Beyond MDG 6: HIV and Chronic NCDs: Integrating Health Systems Toward Universal Health Coverage Brightcove
Kaiser Family Foundation
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DR. JONATHAN QUICK: To come up. I suspect as people familiarize themselves with their packs and get oriented we’ll see if a few more people come. Let me welcome you to this morning’s session on the theme “Beyond MDG 6: HIV and Chronic NCDs: Integrating Health Systems Toward Universal Health Coverage.”

Some of you will remember AIDS 2000 in Durban, protests, hope, controversy, President Mbeki, chaotic, denial, inspiring. After two decades of dithering and denial, AIDS 2000 was clearly a tipping point. Within months, literally there was an explosion of activity. The millennium developed new goals in September. The next year – the UN special session UNGASS UNAIDS, and then the next year the Globe Fund and then PEPFAR. AIDS 2000 catalyzed what was a remarkable, historic and unprecedented and stunning decade of progress. So much so, that we can realistically aspire to realize an AIDS free generation.

Many in this room made substantial contributions, in some cases, landmark contributions. You likely contributed to the just released publications of the Lancet and Health Affairs and JAIDS. But we’re all very much aware of the challenges that it still face us on building up what we know, scaling up,
improving approaches, tackling new challenges as the dual epidemic of AIDS and NCDs grow.

I’m Dr. Jonathan Quick, a family physician and head of management sciences for health. It’s a pleasure to see a number of familiar faces from past and present NSH and a few from the years that I spent in Geneva with the WHO, mostly working a great deal on AIDS issues.

Let me take us first to Mali, a very rural district, mostly agricultural on the eastern border of Uganda. You’ll hear from a courageous nun, Mildred, who’s not only living with HIV, but was also recently diagnosed with a precancerous cervical lesion.

[Video Played].

You’re not only adding value to her life, but giving her hope. Mildred’s story and the perspectives of Jennifer Acio [misspelled?] and Immaculate Jambo [misspelled?] capture both the challenge and the hope of the dual epidemic of AIDS and chronic non-communicable diseases in the coming decade and beyond.

MSH comes at these issues as a nonprofit global health organization of people from 70 different countries working in Africa, Asia, Latin America, the Middle East and elsewhere. We believe health is a human right. Realize progressively through access to healthcare for all and healthy living conditions. We

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also believe that lasting health impact comes from local leadership and strong local health systems. The test of a health system is whether it achieves health impact.

So much of what we do is work to improve the effectiveness of health systems fighting AIDS, TB, malaria, maternal and child health, delivering in family planning and, increasingly, chronic non-communicable diseases. It’s been our privilege to work with scores of national and local leaders of well over 100, probably several hundred; non-governmental organizations, NGOs, and, with funding partners and implementation partners, the USAID, PEPFAR, CDC, and others.

We’re really fortunate today to have a very diverse panel and group of co-organizers. The Pan-American health organization. To those of us who spent time in Geneva, the regional office of the World Health Organization, the Harvard School of Public Health, Tanzania Ministry of Health, AMPATH, the Pink Ribbon Red Ribbon Initiative of the George Bush Institute and not on the panel here with us, but with us in spirit, LiveStrong. You’ll be hearing about each of these panelists shortly. We’re very pleased to have as our moderator, John Donnelly.

We’ll meet – we will hear from each of our panelists, but I want to say a couple of words about Sir George Alleyne who is someone who has done a great deal for the AIDS community
during his service from 1995 to 2003 as the director of PAHO, but even more, it’s really one of the major drivers who has put non-communicable diseases on the global agenda that achieved the high level UN meeting that happened last September in New York and I think a special vote of gratitude is due to Sir George.

I’d like to acknowledge Mildred, Jennifer and Immaculate, really, three women who — who you just saw on the video, who really wanted to be here and to tell you their story this way, and as personally as they could. And I asked for the huge effort in the conference, but also this is a session that they are webcasting today, so I would pay attention to your yawning, stretching and dosing, I know some of you are jetlagged. We have an exciting week ahead. The theme “Turning the Tide Together is relevant to our morning’s discussion.

The title, which I’m going to flip back to, the title and the content brings together four themes that are not often considered together. The AIDS epidemic, for which so much remains to be done, yet much has been achieved. The epidemic of non-communicable diseases in low- and middle-income countries that is looking to be even more devastating than the AIDS epidemic.

Strong health systems which are needed to address the dual epidemics and the fourth theme is Universal Coverage,
which is becoming a driving vision for a steadily increasing number of countries, working to address the issues of accessibility and affordability. Before handing over to our moderator, let me comment on two of those four issues.

NCDs. A few years ago, you could have been forgiven for thinking that NCDs are just a rich country disease or NCDs are for old people and as we’ve seen, chronic non-communicable diseases and they’re not just old people diseases.

I think most of us are aware that 30 million people in low- and middle-income countries die every year from heart disease, diabetes, cancer, chronic lung disease, compared to six million from AIDS, TB, malaria. Already, 8 million children, young adults and working age adults die prematurely, die from preventable, chronic non-communicable disease causes. 8 million children, young adults and working age adults die prematurely, that’s compared with the total deaths of AIDS, for AIDS, TB and malaria.

You have to die of something, but you don’t have to die quite yet. And people in developing countries with chronic diseases die earlier and faster. A 15 year-old diabetic living in Maputo, the capital of Mozambique, who is insulin dependent, has a future life expectancy of perhaps 20 years. Go 800 miles north in Mozambique where insulin’s not available, that same 15

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A year-old has a 6 to 12 month – 6 to 18 month life expectancy. It’s like the AIDS epidemic a decade ago.

Two cancers, cervical cancer, breast cancer alone, kills many women in the reproductive years in low- and middle-income countries as maternal and child health – sorry, as pregnancy and delivery is – in other words, as many deaths, maternal mortality and deaths from cervical and breast cancer and reproductive age are about the same, but you could be forgiven for thinking that poor women don’t get cancer and poor countries don’t suffer from cancer, if you look at the way health systems are structured.

A couple of comments on universal health coverage. Three quick questions: what is it? What’s the status of it around the world? And why should the AIDS community care? Basic definition universal health coverage, is everybody says, what is it? It’s access to appropriate health services at affordable costs. It’s fundamentally about equitable access about providing the needed for essential health services and it’s about risk protection, financial risk protection.

About 100 million people are pushed into poverty every year for health expenses. Three billion people in the world just short of half the population pay the majority of their health expenses out of pocket. What’s the status? Is it pie in the sky? 50 countries already have universal health

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coverage programs. 30 are high income countries, but 20 are middle- and a few low-income countries that have been added over the last decade in Latin America, Asia, Central Europe.

And in recent years, African and Asian countries are starting to move, Rwanda, Ghana, South Africa, China, India. There’s some core principals, but country models vary. They vary how they finance themselves, how they deliver the services at the pace with which they grow.

Why should the AIDS community care? The AIDS community should actually take some pride in the universal health coverage movement, because in fact, the universal access to treatment movement in a very real sense created the brand name for universal access. More importantly, UHC is becoming the driving vision for prevention, care and treatment of and assuring access for HIV positive and HIV affected people.

They live long enough to get chronic diseases and to care for children and the need – the services that are provided through universal health coverage programs. Also importantly, the AIDS community is one of the most influential communities, so if the universal health coverage movement and the universal access movement come together, it will be very powerful.

