what can we do that their children will not go the same way?

So after begging we are finally able to find some money. In 1993, we established a slum community based operation. And since we have cared for over 50,000 people in the slums on the eastern side of the city. Now previous to PEPFAR most of those people have died. We could keep them alive for a few years but then ultimately they would die.

A few months I was interviewed by a reporter and the reporter asked me, his editor had read the article and he said come back and ask what is the difference between 1993 and 2007. In 1993 when we began we were seeing dying patients, people weren't talking about AIDS. The worse conditions you could see for people. And I asked my staff for the reporter what do you think? And they said we only kept ourselves together by supporting each other.

Those of us who work in Africa know that illness very often is not a virus. It's not a bacteria. It's caused by the spirit of something else. And in '93 no one knew about AIDS and in point of fact, our nurses, our volunteer health

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care workers were really considered agents of death and felt that pressure and almost rejection from community and not seeing life but just helping people making them comfortable until they die. And our average time of caring for a patient was about two and a half months until death.

So we have gone from 2003 where we are bathing with suffering and death and staff being rejected by communities because they were the cause of the death. It wasn't HIV. To 2007 where we are keeping thousands of people alive and families intact because of PEPFAR. [Applause]

Now what do we offer? In 20 foot containers, in shacks, in houses we rent on top of the slums, we have been able to put together these last few years a highly integrated model of care offering all the benefits of a comprehensive AIDS care program. So basically we take of care of you from the womb to the tomb. And we don't want to see too many in the tomb. We want to see more out of the womb and into life.

We have always added the component not only that care for patients but prevent. We want children not to be infected. We want adults and wives and husbands to talk to each other, whether discordant couples or one knows their status and not the other. But to work that, not just to keep people alive but stop people from getting infected.

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Presently at the end of the PEPFAR year of 31<sup>st</sup> of March, we had over 7,400 patients that we are caring for in our program. All in the slums. All outside of hospital environment. All being basically lead by nurses, health care workers, and other specialists.

We believe in people and our structures are people. And we began our structure by working within the community. And we found it easy in that we didn't have to go in and create structures in the community. We had within our own church system cells, small communities. We weren't just there to pray but we were called to be service to those with whom they live irregardless of what their faith tradition will be. And from the beginning until today we have this whole parade of health care workers, commitment women mostly who really believe in what they are doing. And let me tell you there is very few men in the slums in their areas that will play around. They are tough mommas and they become very, very influential people in other health care issues.

The most intriguing thing was we never asked, we don't choose. People choose. And what do people look for? They want someone who can keep a secret. You won't gloat and share and to broadcast. And these poor folks, these committed folks have propelled us through all these years and really seek out, find people who won't seek out care and

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encourage them up and to be treated and to be followed and monitored by them.

I would like to talk about a different organizational structure. Out there in general it's very hierarch. It's worse then the Catholic Church in some ways. You know you got a big boss up there in the hospital and you got the chief surgeon walking around and you go through the whole system and they kind of bow to each other. Well that isn't going to work if you are working in the slums. And I don't think it's going to work really when you work with people. And so in the beginning we said we are going to decentralize our operation. We are going to do empowerment within the local situation. And so each one of our individual sites acts as a decentralized authority and accountability.

The nurse is the most effective person to be that team leader. So it's up to them to do their strategies. It's up to them every year you know to qualify you must have your numbers. They have to come with their outcomes, their numbers from their individual sites. We don't plan from the top until the bottom how to do it. It's an ongoing process that every site becomes involved in the process. Any new activity, every site is involved in that process and then decisions and adaptions are made after the decentralization.

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Now what does that mean? It's not the ministry of health or the head of the hospitals telling you that you would do something. It is taking people who buy onto a process, who will become part of that process, have made recommendations how that process will become, and now they are the ones who ultimately have to implement it. So they own the process. I don't own the process but together we own the process.

