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**2007 HIV/AIDS Implementers' Meeting:
HIV, Health, and Development:
Connecting the Dots and Mainstreaming & Panel
PEPFAR, The Global Fund to Fight AIDS, Tuberculosis
and Malaria, UNAIDS, UNICEF, The World Bank, WHO, GNP+
June 17, 2007**

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[START RECORDING]

PATRICK DISKEN [misspelled?]: I'll introduce myself. My name is Patrick Disken. I'm with the USAID Food for Peace Office in South Africa. I'm actually a last-minute replacement as the moderator, but I was assured that I don't require any expertise, that my job here is simply to introduce to you the speakers and make sure that no fights break out. I'll also add that the first four speakers will have up to eight minutes. I've given them the option to donate their minutes to other speakers if they want to, but that is the maximum. Then we'll take questions for a period of time until 11:30, and then the next four speakers will have up to 10 minutes because they have a little more information to share.

So, without delaying any further, let me introduce the first speaker, Mr. Baker Maggwa. His presentation is called, "The Best Kept Secret: The Role of Family Planning in HIV Prevention." I guess after his presentation, it won't be the best-kept secret anymore. Thanks.

BAKER MAGGWA: Thank you very much. I would like to thank the organizers of the conference for giving me the opportunity to come in and share what we consider as one of the best-kept secrets in the fight against HIV/AIDS. As you all know, you know, family planning has been proven to be an effective intervention for reducing maternal and infant

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morbidity and mortality, and it's also, its use has been shown to improve, you know, women's health and their family's health and also their ability to participate in [inaudible] agendas for a very long time.

Now, despite all that knowledge, we haven't been paying too much attention to it in asking the critical question that this intervention that has been with us for a long time - what contribution can it make, you know, to the mitigation of the HIV/AIDS epidemic and its spread?

Now, in terms of, in terms of examining the potential role that family planning could play in the prevention of HIV/AIDS, one needs to understand, what are some of the needs? Is there a need or demand for family planning services among clients who we serve through our HIV/AIDS programs? And recent analysis of the data that is available to us shows that, you know, if you looked at families [misspelled?] who are attending these [inaudible] services, a large number of them have got, you know, an unmet need for family planning services as expressed by them by their desire of, you know, of not using a method but at the same time, not wanting to get pregnant within the next two years. This ranged from a 10-percent to 39-percent in Zimbabwe of clients who are attending those visitor services expressing their desire to do some family planning.

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Now, again, if you look at the data that we have available to us through the DHS, one sees that, you know, there's a very high number of children who are being born HIV-positive as a result of unwanted or unintended pregnancies among HIV-positive women. And using the research data from the DHS, the HIV prevalence surveys, we've estimated that, you know, on an annual basis there's over 400 children who are being born HIV-positive resulting from unintended or unwanted pregnancies among HIV-positive women. Now, with that, you can begin to see what potential role that family planning do play because if we were able to prevent those pregnancies through addressing this need among these women we could have prevented, you know, over 400 infections on an annual basis through effective family planning services.

Now, one way to look at it and say, okay, what, is it cost effective? And again, you know, we've done some wondering using the data that is available to us and looking at those potential over 400 kids, children, who were born to be HIV-positive and, you know, what it cost to kind of prevent those infections using the way we practice PMTCT today, which does not emphasize prevention of untimed or unwanted pregnancies. On one [inaudible] you know, there would be [inaudible] cost savings if we emphasized, you know, you use of family planning as part of our PMTCT strategies in order to prevent untimed and

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unintended pregnancies and that would kind of result in cost savings of anywhere between \$8 million to \$23 million U.S. dollars by year by forecasting more on emphasizing the family planning services within our program.

Now, at FHI, we have been working hard using that information with programs in the region to try and address and respond to the needs of women, of women's family planning needs within the HIV/AIDS center. And we have been able to develop, you know, a process that we follow, which starts off with an assessment followed with advocacy, then developing the integration strategies, training, communication and sensitization, and then scaling up of integrated services and feedback and then underlying all of this we provide technical assistance and continuously assess the program planned for them as we go along. And we, as a result, we have been able to kind of work in a couple of countries, as you can see from that slide using various, you know, programs. Our interventions have ranged from working with visitor programs like in Kenya and Nigeria, working with home-based care programs like in South Africa and Kenya and, as I speak, a colleague of mine is doing a presentation on the integrated palliative care approach, you know, through palliative care, which includes family planning services that we are doing in South Africa. We are also doing, you know, work through PMTCT. We are working

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with the treatment center [inaudible] the comprehensive care center that have been established within the region.

Now, just to share with you some examples where we have been working, like in Kenya trying to look at integrating family planning in HIV/AIDS, we have been able to make certain strides and achievements along the way. As we speak now, we have been able to train up to 150 providers working in seven different sites, and we've also worked with the Ministry of Health to train 38 trainers, again, looking at it in terms of sustainability and rollout. Our strategy was that, you know, we did see FHI continuing to play this role, so we train 38 trainers who are now being used by the Ministry to roll out, you know, this process of integration within their programs through the bilateral programs like the [inaudible] program and other HIV/AIDS, you know, related service programs. We have conducted several advocacy and sensitization meetings and also in the short time we have also had to retrain 18 of the TOT's [misspelled?].

Now, in all this, there's certain lessons that we have learned and what we have learned is when you are thinking about integration, first and foremost, don't assume that FHI integration is the best approach. Proceed cautiously [inaudible] and the types of services that are available to you that are within your country. We've also realized that

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building consensus and buy-in from stakeholders at all levels is a laborious and time-consuming, but essential accessory. Without that you can't succeed. And the other thing that we've also learned is you must be able to assist the [inaudible] infrastructure in order to be able to determine what types of integration, what levels of integration can occur within the services that you are talking about. Again, synchronization with local [inaudible] and global [inaudible] agendas, is critical because without that, you will not have buy-in and you will not have any sustainability. Thank you very much.

[Applause]

PATRICK DISKEN: Thank you, Mr. Maggwa. I guess if I have any expertise on this panel discussion is that I've known, I've had the pleasure of knowing our next speaker for the last few years in particular working in Zambia and HIV/AIDS and food aid issues. So, let me introduce to you Bruce Wilkinson, who is going to speak on malaria and HIV, and I believe we are giving him two minutes. Is that right, Bruce? [Laughter] Maybe we will give him eight.

BRUCE WILKINSON: My buddy, Pat. Two minutes, all right. Let's go. Good morning, my name is Bruce Wilkinson. I'm with World Vision and work in the RAPIDS program in Zambia. It's basically a consortium. Are we sort of expected to [interposing]

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PATRICK DISKEN: Is this part of my job? Is that yours?

BRUCE WILKINSON: I'll continue to talk. Basically what we are doing is the RAPIDS program is basically a civil society response picking up, picking up care and support to families in Zambia. Thank you very much.

PATRICK DISKEN: All right, very good.

BRUCE WILKINSON: And you can see the partners on the bottom. We've got a great set of partners and also we have 110 faith-based and civil society organizations that we give small grants to in Zambia, so we are proud to work with Dr. Chu [misspelled?] and his National AIDS Council in Zambia. We like that.

What I'm doing today is I'm really covering a very small component of the RAPIDS program, and it's on malaria. All the epidemiologists will be very disappointed. I'm not going to be talking about the epidemiology of malaria here today. If you want to do that, there's a lot of experts, I'm sure, within the group that can answer those questions, but basically the premise is taking a large-scale care and support program, 12,000 trained caregivers in 52 of the 72 districts of Zambia. That's what we have, all right, 12,000 caregivers who look after five households each, all right? OVC care, home-based care, we have 210,000 children in the program. We have

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45,000 home-based care patients in the program, and we work with youth, about 30,000 youths.

In addition to that, we have a small granting program, in addition to that we have a livelihoods program, in addition to that I could go on and on and on, but basically what we are doing is taking that platform of an HIV/AIDS program and saying, what are we doing in malaria? Don't our home-based care patients need to be under a net? For example, how about the children? How about the pregnant moms? Okay. So, basically, we work through basically ITN distribution, insecticide-treated nets, okay, and you can see, I'm going to fly here, let's go. We have worked a public/private partnership to make this happen. We've brought in the global business coalition HIV/AIDS who came up with a \$1.25 million through 25 corporate partners for the purchase of half the nets. We worked with OGAC [misspelled?], we worked with PMI, and we have private corporations and donors who are actually supplementing this program.

The target is in 64 districts. What we have done is we've expanded outside the RAPIDS consortium. We said let's bring in all they OGAC partners who do OVC work and HVC work in Zambia. So basically we've cut the deal so we could actually have that many nets, to provide nets to that many partners in Zambia. Well, the [inaudible] populations on and on it goes.