Some of the AIDS communities, see universal health coverage see it as a threat to hard won access to programs, but other see it as the best long-term solution.

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So the essential question for this panel is, how can we design cost-effective, integrated systems for universal health coverage in low- and middle-income countries affected by both AIDS and chronic diseases?

Let me turn to John Donnelly. John’s the vise president of and senior editor at Business Community — Burgess Communications. He writes for a variety of publications and regularly contributes to the Global Post. He’s been focusing on regulating universal health for the last 15 years and for 30 years, has served as a writer for Boston Globe, Miami Herald, Associated Press and reporting for nearly 100 countries.

He’s also the author of a Twist of Faith: A Christian’s Quest to Help Orphans in Africa which was just released this month in hardcover and Kindle. And it’s — whatever one’s faith perspective, it’s a compelling and inspiring story of the joy, frustration, personal sacrifice of true service to those in greatest need. I couldn’t imagine a better moderator. John, over to you. Thank you.

JOHN DONNELLY: Thank you, Johno. I think you can hear me okay. I feel like I’m in the belly of a whale. So couple of housekeeping things before we start. First of all, this will be as informal a panel as we can make it. There’ll be conversations up here and the conversations I hope will extend to you. There are microphones that go up both sides.
I actually hope that the ones in the back aren’t use and that people in the back move closer to us as this goes on. There’s food in the far back, which you may have already seen, but since we’re here together for an hour and a half or so more, please feel free to get up, stretch your legs, get something to drink or eat and come back into the conversation. Just be as comfortable as possible.

And thank you, Johno, for introducing me. I think that those of us who are journalists, and I was talking to my friend, Tom Paulson, who’s in the audience about this last night, it was a mystery to many of us a couple of years ago when we started hearing this weird acronym, NCDs. And wondering why it kept coming up in conversations involving HIV, AIDS, or other diseases.

We sort of looked into it and said, what is going on here, why is the conversation shifting? And I think Johno, as much as anyone, has sort of helped explain that. So, thank you for the introduction, but I also look forward to your thoughts about NCDs, and also universal healthcare, as it happens, because you’re shaping the dialogue.

So, I’m here for two reasons. One is to sort of keep the conversation moving and to make it as interesting as possible, but I’m also here because I’m a storyteller and I
I was in Malawi exactly one year ago. And I was there to do a bunch of stories on different topics and the head of the MSH office in Lilongwe asked me a favor. He said, “You know, will you meet one of our HIV counselors? You know, she’s a really remarkable woman and she has cancer and I just want to get her story out, plus she’s have a really hard time. She has—the care is far away, she doesn’t have the money to really pay for the care, and I would like you write a story just because she’s in desperate straits.”

And I said, Sure, I’d love to meet her. Her name was Lucy Sakala [misspelled]. She was 28 years-old, had an 8 year-old child, and was a wonderful, beautiful woman. She was—her job, as I said, was to counsel HIV patients. And I said, So how do you deal with telling people essentially that awful, awful moment that they’re HIV-positive and moving ahead? How do you deal with that? And also with your own illness inside? Do you ever talk about that with your patients? And she said, “With some I do.

And I do it because I want to tell them to live positively. I want to tell them, look at me, I have cancer, I have cancer of the uterus which has spread to my brain, my esophagus, to my lungs, I’m going a seven-mile round trip to

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Blantyre to get treatment. I have to — I think I have to go to Zambia to have surgery. I’m trying to live positively and that really helps people.”

It really helped her patients to connect, to connect to her. And so I wrote the story. I felt great about the story; it was sort of getting her out there and there was a great response to the story. There was especially in MSH donated a lot of money, several thousand dollars and she actually went to Zambia and had the surgery.

So, three months later, I got an email one morning going into work that Lucy had died. And it was sort of a think that sort of kicks you in the stomach. And just incredibly upsetting that a 28 year-old woman who was so giving to others, dies because of a failure in the system, of something that — of something that can be corrected. And so to me, the acronym, NCD, sort of became Lucy and it had something very real. There was a very tangible evidence of how the health system, though ramped up from this fight against AIDS was still so poor. And still was so spotty in its coverage of people.

So with that spirit, and with that importance of the issue, I think, I’d like to turn to the panelists. Again, we’ll have questions back and forth and then we’ll open it up and please participate as much as possible. So I’m going to

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introduce the panelists and then we’ll go into some individual questions.

Second to my left, we’ll start with women first, is Doyin Oluwole. She’s executive director of the Pink Ribbon Red Ribbon Initiative, which is a great name by the way, at the George W. Bush Institute. Prior to this role, she served as the director for the Center for Health Policy and Capacity Development FHI 360.

To my immediate right, sorry, is Jemima Kamano, who’s assistant program manager for USAID-AMPATH, Chronic Diseases Management Program. She’s also a practicing physician at the Moi Teaching and Referral Hospital, in which she runs a diabetes clinic, medical outpatient clinics, HIB clinics and inpatient care.

To my far right, Ayoub? Is Dr. Ayoub Mmbando, he’s the assistant director for non-communicable diseases at the Ministry of Health and Social Welfare in Tanzania. He has 19 years' experience working in the medical profession in Tanzania public health programs and various African research networks, and I think it’s just critical here that we hear from someone from the Ministry of Health and how important they are in setting the policy and making sure the policy is implemented.

Next to Ayoub, is Till Baernighausen. Sorry, Till. He’s associate professor of global health at the Harvard School

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of Public Health and the senior epidemiologist at the Africa Center for Health and Population Studies.

And to my immediate left is Sir George Alleyne and since Johno’s already introduced you, I’ll give the simplest introduction of all. And that’s Sir George is a global health legend.

So, with that. Let’s start with you. Let me ask the question first though. I’d like you to set the table for us. I’d like you to talk about sort of the state of affairs with non-communicable diseases and low- and middle-income countries today. What do you see as sort of great partnerships that are happening? But what do you see as things just not working well as all?

**SIR GEORGE ALLEYNE:** Thank you very much, John. I thought legends are only after they are dead, but — and I’m not dead just yet. What I really am is an unpaid lobbyist for non-communicable diseases. That’s oxymoronic. I think you understand what I mean. Let me thank Johno for inviting me to be here and I like the point that you made about the conversation because in fact, the conversation about NCDs and HIV is not in a sense shifted, or it’s expanded, really, to incorporate them both and I’d like to think that the conversation now is equally interesting about both aspects of these disease problems.
First of all, let me put a point to some the point later that Johno gave about the magnitude of the problem. If you’re talking about cardiovascular diseases, cancer, chronic respiratory disease and diabetes as the three biggies. The three big problems of ones are the NCDs and as Johno point out, two-thirds — you would be amazed — two-thirds of these deaths globally, thirds of these deaths globally are due now to NCDs. People didn’t believe that. People since started continue to think of the diseases that kill people globally were the infectious diseases. No longer so. Two-thirds of the global deaths are due to the non-communicable diseases.

It’s also myth – Johno pointed out – it’s a myth to think that these are disease of the elderly. In fact, a quarter of those persons who die from the NCDs are young, at my stage, below- the age of 60s young, below the age of 60, one quarter of those deaths are below the age of 60. And an interesting point, the youth die more frequently in a sense in the low- and middle-income countries than the youth in the developed countries. In developed countries, only about a third of those persons who die are below the age of 60.