As part of that process every week whatever the busy schedule in the clinic, the whole group from the sweeper and the cleaner to clinical officer, everyone must sit and talk about what has happened during the week. What are the issues, what are the problems, what do we have to do as a group. Not call me in the office, I have a problem. Your problem, you figure it out. You know, we know.

Working that way and working integrated. We all know integration of services. I want to integrate something I get a piece of plywood and separate a room. I will put a curtain up. By doing that we are not caught in some of the simple other systems when you go in the hospitals. So we can integrate HIV TB, counseling PMTCT, STIs, children and etc. I am basically your local supermarket or Walmart's. You walk in, we are a one stop operation. And if I want to open a new one, that's one more curtain, one more partition, one more

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service we will squeeze in. I don't have to go ask some big shot and say can we do it. We do it. [Applause]

Now one of the most unappreciated clinical cogs within the health service are nurses. Very often nurses [Applause] are the second class citizens down graded by many doctors as being like donkeys. However they are extremely talented. They are multitasked. I said in our operation the nurses are running the show. [Applause]

So from the very beginning we established them all as a nurse and a nurse driven model of care, not a physician driven model of care, not a clinical driven model of care but a nurse driven model of care. And why nurses? Who does the patient relate to most often? The clinical officer, the lab tech, the doctor? Who? The nurse. Hey this isn't rocket science folks.

The nurse is the key relater in the clinical surrounding. The nurse has those psychosocial skills to be able to sit and to talk and to relate to that patient. And so why don't we empower the nurse to do those things. Give them the recognition to do those things and support them to do those things and you are going to see what, later on in our outcome they do it.

Now one of the key factors that we do and we will see later is this question of testing. Who should test the

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patient? There has been debates all over the world. It has to be a lab technician. Send them down the corridor, the lab technician pricks the finger, do a rapid test. Somebody else says no, it has to be the clinical officer. Go see a clinical officer, prick the finger, get a rapid test results. We think that is nonsense. Who does it? The nurse. Not rocket science folks. The nurse. And we will see the outcomes. Use the nurses.

So using this nurse driven model who is the team leaders and sometimes even my clinical officers have a problem if the nurse is the team and we work as a team. All the different services. They have a problem, the nurse is usually a woman, the clinical officer is a man. They have problem, who is this woman who is team leader and shes a nurse, I'm clinical officer. And let me tell you if it gets too bad then I have to step in. and I have one statement. The day the clinical officer becomes a neurosurgeon, come and talk to me. But before then listen to the nurse.

Alright, working on this model, we have developed special congruity of nurses specifically for handling the more technical components of PMTCT and just to finish training a set of nurses and pediatric AIDS care. This just kind of looks at the model that we use where the centrality of the patient, the health care worker, and the nurse in the

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middle. And nurse being the coordinator for all the services that we be bringing to the patient. Very simple.

As a senior management we believe the same way that we are talking on the sites. I might be the boss folks but let me tell you we sit in a meeting. Anyone can tell me Father, you're wrong. And they do because we believe from the beginning, if we don't do it as a team then how are we going to ask our folks in the sites to do it as a team.

So we also model a team model of management. And from the very beginning, I said make it Kenya, make it Africa. I am the only pink person in my whole organization. [Applause] Everyone else is African and that was our strategy from the beginning. The abilities are there, the skills are there. You just have to put the folks together, give them the support, give them the encouragement, trust them. Remember I'm telling all takes of radially different people you are in charge. I'm telling nurses you are in charge. I'm a priest, I'm telling you all you other people are in charge. This is right away from what folks suppose to be agreeing.

Everybody in Africa knows the priest is like a big man in the system. So culturally, I'm upsetting the whole cultural apple cart both clinically and even within other circles.

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I would like to spend a minute on what I think is an important dynamic. It's a business dynamic. The same as our integrated model of teamwork. That actually is a business model. I was told last year that the Dean of a business in the United States there is decentralized model of service, etc. is what the business schools in the United States are teaching the business world. I told them I know nothing about the business world. I only know how to take care of poor people in slums.