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We have delivered the nets to eight different hub sites. We don't put them all in one place, you know, the logisticians in here will like that. When you are bringing the nets in from the outside, put them in different places around the country because trust me, 500,000 insecticide-treated bed nets presents a bit of a challenge for logistics. That's basically you are taking one site there and then that's how it scales down, okay? From one site into our partner organizations and then right down to community based organizations. It's basically a vertically integrated program. We receive the nets, the nets come in to the various hubs, the hubs then take them to the district level with our, we are like great partners and then from there we have a donor who gave us 23,000 bicycles. So the bicycles, so the caregivers all have bicycles. The nets go on the back of the bicycle, the net goes right down to the household, the household members are actually trained by the caregivers who have been trained by the DHMT malaria focal point persons in Zambia, and then those caregivers take the nets into the house, open them up, hang them with the clients, and actually talk to them about malaria.

On average, three nets are going into each household, so we have basically been working on this for some time. We are working with the National Malaria Control Center in Zambia. Excellent support from that. We are actually integrated right

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into the National Strategy on Malaria in Zambia, and the government of Zambia has donated a warehouse and given us an incredible facility on which to have a logistics platform working for this.

You can't take the nets in there without providing IEC information education, all right, communication. So, basically we've produced a pamphlet, very simple pamphlet, sixth-grade reading level, goes into every single household and stays there basically on the use of the net and also what to do in case you do get malaria. Very simple, but very straightforward. The caregivers themselves receive the nets and become actual models in their own community for having the nets in their households so they are actually modeling the practice we'd like to see in all of our targeted households. Those are the indicators. You can see the number of nets, number of households that receive nets by beneficiary type.

The caregivers are now also monitoring, the two questions they ask when they go in on a weekly basis to see their clients when it's OVCHBC youth, who slept under the net last night? Very simple question, all right, even though sometimes people don't sleep under nets, right? Right. And we provide the government of Zambia with all that information and then the sentinel sites were really looking at six sentinel sites we are really going to look at very detailed information

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and what difference has this distribution of malaria nets and [inaudible] actually produced. So that will be available, but it won't be now.

There's, you know, caregivers, they are the salt of the earth, these caregivers, 12,000 of them. There's one giving a net to a household and airing the net first, of course, and the proper procedure. That probably does it.

[Applause]

PATRICK DISKEN: Thank you, Bruce, for keeping that to seven minutes. Let me introduce the next speaker from the Millennium Villages Project. Mr. Pedro Sanchez began implementing the integrated approach, the Millennium Villages. Thank you.

BRUCE WILKINSON: While Pedro is teeing it up, I just want to let you know that that platform is also being used to deliver albendazole and Vitamin A supplementation into the same household.

PEDRO SANCHEZ: Sorry, last slide here. Okay, I want to talk to you about a new activity called the Millennium Villages, which are basically how to empower typical African villages in hunger hot spots of sub-Saharan Africa to achieve all the millennium development goals, not just one of them, but all of them.

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If I may say so, I'm an agronomist. I'm an agricultural scientist, and I worked all my life in the tropics and occasionally at airports, I used to meet this nice person and what do you do? Oh, I work in malaria. Another one, how do you do? Oh, I work in AIDS. I would say that's interesting, but nothing clicked. The point is that all of us are just working one piece of the elephant, and if we don't get it together, we may miss something. So this is an attempt to really put it altogether.

The Millennium Villages Project is based on the recommendations of the UN Millennium Project for estimated cost in rural Africa what it takes and what it takes is actually quite a bit of money, but within budget. It's about \$110, U.S. dollars per capita per year, over a period of five to 10 years of which the household share is 10, mostly labor. The government's share is 30, which is about three times as much as normal. And the rest has to come from donors, and we have a division of that \$70 from donors at 15-percent agricultural and nutrition, 30 health, 20 infrastructure, 20 education, and 15 water, sanitation environments.

It sounds like a lot of money, and they are about 100,000 of such villages in hunger hot spots of sub-Saharan Africa with about 5,000 people each. Sounds like a lot of money, but certainly it's nothing compared to what the donors

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have promised. We figure out that it's by some miracle it happens all at the same time, 100,000 villages, 500 million people, that will take about 0.12-percent of the GDP of rich countries where they have promised, as you know, 0.07. So this is within budget, but it's at scale.

The villages are located each in [inaudible] Africa, each one representing a major agroecological zone or farming assistance since agriculture is the main occupation of these people. So, they range from fishing villages in [inaudible] Senegal to a rain forest, slash and burn villages in Ghana, to a pasture villages in northeast Kenya, and we have four villages here in Maghandi [misspelled?], about 30 kilometers away from here. You are cordially invited to come and take a look at it and see what I'm talking about. So there are a total of about 80 villages in clusters around these areas in 10 countries that have been chosen because we consider them recently well governed and that's a stretch because we include in those countries like Nigeria and Kenya. Not all like Rwanda, but working with the head of state and with the government the villages are selected.

Our main point of departure is the community leads, but it is science-based and it is interaction between proven science, proven technologies and community empowerment that makes it happen. We have found now that after working for

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about two years that there are basically two steps and the first one is to tackle the basics. To tackle hunger, disease, and drinking water through increasing food production, through a clinic, through the malaria bed nets, and clear and clean drinking water.

Increased food production, which is sort of my area, has been very, very successful. The main problems that these farmers face throughout sub-Saharan Africa is depleted soil fertility because the nutrients have been taken out and not returned from early nitrogen and phosphorous and uncertain water management. So we have, with the communities, decided on a level of fertilizer, mineral fertilizer obligations and improved varieties or hybrids of the basic food crops. This is the case in Uganda, and I'm very happy to tell you here that the average increase in yields in basic food crop yields in all these areas it's in the order of four times, and in addition, most of the areas because of the availability of fertilizer and seed, they also have increased their crop area without any deforestation or anything else. Just using on fields that were abandoned. So this is going very well and certainly, all of these villages - with exception of Senegal, where there was a crop failure - have reached self-sufficiency. This has happened right here in Rwanda and now they have a surplus to markets. So that's the first thing.

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In no particular order of priority, a health clinic. So, in the places like the first village in Sahoudi [misspelled?] in western Kenya, the people wanted a clinic. The hospital was a few kilometers away so we said build one, get the plans from the Ministry of Health, and we'll support you with cement and paint and a generator, but you build the thing. So they did and they did it in six weeks out of a cost of less than \$10,000 to the project. The clinic now is staffed by Ministry of Health people. They are, this is a large HIV/AIDS prevalence area, about 25-percent [inaudible] district in western Kenya, and the village has a lot of them. So, they are provided with malaria therapy with ARV for those who go through voluntary counseling and testing and immunizations, emergency care and community health workers.

Malaria prevalence, we, we noted that it was at a peak of about 70-percent outside the village and dropped to about 20-percent after a few months of everybody, everybody absolutely, 100-percent long-lasting malaria bed nets and plus other treatments. Safe drinking water is the other one that's key.

The second phase, which I'm not going to talk about here, is now enter the market and get out of the poverty track. That means first that you have to generate cash by selling crop surpluses and that's happening, but you want to sell your crop

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surpluses at high prices using mechanisms such as serial banks then diversify the high-value crops, get farm inputs from agro dealers, microfinance, contract farming and crop insurance, and we are working on all of these in the more advanced villages.

What we see right now after three years in, into the third years in the oldest villages in Suri, you have here the head, the chair of the executive committee of the village, a woman, and Dr. Patrick Matuer [misspelled?], our lead scientist there. This interaction has really worked well. It has empowered people. Last Tuesday, this is the same lady in the back there, Monique [inaudible], President [inaudible] that you see sitting down, inaugurated a new refurbished [inaudible] hospital, in which we put about \$150,000 of equipment, and now for the first time - this is strange - a luau [misspelled?] woman, those of you who know that culture, speaking to a President of Kenya, it's not - right.

So, another point is that we are taking a look at the costs since now it's pretty straightforward that these people can feed themselves, then you have three choices. If you have food aid delivered, it costs about \$585 per ton of food, which is enough for one family of five. If you do local purchase, 240, but instead of doing that, if you invest in fertilizers, hybrid seed, [inaudible] pumps and so on, it will cost anywhere from 23 to \$50 to produce an extract on the food.

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So, you take your choice. I think we are at a point now that we should be pushing more food production together with health, together with water, together with education and the whole thing together.

Here's my bottom line. This gentleman to the left, this picture was taken three days ago, Joseph Oldwich [misspelled?]. He was bedridden with AIDS, and he was put on ARV treatments. The ARVs came from the government of Kenya and PEPFAR. Now, Joseph is not only standing up and healthy, but he's growing a bumper crop of maize and to me, this is the bottom line. You empower people, you get them healthy, you get them well fed, you get them educated, and I think we have a future. Thanks very much.

[Applause]

PATRICK DISKEN: I'll introduce William Philbrick of CARE USA.

WILLIAM PHILBRICK: Thank you very much. My name is Bill Philbrick, and I'm with CARE USA, and I based in Atlanta, and in five minutes I'm going to try to tell you a little bit of something about the use of microfinance programs in OVC.

What do we mean when we are talking about microfinance particularly as we do it in CARE? We are talking about informal, not formal, we are not talking about banks or formalized microfinance institutions, informal, self-selected,

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community-based groups. They are also known as group and voluntary or villages savings and loans associations. It's sort of the acronym of GS&L or VS&L groups. In CARE, we target primarily women, so the vast majority of these groups are composed almost entirely of women or caregivers of OVC, but we have also been able to make loans to OVC and other youth.