We know a lot about these diseases. We know a lot about them. What they are, we know they’re risk factors, we know their pre-disposing factors and the one I always like to focus on is obesity, one of my favorite topics – obesity

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because our people in the low- and middle-income countries are simply getting fatter. They’re just digging their graves with their teeth. They’re getting fatter. And 2.8 million people died here from obesity.

And it’s not only the adults who are digging their graves. It’s the children as well. WE are observing in the developing world an impressive epidemic of childhood obesity, an impressive epidemic of childhood obesity and with childhood obesity, brings consequences, chronic diseases and diseases like diabetes, of course. If a child in a developing country now has diabetes before the age of five, that’s virtually the kiss of death, virtually the kiss of death. So what I want to transmit to you is that it’s a big problem. It is a problem of which we know a lot now.

You asked the importance of existing services. You mentioned quite rightly that sometimes failure is due to failure of the existing services. And what we like to say is that, a, both HIV and NCDs are chronic diseases. Those of you who haven’t done it, I urge you to read David Brown’s article in the Washington Post this morning, which points out beautifully the chronicity of these diseases and the need to address chronic diseases in a specific way.

I make the point that what we need is chronic care. Not necessarily chronic treatment, chronic care; I emphasize
chronic care because we now believe that to give that care, that continuity of care, which sees the patient at the center and the patient relating to the services, relating to the community, we see that care as being the essence that and now the pith of what we like to see as a re-conceptualization of primary healthcare.

We like to see primary healthcare through a different lens now. We like to see if dealing with — not only with episodic and chronic diseases, but with chronic diseases and with episodic acute episodes, which, pardon the redundancy, which will occur as a result of these chronic diseases.

Indeed, when the heads of government met in New York last year at this historic high-level meeting, certain requests were made of them, to go back to their countries and do several things. And three of the things they asked them to do was, one, to refigure their health systems, reconfigure their health systems to take account of the chronic care.

Secondly, to make medicines and technologies available to all the persons, another aspect of universal access, Johno, and also, we urged them that there be systems for monitoring and evaluating what they actually did. If you asked me what are the biggest challenges that I see now, I would’ve said one of the challenges is to do what Johno said, to dispel some of the myths about the NCDs and have all of you go from here.
saying that there certain myths of the NCDs that we must dispel. We must dispel the myths that the disease of the rich. The disease of elderly men in developed countries and that there are no effective interventions. We must dispel that myth, number one.

The other thing that we need to do is to insure, and you can play a major role in this, people like yourselves, ensure that what heads of government decide in New York, that when they get back home, they translate those into actual programs and their feet are held to the fire that they translate those into actual programs.

And the third thing that I see as a major challenge is what many of my colleagues here know very well, how do we get the various sectors to cooperate within government and outside of government? How do we get these sectors to cooperate? And the last point that I’d like to make is this, inter ms of biggest challenge, in May of this year, the World Health Organization, I think the word boldly, adopted the goal that the world should have a 25-percent reduction in mortality from NCDs by the year 2025.

That is what my – one of my gurus James Collins [misspelled?] would call a big hairy audacious goal. I’d like to see us agree that we can help our member countries achieve that goal. Thanks.

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JOHN DONNELLY: So both you and Johno both mentioned universal healthcare. How are you going to move from expanding the HIV platform to the NCD platform to universal healthcare for all?

SIR GEORGE ALLEYNE: How are we going to do it?

JOHN DONNELLY: Yeah.

SIR GEORGE ALLEYNE: I think that the first thing actually is to have acceptance that it is possible and the first thing is to dispel this shibboleth that poor countries cannot afford access. That is I think the major problems that we have. There’s a myth that universal coverage is an expensive proposition and our countries so poor they can’t afford it. Nonsense.

There is no country that cannot afford universal health coverage – universal coverage. What may happen is that countries, the package to be offered may be different in view of the resources available in the country, but to my view, is not the technical aspect that I see as the major challenge. It’s the political aspect that I see as the major challenge.

How to get acceptance that is universal access is feasible, socially desirable and economically possible? And I make the point of social desirable without apology because I think it’s a matter of social justice that there should be universal coverage.
JOHN DONNELLY: Johno, any comments about that? Particularly the need for more political leadership?

DR. JONATHAN QUICK: Yeah, yeah, I get — yes, yes, absolutely. You know, it’s funny how the conversation changes. When nobody has done something, all the conversation is around why it can’t be done and there are only a few people who go out and do it and once you’ve got a few people who’ve gone out and do it — and done it — sorry, I think I’m jetlagged too.

Once you’ve got a number of countries, and we’ve got a lot of countries who’ve gone out and done it, then the conversation changes to, how did they do it? And I think that one of the things that has bedeviled the whole field of global health for decades is this vertical and horizontal; and I think what we’ve got to say is that targeted disease in need-specific — disease-specific and need-specific advocacy, goal-setting and accountability are fine, but what we must have is integrated health systems approach to planning, financing and service delivery.

It’s what some might call a diagonal approach, but it’s more of a perpendicular — that is, advocate for AIDS, advocate for family planning, advocate for child health, advocate for immunization, set some goals, but integrated at the delivery level. Rwanda did this. They said when they were setting up performance based financing and taking out PEPFAR funds, we’re
gonna accept the PEPFAR funds, but we’re not going to focus them and segregate them.

And with the system they set up, they set up a set of targets in the health facilities that addressed AIDS, but that also addressed family planning, also addressed child health, also addressed immunization, and guess what? They were able to deliver in an integrated way and family planning didn’t suffer. AIDS didn’t suffer.

Everything went up. Not all equally in all, so I think that moving with the vision of universal health coverage, realizing that it takes time, some of the best successes, Thailand’s one, it’s been at it for 20, 30 years, but they’ve built this system with a vision. If you don’t build the system with a vision of universal health coverage, you’ll never get equitable access, essential services and fair financing.

JOHN DONNELLY: Thank you. Till, let’s move the conversation to you. And let’s move it to what will be happening in the next few years. What does the future look like with the HIV/NCD platform expanding?

TILL BAENIGHAUSEN: Thank you, John, and thank you, Johno, for inviting me to this panel. I would like to may be to contribute a bit to the setting of the scene as Sir Alleyne has already started with a few numbers of our own research. SO we recently in a microsimulation model of the aging of the

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epidemic in sub-Saharan Africa for each sub-Saharan African country, I estimated the impact of ART on the aging of the HIV-positive populations in sub-Saharan Africa and we find in this microsimulation exercise, that the total number of people of 50 years and older, HIV-infected is likely to triple over the coming decades from 3.1 million in 2011 to maybe 9, 10 million in 2040.

We also see that over the same period, the proportion of HIV-infected people over age 50 will increase from 1 in 7, as is currently the case, to maybe 1 in 4 or 1 in 3. So there will be a dramatic aging of the HIV epidemic and admittedly, that’s microsimulation exercise, so there’s uncertainty about our assumptions regarding the ART scale up, which hopefully will continue, which of course will lead to a reduction in to improve survival and hopefully lead to a reduction in incidents, but given this assumption, I think we would highly be – highly optimistic that such an aging will not take place and in empirical work, we have actually seen that it has actually already taken place.

A colleague of mine at the Africa Centre, Jaffer Zaidi, has shown that the adult prevalence in rural community in South Africa with a starting point HIV prevalence in 2002 of 22-percent has now increased to 28-percent and when we look which of the population groups by sex and age has driven this
dramatic increase, it is older women who are the population group that is also mostly benefitting currently from the ART roll out with good coverage under 200, increasingly good coverage under 350 in South Africa, so there is a population coming into existence that previously has not been in sub-Saharan Africa and of course, aging is a major risk factor for AIDS and lifestyle-related diseases, so we would really expect dramatic increases for the need for NCD screening and treatment.

