

**International Women's Summit:
Leadership on HIV and AIDS
Special Session: African Case Studies
World YWCA
July 7, 2007**

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MONICA ZETZSCHE: – moderator and the one that will be introducing this incredible panel. She is the current affairs editor for a news anchor at International Media Group, so I will welcome Julie and thank you for moderating this panel. Thank you.

JULIE GICHURU: Thank you very much Monica. Asanta san. Thank you all for joining us for this session on HIV/AIDS and I would like to just thank all of our panelists for being here and welcome them. On our panel today, Honorable Phumzile Mlambo-Ngcuka -I can not say it; I've tried though-the Deputy President of South Africa. It's a great pleasure to have her with us. Also with us is Dr. Sheila Tlou, the Health Minister of Botswana. Canon Gideon Byamugisha, who is actually from Uganda and the Canon, was formally the Chair of UNERELA, a member of the Uganda AIDS Commission. Thank you, Canon, for joining us and also with us is Honorable John Muñoz, Minister of State for Special Programs. Well, we'll go straight into it.

It is a discussion rather than presentations and towards the end we will be able to take some of your questions. So, Deputy President, in Waseri [misspelled?], you just held a press conference talking about how Africa must take the lead, but what is the situation on the ground in our respective countries and, Deputy President, let me begin with you please.

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HONORABLE PHUMZILE MLAMBO-NGCUKA: Thank you very much and good afternoon. [Inaudible] is indeed one of the countries with a very great challenge and, of course, in the last few years we've been identifying different ways of responding and I would really characterize our response as a multi-sectoral response where governments, private sector, business, NGOs have a joined approach led by the Department of Health but we formed a formal partnership on the South African National AIDS Council. We are convinced that in relation to women, specifically, the most critical response is the only importance of economic empowerment of women. In the long-term, this is what is going to turn things around, when women are able to make their decisions, when women are able to look after themselves so they are not stuck, for instance, in abusive relationships. We all know that, however, is rather long-term so in the meantime we've got to deal with the specifics. So, we have been working on prevention, targeting young people, addressing the issues of lifestyle choices, and within that, a very important message for us is that young people must see themselves as having the capacity to reverse dramatically the trends, and even, they must actually dare dream of an HIV/AIDS world and continent so that they are so passionate and so committed to make a change. We have a big program on treatment as well and, of course, some of the challenges that you face in regard to that are also the capacity of our public health

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system. Like many other countries, diseases are a challenge because of many of the other things that you need to address in our public service. So, we also have a big program just to revitalize that health system, human resource infrastructure, etcetera, so that we are able to deal with a lot of other conditions that would make women even more vulnerable. We also recognize that the fight against HIV and AIDS is very labor intensive, so just the sheer numbers of people that you are able to deploy becomes important. That is why the partnerships therefore become very crucial.

We also have now even greater appreciation of skills such as social workers, assistant nurses, and of course, home-based care. Home-based care, which in the men is in the hands of the women and in many cases those women, would bring their own resources to start an initiative. I think for me, home-based care has actually become another layer of the public health system in the sense that it is so dynamic and women provide a lot of care and provide a lot of leadership there. I think the challenge that you have as nations is to support and invest in home-based care so that women who take those initiatives don't feel that they are alone. Women also do an outstanding job in addressing the issue of vulnerable children within the context of home-based care. And, of course, women living with HIV and AIDS, I think in all our countries, those are real heroes; because for many of us, we would not be where

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we are in terms of the extents to which we are fighting the stigma, the extent to which people are able to disclose, if it was not for the brave women who came out first and took a chance to actually say publicly that they are living a disease. In my country, those first women who came out were under a lot of pressure and, in fact, we have some women who were actually killed for having come out and because of the stigma, women and their children also suffer. So, that is also a very big part of the fight-to address the issue of stigma and, of course, we are investing a lot on research collaboratively with other institutions that are active in research. So, I have been told by the UNAIDS, that the South African program is the biggest in the world in the public sector. The components that we have, the funding that we have put forward for it, but obviously, you can not just throw money at the problem, the actions that we take collaboratively is what we continue to look for and we continue to mobilize more people to participate.