The idea of these groups is that they make loans to each other for income-generating activities and also loans for emergencies such as emergency hospital visits, et cetera, so there's an emergency fund like a social safety net and that the revenues from these loans and income generating activities can be used to support OVCs in the families and protect against AIDS. For example, the revenue from some of the activities can be used to pay for school fees and uniforms.

These programs, these VS&L groups, can be explicitly linked to OVC type programming where basically the training for making loans is provided to the guardians of OVC. We've done this in Rwanda with Acunda Bona [misspelled?] Child Mentoring Project. We've done it in Ethiopia with under the PC3 Program where CARE is receiving, we are a sub-grantee of Save the Children. And we are doing it in Kenya and Uganda through our early childhood development programs, but there's also need not to be explicitly linked with OVC programming where we are doing this in Mali, Tanzania and Malawi, where the programs are

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actually tied with sexual and reproductive health programmings, food security programs, and an HIV explicit program.

We have tried, at CARE, we have tried to initiate - well, we actually have initiated an impact study to answer the question, what impact, what, how are these programs changing the lives and increasing the well being of OVC? And we've actually conducted so far two studies in Mali and Tanzania, which are actually two programs that are not explicitly linked to OVC programming, and we have now come up with a number of indicators, which we feel are indicators of child well-being, which for example, vaccination, education expenditures, amount of work, number of hours worked inside and outside the home, whether or not siblings remain together, literacy rates, and accessing health care services. We have found thus far just from our preliminary results in those two countries that there's a positive correlation between participation between the, participation of either guardians or parents in these groups and these indicators of a child's well being. But in a couple of cases, actually in several cases, we have also seen some concerned results like, for example, in Mali we saw literacy rates lowered when there's participation in these programs and in Tanzania we saw the number of hours of children working inside the home increase. We attributed that because we believe that perhaps the children are actually helping out

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with the parents in their income-generating activities, but this still begs the question, we still need to do more impact studies and dig a little bit deeper to answer the questions about why we are getting these results. We are going to be doing, we are planning two more impact studies in Tabera with our ECD Program and in Busia [misspelled?].

Some surprises. These are not really surprises, just really cool, astonishing things we have seen. We have been able to in a couple of our programs empower grandparents and caregivers and women to establish thriving businesses, and we have been able to do this in eight months in Uganda. When I write there's an exception, I don't mean that there's an exception we have been able to empower caregivers. It's an exception that we were able to do it in such a short period of time in Uganda.

We've also seen in a number of cases that the stigma within groups, particularly when the groups are composed of HIV positive folks, that the stigma has been so reduced that without any prompting that they are very, and these are in conservative environments, that the members are very, very, will actually voluntarily disclose and discuss their status with the other group members. We have been very surprised with that even though it's not necessarily part of the work plan that these groups will actually go ahead and link with formal

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microfinance institutions to get bigger loans, and it's been really neat to sort of see the number of other services into which VS&L can be an entry point, i.e., HIV services, sexual and reproductive health services, nutrition and food security. And also another cool thing that's actually happened is that youth and older OVC can also form their own groups and participate in income generating activities.

What would we do differently? There have been some problems that, there have been some problems in a couple of cases that the, that there was not sufficient training in income generating income activities. If you are going to do these loan type groups, there has to be, it also has to be accompanied with sufficient training and income generating activities and vocational training. There's sometimes an expectation if you give capital or cash at the beginning that there's an expectation of dependency for a bump-up in capital when they actually start making money. So, like for example, in Uganda we didn't provide them with initial seed capital, but we gave them coal to start their group and they were able to start that way and there was no dependency or sense of dependency in those groups and also clear instructions that the funds should be invested and sometimes there is a tendency, and this is partly because there's the income-generating activities are not properly well thought out or insufficient. There's a

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tendency to save and not to reinvest. Critical elements obviously this needs to be owned by the community. We try to encourage explicit referrals with health services and other OVC services. Again, more impact studies, longitudinal studies carefully selected income generating activities and vocational training that are appropriate.

We have tried to promote self-sufficiency. As I said, if possible, try to avoid initial seed capital. Youth participation can be a really good thing to help build the revenue abilities, the revenue generating abilities of the youth and also the use of the social safety net that some of the money should be invested in a reserve that can be used for emergency cases, and anyway, thank you.

[Applause]

PATRICK DISKEN: Thank you. [inaudible] speakers and try to remember your questions for AIDS. We are going to break it up for about 15 minutes if you have questions. We have a microphone that will come around so if anyone has questions for the first four speakers. Yes, go ahead.

FEMALE SPEAKER: My question is for Bruce's presentation. I'm very interested to find out how the bed net project is working and how it ties to your A&C program, if you have an A&C project. And if the bed nets are given free to the people in the communities.

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BRUCE WILKINSON: They are given free, and the other part of that question was? What was the other part of the question, I'm sorry?

FEMALE SPEAKER: The other part was if you have a maternal and child health program or malaria program where you have a subsidized, not subsidized, but a social marketing program for bed nets or subsidized for your A&C clinic how that ties to this project?

BRUCE WILKINSON: Yeah. The government of Zambia has actually adopted a very, very aggressive mass distribution program of ITNs for the country. So what we have done is actually very targeted distribution to what we call vulnerable households and there is a mass distribution program, which in fact is very significantly funded and is moving forward. So, what we are doing is strictly a very nice complement, but we are covering 12-percent of Zambia's population with these nets. So, it is a significant part of their overall plan for malaria.

PATRICK DISKEN: Okay, another question? I see a microphone has been given over there.

MALE SPEAKER: I also would like to ask the gentleman who presented on the HIV and malaria in Zambia, not that one is not grateful about that project, but I just need more clarity what does two nets per household do? I mean, I understand one bed net for mother and father bedroom or kitchen and the

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children, the boys and girls, how do you really find the effectiveness? I heard you say you come in and ask, "Who slept under the nets today?" I mean, so you expect that some of the people may not be using the nets consistently. So how do you measure the effect of the bed net?

BRUCE WILKINSON: Yeah, I may have misspoke. We, on average, we are distributing three nets per household. We will go up to six nets. If the family structure needs six nets, they will get six nets. If a grandmom is living with two grandchildren, they might get one net or whatever that is so that's one. Number two on the effectiveness, we are actually measuring this in the six sentinel sites to actually monitor the impact of the incidence of malaria over a longer-term period of time, monitor bed net usage [gap in audio] and that is being collected actually on a weekly, biweekly basis by all of our 12,000 caregivers. So it's going to be a massive data collection exercise. We are just hoping the analysis proves to be helpful for others.

MALE SPEAKER: Okay, yes, this is also a question for Bruce on the RAPIDS program. I know this is a bit of a policy issue in Zambia. Are any of your 12,000 health workers paid in any way or are they fully volunteers?

BRUCE WILKINSON: All right, there we go. The volunteers in Peace is a huge issue. We have 12,000 volunteers

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we say are trained and equipped. Every one of those volunteers gets a bicycle, thanks to the gracious private sector donors. Those volunteers get bed nets within their houses for their needs. Those volunteers we also do a big seed distribution program just before the rainy season to vulnerable households. Those households, the caregivers' households all benefit from the seed distribution and then we also are fairly strong in kind distribution platform, which caregivers will get things like a pair of shoes or those kinds of things, but what we call them is work-based tools.

We are not going into compensation cash wise because the Zambian government that is something we are trying to make sure we are following the government policy on that and there's some good debate within Zambia as to where that's going, but what we really feel is you cannot expect a volunteer caregiver group 12,000 strong, we only have 2-percent dropout rates at this point, and that's over a two-year period, but I think the reason is because they actually have, we give them a care kit as well. They have a home-based care kit for each of their home-based care clients.

So, you can't expect volunteers to go into very desperate situations continually without being equipped and trained. And so I personally wouldn't go forward with a caregiver volunteer system if we weren't able to equip these

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volunteers because eventually you may either erode that ability within the society. It's one of the greatest assets in Zambia is this willingness to go and help your neighbor, and number two is compensating them. In the long term, I think this resource infusion may eventually take and erode some of that, that the beauty of that society in terms of helping their neighbors. So, anyway.

PATRICK DISKEN: Okay, I see a queue is forming for the microphone there. About four people in the queue. I don't know, we may not have time for more than that four, but let's continue.

MALE SPEAKER: Larry Marm [misspelled?], CDC, Atlanta. Ah, for Dr. Maggwa, thank you all for your presentations. Two quick questions. One, a clarification. The 412,000 children from unwanted pregnancies, was that exposed children or was that infected children? Could you clarify that? And the second, I think one of the challenges has been to incorporate HIV testing as part of a routine standard of care in family planning clinics. Have you incorporated this into your programs? Thank you.