If you follow that model and you are empowering your staff people your service, it leads people what I call reflective model of service delivery. People get into an attitude, a reflection that's part of their process of service delivery that they continually evaluating their activities. They are involved in the planning process. They are doing the implementation. They are doing the reviews. They are identifying the problems. And they rectify it.

So they don't have to wait from us at single level to raise questions. It's an ongoing process, very simple but it means that you are telling people I trust you, I believe in you, you have the skills to do it, you own the outcomes, here's the process you should be following. It's not rocket science folks but I'm telling you most places doesn't have it.

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When they asked me to give this presentation, they said well Father you got to talk about partners. So I say okay. I said I'll make sure I put partners in. Now I have to tell you I wasn't the most welcome person in the world to international partner community at one time in my life. And it was basically [inaudible] not by me personally but within the western world last 20 years ago there has been a major radical change within how to vibes impacted by centralization of society. And so in Europe or the United States, North America, as centralization society went, faith based organization, churches went into attention. And basically churches, faith based organizations really like second class communities. It was a cultural phenomenon. It wasn't a personal phenomenon against myself.

Now that has radically changed. We know from PEPFAR, they ask some questions about that. World Bank, interesting enough now has an office in the World Bank saying yeah churches do have something to play in the world. So the World Bank even has an office now. But back in the early days, I was like an age pacer, stigmatized. Father you are a priest, you are a pal, if we could take an AIDS, we ain't taking care of you, go someplace else.

In 2001, I met a couple who I call counter cultural people. Kevin Dekalb [misspelled?] who many of you have

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heard this week from CDC and another doc from CDC called Elizabeth Marcum. And they believed in what we were doing. And they had no money really. The funding stream wasn't inside them, the US government. And I had no money. But all we had was professional skills on both sides. The CO to move together in the beginning stages of long [inaudible] counseling and testing and then upscale TB services.

And so we have probably been luckier than most other people. I heard what Mark spoke about on the very first day. A partnership of equals working on the skills, the abilities, the professionalism of all of us to work together for an outcome for the benefit of people. Last week when I had finished my paper, I gave it to my clinical director. And I asked her, read the paper, give me some comments, what should I change. And so you notice a point on the PowerPoint presentation equal not superior inferior relationship. And that really is the relationship that I have had with Kevin when he was there. Elizabeth but with my CDC partners.

And my clinical director said when you go there I want you to tell the people one thing. We have equal partnership with CDC however very often she has walked into forums, she doesn't have a MPH from Harvard or Tulane. She is a mother, she is a nurse midwife. She is a trainer. She is a tutor. She has been running an AIDS program now for

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over 14 years. And they treat her like a fool. Who is she? A woman from Africa, a nurse. You don't know how to take care of AIDS patients. She could run them around circles.

But if I don't do this I'm telling you her son is a nutritionist and he's here. He will go back and report to his mother, Father didn't say it and I will hear it tomorrow in the office when I get back to Nairobi.

But I think this speaks also to a dynamic I think we have to address. We have so much talent amongst the African community and are we using it. Do we really recognize [Applause] the skills and the talents in the pool I know. I believed them from the beginning. She knows but I think we have to take deeper thought on our relationships, our partnerships as Mary mentioned in the first part of it. And I think we have to really consider why are we not using the skills and the talents of many of the people who is here speaking this morning, other people I know. Are we sending them in other parts of Africa to share amongst ourselves and others on how we can improve ourselves? Or do we have to wait for someone to come on the seven-seven-seven out of Europe or the United States or God knows where who is going to come in now and tell us how to do it.