JULIE GICHURU: I think it's incredible to hear that an African country has the biggest program globally in the public sector, so that's something to applaud certainly. Let's move on to Botswana now, please tell us, what is the situation on the ground in Botswana?

DR. SHEILA TLOU, HEALTH MINISTER OF BOTSWANA: Thank you very much. I think one of the messages that I want to put forth is that, as we respond to HIV, we must know that the

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response for it to be really successful, it should not be in a vacuum. That Botswana is seen as a success story but it is because of happened in the past. So, let me simply start by saying that before HIV, our government was able to put out one of the best primary health care systems in Africa. Every citizen, in fact, 90% of the citizens were within 5 kilometers of a health care facility, fully staffed, fully with drugs and everything. So, in the '80s, our infant mortality rate went down to 36 per thousand, under five mortality rate 48 per thousand, life expectancy 67 on average, and maternal mortality rate was about 200. So, that's where we were and, of course, we also had programs that really ensuring that poverty is alleviated. For example, since 1974, we've always had free schooling all the way from standard one to PhD. As long as you were a person, you were going forth and, indeed, because of our [inaudible] rearing situation more girls were enrolled in school than boys. So, our female retracing is right now in the 90's and mainly traced in the 70's so it was really some of those things and we had also put forth a universal old age pension, where one started age 65 whether you ever worked or not, you need to think about your pension, no certain amount. This will help later with the prevention of HIV because sometimes these old women were actually the only bread winners in the home so they were able to then care, even before the government was able to put up the local programs in place. So,

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now, with the advent of HIV, we became one of the most affected countries in the world. We still are and the overall prevalence is 17% in the general populations, with 24% in the sexual active population and we've had, among pregnant women, it's now about 30%, so it's still very high. It's plateauing and it's going down. So, we had no choice but to really preserve our people because we're in a country the size of France with the population of 1.5 million so every one of those we have to save. So, in 1999, we started a program on HIV to prevent mother to child transmission and we have seen it grow from 28% in 2006 to now where the uptake is 93%. So, the access is 100% but 93% access it and the result has been because it was stated in the opening, where we've seen transmission go down from 40% to where now it is less than 6%. So, the aim is to continue to ensure that the 9% who are still not [inaudible] access and can bring it down.

Now, regarding ARV, we started in 2002 and we introduced a free ARV program because health care is free anyway, so by the end of 2005 more than 50% of the people who needed ARV's- anyway one of the first three countries to reach the bridge or three by five. As I'm talking to you now, 90% of the people who need ARV's are on ARV's. Funerals have gone down. Funeral parlors are closing. There is nobody on home-based care except old women who are being cared for because stroke or whatever and, indeed, the stigma has definitely gone

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down. Let me simply say that how I experienced just demonstrated accessible, affordable, and effective HIV treatment programs can create a favorable environment for HIV prevention as well as stigma reduction. We have our challenges. Human resources are one and also financial resources. We had to put in our budget, a budget for HIV, so 90% of our programs are our own budget and then 10% are from the donors but that 10% helps because we are then able to see where we are short of supplies. But it has not been easy, right, now we're trying to roll out ARV's to clinics, to shorten the distance that people have to travel to access ARV's.

Let me simply end by saying, for me, there are four ingredients that are necessary for any one country to respond effectively to HIV and AIDS and, really, especially, when we look at a gender sensitive lens. The first is political commitments. In Botswana, our Head of State is quite local wise for being the gender and AIDS activist and he is the chair of our National AIDS Council. I'm the Deputy Chair. I've missed some of our meetings. He never misses a single meeting, even if it's in a state, he says, postpone it; I have to check this meeting. Good governance is important. A good governance that listens to and sees civil society as partners rather than political threats, that's what we've done in Botswana. Our civil society's challenged because Botswana is a middle income