BAKER MAGGWA: Thank you, Larry. The first question, the number that we are talking about, the 400,000 affected babies, this is an estimation, you know, using the DHS, the HIV prevalence, and looking at the transmission rates. So, as you

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know, kind of a number that has been derived looking at, you know, what is happening among these HIV-positive women without meeting their unmet need. That's the number of expected, you know, [inaudible] would be positive who could have been prevented had these women had access to family planning services. Then the second question is that, you know, there is right now, what's going on both in Kenya and in South Africa where we are looking at what we are calling the reverse [misspelled?] integration, integrating, you know, [inaudible] into family planning programs, and we that as, you know, as one of the most, another, you know, a good strategy to do because family planning services already exists and they are widely distributed out there so we are moving into that direction right now.

KEITH MCADAM [misspelled?]: Thank you. Keith McAdam from the Infectious Disease Institute in Kampala. I would like to ask about the microfinance presentation and also as it was related to the Millennium Village Project. I think in Uganda, there are hundreds of microfinance companies, and when you go around and try and compare them, one of the bottom line issues is what's the interest rate annually of borrowing that money amongst very poor, and the poor people involved with that are in our clinic are HIV-positive entrepreneurial people wanting to get restarted once they start ARBs.

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I just wonder how you are approaching HIV-positive people and whether your lending to groups of them might not be in the same family, but share that common attribute?

WILLIAM PHILBRICK: Thank you for that question. You used the word microfinance, I think you used the word companies. Again, what we are doing [inaudible] finance groups. So, these are [inaudible] in the community and they all know each other. Generally interest rates can vary within the groups and they are generally at the market rates, at market rate, but I have seen depending on the context anywhere as low as perhaps 7-percent per [inaudible] high as 20-percent. I, well, probably high. I'm talking to you about my own experience at least from what we've observed in CARE, and I know they are, can be higher. Generally, these groups can, the people, it's been our experience that generally they can be paid back, but in the context of HIV participants, sometimes they set aside a 1-percent insurance fund, which would, should cover the circumstances with revenue comes in 1-percent is set aside as an insurance fund to cover those cases in which HIV positive folks cannot pay back because of illness or something happens.

PEDRO SANCHEZ: Let me add a point from the Millennium Villages. In the Millennium Village in Uganda in Ruhira, the Senegal south district [inaudible - bad mic] have some of the

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people have even been taken to jail because they haven't paid on time. So [inaudible - bad mic] so, it's, ah, it's something to consider, but in all cases don't make any distinction between HIV/AIDS0positive people or not. The HIV/AIDS0positive people are getting treated if they wish, but they are [inaudible due to mic].

FEMALE SPEAKER: [inaudible due to mic]

BAKER MAGGWA: Ah, questions one, response to question one is all our programs with the National Family Planning Programs so whatever [inaudible] you know, are available and [inaudible] the National Family Planning Programs are promoted, you know, to the women whether they are accessing the services through the HIV programs that we are working with or they are accessing them through the Family Planning Program. So whatever combination of methods is promoted is driven primarily by what's available within the National Family Planning Programs and if optimal programs are available then they are promoted, but where they are not, then, of course, you know, you can raise the [inaudible] but they will not be able to access it.

Now the issue of stigma, that one, you know, is something that we continuously have to deal with and the way we are dealing with it is really trying to do training as much as we can and also to provide a more comprehensive service such

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that, you know, people are not just going in for a single service, but they are getting much more services in that way. You try to address issues of stigma, but the [inaudible] is really training the service providers to assure that they can be able to handle it just like, you know, we do in conventional PMTCT training and [inaudible] training. That's what we are trying to do and ensure that, you know we [inaudible].

PATRICK DISKEN: I'll let Pedro respond as well, but I notice the queue keeps growing there. So, I'll say let's agree that those are the last three. Nobody else should come and join the queue. We've only really got a couple of minutes left for questions before the next presentation, but go ahead, Pedro.

PEDRO SANCHEZ: Thank you. On the agricultural side they are very good questions. Again the decisions were made by the community and the scientists and this is the first things, all the communities decided that they want to grow with chemical fertilizer first because they know that you get a rapid return, and hybrid seed even though they have to plant every year as opposed to, as opposed to open pollinated varieties. They made that decision. In the second year, we started agroforestry. Nitrogen fix in trees, but they take time. I used to be the Director of the World Agroforest Center. So for me to start saying fertilizers and so on it's

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just a realization that you need something that really hits hard with impact and high yields in the beginning.

Agroforestry now in the third year is beginning to show its results in terms of [inaudible] trees and cutting down the [inaudible], and conservation pillage [misspelled?] and soil conservation [misspelled?] instruments and all of that come in, but after, after, after, after they had a bumper crop. After they realize that the land is worth something.

PATRICK DISKEN: Okay, next question.

FEMALE SPEAKER: Thank you, Mr. Director. My name is Mary [inaudible]. I'm the Director of Wonder Women Community Development Network. Thank you to all presenters. One of my questions, which was on microfinance has briefly been responded to, but my second question is going to Mr. Sanchez of the Millennium Villages. I would be very interested to learn from you, Mr. Sanchez, how, what could be your lessons learned from all the ten [misspelled?] villages? And what could have been the challenges and the possible commonalities that you might have found in these kinds of villages? And then my last question again to the Millennium Villages. I would also be very curious to understand, they are wondering how far you are and would also like to hear how you are incorporating the whole national agenda policy on the [inaudible] consideration, especially when you are interacting with the communities? And

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lastly, if you could also share with us issues around the present issues. Is this part of your interest or so in the village? Thank you.

PEDRO SANCHEZ: Thanks very much. Most Millennium Villages are in their first year. Some are in their third. So the lessons learned varies, but one thing, my main, my main take is this: If the community is involved from day one and they are empowered with decision making, they usually make the right decisions. And after the big bang of bumper crops, malaria going down, a clinic, anybody with AIDS who wants to be treated will get treated and all of that, and other things I've mentioned like school meals. We've locally produced foods for the entire village. One hundred-percent malaria bed nets. Everybody gets it. Everybody gets it. It's just like immunization. The people are empowered and they begin to say, what's next?

What's next? And next is crop diversification enterprise development. The villages are very much related to the national agenda. The [inaudible] and Millennium Village at Bugasera District was actually selected by the Cabinet of Rwanda. So, it was their decision. They are very involved in providing services and there's a lot of partnerships going on with other agencies including PEPFAR, including the Global Fund, including a lot of national base level NGOs as well.

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Everybody is welcome. It's essential that it is connected to the national agenda, because there is a big scaling-up issue. These are 80 villages. World Vision has something very similar to this also, but the numbers are small compared to the 100,000 that need to be there. Scaling up has to be done by the government and this is what we are working now, but I'll be working this week here with the government and with Dr. Josh Ruskin, our leader here, to begin to get additional scaling up so these villages won't be islands of prosperity in a sea of poverty.

PATRICK DISKEN: Okay. Thank you. Next question?

MALE SPEAKER: My question goes to Baker Maggwa, and I would like to know what your experiences have been with regards to integration of family planning into HIV programming, especially at the first level, the level of prevention where resources are heavily skewed towards abstinence or abstinence and fidelity-only programs. Thank you.

BAKER MAGGWA: That's a difficult question for me to answer maybe in a very short time, but I believe that, you know, we could kind of discuss that a little bit later on. But the bottom line is we have not really sat down to work out the expenses maybe in the way you have put them, but we have done some post-analysis of what it would take to do some of those work on integration, and I don't know that you were alluding to

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sources of funding. This is something I missed out in my presentation that, you know, all the funding that we have used in working, in all the countries that we are working in, these are both, you know, [inaudible] and HIV expressed through PEPFAR and the missions that have been supporting these activities. So they are very, very closely linked to what is going on with these, the [inaudible] parenting plans so that's how we get the funding through that. But the actual cost in terms of post-effectiveness is something that we are working on and that something that is evolving, but I could, you know, discuss that with you later on.

PATRICK DISKEN: Okay. Thank you. We'll take the last question.

FEMALE SPEAKER: Thank you, Chairperson. Because of time, I will leave my questions mostly related to the presentation on Millennium Villages. I just like to ask one now. It's about partnerships, you know. In the spirit of scaling up partnerships, is your program thinking about expanding to other countries? Thank you.

PEDRO SANCHEZ: The answer is, the answer is yes, but we are not going to do it all. Our program, by just doing 80 villages, that's big enough. We need partners. We need partners who are going to implement. The scaling-up basically has to be led by the government, but we need partners like many

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of you in your institutions here to take the idea of integrated development. Not only work in HIV/AIDS, but work in the rest of it as well. There's knowledge in all these other areas, like we rely on your HIV/AIDS knowledge for our HIV/AIDS program.

So, the vision is this, scaling up. This country now has a plan to scale up nationally. The want Millennium Villages in every district. The government of Kenya is now going into nine districts. The government of Uganda has been invited by [inaudible] to submit what they call a sub-county program, which is basically two or three villages. So this has to be scaled up, but it's not going to be done by one entity. It's a model. It's a concept. It's an idea. And hopefully, the government and the NGOs and the donors will put it together. Again, I can say it's perfectly affordable, according to what the donors have promised. Thank you.