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I really think we got to be thinking about developing our true pool of African experts and start cross fertilization on this continent. [Applause]

Now before I move on to outcomes, let me do one more thing. Performance based contracts, you know I'm a little bit crazy because I work in the slums. I was finally able to get a little bit of money through PEPFAR, through CDC on a creative element called performance based contract. And I think it's a great idea. Because you pay on your outcomes. You pay if you are doing your job right and it's cost effective. Mark's an ambassador but outwardly this is all under Health and Human Services. Medicare in the United States. There is a set rate for everything. You go to an insurance company. There is a set rate for everything.

Are we really looking at set rates? I will bet you ladies and gentlemen that if we started looking at set rates that if we decided to look at the cost effectiveness which the rest of the world does, I am telling you we would have more patients under care. We would have more children that are being assessed for orphans because the money we would ultimately be getting and a higher percentage factor where it should instead of being absorbed in many multiplicity areas. Now I don't have to worry. I don't have an interest. I make \$300 a month and I have for the last 35 years. And I was

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just told next January I get a pay raise to \$500. So it makes no difference in my own personal life but I do think there is a challenge there for all of us and I'd like to go look at it.

We talk about training. Real training is not from [inaudible] I would you to take a look at training in a different way. Training is an industry. I'm not talking about the hotel industry now but I'm saying let's think about a different way of training. Using the reflective process, training becomes skill identified. You need to diacetic training but more you need skill identified training within your institutions. So if there is a problems in doing outcomes or services, empower the people there. Identify the problem. Our system purely reflective, reflection process and decentralization. They tell us where our problems are. My response with others then do we support them. So it's more targeted and it's targeted outcomes. And the outcomes isn't for PEPFAR. Me, the outcome is better quality care of our patient.

Communication, we spend millions of dollars on advertisement which is important; signs, which are important. But have you ever stop to vote [misspelled?], what is the real basic communication. It's that one and one communication between the clinician and the patient or the

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client. And we have always said keep it simple. Keep your messages simple. And we have created some messages and you will see the outcome by using these messages of telling patients we care for you. We want to give you the best possible care, if we have to go, we have to know your status.

My clinical director said in the beginning, begin PMTCT, she guaranteed me there is no African mother that will not agree to HIV testing if you talk to them in the correct way because they want the most for their baby as any other mother in the world. And let me tell you, she was right.

[Applause]

So therefore we created a whole series of simple messages talking to people in the language they understand with the motives, the care, and the concern we have and we get almost a hundred, we will see that almost a hundred percent outcomes in all our testing. How many times, going around very quickly, I know nothing about how to write programs. So what I do? I hired a couple of kids out of the University of Nairobi who are unemployed. I said we are running a program, I need to do some data. We want to do some quality controls. And they just sat down and they started to write software programs. And they have done a super job. And our programs aren't only for outcome into PEPFAR has certain other indicators so we can come back and

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see how is the party outcome of our patient. It's probably the only area where we really haven't had support. And CDC actually this year is going to bring somebody in so we can upscale. But these are, none of the guys and - listen to the light, only came out of the University of Nairobi and say [inaudible]. They are walking the streets of Nairobi says come on, do it, and they did it. We went from EpiInfo system up to Access and now we are blowing out the server.

Health education, we all talk about it. We say education of a patient is empowerment. The patient is not a passive agent. It's an active agent in care. And as all of you are doing health education, we did the same. We have curriculums developed.

But I would like to just stop because of time and to very last point in the PowerPoint, yearly adherence certificates. We're asking people to take a medication for the rest of their lives. So how do we motivate them on a consistent basis to take medicines on the rest of their lives? Well, at least I can tell for Kenya, I cannot speak for the rest of Africa, Kenyans love certificates.

[Laughter] And so I said, hey, let's make certificates. If you take your medication well, the end of the year you are going to get a certificate. It's also stigma grader.

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Now there is more than just giving someone a certificate. There is always a strategy behind anything we do. In psychotherapy and in group therapy one of the dynamics is called story telling. So when you give out your certificates, and you have to take your medication well, every one is asked to tell a story. And they will say where they were last year in their health and their treatment and where they are now. And let me tell you folks, these are all slum dwellers. Everyone will pull up their CD4 when they began ARVS and they will tell you right now what their CD4 count is.