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country. As a result of that, a lot of the donors have moved out so that capacity is a problem but we still collaborate with our civil society. The third, of course, is zero tolerance for corruption. You know, Botswana is the least corrupt country in Africa because we know where the money should go to and it goes there. And the last, of course, is food and spending. You know, in the argument, we have to prioritize and channel the money where it is most needed. In Botswana, I always tell people the story of our own President who had one car. Who still has one car? But, this car he had had it from the first President. So, with the advent of HIV it meant he could not afford another car. It kept breaking down on him until even though position said, "For heaven's sake, buy the man a car." So, he didn't exactly want a new car, but simply because, now, we're starting to save money as we're seeing the epidemic level down. And of course, gender sensitive responses that don't leave men behind but simply say, let's assist men to redefine their masculinity, especially in a changing environment. Thank you very much.

JULIE GICHURU: Excellent, thank you so much. The next is Wasili John Munez [misspelled?], and Wasi, the same question. What is the situation on the ground in Kenya and also perhaps, we've been given four ingredients, does Kenya have those ingredients?

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WARIO ALI: Thank you very much, Julie. Maybe a small correction, my name is Wario Ali, Assistant Minister and Office of the President in charge of Special Programs. I'm standing in for my Minister, Dahn John Munez, who was committed elsewhere because of other national duties. May I take this opportunity to welcome the delegates? As the host, I say welcome and felitome.

Well, Asanta Caribone [misspelled?], you lead the first AIDS crisis both in the region and the country discovered in 1984. The government established National AIDS Committee and the Ministry of Health. By then, we taught this was a health issue. By 1999, the National AIDS Control Council was established as a corporate body and that the third corporation act by prudential orders and legal notice number 170. This was November 1999. We moved the approach from a health issue to multi sexual issue and that why HIV/AIDS is today that the Office of the President and the Ministry for Special Programs. Because of that approach, we managed to reduce infection from 85,000 per year to 60,000 yearly. We relate that success one to the dispensary approach because in 210 consequences, we established AIDS control committees patrolled by the elected members of parliament of that respective constituency, and nationally, it is being spear-headed by his Excellency, the President. By this, we have managed to achieve some reduction and we have a very ambitious program of seeing, of reducing the

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infection bred to 5.5 to 2010. Thank you very much, thank you Julie.

JULIE GICHURU: Thank you so much. So, we have the four ingredients and we're moving and we hope to achieve that.

WARIO ALI: Exactly, yes.

JULIE GICHURU: 5.5 %

WARIO ALI: Exactly, by 2010.

JULIE GICHURU: Fantastic, thank you very much. Let's go on to Canon. Tell us the situation on the ground in Uganda.

CANON GIDEON BYAMUGISHA: Thank you very much. The situation in Uganda is that, as you know Uganda is one of the few countries in the world where outbreaks of infection have quickly climbed but we also seek a [inaudible] these days because we moved from 5.8 and now we are back to 6.1. But, the good news coming from Uganda, too. One is that HIV is preventable, 100% preventable and AIDS is monitored on the condition that you have increased and sustained leadership commitment. Uganda achieved that success by doing four things. One, by applying and appropriate package that would give people information, changed people's attitudes, provided people with skills and services for self protection and care, and a supportive economic environment for making environments less risky. As you know, Uganda has been having an economic growth rate of 6% for the last 10 to 12 years that has been a very important achievement. [Inaudible] prevented places like

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universal, primary education, poverty, the eradication plan; it all goes we are giving empowerment to people. Uganda also applied appropriate interventions. Interventions that we will stick to, interventions that are multi level, moving from national to village level and to visions that are multi dimensional, targeting the spiritual, the physical body, and the emotional body. Uganda also tried to deduce a very important kind of [inaudible], which I see many people in the world are mixing up when it comes to HIV/AIDS, trying to explain to people that having loveful and faithful safe sex is not enough to give you 100% protection from infection; rather, it must be a loveful, faithful, and safe sex so that [inaudible] age old question but both. And although people have tried to understand what has happened in Uganda, we are still committed and explaining to people that you have to have comprehensive to HIV prevention. Finally, Uganda applied a specific piece that has helped us reach where we are. One is putting appropriate policies culturally, with treatment in place, having strategic plans that cover the whole country, putting practical programs for prevention and treatment and offer support; training personnel so that they are more AIDS competent, establish patterns for prevention and care, more rising resources. I think we are very successful in attracting very big funds to help in the HIV fight and making sure that we do the right proclamations around HIV. So, the lesson coming

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from Uganda is that, yes, we can do well, but also, if AIDS becomes very [inaudible] then you can miss the target. You can begin going down because we are moving away from a comprehensive prevention approach to an approach that focuses on abstinence only and problems with some faithfulness and a very small scene for condom use. Thank you.