PATRICK DISKEN: All right. I see one more person is insisting, so if it's a short question, because we are a little behind schedule.

MALE SPEAKER: Thank you very much for giving me the last opportunity. Mine goes to the family planning.

PATRICK DISKEN: Mr. Maggwa?

MALE SPEAKER: About, I'm [inaudible] from Uganda, about the involvement of religious leaders [inaudible]

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organization in HIV/AIDS programming and family planning
[inaudible] with your experiences the involvement of
[inaudible] and this organization and responding to HIV/AIDS
and the family planning. Thank you.

BAKER MAGGWA: Again, like I said, before all the interventions that we are working on are kind of built within the National Family Planning Program and also the National HIV/AIDS Programs. So, we are working with other partners that are involved in the provision of those services, and we organize, you know, the role of the faith-based institutions and also we respect their views in terms of being able to promote certain methods and not others. So, again, we are working with them in those centers where they are working. We respect that view, and we work with them to promote those methods that they are able to promote. And also through international working groups like the National Family Planning management committee, they are presented on that committee so whatever ideas get, you know, filtered out, you know, they are part and parcel of the whole process.

PATRICK DISKEN: Okay. Thank you. I see that the timekeeper is getting angry with me, so I have to cut off this one. Maybe just a round of applause for our first four presenters.

[Applause]

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Okay. So, we'll move on to the next four presentations. Without further delay, let me introduce Ms. Maggie Baingana – I hope I said that right – who will talk about Rwanda's HIV & AIDS Public Interest Fellowship Program. Thanks.

MAGGIE BAINGANA: Good morning. I'm going to be presenting on "Rwanda HIV & AIDS Public Interest Fellowship Program." It's centered on progress in human capacity development in HIV/AIDS. It's a program that trains and recruits young Rwandan recent graduates from non-health backgrounds and places them in paid internships [inaudible] for public sector. The aim is to make them HIV/AIDS program managers in the not-for-profit sector, including public institutions.

Now, why, why the fellowship program? What are we responding to? First of all, trained managers are cast in Rwanda due to the demographic influx of genocide and due to HIV/AIDS impacts on the work force. New graduates from our universities cannot be hired to fill these voids because they have no professional experience and because training at universities is still largely theoretical. The other problem is that HIV/AIDS is still largely addressed a health problem only, and our aim is to make sure that it's looked at as a societal [inaudible] in the development of progress.

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What are our objectives? Being the first of its kind in Rwanda, the fellowship program supports the government of Rwanda's objective to build sustainable human capacity in leadership while increasing capacity to fight HIV & AIDS. It also provides Rwanda non-health university graduates with practical skills and experience in sector HIV/AIDS programming. It also provides the knowledge and tools needed to better integrate HIV/AIDS in all aspects of life. It also improves the overall management capacity of Rwanda's School of Public Health to implement these programs with no external assistance. It increases capacity of Rwanda's HIV & AIDS focal points to fulfill their mandates at their given institutions. This program is done through partnership with University of Rwanda's School of Public Health and it's financed by PEPFAR through CDC, and we also partner with our Ministry of Education, our Ministry of Health, and our Ministry of Labor and Public Service.

The way that we run this program is through recruitment. We recruit fellows, the young recent graduates, and we also recruit host organizations from the government and from local NGOs. The selection process is highly competitive, and we usually get a lot of applications from graduating students, and we also get applications from host organizations that are interested in hosting these fellows for a period of

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two years. After we select the fellows and the host organization, we do a matching based on the criteria that the host organizations ask for. After the matching is completed, then there's a training program. The training is in two components. There is a classroom type of training, which is placement training after they are recruited before they are placed. They are trained in basic HIV/AIDS behavior change, [inaudible], HIV/AIDS development, monitoring and evaluation, reduction of stigma, cross-cultural and gender communication and so on. And then after, they are placed every six months there are refresher trainings and things like grant proposal writing and basically HIV/AIDS programming.

At 18 months, a nine-credit certificate course is incorporated in the fellowship. So the fellows enroll for two months in a nine-credit certificate course and those credits could be applied to towards a master's public health or any other post-graduate study that's recognized in Rwanda. Then we have on-job type of training that placement into paid internships in host organizations. They're provided with a stipend, a salary that's equivalent to entry-level civil servants in Rwanda. They are provided with computers. They are provided with health insurance, accident insurance and this facilitates their training on the job. They are also supervised by more experienced persons in the area of

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fellowship in the host organizations and also we had planned an international mentoring component where the fellows would be mentored by more experienced professionals internationally.

The achievements to date: Tools for fellowship implementation, including the curricula that have already been developed. We have 29 fellows successfully placed in host organizations across Rwanda. We had the graduation of our first cohorts of 10 last month and out of the 10 sites have been retained by the organizations they are working in, one has been hired by another institution also dealing in HIV/AIDS and one has gone for post-graduate studies in the area of public health.

Now, towards sustainability and institutionalization. Some of our achievements as well. I [inaudible] certificate host and MTH [misspelled?] credits have been integrated into the fellowships. This is going to assure its sustenance. Then we have 50 HIV/AIDS focal points already trained through the fellowship curriculum. We have fellowship implementation responsibilities largely transferred from Tulane University to the University of Rwanda School of Public Health and our Ministry of Public Service and Labor has adopted a fellowship model and it's now working with the School of Public Health to replicate it at the national level.

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What are some of the lessons that we've learned? The International Mentoring Program that I talked about earlier was costly and difficult to implement, so it was abandoned. It also is not possible to place as many fellows outside Uganda as we hoped because of logistics regarding training and the like. Lastly, there is also a greater need for the fellowship opportunity from both fellows and host organizations than resources actually permit to supply. And thank you. That will be all.

[Applause]

PATRICK DISKEN: Thank you, Ms. Baingana. Let me introduce the next speaker, Mr. Geert Haverkamp from PharmAccess International.

GEERT HAVERKAMP: PharmAccess, the organization I work for, started work-based programs in the private sector in 2000. In fact, we started with the Heineken Brewery Project here in Tanzania and the idea of work-based programs and concept and tools that we developed for that are now being used also in the public sector programs like the Army Program. The collaboration with the TPF started in 2003 was a small program, but it has been extended since 2004 - 2005 through the PEPFAR program. Military institutions, they share many features that private companies also have like hierarchy of functions. A lot of training is being done and, of course, the organization,

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whether it's company or Army, is highly responsible for the health status of staff and these elements are being used for that work-based program.

The target population for this Army program in Tanzania is 35,000 servicemen and -women, their dependents and it's very nice Tanzania program, which is the case in several countries, but not everywhere is the medical services, the hospitals are not only open for military personnel and their dependents but also for the public living in the vicinity of these facilities.

The program consists of five major components. It's prevention, counseling and [inaudible], PMTCT, care and support and the development of an HIV policy and all these elements together make it into a comprehensive program we think. On prevention, dedicated materials have been developed or they have been borrowed from the military from other countries. Amongst others, we have developed a card game of which now 5,000 copies are being distributed all over the country to the different military camps and hospitals. TOTs and peer educators have been trained, and we have started doing that mostly with officers from the higher ranks. This is somewhat contradictory to the term "peer educators," but in the Army, you have to work through the system and the hierarchy is very important to use. Of course, there's a big common [misspelled?] distribution program, and we organize open-house

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days, awareness campaigns to make sure that all that is happening in the military sites and the hospitals is being known to the public in the area around the hospitals so that's being used.

We trained counselors, clinicians, [inaudible] and pharmacists on, PCT, PMTCT and care and treatment services, and a lot of refurbishment has been done. Most of the hospitals were in very bad shape when we started, and now we are also starting with involving community support groups and increasing more access to these military sites. I'm sorry, this, if you turn your head, you can see a parade. One of the ways to get more and more people also from the communities around the hospitals for PCT services, through the hospitals we organize all these open house dates. Usually they start in an almost military way with a parade going from a spot in the village to the place where, to the hospital, and in that parade, in the walk to that hospital, sometimes at least hundreds or sometimes thousands of people follow it to that event. And our last event that we did in [inaudible] more than 480 people tested at that location of the open house event.

A lot of effort has been put in financial management. One of the problems that has been there in the military programs is that if whatever donor funds for AIDS Program goes directly to the ministries, it's hard to get the money

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underground at the hospital level. So, with the flow of money going through an NGO like ours, now we have the contracts with individual hospitals. We have budgets for the sites, and we look after the money that comes through the system. Actually, it's being used for what it's meant for.

In the last half year, two and a half thousand people have been tested. Eight hundred and four people women have been tested for PMTCT services and currently 2,300 persons are on treatment, and as a result of this community involvement, you can see that in most cases the majority part of the participants are women, which is around 90-, 95-percent of the Army are male.