And aging, of course, is only one of the risk factors that we would expect to exert increasing force over the coming decades on HIV-positive populations. HIV itself is course a risk factor for NCDs and a risk factor that maybe we haven’t seen the full force of because it exerts its influence over time and when people are still dying of HIV in young ages, the HIV-independent risk factor effects might not — might have been hidden from our few.

ART leads to weight gain of course for NCD and many of the ART side effects, of course, can contribute or cause diabetes, cardiovascular disease, stroke, myocardial infection or osteoporosis, and of course we would also fear increasing carcinoma and cancer rates.

So, given these numbers, I think it is an important question and I think for the future in emerging research agenda
because we really do not know yet what is the model that will be successful to address this coming NCD epidemic in HIV-infected populations. Do we tack on to existing ART services screening for NCDs? Do we also provide with ART services NCD treatment?

In many cases, I think we could argue that is a good idea because these services are teplich, they’re functional, they’re well-supported and ART patients are facing large retention and adherence hurdles, so by providing in another setting other chronic healthcare, we might fear that the burden retention and adherence might be unovercomable.

At the same time, of course, as has been pointed out by the previous speakers, NCD is not confined to HIV-positive populations in a sense, they are newly coming into NCD need while there is already an existing high NCD burden in HIV uninfected populations, which is many sub-Saharan African countries has remained unmet.

So given that, should we do chronic disease platforms that specialize on chronic care, as you had suggested and are open to HIV uninfected and infect populations, or should we strengthen existing health systems and then the question is, who are the health workers who best placed to provide increasingly comprehensive care to provide primary care systems.

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Are they community health workers? What role do nurses play? How do we improve supply chains? So many, many studies and experiences are needed, I think, to inform us and it’s a challenge that we have set to ourselves by being extremely successful in the vertical rollout of ART and I think it’s an open question whether that should now turn selectively into integration with NCD services, TB, mental healthcare, diabetes, cardiovascular care, whether we should fully integrate into existing primary healthcare systems or whether there should be some improved into action and maybe diagonal strengthening of vertical systems spill over into the horizontal systems.

JOHN DONNELLY: So — so what really worries you? I mean, you talked about older women, you talked about the maturation of people now on ARTs for years and year; what when you look at what specifically what diseases, what populations worry you?

TILL BAERNIGHAUSEN: It’s a range of the diseases. Certainly cardiovascular, stroke, myocardial infection, diabetes, and of course, we would also worry about mental diseases, depression, which interacts with ART adherence and retention and the ability and willingness to seek care.

When I look at specific populations what we have seen in sub-Saharan Africa and recently in a population-based study, that the need of course that now arises in HIV positive

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populations is a result of a tremendous success, but not everybody has equally benefited yet from the success, even in very successful countries such as South Africa, there may be 50-percent of people needing ART on an eligibility criterion of CD4 comp lower than 350 are currently receiving treatment. This 50-percent is not equally spread across all population subgroups and in particular, older adults and men are not yet benefitting equally. So we find in sub-Saharan Africa, that controlling for other factors in rural South Africa, men are half as likely, given need, to access ART, to really access it, than women.

So we wonder, what is it in being a man that prevents you from accessing successfully as equally aged and wealthy and educated and employed women services that help you survive. So there’s still a lingering worry that the ART results hasn’t succeeded, but once we’ve improved access of all populations, including men who are, of course, also to some extent, more affected than women with NCDs if they manage to survive, what do we do than and who are the populations that we then need to worry about? And obviously then it would be the aging populations.

**JOHN DONNELLY:** Such an interesting question in general about need and how to find where the unmet need is. Jemima, among us, you are perhaps the person closest to services. You
see things in front of you all the time. Tell us what you see every day on your job.

JEMIMA KANANO: Thank you very much for that question, John. One of the hardest thing for me as a practicing clinician in Africa is to sit at the HIV clinic and treat the HIV patients, counsel them and give them drugs and see them improving, but the minute they develop diabetes or hypertension, then I tell them unfortunately I can’t help them.

I give them a prescription that I know they cannot afford, even if they can afford, the drugs may not be available anywhere near them, and I see them getting a stroke that I can do nothing about and finally dying of something that has been treated for centuries now. And that’s what is happening on the ground.

And so in western Kenya, what we have done, because of the need that we have felt, because we’ve realized that our wards emptied from HIV-related admissions, but filled up quite soon after that because of non-communicable diseases and we were back to where we were in the early 90s and in the late 90s looking at people dying without doing very much.

So we realized we had to be innovative, we had to start layering on, we had to start choosing the infractustre that has been laid down to treat health, to improve health as a whole;
because succeeding in HIV doesn’t mean that we’ve succeeded improving health outcomes at all.

And so what we are doing is that we have started changing the vertical program that Till talked about into a diagonal program. We are converting our HIV comprehensive care clinics into chronic care centers and we are able to use the same stuff that we have trained for HIV because of HIV training that they’ve undergone, they’re very good at choosing algorithm-guided care.

They’re very good at actually getting training from a classroom and translating that into work in the clinics and that’s one strength that we have used to now start layering on treating them how to treat hypertension, creating algorithms for treating hypertension care for diabetes care.

We have taken it a step further and translated our door-to-door testing and counseling for HIV into door-to-door testing and counseling for and screening for NCDs. And so with one drop of blood that is drawn to test HIV, one — just one prick, you get enough blood to actually test for diabetes and HIV. And many times you find it’s negative for HIV, but the person actually has diabetes.

So even if you would’ve walked away happily that they don’t have HIV, a few years later, they’ll still knock on our doors with complications of diabetes. And death is death after

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all. It doesn’t matter whether they die of HIV or diabetes or hypertension, you still die earlier than you should’ve died. And so this is working very well.

We’re having to do a lot of task shifting. Starting to look at the role of nurses in our healthcare systems. We think they’re underutilized and actually they are. You teach them how to treat hypertension and they can take care of a big percentage of the hypertensives out there. They can take care of a big percentage of the diabetes and obesity and counseling and teaching people to change their lifestyle. They are doing a lot of these things and they are actually very excited to do it. You’d think they’d worry about the workload, but they are happy to diversify what they are doing to actually feel that they are making a change.

So that’s a long answer to your question, is that a lot is happening on the ground.

JOHN DONNELLY: Door-to-door testing – so what are you finding?

JEMIMA KAMANO: We are finding that the prevalence is triple of four times the prevalence of HIV in every homes that we go. We are finding that we thought hypertension or diabetes are diseases of people in their sixties as Sir George said, but it’s actually there in people in their thirties, in their forties, and these ridiculous figures, you get someone walking
around doing their usual jobs with hypertension that could actually be classified as a hypertensive emergency if they walked into an emergency room and they have no idea, meaning they would have walked into a hospital in a few weeks with a stroke.

And so we are finding very interesting and shocking results. It may scare us at times. We wonder whether we will be able to handle the burden of disease out there, but then the truth is that with task shifting, if we are to be successful, we must find these diseases, we can’t sit back and wait. By the time they come to us, it’s time for dialysis or amputation. We don’t have the resources to do that. We must find it earlier and then we can intervene with the little resources we have.