JULIE GICHURU: Thank you very much. Just on the issue of abstinence only and what we can learn from each other; let's take that as an example. I would like to know, are African countries making an effort to come together to relate their experience as governments and in sharing those experiences to learn and move forward? Are there are any efforts of that kind, seeing as people are talking about a United States of Africa? In terms of health, HIV, and even in terms of HIV and how affects women, is anything being done by governments to share information?

FEMALE SPEAKER: At a certain level, we have an HIV and AIDS program that encompasses all of the countries so we are able to talk about where we are and how we can help each other in this stage. We even have some cross border programs. The problem, of course, is funding because it means getting funding that can accommodate all the countries while at the same time funding for your own country with need.

JULIE GICHURU: Well, that's very interesting. Please, tell me [inaudible], do we in East Africa have anything of the

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kind cross border programs or even a program within the East African community that actually looks at what's happening with respect to HIV/AIDS and women in the countries?

MALE SPEAKER: Thank you, Julie. Yes, there are programs there but it depends how you approach your issues first before you look to what we do across the border. Depending on some of the issues of funding and the other program, yes, the program is there but not getting the concentrating here first then we can plan how we can move forward in neighboring countries.

JULIE GICHURU: Okay, so the programs are there but they have not really been put-

MALE SPEAKER: Not, we've been concentrating on our internal issue, our programs first, then we can extend-

JULIE GICHURU: But, there's a lot we can learn Uganda, so maybe something we should take from the Southern African countries and try to adopt?

MALE SPEAKER: Well, it needs, as they are putting it into regional approach, that where you can not fight the AIDS war alone and win it but we have to put our structures in place. We have to be ourselves first then see how we can share with other countries.

JULIE GICHURU: Do we all agree, Canon, do you think internally first as nations, we must build capacity before we go out and learn from our neighboring states?

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CANON GIDEON BYAMUGISHA: Yeah, it is very important for building internal capacity as a person has all ready shared that HIV/AIDS is just a symptom of things that have gone wrong. It's not just a viral disease that needs medical interventions but if you fix the climates, if you fix the politics, if you fix the education systems, and the communication infrastructure and the [inaudible] infrastructure, you are moving towards becoming AIDS competent so you can then have lessons to share with your neighbors of what you have done in different sectors. That is why Uganda moved away from a [inaudible] provision started to a more sexual program, because we had AIDS control program first, AIDS Control Minister of Justice, AIDS Control Program Minister of Education, AIDS Control Gender, you know, all these departments having programs, and we even had one on agriculture, which was focusing on making sure it is high nutrition taking the [inaudible] out to the fact that laborers going down as do or die so what do we do, how do we replace the declining labor and all of the that. Multi sexual, multi level, and multi dimensional approaches then can be shared across the borders.

JULIE GICHURU: I would wonder, do we then risk, though, leaving some countries behind in the fight against HIV/AIDS and in empowering women, we've said that economic empowerment, for instance, is one of the key issues here. Some countries which don't have the capacity or the will do we then

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leave them behind as a continent? Let me bring that to you, Deputy President.