This is also a picture from one of the open house events whereby to our surprise that these, a lot of discussion on stigma. Well, we didn't notice much of it because people really lined up for testing. This gives you an idea on what the hospital looked like before refurbishment and after refurbishment. The laboratories, they have been scaled up. The last item of what was mentioned to have a comprehensive program for the Army is, and that goes in general for workplace programs is that the organization that has a work-based program should have a policy on HIV/AIDS, and this has been discussed a lot in the Tanzanian Army to have a, well, more or less mandatory testing to become part of the program and then in

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this case, it means that currently all military servicemen have a physical exam once per year and counseling and testing on HIV/AIDS becomes part of that yearly medical checkup. The other part of the policy stipulates that not only testing is being done then, but also that the position of every serviceman is being guaranteed whether HIV-positive or not.

In conclusion, we think that the work-based program is very effective model to have a comprehensive program. That that not only go for private companies, but just as well for the uniformed forces, and we are in Tanzania now also discussing with police and prison forces to have the same program in these forces established. The big challenge of the policy to have everybody tested once per year is that not only the hospitals, but also all health centers and even the smaller facilities where the yearly medical checkups are being done also need to be prepared for counseling and testing and in the long run also for care and treatment services. In the end, we think that this policy whereby everybody is tested will have a positive effect on reducing the infections and having less stigma in the Army. Thank you very much.

[Applause]

PATRICK DISKEN: Thank you, Mr. Haverkamp. Our next speaker is Christina D'Allesandro, who will talk about moving upstream.

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CHRISTINA D'ALLESANDRO: Thank you very much. I appreciate it. It's going to be a long session so if people need to get up and jump around, they should feel free. What I am going to talk you about is a piece of research that I'm doing, and I'm here representing the U.K. Consortium on AIDS and International Development and within that organization, which is an umbrella organization, a brother organization for all agencies working on AIDS and for its national development in the U.K., I co-chair a section of the organization called the OVC Working Group, and I do that with a colleague of mine, Stuart King [misspelled?], from [inaudible] U.K.

And we, I'm then, therefore, able to speak on behalf of about 26 agencies that are interested in working with [inaudible] children and many of whom are actively working on those issues, you know, across the world has been a great benefit for us.

One of the things we've now decided to do is take on more of a research agenda because we think the fact that we represent not only 26 agencies, but all of our collective partners really gives us quite a good position in ensuring that work that is done or research done is widely distributed and involves many partners, involves a diverse number of partners on the ground. And so that was why, anyway, we decided to take

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on this research, and I think some of that will come out as I present the research.

The research that we are looking at is looking at the inclusion of children affected by AIDS or [inaudible] OVC into national development instruments. This is the, probably you've got some strategies, national development plans really determined by what is authority in that country, and I think the reason this came up and this research was commissioned by UNICEF's Sosoro [misspelled?] Office and is granted to the consortium, which we often find that OVC and KABA [misspelled?] programs are fragmented. You'll have health and education sector plans existing in countries some of which, many of which will have [inaudible] of children, but not particularly specifically OVC and KABA increasingly you have more and more social protection plans, and you have existing in many countries poverty reduction plans and poverty reduction strategies.

We think and this is also a recommendation that came out of the global partners forum that was held in London in 2005, that if we can move the needs of OVC and KABA and more centrally locate them within the existing national government plan, we'll move away from that fragmented response to a far more cohesive, collective response and one of the key recommendations from the global partners forum was to look at

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how do we promote this multi-central response for children affected by AIDS and specifically focusing on looking at inclusion international development instruments.

So, of course, a lot of this comes from assumptions of that integration is going to bring about benefits. So, within the research, we not only looked at the state of the state for children today and their level of inclusion, but we also tried to look at lessons learned from other types of inclusion. The inclusion of HIV/AIDS and development planning. The inclusion of children more generally and child poverty specifically and the inclusion of gender, and the assumptions are made with integration you'll start to place the issue that you are integrating at the center of national discussion. You'll start to see longer-term ownership because it comes known to not only within one ministry, but hopefully collectively across a number of ministries, and it will get, therefore, considered in their planning.

We are hoping to [inaudible] coordinations across the ministries that are interested and certainly when we talk about issues for children, you are talking about a multi-pronged approach, a multi-central response. Increasingly, with more and more countries moving towards decentralized planning, the most effective way to get your issue highlighted in decentralized planning is to make sure it's appearing in your

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national strategies and ultimately, we hope this will lead to increased funding and then the issue for children [inaudible] hopeful increase domestic one day because we see this as a long-term issue that's going to require a long-term investment and currently where we have in place a number of these national plans of action, they are not funded. They are funded up, maybe up to level 30-percent.

There's other money coming in, some of which is on budget, a bulk of which is off budget, but how do we actually keep this as a national priority and get increased funding where appropriate from the domestic sectors?

So, to just give you a brief overview with the research, and I do it as this is the implementers [inaudible] want to get into some of the specific findings. We are still at the initial stages of the research. We've gone through the first stage but we basically propose a two-prong strategy, which is a desk [misspelled?] review followed by more in-depth case studies. We selected six countries for these case studies, and they are all countries that have some level of integration. The countries are Malawi, Kenya, Tanzania, Mozambique, with a particular focus on Uganda and Zambia. Uganda and Zambia, with this additional focus, had a number of in-country interviews going beyond the desk [misspelled?] research. In in-country workshop and one in Zambia was

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conducted last Wednesday and Uganda will be coming up this week, and these were leading towards an action plan and that will become clear when we look at the outcomes of the research even where there is inclusion it isn't necessarily meaningful so we wanted to make sure as we are coming here representing a wide variety of civil society organizations that this research albeit consistently strong desk proportion, had an actionable and outcome oriented side as well.

So, these are the key research questions. I'll walk through them quickly. We wanted to validate what are the key advantages and disadvantages for integration in your context. We wanted to look specifically at what, which development instruments are most important because we do find this varies on national context. We wanted to then look at what are the key factors? How did you get it in? Because we did want to make this also practical and that other countries interested in doing this integration could have lessons learned from where the integration had been successful and then lastly, and I've got bit a strange order here, but what have been the benefits? What have you seen happening in your country?

So, now I'll walk a bit through the interim findings. We are finding, and there was a study many of you may be familiar with that occurred a few years ago that didn't see much of a mention of children. Well, that's changing. We are

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seeing children. They are in every national strategic framework on HIV & AIDS and they are mentioned in some of the poverty reduction papers. What we are hearing is that integration is a great first step, but in and of itself doesn't lead to allocation of resources. So, we are feeling, we are seeing the mention, but when we look at the log [misspelled?] frames and we look at the indicators, we are not seeing things that we can actually tie back any kind of attributions maybe follow on funding or real, ultimately real change for the children we are looking for. And one of the things that's been highlighted particularly out of the Zambia workshop was where are the social indicators? Where are the child [inaudible] indicators? In almost all of these there are economic indicators, but where are the social indicators? We've got a true lack of those.

Where Zambia has been, and I'm drawing heavily on Zambia because that's the completed case study, they found that cross cutting was great in some ways, but it did create multiple managers and that blurred the line of accountability and one of the things that we found in this research we are trying to represent in the findings is a balance between the [inaudible] integration where you are speaking, you know, more to one master where you have more space for innovation, and you can ensure your issue is better protected with the benefit of

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going a larger, broader, multi-sector approach. However, that can lead to confusion, particularly where your OVC secretariat isn't a very strong body or it might not be a strong body in your country, or when the lead ministry is not as empowered within the national structure. So, then that's what we certainly have found as the lead ministries are often weak.

We found, we have struggled to find the benefits of integration over the short term and this is something I think we expected. I still would go back to the initial ideas of why we integrate, but in the short term, they aren't as observable and we need to in the immediate future make sure that we balance the response and balance the pressure on this type of integration with other ways of getting funding and [inaudible] children affected with AIDS and one of the points made is we do have civil society and in a lot of ways it places us as lead implementer. In the long term, that may not be where it's sensible to go, particularly if you want a longer-term sustained support response that's driven by government priorities, but we need to balance that.

Okay, I just want to focus quickly on the lessons learned. We were very clear that we wanted this to be actionable. So, we wanted actionable outcomes, action oriented, and that went both from the lessons learned of how the integration occurred and the ability to share that as well

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as within the focus countries making sure that all partners both government, civil society and donors left with clear actionable outcomes. I think we have a bit underestimated the amount of time and effort that that takes. I think we will be fairly honest we were fairly ambitious with a fairly small budget to study. We are amazed at the level of in-country participation. People have been very interested in this issue – partners from all sides – and very willing to devote their time to it so I think we certainly feel that the participatory approach was a good one, but time consuming. We had challenges in the methodology. With a limited budget, we intended to do a lot of this through alternative communication mechanisms, not in-country interviews, we tried to do phone interviews, we tried to utilize stipend of the technologies. The lead researcher was southern-based and there proved to be challenges.

We found when we went in and spoke to our country partners as well as a lot of the officials working at OVC, we were still struggling with a lack of understanding of the instrument, a lack of knowledge about how to engage in the Ministry of the Finance, this still remains a purview of the very few. So, I do think that a positive outcome of this study as we have got more people around the table, we have got more

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people engaged, but I think we do quite appreciate how far we've come.