JOHN DONNELLY: That’s great. I want to sit and interview you. So, but let’s turn now to Doyin. Doyin, you’re with the George Bush Institute. Why are they involved in this now? Why are you involved in it?

DOYIN OLUWOLE, M.D.: Thank you very much, John. Let me say a big thank you to MSH for inviting George Bush Institute Pink Ribbon Red Ribbon to be a part of this very important panel.

Pink Ribbon Red Ribbon George Bush Institute are there for three reasons. One, it’s the magnitude of the problem os
cervical and breast cancer in women. When you look at the numbers that we have die annually from maternal mortality, it’s about the same number of women that die from cervical cancer. Twice that number is dying from breast cancer. Every 4 in 5 of these women are from developing countries, specifically from sub-Saharan Africa and Latin America. And it’s just being neglected for so long because of the needs that have been talked about before, but also because of the stigma that associated with having cancer in developing countries. Women would have cancer and not be able to disclose to their husbands or their mothers and silently, slowly, they die. By the time they present in hospital, it’s too late to salvage.

The second reason that Pink Ribbon Red Ribbon is involved in this is because it’s smart public health. It is smart economics. Women are the center-pole of the family. We all know that if a woman dies, her child stands multiple risk of dying before the age of five years as opposed to a child whose mother is alive.

But also because Pink Ribbon Red Ribbon is leveraging the platform, the successful resources and human and financial platforms that have been put in place by PEPFAR to see these women screen and treat them. This is smart public health. This is using the system that’s been put in place by PEPFAR to
deliver more for women who have always delivered for the world.

HIV wears the face of a woman. And we know cervical cancer, for example, is 4 to 5 times more common in women who are HIV positive.

Therefore, we have the clientele in the ART clinics and adding on additional skills for these health workers to screen the women and make sure that they are caught early and treated is smart economics.

The third reason that we’re there and interested in this chronic diseases is because it is a moral imperative. President and Mrs. Bush believe that it is ethical and it’s a moral imperative for us to make sure that based on the work that PEPFAR has done, we do not allow women to be saved from dying of HIV, only to die of a highly preventable disease, especially cervical cancer.

For example, in countries now, we are seeing women in the prime of life, between the age of 20 and 39, with cervical cancer and I’m talking of invasive cancer. The last one that we saw in one of the African countries was a 19 year-old girl who presented in the cervical cancer screening clinic with vaginal bleeding and when she had visual inspection with acetic acid done, of course she was diagnosed with invasive cancer. Within a few weeks, she succumbed because very little could be done for her.
Leveraging these platforms to make sure that we do not allow women who survive HIV, who survive giving birth to HIV-negative children, themselves now die of a highly preventable disease; it’s one of the other reasons that we are there and spending time, energy, advocacy and resources making sure that we’re able to catch them at the precancerous stage and give them the cure that they need.

JOHN DONNELLY: So we heard the why, could you briefly tell us the what? What exactly you’re doing in the field?

JEMIMA KAMANO: Pink Ribbon Red Ribbon is an innovative partnership that leverages investments in public and private sector to address women’s cancers, specifically cervical and breast cancer in sub-Saharan Africa and Latin America. And what we do is we are focused initially on the level PEPFAR countries, promoting simple, low-cost prevention with a visual inspection with acetic acid and if the woman found with precancerous lesion, then she can receive cryotherapy and cryotherapy has been found to be effective in curing precancerous lesions.

It’s a one-stop shop intervention. It’s low-cost and it is administered by non-M.D. health workers. Therefore, we are able to carry out this in countries, even in rural areas. It’s not just at the capital cities. Recently, we’re out in a district in Zambia called Kabwe at the Ingungu Health Clinic.
That clinic had been dilapidated for years and it was not functional.

Within a period of one week, we all worked together to renovate that clinic and the first set of patients that was screened for cervical cancer on July 3\textsuperscript{rd} this year, 33 women were screened and to date, a number of women – 163 women, have been screened in that rural clinic. 30-percent of them are HIV positive. 20-percent of them were found to have lesions.

These lesions could be precancerous, they could be established cancer and out of these, seven of them could actually be treated with cryotherapy and considered cured. The remaining were referred to the general hospital where we have staff who have been trained in LEEP that’s loop electrode excision procedure who can then go ahead and do biopsy or surgery, chemotherapy or radiotherapy if needed.

So this is the way that we are [inaudible] as a partnership so 14 national strategic plans and providing the necessary technical assistance that is required to make this functional.

JOHN DONNELLY: Thank you Doyin. Okay. So we’re going to move to our last panelist but before I do that, just to quickly let you know what’s coming in the next 10 minutes, Ayoub will give is talk fairly quickly. Jon unfortunately as to leave at about 12:30. I’m going to turn to him then and

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then I’m going to open it up to all of you for questions. So soon we will have some questions.

Ayoub, tell us what’s going on in the Ministry of Health in Tanzania and what you’re doing to sort of expand your services to chronic diseases.

AYOUB MAGIMBA: Thank you John. The Ministry of Tanzania first started to develop a section within the Ministry which dealing with the non-communicable disease and this section assists the Director with two heads, one dealing with the physical non-communicable disease which include [inaudible] but the other one is dealing with the non-physical communicable disease just mental health and in substance abuse.

But also we have a national steering committee. The national steering committee for NCD is chaired by Chief Midcofsa [misspelled?] but there is still a community within the different hospital, all the different hospitals we have with the [inaudible] they formed a steering committee and the mandate of this steering committee is to coordinate the NCD within the hospital as well in the nation.

But also we have already developed the national NCD strategic brand and it has also four components. One of the components key components is promotional activities in which we promote the — create the awareness for NCD to our people but also the healthy life styling. Also we have a component of

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prevention and in this prevention we address issue of early detection of NCD related disease but also screening for cancer, diabetic hypertension within the clinics.

But also it focuses on care and treatment and the main objective here is to integrate NCD within the existing healthcare system and also it takes care of rehabilitation. And rehabilitation takes care of two things. It takes care of community bases rehabilitation but also preventive care. So the only component, the main component of our strategic care, national NCD strategic plan is to make sure that there is a reduction of risk factors such as to do with NCD but also to care, treatment and the rehabilitation for those who are having NCDs.

JOHN DONNELLY: So you have these amazing processes that are going on. What’s the motivation? I mean, what is — do you have a personal motivation to get this going or what’s the problem that you see?

AYOUB MAGIMBA: The motivation we have, we have already existing structure. Having experienced with the HIV/AIDS program we have well expanded the HIV program within our country. So the making of NCD took a chance of existing these programs already in place. There is integration of our NCD program within the existing program like HIV, like PMCT whereby
we screen cervical cancer within that program, but also we screen this cancer with PMPCT a program.

So there is integration program which gives motivation to our health workers. But also, although we have a few [inaudible] but since we are using the existing human resource it means that we have capacity to make sure that those who are — we apply them to the maximum so that they care, even the NCD.

JOHN DONNELLY: Okay, great. I know Jon, you have to scoot. Any takeaway thoughts that you have from today’s talk, then we’ll open it up.

DR. JONATHAN QUICK: Yes and just to have — I’m actually not abandoning the group, I’ve been asked to actually share some of the key messages with the discussion that’s going on with UN AIDS and WHO on a similar topic, but with a little different thrust. I think what is — I’m feeling both really discouraged and incredibly encouraged.