But the most important dynamic is it helps them to reaffirm for themselves where they were and where they are going. And at the same time in the dynamic they hear the stories of others. And I remember the very first group we did the certificates. There was a beautiful young woman stood up and she told her story. And she had told over the year before, she was brought out of the slums on a push cart. And she had been – the nurse reviewed her, the clinical officer reviewed her and they both figured she was going to die. We take care of her until she dies.

What happens? She begged, she had a little baby. She begged do something for me. And so the nurse, the clinical officer, we think she is going to die, she is really

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begging, we will try. A year later, beautiful mother. She had a CD4 then at 220, was a very low but here is a mother, she got about a little, maybe 15 to 16-month-old baby and it's her and it's a smile. And that's a story we all can tell.

But that's the story that she tells the others in the group, which reminds her she better take the medication and she hears the story of everybody else. So storytelling which is a psychotherapeutic model also gives you and it's cheap. It's empowering and reinforces your patients.

Let's now go to what are your outcomes. Last clinical year, PEPFAR year, we had over 26,000 people come into our VCT sites alone and be tested. With HIV strategy outcome of 32, 13.4-percent, 26,000. These are all out of the slums. We are hearing about should we have the patient – a physician or a clinical intervention for testing. We call in Kenya DTC. Last PEPFAR year we had 8,200 patients to be invited to be tested for HIV for clinical reasons. These are not the mothers now. Ninety-seven point two percent of those patients all said they wanted to be tested for HIV because what do we have folks? They have heard the message. We care for you. We want the best for you. And we can't give it to you unless we know your HIV status. We have our health care

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workers in the slum saying you are going to go up to be, you are going to be tested, it's important to be tested.

So don't tell me patients will not accept to be tested in a good way for clinical care. There are 8,000 patients right there who accepted. And then, these are the basic outcome.

I would like to now very quickly look at the subset of using this model amongst TB. You heard yesterday from Dr. Chatterji about TB. There is a lot of discussion about TB integration with HIV services and the use of rapid testing for knowing HIV status for TB. Out of that group of over 8,000 patients, we had target that we call a subset of TB suspects who come in. we don't know if they have TB but they are presenting with TB symptoms. And that acceptance rate was about 96 to 97-percent of those patients.

But what I want to get at is this. If you notice in the green part of the slide, 62-percent of the TB suspects, not TB patients, were HIV positive. Now the problem is people are testing TB patients after they have been diagnosed with TB. And I can tell you in Kenya, we had a big discussion last year but the protocol has now been changed and moved toward suspect. If you discharge a patient out of a TB clinic diagnosed not having TB and you haven't tested that patient for HIV because you are not going to test them

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if they have TB, only 42-percent of this big green figure ultimately came down with TB.

So the largest percent of those TB suspects were HIV positive presenting with TB but since we test at suspect level we are able to identify them. We don't test at diagnosis level for TB. And if you don't test at suspect level, it costs you some money but there is a whole code of patients that you are losing. You are sending back into the community especially in the hospital surrounding. They are discharged, you're gone, you have lost the opportunity to get them into care because you say they don't have TB. Test them at suspect level. Kenya has now changed their protocol from testing for HIV at diagnosis of TB to test for HIV at suspect level of TB. [Applause]

This just shows that substrata, the male female part of it.

Alright healthy mother, healthy baby. These are just our results from last year. We had 736 mothers either go through at that time, we had one ANC clinic and we network out where we didn't have clinics. But women under our care we had 736 mommas or mothers come in for antenatal care. And we did we have, we had 736 mothers agree to be tested for HIV. and we have had almost a hundred percent testing from beginning of our antenatal care program. Why? Messaging and

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nurses. They know how to talk to the mother. They give the mother the message. And so we have a historical phenomenon which never goes down at 100-percent test. And if the mother says no the first time, that means [inaudible]. My nurses are like pit bulls. Next time momma comes in she is going to be asked about testing.