HONORABLE PHUMZILE MLAMBO-NGCUKA: Well, of course, we wouldn't do that deliberately. If it does happen, it would really be an unintended consequence. The different original bodies, be it Sonic, Eqouis, all of us have coordinated activities that we undertake depending on the resources and so on. Some work better than others. In the African Union, also, and I'm sure the Minister of Health could say much more, that also provides us with a forum where we're able to call in aids. But, I do want to highlight one institution that I think is very important to all of us to also count on as a sight of struggle, not just HIV/AIDS, but abusive women. It is the family. Each one of us belongs to a family. You don't need membership fee, it doesn't matter what political party you belong to, what your social status is. At the end of the day, each one of us comes from a family and I think that, in many ways, we have underutilized that institution and we have not invested in it enough. It's also an important institution to fight poverty because if we make every family a participant and a service provider in the fight against poverty, it's the closest that you could actually deliver to the service to where it is most needed.

In relation to HIV and AIDS, I think that as we teach lifestyle choices, we must make sure that young people get that

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message at home, even before they come into school and as they come back to school there must be a continuous message that they are receiving from their institution. In many countries, including in my own, the violence against women and the abuse happens in the home. So, in every home, there would probably be a mother, a sister, a cousin, a mother-in-law, and sometimes there is a conspiracy of silence. From that perspective as well, I would like to say let us not-but before that, what we can do as countries, across border, and relieve our own families as important institutions to invest in and to fight against HIV and AIDS.

JULIE GICHURU: Thank you very much. I think a very strong point there and just to redirect slightly, it's commendable that there is action on treatment on the continent. That ARV's are available to some extent, to a large extent to people in many of the different countries. But, there's some concern that perhaps we're focusing too much on treatment at the expense of prevention. Is that happening?

DR. SHEILA TLOU, HEALTH MINISTER OF BOTSWANA: I see treatment and prevention going hand in hand. For us in Botswana, treatment made sure that people reduce the stigma and to see AIDS as a long-term, chronic illness such as hypertension and all that; but at the same time, we make sure that treatment was tied in with prevention because, indeed, if you have this treatment alone without greater emphasis on

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prevention, it is not sustainable. Am I right? Now, I'm saying 90% of our budget, the budget on HIV is from the government. Education gets 27%, I get 22%. It can be sustained. There has to be at least a decline that we can be able to maintain.

JULIE GICHURU: Canon Gideon?

DR. SHEILA TLOU, HEALTH MINISTER OF BOTSWANA: I do have to say something controversial because I think there was a time where so much under pressure around issues of treatment. That's a thing many governments went the other way. I think now, we're balancing. We're doing everything reasonable and in accordance to the demand. I think, for me, the private sector, still has not come on the side of the poor to bring down the cost and ensure that they do not treat this tragedy as business as usual and I do not think that we are highlighting that enough. Once we make the commitment to be the market we actually do risk a compromising on other aspects. So, the balance is very important and the corporate citizenship of the private sector in relation to these challenging times is something that we need to continue to call for.

JULIE GICHURU: Thank you, important there. Canon Gideon, your thoughts on whether we're balancing the attention we give to treatment and to prevention. We can begin with you.

WARIO ALI: Actually, there is no age at all for prevention and treatment because if you do treatment very well

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you facilitate prevention because it has been proved, really, that treatment is an incentive for people to be tested and so, like me, when I tested positive, they told me that you can guard against infection and live longer and if you are good at guarding against infection you are actually breaking the transmission chain. So, once you do treatment very well, you can also contribute to prevention. The biggest problem for me, ladies and gentlemen, is that many people who are positive, 70 to 90% of people who are positive don't know that they are positive; those who know fear to disclose, those who do disclose do so too late for effective prevention or for effective treatment. And another thing, I think they are all ready finished, so they don't take measures. So, for treatment and for prevention to happen, there must be a [inaudible] focus and a blurred-one of the Ministers here part of the [inaudible], because it has just been debated that you can not fight the stigma because they are not measured. You can not move away from the situation where 90% of people do not know they are positive if you don't focus on fighting stigma, shame, denial, discrimination, unnatural enemies' action. The stigmatizing messages must be dealt with. So, whether we focus on prevention, whether we focus on treatment, as long as the evils of stigma and shames and discrimination are there, we may not go very far.

JULIE GICHURU: Thank you, go ahead.