I think Till’s review of the chilling statistics, the dramatic expansion of NCDs, some of the trends is really disturbing and Jemima’s image of wards emptying from AIDS are now filling with NCDs. I mean, that’s really unsettling. But at the same time, I’m really encouraged at how quickly these adaptations are happening, changing AIDS centers to chronic care centers, extending the lives of HIV positive people, door to door testing.

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So the images from Jemima come out – the basic logic – I mean, we should get that and actually make that into a spot. The magnitude of the problem of women’s cancers, it’s smart public health, it’s smart economics and it’s a moral imperative. And I think Ayoub’s example from Tanzania of really getting it into the ministries of health. I don’t think we started – we didn’t kind of hatch together, maybe Sir George already figured it out, but the three myths to dispel. They myth that NCDs a rich country and old people disease.

I guess we’ve tag teamed on that one. But really dispelling that myth, really clearly and repeatedly. The myth that the failure of knowhow is a failure, but it’s not. It’s a failure in healthy systems in the wider society to deliver prevention and treatment that we know works and that we know what the best buys are. If you think about where we were in the year 2000 when we set out with a three by five, we were building the ship or maybe even building the airplane as we were flying it and it wasn’t certain in the year 2000 that we wouldn’t crash with unfulfillable aspirations.

Most of you would probably – well you come from different generations, but if you had described to many, maybe even most of the public health community in the year 2000 what actually existed in 2008, they would have said no, not in the world I know. And they were inventing things as they went.
because it wasn’t there. We know what to do, so the myth that it’s failure of knowhow, it’s not. And finally dispel the myth that poor countries can’t afford universal health coverage to deliver it. It’s about reorganizing domestic financing with a focus on three things, universal coverage, strong health systems to deliver essential services and financial risk protection.

And as George says, it’s operationally feasible, socially desirable and economically achievable. So it’s a really daunting task [laughter] and there’s much more to do. But there’s lots of reasons for optimism.

JOHN DONNELLY: Thank you. Thank you and thank you for joining us. I appreciate the contributions today.

DR. JONATHAN QUICK: And thank you.

JOHN DONNELLY: Gloria, can you come up and join us?

So we’re going to have join us Gloria Sangiwa who is Director of Technical Quality Innovation at Management Sciences for Health and she directs the MSH’s implementation of chronic non-communicable diseases strategy. So let’s open this up for questions. Again if you could walk up to the microphones if you have some questions and identify yourself and your organization. Go right ahead.

KATE GREENWAY: Hi, my name is Kate Greenway, I’m with Catholic Relief Services. I want to thank the group. This has
been a really inspiring presentation. I have one doubt and maybe I’ve missed the boat here somewhere, but I’m not sure we really do know what we’re doing with the nutrition related NCDs.

I don’t think we’ve got that cracked on this side of the water and I don’t have a clue what to take to my colleagues in Africa about obesity and the management of diabetes and the management of hypertension in a real practical way that says we know how to do this in the States.

I feel completely inadequate on that score. I think on cervical cancer and breast cancer, on these kinds of things, it’s very clear, but on the really lifestyle aspects, the nutrition related lifestyle NCDs, I don’t think we’ve written that book yet.

**JOHN DONNELLY:** We can hear about half of what you said, I’m sorry. Are you talking about the health response or are you talking about sort of the social response to these issues?

**KATE GREENWAY:** I’m talking about how to shape programming I guess for the nutrition related NCDs, for the things like hypertension, diabetes and especially overweight and obesity. We’re seeing a lot of – are you having trouble hearing me?
JOHN DONNELLY: I can — can you hear? Yeah, we’re having a hard time.

KATE GREENWAY: Want me to abandon the mic and just shout?

JOHN DONNELLY: That’s better, yeah [laughter]. Okay. So the question is, how do you address programmatically or strategically the nutrition and the lifetime aspect of some of these NCDs. Let’s take another question, right here.

GEORGE RUTHERFORD: You want me to come up and — or can you hear that? No. Okay.

JOHN DONNELLY: We’ll try again.

GEORGE RUTHERFORD: My name’s George Rutherford. I’m with the University of California, San Francisco. We okay?

JOHN DONNELLY: Okay so far. Yeah.

GEORGE RUTHERFORD: This is sort of the other part of this question, which is there is a magic bullet for chronic diseases and that’s tobacco control. Now unfortunately, lots of countries that develop in low and middle — lots of low and middle income countries have large tobacco growing industries. It’s a real question I think that I think should really be kind of a very clear part of strategy, sort of how far are countries willing to go with tobacco control, how do they balance the economic interests that tobacco growing brings for countries say like Zimbabwe, it’s a big chunk of the income.
How do you control tobacco without creating a black market industry? It’s a really complicated question, but I think far more than the nutritionally related chronic diseases. Tobacco control really does represent something of a magic bullet for certain types of cancers and for a lot of respiratory disease. So I’d like to hear that discussed [interposing].

JOHN DONNELLY: Okay, great.

GEORGE RUTHERFORD: It’s really sort of the larger issue of structural interventions and policy interventions and how you’re going to take those.

JOHN DONNELLY: Okay. So the question is looking at the tobacco control aspect of this, are there any lessons from that structurally to be done? Also, the equation of how important the tobacco industry is in many of the countries, how do you also deal with that? Okay. Do you want to take maybe the first question just on sort of how you can address the nutrition related NCDs? What have your experiences been?

JEMIMA KAMANO: I think we need to realize that it doesn’t have to work in the West for it to work in Africa. It doesn’t have to work in the developed countries for it to be borrowed down to the developing countries. Some of the solution’s actually going to come from the developing countries and I think they’ll be borrowed to the developed countries and
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actually implemented there. The good thing is that in Africa the epidemic is at its onset. It’s in the [inaudible] we have the opportunity to actually study as it’s growing rather than in the Western countries where it’s out of – it’s too much, it’s out of proportion and we are groping in the dark and trying to get a solution to a obesity when it’s already epidemic proportions.

In Africa we’re in the [inaudible] and so we have all that we need to actually be innovative and get solutions there, which we then can actually bring to America or to the rest of the developed countries.

JOHN DONNELLY: Anyone else on that question?

AYOUB MAGIMBA: Yes. When you’re talking nutrition, you’re talking to two sides. You are talking about the over nutrition but also you’re talking under nutrition. So these two aspects here are contributing to NCD. So we in Africa, we are seeing a lot of under nutrition and we develop our strategy when we talk nutrition, the emphasis is under nutrition although we sometimes tackle over nutrition because all of these contribute toward NCD.

SIR GEORGE ALLEYNE: Thank you very much. That’s a really fundamental problem which we’re all addressing. I have to make two comments. One is we have to start with the children, the mothers and children. I would have to say
there’s one thing that I would advise in terms of addressing obesity and chronic diseases is the first thousand days of life, to make sure that mothers are well fed, to make sure that babies are breastfed and make sure they have adequate nutrition the first two years of life. That is probably the most important thing we can do in nutrition today.

Most of what we’ve done in the past trying to make the individual feel guilty, waste of time. I would advise – I’m not saying forget the adults, that’s important, but the best thing we can do is to start with the children. The first thousand days of life represent the most critical area of time for addressing obesity and all the others. 46-percent of your chance of dying early of a heart attack are determined at birth.

JOHN DONNELLY: Tobacco, George?