Equally, we struggle to get access to documents and even now we are continuing the process to get access to all of the plans that we mentioned. We have tried to get the [inaudible] plan, we've tried to get the latest national plans of action for OVC, poverty reduction papers, swaps [misspelled?] as well as national development plans, and where a lot of people would say to us I can get you that, they are aren't available certainly in a digital media. We are often chasing hard copies, and I think more probably needs to be done to make sure the most current versions are out and accessible and available and that continued to be a struggle, but we are making some progress there.

So, lastly I'll conclude as I'm over time, with our next steps. We are finish the two case studies at the end of June. We have a focus mention the six countries, we have continued focus on working to get lessons out of the other four countries that weren't selected for in-country visits to get more information out of them and to make sure we are validating that information appropriately, and the final report, we are hoping, on this budget will come out in the middle of August. So thank you very much for your attention.

[Applause]

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PATRICK DISKEN: Thank you, Ms. [audio gap]

MALE SPEAKER: - leadership, involving HIV-positive teachers. Now, KENEPOTE is a network comprising of separate groups from different districts in Kenya, and before we formed this group, we had a very pathetic situation for teachers in their places of work. For example, teachers were rejected by fellow teachers, parents and students. There was a lot of breaching of confidentiality for those who tested positive. Many teachers who turned HIV-positive did not live long after their HIV status was known, and there were many [inaudible] salaries by the employer arising from the fact that most of them could not cope with the level of stigma. Some were unable to perform, and therefore, by reacting, they were sent home. [inaudible] a lot of drinking and teacher unions were not very much concerned since this HIV problem was not their own problem so they were not standing for the rights of the HIV-positive teachers.

All right, what are the KENEPOTE objectives to reduce stigma and discrimination against HIV-positive teachers? Intensify advocacy and lobbying for the protection of HIV positive teachers' rights. There's a problem of [inaudible]. Promoting [inaudible] and the voice of HIV-positive teachers in various local, national, local and national committees. For example, the Constituency Development Funds [misspelled?].

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Promoting a safe, quality care, support and treatment. One approach that we adopt, one of them is sensitizing of stakeholders. These remain the teacher [inaudible] with employer of the teacher. The Ministry of Education. Teacher Unions, that is Kenya National Union of Teachers and the Kenya Union of Post-Primary Education Teachers on the plight of HIV-positive teachers. We also created forums for student sharing for attitudinal change from the stigmatizers. We also opened [inaudible] with a teacher service commission for HIV-positive teachers [inaudible] policy. I must say that although we really did open this [inaudible], we were not really involved in the actual writing of the policy. When it was being developed, we were not there. There was also committed mobilization through [inaudible] of [inaudible] groups and carrying out outreaches to schools.

Who are our partners in this? We have health policy initiative, which is funded by USAID. These ones give us technical support and also funds. We have teachers, service commission with our employer, Ministry of Education, and we also [inaudible] Kenya International Union of Teachers, [inaudible], and we have Association in Development for Education in Africa, ADEA, which also helped us to develop a feeling in which teachers from different parts of the country shared their experiences at their workplace.

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What are the outcomes of our activities? Because of limitation of financial resources, we have not been able to assess our input properly [audio gap], but depending on the reports that are coming from our grassroot support groups, they are following our observations. That means that we don't have actual data because [inaudible]. There has been slight behavioral change from Board of Education managers and teachers. Nowadays, there are no more [inaudible] become very few. Not many teachers are turning to reactive behavior due to stigma and many of them have opened up are able to cope. And the education managers have learned how to [inaudible] HIV-positive teachers carefully. More teachers are seeking visitor services and care. There is formation of separate groups, we have more than 20 separate groups countrywide. Other countries are also [inaudible] like Uganda, Zambia, Cameroon and Tanzania.

What are some of the challenges that we have gone through? We have stigma in this [inaudible], which is still high. We have limited resources for institution of management, team building and leadership strengthening. [inaudible] is not in practice in their education sector, so we must acknowledge, we must commend the teacher service commission for employees [inaudible] can report to members in the advocacy [inaudible], but that's not all that we wanted. We want to be involved

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everywhere. Whenever there are meetings for decision making, when they are writing these policies, we want to be fair and be part of the whole process. We don't want to be left aside. So, when they are [inaudible] of our own, it doesn't mean that is enough [inaudible].

Lessons learned. [inaudible] is an important part of program that cannot be left out if progress is to be made. That is one of the lessons that we learned. Our recommendations, more dialogue should be encouraged to educate managers and teachers and also among the teachers. There should also be dissemination of the TSC, Teacher Service Commissions, [inaudible] policy on HIV and AIDS and advocating for its implementation. The workplace policy should state clearly punitive measures for any teacher found stigmatizing another and action taken promptly. We have never had anybody punished for stigmatizing a teacher in our country. I've never seen it happen, but we want such measures to be taken. That is showing seriousness. Views of HIV-positive teachers should be sought for any further amendments to the Teacher Service Commission subsector [inaudible] policy and the other thing is funding for M&E. With all of that, thank you very much.

[Applause]

PATRICK DISKEN: Thank you, Mr. Katucka [misspelled?].
Let me just say, in case people are not aware, that for these

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last four presentations, if you want more information there are abstracts in that big, thick book, which was not true for the first four presentations.

So, we have some time now for questions. I don't know if you want to raise your hands or you want to go in the queue in the center again? I'm not seeing any hands. A question? Okay, yes. I see two there.

FEMALE SPEAKER: I would like to thank the presenters for their presentation. I'm [inaudible] from USG Nigeria. I had a question for the OVC presentation, and it is I just wanted to know what you considered in selecting the countries that you chose to do this research on? Was it countries who had developed their national plan of action? Or countries where the OVC children are affected by HIV/AIDS issues were already integrated in any form of their poverty reduction strategies?

And then secondly, do you have any plans to scale this up to involve other countries? Because I know that 17 sub-Saharan African countries have been facilitated to work towards developing plans of action for orphans and vulnerable children. Thank you.

CHRISTINA D'ALLESANDRO: Yes, thank you. I mentioned that in the heat of the moment, but they were selected with, this research was commissioned by UNICEF Sohero [misspelled?],

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so we limited in the basic set of countries to those that had a national plan of action. When we looked at budget constraints in the idea that we wanted a nationable component, we then settled in consultation with UNICEF on six criteria and they are, one, have to have a well-honed OVC and national plan of action. Existence of an OVC steering committee we could work with and contact. A strong civil society group that was working on OVC, and that one I think because we as the conducting the research on civil society ourselves that was one of the outcomes that we put into our proposal. We wanted to have the potential within the inclusion for improved integration for children, and it did end up that we selected countries that had some degree of integration, but we felt there could be certainly more and better integration.

And then we had to have from our, since we were working through our partners, reasonable number of partners working in-country as well as a strong local contact because we did want to be, to have this be country level. One of the outcomes I know UNICEF is looking at is some kind of support tool kit that's going to support other countries that are looking to do this integration. So, we already have a checklist that's currently appended to the [inaudible] draft, which I would be more than happy to share with you, but we are hoping that this becomes the framework for more work to be done and maybe work

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specifically with some companies driving [misspelled?] that, but for the constraints of this research it was to come up with a checklist that could serve as the basis for that.

PATRICK DISKEN: Okay. Thank you. Yes.

FEMALE SPEAKER: Christine Naridio [misspelled?], and I work with [inaudible] Uganda. I would like to congratulate all the presenters for the wonderful work that you are doing and maybe a cross-cutting question to all of you is, what are the efforts to ensure that we can exchange this wonderful work across countries in the region, even beyond the meeting like this? The Millennium Villages Projects, the Teachers Associations?

In Uganda, I think stigma amongst the professionals is really at a very high level, and I don't know whether you have had an opportunity to have exchange with the professional associations of teachers across the teachers associations in the region. I don't know whether the East African community will help us in addressing some of these issues. I'll smuggle in a question for the Millennium Villages. What happens to village members who have no land or may be very sick? What happens? In Uganda, we have had climatic changes. June is supposed to be a season of, you know, no rain and now it's raining and in March, when we are supposed to have a lot of rain, it's not raining. What's happening? Do you have much

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experiences? I also want to congratulate Rwanda's Maggie about your fellowship program. I am a pioneer fellow from the Institute of Public Health in Makerere [misspelled?], and one of the issues that we found as new fellow pioneers, people would ask us, what is that? Who are you? What have you done? I don't know whether those are questions that you've met in Rwanda, and how you are marketing the fellowship program?

But I would like to say as a product of this program, I'm very happy to see it happening in Rwanda, and I would love to hear that it's happening in the rest of the region. Issues that are being discussed around the table about agenda, microfinance and economic development challenges, how are these being incorporated into the fellowship program for fellows to come out being aware that actually when you go out there it's not only ART [, but it's nutrition, it's gender, it's development and microfinance. How are we making sure that the fellows actually come out when there is strong even beyond their areas of expertise? Exchange visits, are these happening? I would love to hear that the fellows in Rwanda [misspelled?] have visited the fellows in Uganda and, you know, we shouldn't make the same mistakes that we are making in Uganda in Rwanda as we move forward and the last is, of course, the exchange across the regions for the various good work that you are doing. Thank you.