Intriguing we still have very high numbers, 24-percent of our mommas are negative, are positive. Then this other subgroup which I think everybody about understands, women on AITs are feeling good. African women want to have babies. And a lot of women now on ARVs are deciding they are going to have babies. And I got to get moving. I'm going to get the boom.

The problem with being a clinical person and a preacher gets you in trouble. Okay, move very quickly into TBH IV. There is a lot of discussions about how do we integrate TBH IV care. We do complete integration within a slum environment of TBH IV care. Every HIV positive patient gets screened for TB in our surrounding. Last year it was over 1,066 patients were HIV positive and did have TB. And then we as Dr. Chatterji mentioned yesterday. We were one of only three sites in Kenya who allow to use ICE/ICE [misspelled?] prophylaxis therapy with HIV positive patients.

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Very quickly, we integrate antiretroviral care into HIV treatment. The last PEPFAR year we had 10,056 TB/HIV positive patients, 65-percent of them received antiretroviral care, 263 that year had begun treatment or their CD4s were too high and that final figure was people who had finished treatment had CD4. those who are not enrolled we can track down and the main reason was high CD4s. the median amongst the adults was 507 and then we had 14 children with positive TB and they had a CD4 count of 767 and so they weren't put on ARVs.

I want to move forward into some children's issue because of time. I think one of the most major challenges we are asking for right now is pediatric AIDS care needs empowerment. We are talking about it but I don't think we are asking the right question. We have found that the issue is not drug formulations. We have found that it is psychological issues amongst the parents and the guardians that have become barriers that are bringing children into care. And we had strategized from the beginning. We have seen denial. We have seen depression amongst the parents and the mothers. Many who drop patients. And just I think it was the pain of the mother even knowing that care is there for her child, finds it difficult, and goes into a denial stage.

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So we have seen all those. Some of the burden, problems are lack of primary care giver in the family. So the whole family system is really disrupted in a HIV positive home.

Why do we look at these two figures is because if you can't a child into testing you are not going to get a child into care. And this is over 18 months amongst 947 children below 18 months. And you see the decline factor was 42-percent, rejected by their parent or their guardian. The child doesn't say no to testing apparently. So it's a challenge we have to face. Then the HIV status you been noticing, the children below that 3.6-percent.

Now if you move into the other categories rather intriguing. Once you get past the 18 month level, we find a higher acceptance level of HIV over children for some reason the parent will accept. We have a HIV testing rate of, acceptance rate of 84-percent and a positive rate I think it's almost 17-percent. It's the next slide. Yeah, 15.5. So that's the challenge.

Alright let me move to some conclusions before I get the big boot because she said seven minutes now I'm down to two minutes. Let me move to the conclusions so we can move on.

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I would like to say one thing then we move into conclusions. I think we have to start changing the term for care for children. I think we have to talk about the issue is family. We have to start focusing now on family, the HIV vulnerable family, and not the child by itself.

Conclusions, I think a strong community program will give you effective outcomes. Nurses are a key player in it. Then a couple of recommendations, I think you have to break down the hospital model if you are going to get to the people. I think we have to really work strong at integrating TB services with the HIV. And I have a question you need to think about. Is failure to offer of clinical testing malpractice? Something I think we have to really ask. And then finally, acknowledgement to all the people that have supported us all these years. Thank you very much. Have a nice day. And as they say in Kenya shara enjama [misspelled?].

[Applause]

**CAROLINE:** Thank you very much Reverend. It was interesting, don't think - it was very interesting only that time rushes so fast. But thank you. It shows that they are all of the Church. The Church can do a lot if it chooses to be active and not play you know, sit aside, and let the others do their job. We all know that even in the most

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remote places, you will find a nun, you will find a priest,  
and so if they can really play an active role we can make  
difference. Together we can partner and make a difference.

[END RECORDING]