SIR GEORGE ALLEYNE: Tobacco, we have found – and I say we because I know about this – we have found that the framework convention is still a very powerful instrument. We have found that you’re not going to have the tobacco industry go away and what is, the countries that I know best, it is the popular outcry for the people to be saying to the policymakers, look we need you to stand up and face the tobacco companies. I know of – telling a story, I know of one specific area, I come from the Caribbean and we have worked very hard to have adequate

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messages on packaging. And it has to be agreed by all of the member countries of the Caribbean community and there’s one country that holds it up. Why? Because of the powerful influence of the tobacco.

And the only thing to do is really for the civil society to strengthen the hands of the politicians. This is why I place a lot of emphasis on civil society; strengthen the hands of the politicians so that they get the appropriate legislation passed.

GLORIA SANGIWA: And just to complement what was said earlier on by Sir George on the nutrition to start with the young people, let me focus on the tobacco control because there is actually evidence that if we work on the promotion and increasing awareness on the lifestyle changes for the young people and improve their — and make sure that they understand the issue of smoking and have them from starting smoking.

If people don’t smoke before the age of 20, studies indicate that they will — by the age of 20 of not smoking, you have not started to smoke, only 2-percent of people — there’s only a 2-percent chance of you smoking after the age of 20. So the issue again talks about promotion and focusing on young people in adolescence and there have been some studies to try and see how this can be done and influence in moving that agenda.

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In terms of the nutrition, in addition to what Sir George said on focusing on the first thousand days, there are studies going on right now looking at innovative service delivery models that will address both under nutrition and over nutrition in resource poor setting especially in focusing on [inaudible] poor. These are done – they’re supported by Medtronic Foundation working with the UHC and they’re still population based but there will be a way of showing how it can be done.

In that particular group, they believe those models would then form their front line and middle income country as Jemima was saying, they’ve probably been informed what could be done elsewhere.

TILL BAERNIGHAUSEN: Since we are at an HIV conference, I wonder what we can learn from the HIV response and I think in HIV certainly we are still struggling on the prevention side, even though there are successes but we have been very successful in treatment, screening, detecting, giving access to entertaining and ensuring hopefully adherence in the longer term of patients needing HIV care and what can we learn from this successful treatment response for NCD responses.

Certainly there are some lessons I think at the programmatic level that we can learn, simplifying tasks, clear guidelines, health workers that are dedicated and well

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motivated to an NCD response and if that can be piggybacked on existing AIT programs, that’s excellent. If that needs to be established where it should already be in place in primary healthcare systems, that would be I think a learning experience for primary health systems. What are the elements that we can take from the HIV response that could very well be successful in existing primary care structures? And I think there are a range that we could take and move into these structures.

JOHN DONNELLY: I think we have two questions in the back. Sir?

SHESKA IMEADO: I’m Sheska Imeado [misspelled?] from National Center of [inaudible] and currently working in Zambia. I have two questions. Is it clear? You can hear me? Okay. I have two questions. The first one is about a prevention strategy for the NCDs. I totally agree that utilizing HIV/AIDS strategy to the NCD strategy, but both diseases includes some structures prevent, treatment and care.

For the HIV/AIDS this entry, especially prevention sides is more difficult, they say that treatment should be used as a prevention. But for the NCD, we cannot use a treatment as a prevention. So how can we think about that prevention side as a more difficult side than treatment and care for the NCDs? How can we deal with that prevention strategy in the NCD? This is the first question.

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And the second question is for NCD, as everyone mentions we need the universal health coverage and universal health treatment and health system strengthening. But to make it successful we need the [inaudible 1:24:02] healthcare services especially in the rural settings, in developing countries. Actually we had the discussion about the primary healthcare services more than 30 years. After that our model is decoration but how can we go beyond that discussion? We have always discussion about the primary healthcare and health coverage but we cannot go ahead.

So how can we go ahead of a discussion for the [inaudible]? This is my two questions.

JOHN DONNELLY: Thank you. Let’s go to the second.

LAURA MCCLOSKEY: Hi, my name is Laura — can you hear me? Can you hear me?

JOHN DONNELLY: Yeah.

LAURA MCCLOSKEY: Okay. My name is Laura McCloskey. I’m from Beck and Dickinson. Thank you for all the panelists. It was a very inspiring session. My question is specifically around the chronic care centers. I would like some feedback from the panelists on what specific test beyond HIV and glucose would have the most impact as you’re trying to look at prevention and also getting people into the healthcare system? So door to door testing, but also health clinics, what type of

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things are you looking from from industry to provide to help you in your roles?

JOHN DONNELLY: Okay, great. So did you hear the first question? Should I repeat them? Okay. So the first questions was comparing if the HIV/AIDS prevention strategies with treatment as prevention but since we do not have that option in NCDs, what are the most effective prevention strategies? And he also asked, just we talk a lot about primary healthcare strategies, but how do you go beyond that?

Did you hear the last? Okay. Anyone want to take either one of those? Doyin?

DOYIN OLUWOLE: Just a quick reaction to the prevention aspect, for cancers we do know that one of the preventable cancers is cervical cancer because of its association with HPV, human papillomavirus. One of the things that Pink Ribbon Red Ribbon does together with countries is to promote primary prevention with HPV vaccination of young adolescent girls usually within the age of nine years and 13 years.

Some of the countries have actually advanced in this, especially Rwanda, looking at school age children and vaccinating them both within school and out of school children, developing creative, innovative methods to catch this young adolescence with three doses of HPV vaccine. And the good news is that GAVI has now approved the use of HPV vaccines and from

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this fall would open up the applications for countries that are GAVI eligible to actually go ahead and apply.

But the other aspect is the lifestyle issue which has been talked about earlier on. All the general lifestyle issues related to tobacco smoking and, you know, sedentary life, exercise, all those would actually impact any non-communicable disease in terms of incidents, prevalence and even severity. So it’s important to look at them in a package and use whatever vaccination options are available. But the secondary prevention is also very important, early detection and treatment.

**JOHN DONNELLY:** Jemima.

**JEMIMA KAMANO:** I want to answer the second question, but before that just to add the comment to that is that we know very many NCDs that for years treatment has been prevention. One is rheumatic heart disease which is probably the biggest cardiovascular disease in Africa and the prevention is basically treatment of sore throats in time and it’s not happening. The other is cardiovascular disease as a whole. Hypertension is one of the highest risk factors for cardiovascular disease. Diabetes the same and so getting these diseases and treating them is actually prevention.

The second one is, I hope I got the question right, is what testing strategies are best to implement in the chronic
care centers. I think it depends on the burden of disease and on advice from the sister disease. Let me give an example. For cervical cancer, for breast cancer, the door to door screening of course will not work very well because you can’t have a counselor going to do pap smears door to door.

But for diseases like hypertension, for diabetes and even for chronic obstructive pulmonary diseases, very simple procedures can be used to screen for these diseases and the tests are quite straightforward and easy to teach to a person who is not a medical person or such.

So for this we thought the easiest to start with and then would have to get different strategies for other diseases such as prostate cancer or cervical cancer. I hope I’ve answered your question.

SIR GEORGE ALLEYNE: May I just add a bit to the issue of prevention? In addition to what—answer I agree entirely, a couple things that we well establish, raising tobacco taxes is the most cost effective approach to reducing NCDs. Second, if we can reduce or slow intake low 5 grams a day we will reduce hypertension across the population. Those are two specific things with numbers.