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PATRICK DISKEN: Okay, that was quite a few questions including a smuggled one from the first panel, but do you want to start?

PEDRO SANCHEZ: Thank you. Related to what happens to the very vulnerable people in the villages, I'm happy to tell you that the community has initiated programs to take care of them. In [inaudible] Village in Western Kenya, out of a thousand households, they have identified 49 households that they call the destitute people. Usually, widows, husband died of AIDS, their house is crumbling, some of them very sick and they cannot even grow the bumper crops. So they created a welfare committee and they, the first thing they did was rebuild houses for all those, I think 48 out of the 49 people, have gotten the houses. The Millennium Villages projects supported them with the usual things, cement, nails, and all of that, but the community build the houses for these widows, and I think it's a community taking its own responsibility for its most vulnerable people.

Then you posed the very difficult issue of climate variability and climate change. In all this equatorial East Africa region, everything is messed up, and it's going to be, we know that climate variability is one of the consequences of the climate change that we are suffering right now. The best answer we have is two things. One, is forecasting, better

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forecasting methods and there is an Institute at my University of Columbia called the International Research Institute for Climate on Society that is getting very good at predicting the short rains in this area. Unfortunately, not a long range yet. That's one thing. The other so more, more predictability and linking, linking the climate community, which is quite strong with your community.

The other thing is crop insurance. Farmers in the U.S. and Europe are also rain-fed farmers they have crop insurance. They have a safety net. So, we are working with many institutions around in getting crop insurance plans for these poor farmers who have no, it's difficult for the insurance companies because they have no collateral and so on. We've tried to work that innovatively with many insurance companies and also the World Bank is doing quite a bit of that and so those two things, the answer to the climate issue is both better forecasts and crop insurance.

PATRICK DISKEN: Okay, who else on the panel would like?

MARGARET WAMBETE: Thank you so much for those questions related to the fellowship program. The first question you asked, whether we have questions like what's a fellowship program? What does it do? That is very true. We also experienced that in our first year and also in our second

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year. We are currently now in third year and nobody knew where the fellowship is. Nobody had even heard of the name. And we had to do a lot of campaigns. We had to do a lot of marketing and because we created brochures, we created presentations in different seminars and conferences and more organizations and students from [inaudible] from our universities came to know what the fellowship is about.

The other question about whether they only receive training in HIV/AIDS specifically or [inaudible], they are actually given diverse topics and modules that are in HIV/AIDS programming and most of them are placed in organizations that do different things. Some are doing OVCs, others are doing things to do with income generating activities for vulnerable people. Others are in organizations that may be agriculture institutes and they are trying to incorporate how they can tell the farmers [inaudible]. Basically by the end of the two years, they have a big, a wide range of experience from their organizations and also from the theory that we give them. About the exchange program. There hasn't been any so far, but that is something we are looking into, and I'm glad that one of the points of reference is the Institute of Public Health of Makerere University. It's sort of different because it's a higher level. You get doctors and Ph.D.s and for us, we recruit young, recent graduates with no experience whatsoever,

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but that's definitely an area that we would be happy to look into. Thank you.

PATRICK DISKEN: Anybody else on the panel want to respond?

GEERT HAVERKAMP: When it comes to exchange of experiences and what has been developed, you can look at it between countries but also within the country, the Army program that we do we also want to expand to police and prisons, but between countries I think specifically on the fields of prevention and policy development, there's a lot to be gained from sharing experiences and [inaudible] yesterday started with a big meeting about military issues and there was an exchange of ideas about the development of policies. When it comes to the prevention program, I think a lot can be gained by sharing the materials and the experience that have been developed between the countries.

We have started something, the Nigerian Delegation is coming to Tanzania to see how the program is being organized there.

MALE SPEAKER: On the same question of [inaudible], can a [inaudible] of Uganda and Kenya. We've had several meetings. We've, teachers from the region, which one of my colleagues seated there has attended and maybe she can give us a brief

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detail at what happened at those meetings and which countries who are attending.

FEMALE SPEAKER: First, [inaudible] HIV-positive T-cells. Last year in December, [inaudible] to second December, we had a regional meeting, and we had HIV positive T-cells from South Africa, Zimbabwe, Zambia, Uganda, Tanzania and Kenya. So, in [inaudible], we had meeting with the teacher unions from both countries, and we formed partnership. We had several issues, which we discussed on meaningful involvement. Already South Africa has created a [inaudible] as a teacher's union manned by an HIV positive teacher sent to Zambia. So, we are asking other countries that were in that meeting to implement what we agreed on. Thank you very much.

PATRICK DISKEN: Is that enough from the panel? Okay. I see three people still in the queue, and I see there's only three minutes left, so I am going to ask a couple of things. One, that that be the last three and that the questions and answers be fairly brief and though I haven't checked with them, I'm pretty sure the panel members would be willing to entertain questions individually at the end. Am I right? Yeah. So, let's try to keep it brief because it is just about 12:30 already. Thanks.

FEMALE SPEAKER: Thank you very much. I'm Georgina from Ghana. I'm very interested in the Tanzania people's

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[inaudible] the open house. I can see in my mind's eye how interesting, how very beneficial this can be the population. My worry is normally when the military goes on a parade or route march, you have a lot of people following. The military has limited resources. So, assuming this happened in Ghana, and I'm going to sell this to them, how do we fund the [inaudible], for example, for the civilian population that will follow? Thank you.

GEERT HAVERKAMP: What they usually do with these organizations they also involve the organizations that do counseling and testing locally involvement to come to the grounds. You set up tents, you have counselors from the other organizations like in Tanzania, we work with [inaudible] from there, and they come with their test kits.

PATRICK DISKEN: Okay. Go ahead.

FEMALE SPEAKER: Thank you. I'm Flazera [misspelled?] from [inaudible]. Thank you for the presentations. My question will go to Maggie. I'm interested in the capacity building. This was very great for you to initiate this as one that comes from the genocide and is starting from scratch, but I was interested to see how suddenly you have created this will to support young people to work through internships. Your last slide demonstrated what you call lessons learned. Allow me to understand it as challenges because you talked of program of

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mentorship by experienced people from outside. You talked of program replacement in intern because [inaudible] is a limited place and they wouldn't go in remote areas in the districts. So that's why I call it challenges. So how do you or what type of strategies do you have to take to address this because I [inaudible] that you have great expectations, how are going to meet these expectations raised among these young people? Thank you very much.

MARGARET WAMBETE: Thank you for that question. Ah, first of all, about how we are going to deal with these challenges. We decided to opt for national mentors. Not international mentors. And we select supervisors from these organizations that apply to us, and we get people with far more experience than the fellows because it's much easier to follow them up. They are here, they can see them, they can talk to them other than embarking on the international mentorship program. So, they still get guidance and mentorship, but from [inaudible] or other people that are in senior positions that work in Rwanda. [inaudible]. And about the challenge of sending them to different areas, even if we wanted 50-50, like 50-percent to be in the rural areas and 50-percent to be in [inaudible], it's right now about 80-percent in [inaudible] and 20-percent in other areas. We, our main concern was basically to make sure that these fellows get enough experience and even

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if most of you [inaudible] the fellows do a lot of walking the fields in other areas of the country, and we saw that we are not missing [inaudible] they were actually on the field in different districts even if they were [inaudible]. And basically that it's - I hope I've answered your questions.

PATRICK DISKEN: Okay. Thank you. I've been told we are technically out of time, but if they are very brief, I think two more people have defied the chair and joined the queue, but [inaudible] very brief, please, so others can move on to what they need to do.

MALE SPEAKER: I'm Bill [inaudible] from the Uganda People's Defense Process. My question goes to the presentation from the Tanzania [inaudible]. I wanted to know the role of the medical services in your program. The medical services of the Tanzania People Defense Process in your program. Then also to know whether you faced any challenges in dealing with the military especially in relation to [inaudible] generated from your program. I'm asking this because in Uganda despite our openness on matter of HIV/AIDS, when it comes to HIV/AIDS and the military, the data is almost classified.

GEERT HAVERKAMP: And the data on the military program of Tanzania are also not available. That is maybe because they don't like to come out with these data, but also when it comes to the medical services, I explained that the hospitals are

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open for the public in general, and we noticed as I showed in the presentation that many people who come from counseling and testing, because, of course, everybody wants to know what the prevalence rates is, but for counseling and testing at the military sites it is open for public and for military personnel. So the only data I have is on the general population there. Not only specifically for the military.

PATRICK DISKEN: Okay, yes?

FEMALE SPEAKER: Thank you very much for presenters.

[inaudible] Managing [inaudible] of Women [inaudible].

Chairperson, allow me to ask one question on microfinance and last presenters. I'm sorry to come at this time. You know HIV is very much linked with poverty and [inaudible] poverty reduction as a strategy and mainly women empowerment for some women [inaudible] poverty. Then when microfinance issue, we know that microfinance offers savings and credit services to the clients, and of course, [inaudible] financial services. Then to the first presenter, he said that-

[END RECORDING]