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CANON GIDEON BYAMUGISHA: Maybe Julie, just as a closing remark on this. The [inaudible] position remains with him but if you speak about treatment and prevention and there comes again the questions of poverty and awareness. I mean, all of this needs to go hand in hand. Treatment, prevention, how do you give medicine to somebody who has not taken lunch today? This is one big question. It's the million dollar question. So, that's the whole question of poverty. How do you succeed in addressing HIV/AIDS issues without addressing the question of poverty or awareness? Thank you very much.

JULIE GICHURU: Economic empowerment certainly key people do need to eat when they are taking these ARV's if you're looking at people who can not afford to buy food then this is a whole other ballgame. I think just to go back to the issue now of the testing and people knowing their status. We have a lot of VCT centers in Kenya, I would imagine it's the same in Uganda, Botswana, and South Africa, but how do you compel people to go and get tested? And, the issue of opt out testing, what are our thoughts on that? Your Excellency?

DR. SHEILA TLOU, HEALTH MINISTER OF BOTSWANA: Botswana became the first country to have what we call, Provider-Initiated HIV Testing and that model has recently been launched by the bridge board to guide other countries on how they can improve access to testing. What happened was once we had PMTCT and ARV's it was very interesting that very few people were-the

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number that we're up taking was not the number that we were expecting and we had to then call all state voters, civil society, to say, what is happening and we actually found that people are not comfortable in just going to test but they would be more comfortable if, for example, they go to a clinic a provider would initiate that test. So, what we've done as to have nurses, doctors, every body, change in how to initiate that request to say, would you like to have an HIV test? And also, even a support system to have PLWA's [misspelled?] working with doctors to give them that support and the courage to be able to ask and indeed and that's what brought our numbers up because now people started going and people started even to complain to me as a Minister to say, I saw a doctor today at the clinic. He didn't ask me for an HIV test. What kind of doctor is that? You should have encouraged him. So, it's now that open that more than 50% of Botswana knows their HIV status and I hope we can continue that.

JULIE GICHURU: So, it's working in Botswana. Now, I want to open the floor. I want to take questions from audience members, anybody, please who has a question. We have one in the back. Please go ahead.

NON ENGLISH SPEAKING FEMALE: Merci. [Foreign language]

JULIE GICHURU: Thank you; hold on a minute, could we just have some body to translate for us, please, shall we? In the meantime while we get it set up, could we take another

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question and we'll come back to you? Let's go ahead on this side.

GLENACE ALONZO BEATON, YWCA GAYANO [misspelled?]: I happen to have the opportunity to visit South Africa so my question is to your Excellency, we have a partnership with the safaris and now we're developing a document that would assist the South Africa YWCA. Last night, you alluded to the point that your YWCA in South Africa needs resuscitation. I'm very happy for that. We went at a time when you were extremely busy. We are in here today to get five minutes of your time since we know we can not do it without your government in order for us to really carry out women's policy that your government is alluding to. Would you be able to give us five seconds of your time when you are finished today?

JULIE GICHURU: Is it five minutes or five seconds?

GLENACE ALONZO BEATON, YWCA GAYANO: Seconds, seconds, I don't think she could give us five minutes. Five seconds will do.

JULIE GICHURU: Let's take the next question. We'll take three more and then go to the panel for responses. Yes, go ahead.

FEMALE SPEAKER: Thank you, I work in this region in East Africa in the home. In some of the key challenges that we've faced is the models for community-based care and home-based care in conflict situations, where the home itself is

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fragmented, where people are on the move, and or are in ITP camps. It would be very interesting if you could share with us, maybe Canon Gideon, maybe from the experiences of Northern Uganda, on how we can address the different challenges facing women caregivers in situations in conflict where we know that at times, even the best in social services do not exist and what are some of the approaches which organizations like YWCA would take in moving forward in ensuring that there is a support mechanism on the ground.

JULIE GICHURU: Thank you very much. Are we ready to take that call now? Sorry, I do TV so I'm always taking calls.

NON-ENGLISH FEMALE SPEAKER: [Foreign language]

JULIE GICHURU: Thank you very much. Excellent, we'll just take one more and then go to the panel.