We debate the quantum of exercise you should have that’s very difficult because what does constitute vigorous exercise? To get your heart rate up to X or that is very— what
we do advocate is vigorous exercise, 20 minutes of walking 3 times a week, but vigorous exercise. The point also as [inaudible] has made, exercise is advantageous even although you do not lose weight. Exercise is per se a preventive as far as cardiovascular disease is concerned.

Then thirdly, responsible drinking; now I have a great difficulty with what is responsible drinking? It impairs, I’ve written about it but in practice, what does constitute responsible drinking? As the Greeks say, nothing in excess, that’s the best advice I can give nothing in excess.

The specific things I would recommend is that we can raise tobacco taxes; we can reduce salt and let me tell you if you reduce salt the population doesn’t notice. You can reduce salt slowly and there’s no one will raise a finger. The bread will still be sold if the salt is reduced. I agree with you, universal vaccination, girls and boys, is a major preventative strategy.

JOHN DONNELLY: I feel like I’ve just been to my doctor’s office. I think we all will meet our exercise quota at this conference. One more question? Go right ahead.

LILLIAN OTISO: My name is Lillian from LBCT, a Kenyan NGO. I’m wondering what type lecture to get out of this is what the NCDs we need to focus on are? As I go back and go programming and actually informing policy, what are the

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diseases that I need to say we must focus on this to get the maximum impact? I’d also like to know one of the things that we did in terms of HIV is there’s a lot of services that are offered to HIV positive clients that are not offered to the HIV negative and the result is that imbalance.

That if somebody’s HIV positive they might even get their flu or pneumonia treated for free yet the negative person would have to pay and go through the health facility. What are we doing in terms of NCDs to make sure that that doesn’t happen; that we’re actually addressing the entire population, not just the HIV positive because that will still remain a problem?

In addition to that, how do we address the health systems issues that will come from this? We know that as it is with HIV we got huge workload and it did affect the service delivery. We needed the human resources for that and we’ve come up with tax shifting, but how much more can the healthcare worker or even the community healthcare worker actually handle as we add the NCDs to the scope of things that they have to do?

Especially for governments, are we thinking about how many healthcare workers do we need to have to address the pattern of NCDs? How many community healthcare workers do we need to have? What should they be doing as consider all these factors? Thank you.
JOHN DONNELLY: Okay great. Those are great questions and I guess it goes to the heart of what should be the priorities? What are the implications in terms of health care workers and how do avoid the case where we’re giving sort of NCD exceptionalism? Are there people who have NCDs more treatment than those who don’t? What are the best steps ahead which is a great question to end the panel with? Any—

TILL BAERNIGHAUSEN: I have some thoughts on the health system’s response and of course we started out by saying that we don’t really know yet how primary health systems should actually be delivering a good NCD care and not succeeding in doing that. I would, in a sense, as a first step suggests is to learn from the existing HIV programs and the HIV treatment response.

Also systematically examine what in the HIV response we can use very quickly and successfully without putting new structures into place or without overburdening existing structures to also address NCD treatment need. There is certainly the type of door-to-door testing that Jamima has described. There is certainly an opportunity to add to existing AIT programs, a range of screening processes that’s a quick win.

Then it’s a secondary question for the health system to decide whether the NCD need that is detected in AIT program

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should be met in the general health system or should be added on to existing AIT programs that are usually quite well functioning.

Thus, I think there would be an argument to at least initially provide for HIV infected patients who are detected with diabetes, hypertension, treatment need, and those services in the existing structures that have been successfully built. I think a systematic examination of those opportunities would be really useful in specific context because it will differ. It will be different in Kenya from Tanzania, from rural South Africa.

AYOUB MMBANDO: I think in Tanzania it’s the same like what you say we are seeing. What we are doing is to use the existing health system to manage the NCDs. We don’t in the shared parliament system for NCD. Also we go far to the community. We have involvement of the community leaders as well as the people in the community so that they know the lifestyle and how they prevent the emerging of the NCD. That’s what we are doing.

JOHN DONNELLY: Anyone else?

JOHNATHAN QUICK: Yes, to go back to—can you hear me?

JOHN DONNELLY: Yes.

JOHNATHAN QUICK: What to focus to make the maximum impact I think different countries have decided on different
things. Many of the countries have adopted what are called “the big four,” cardiovascular diseases, broadly that includes hypertension and everything else; diabetes, cancers and there are focusing at least now to be focused on cancers of the women and sometimes of the young children and chronic lung diseases. In some countries they’ve added the others; the others can be mental health, the other can be whatever it’s determined as other and specific. Clearly it cannot be generalized but it’s context specific.

In terms of health system, it is when you are talking of integration you can dissect it in a different way. Integration can win adding diabetes screening on HIV and AIDS. Or integration might mean when we are doing the healthcare worker training we are expanding that at all levels. We are talking about health; how are we going to expand the training or the focus on healthcare to integrate so that these providers at different levels? Whether they’re community healthcare workers and all the level high; they’ll be given the initial issues.

How do we take the lessons we learned since when HIV/AIDS conference; there has been documentations of lessons we learned on building the system on HIV and AIDS and what it requires. The continuative care, issues related to access to drugs and medicine, issues related to information and some of

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those lessons can be translated and see what can be taken to improve the continuative care since that it’s related. Focusing on few related thing, including different service delivery approaches to reach different target audiences and different groups.

JOHN DONNELLY: Doyin and then we’ll go to—

[interposing]

DOYIN OLUWOLE: Yes, just a quick addition to all that has been said. An attention to pre-service training takes care of the burden that we think about when we say health workers are being overloaded. If the focus at pre-service level is modified to make sure that the country specific issues are addressed at that level. It helps health workers to acquire the skills and acknowledge before they begin practice.

JOHN DONNELLY: Thank you. I just want to turn to Sir George just to wrap things up in a minute or two. He’s the elder at the table. I want to know what was important today that you heard?

SIR GEORGE ALLEYNE: Thanks very much John. I’d like to think that the panelists made it quite clear it’s not my disease versus your disease. I think I hope the panelists got through the message that there is a problem of chronic care; that the world is living longer and people with HIV are living longer; because those with HIV and those without HIV are living
longer the possibility of these noncommunicable diseases affect them at some time in life that is a real possibility. We must be alive to the possibility of treating a population that is getting older. For that reason alone, even without reducing the risk factors, they’re more likely to have HIV.

One of the things that were mentioned in much of the write-up of this conference the idea of an AIDS free generation. There’s a little difference with NCDs we will never have an NCD free generation. What we can dream of is a generation that postpones the development of NCDs and when NCDs do develop at that time of life there’s adequate treatment for them. That should be our “holy grail;” really to postpone the development of NCDs and when they do occur to have appropriate treatment for them.

The last point I would make is this, in came up in the title to this session, is post-MDGs. The MDGs are supposed to go to 2015 and we know that NCDs were not included the diseases to be addressed then. After 2015 there will be a set of sustainable development goals.

One of the things I would hope encourage, enthuse people about is ensure in the circles in which you move that the NCDs are included in the post-2015 development agenda. I agree with you John, one is not asking for special treatment for NCDs, one is saying that the disease profile of the world

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will be such, increasingly so that we need to give attention to a major health problem that is going to be with us for a long time to come. We have the responsibility I think to recognize that we can prevent many of these disorders and we can treat many of these disorders at the last point. When people come to die as a result of these disorders we can help them to die with dignity.

JOHN DONNELLY: Well with that I just to have you join me to thank the panelists for an engaging session. Thank you for coming. [Applause]

[END RECORDING]