LYNN FRANCIS, ZIMBABWE: Thank you very much. I'm Lynn Francis from Zimbabwe. There are three people, at least, on the panel who are part of what the Minister referred to as a family, the family of sub-Saharan Africa and I want to ask two things. I know that you are often pressured to put pressure on our government to be more open and to help out people, and particularly our women living with HIV, but also could you not put pressure on the international community not to basically put health sanctions, which are against the Geneva Convention, against our country because of politics. So, you're influence could work two ways. You could be an honest broker, as it

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were, to assist the people of Zimbabwe who are part of your family. And secondly, we know that the costs of drugs come down when you reach economies of scale. As a region, we have two or three countries that are able to produce generic drugs and if we club together to buy from the generic producers in India, we could bring the cost of drugs down enormously so that more people in sub-Saharan Africa could access it.

JULIE GICHURU: Excellent, thank you very much. So, let's go to those questions. So, let's begin with East Africa, the models for home care and the idea that in conflict areas there are various challenges, how do we then deal with those challenges on the ground?

CANON GIDEON BYAMUGISHA: The challenges in the conflict situations are not to be merited. They are very, very tough. If in Uganda, for example, the Northern Uganda still has the highest [inaudible] rates which is compared to the rest of the country because of the conflict and unsettling situation there; so, what people have been trying to do and I happen to be associated with Christian Aid in trying to mainstream HIV and AIDS within [inaudible] and [inaudible] situations. Rather than impending and other programs, it pays better to mainstream as you design the disaster and conflict situation approach how to integrate HIV/AIDS issues with the programs so that right from the word go you are trying to get an environment that addresses four things. One is safe practices in conflict

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situations. How do you ensure when women are in a conflict they are not encroached upon by being raped, by being forced into sex that the man has for food or for share cut. How do you integrate treatment concerting within your programs? Through people with HIV who need treatment in the camp but everyone has immunosuppression because of having a considerable environment then the other one is what we have talked about on the routine counseling and testing.

How do you ensure that people who are moving from one place to another, who are in camps, can access those testing? The biggest point really in addressing HIV in conflict situations is to accelerate the end of conflict but before that, ensure that there is some empowerment, some schooling [inaudible] in whatever form, some AIDS information and education is still going on in whatever form. In some skill building for negotiation and for safe behavior can be adopted. It is very tough, of course, because in a conflict situation, HIV is not a priority because the priority is, can I stay alive one more day? With us, HIV/AIDS can kill you in 15 to 20 hours. Lack of food or meeting a bullet doesn't give you a whole lot of time. So, it is challenge to all designers and I'm sure policy because of [inaudible] these issues.

JULIE GICHURU: Yes, Mashimiwa [misspelled?].

WARIO ALI: Julie, I wanted to share with you a case of Bora. Bora is the consequence I present in the National

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Assembly. There are more tests and the people leaving there most of them are posturalists [misspelled?], their way of life determined by the environmental condition they live in. They keep on moving from one place to another. Now, it's just like conflict. So, the best thing here is that you have the right structure to deal with this. For us, we have the Constituency AIDS Committee. The constituency is the lowest level where some members come from different locations and they will share with you that we are going to move from this man to this man. We have our people, we have people who are suffering from HIV/AIDS, we want ARV's, and how do you get them. Then as a company, you will sit, you will assist them. So, it is policy and the structure that are very important in this aspect.

JULIE GICHURU: That is operational in Bora?

WARIO ALI: In Bora, yes.

JULIE GICHURU: Fantastic, that is very good to hear.

Well, the next question. We've been asked, do you consider, in your programs with donors, job creation? How important is job creation when you're dealing with HIV/AIDS and with donors? I'll come back to Mushmu and then to—

DR. SHEILA TLOU, HEALTH MINISTER OF BOTSWANA: Okay, thanks. I'll start the one on job creation and the one on pharmaceutical and I'll think I'll also be answering for my Vice President because I'm Director Programs at Regional as well as at Africa level. Now, take the pharmaceutical one.

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We, at certain level, in our plan of action and program we have actually a component that's looking at pharmaceutical collaboration so that it is really going to save countries that will be able to do that should be encouraged. But also, I have just been the chairperson of the African Union, Ministers of [inaudible, and one of the things that we did was to come up with a pharmaceutical, an AU program on pharmaceuticals, that looks at all those three issues but really, we're hoping that can be implemented.

Job creation, you know, the problem is that donors- that's why it is important that this country is not to rely a lot on donors because donors come with their own agenda. They'll say, I'm giving you money but you are going to do thing, thing, thing with it and that's it. So, that the job creation should be within and really comes from ensuring that girls go to school and all that but I wanted to add that in our own side plan of action on HIV and AIDS, each country is expected to pledge money so that we have a side fund on HIV, which is different from the Grover Fund; our own fund, that where we can be able to undertake those cross border collaborations.

The last one, somebody talked about the physically challenged. It depends if in a country that has a council for people living with disabilities is there one in Botswana, South Africa-we make sure that we have a program on HIV/AIDS and

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disability. Granted, sometimes, you come to the utmost because of funding but you are doing this at basic level where you are covering everyone, including people living with disabilities. In our country, Botswana, the major challenge, for example, of people who are hearing impaired, is that even messages on television, they are not going to be able to get a spontaneous interpretation. So that, that disadvantage when it comes to information so we are trying to take care of that with the Minister of Education. But really, in terms of access to services, all of them have access to services.

JULIE GICHURU: Let me come to you Mushmu [misspelled?] you wanted to contribute.

MALE SPEAKER: Yes, thank you Julie. Other than addressing the job creation, why can't we address the question of economic empowerment? How many people are you going to address for you to be satisfied that you have addressed the operation of HIV infection? Why can't we generally address the question of economic empowerment then address the operation of job creation?

JULIE GICHURU: Or both.

MALE SPEAKER: Or both.

JULIE GICHURU: Yes, please, your Excellency.

DR. SHEILA TLOU, HEALTH MINISTER OF BOTSWANA: I also want us to emphasize the general economic empowerment of women as well as the education of women and girls as the problem more

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comprehensive. I wouldn't leave that with donors. I think countries and governments need to take responsibilities to make that happen for their citizens. I think for, specifically, people who are living with AIDS, the important thing is to make sure that they are not being discriminated against when they are looking for jobs in economic opportunities because of being HIV positive and that when that happens we must be able to have records so that we can actually address it. You do find, certainly, in South Africa, some Angiols [misspelled?] who actually work in a dedicated fashion to support people who are HIV positive with economic activities. These would include production of crafts and things like that and other activities that lead to self employment. So, you find that being initiated more at a local level, some municipalities also will do that, but I think the challenge there is also the issue of stigma. People don't want to go to work where HIV positive people work. They just want to get a job especially if they're well enough to work anywhere that anybody would- so I think that's the thing, to isolate it like this.

On the issue of disability, in the partnership for HIV and AIDS, one of the strongest sectors that we have in South Africa is affiliated, is indeed, people with disabilities. It's very active and through that constituency we are guided about the interventions that are needed, but I know that that's the concern that we've shared with them is access to

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information, given that when you say disabled people generally you don't reflect the variety of people who are in wheelchairs, people who are hearing impaired, people who have-the variety-so I wouldn't say we're on top of the delivery for each and every contiguity of the constituency of people who are disabled.

JULIE GICHURU: But, seeing as you are aware of it, I'm sure it's something that's been worked on. Let me bring this to you, Deputy President, the issue of Zimbabwe. Is it possible to lobby support so that the people don't suffer because of political issues?

HONORABLE PHUMZILE MLAMBO-NGCUKA: I think the point there is taken. I think this was a suggestion one doesn't really need to answer, it's something that we need to work towards with our governments in that respect. So, the point is taken.

JULIE GICHURU: Thank you all very much, our time is just about up, so I'd like to thank you all for taking part. Let's also thank our panel, please, for being here to discuss these issues with us today and I'd just like to call on the world wide of UCA President, Monica Sechae [misspelled?] to close the session.

MONICA ZETZSCHE: Well, thank you very much. Let me thank the overall panelist for taking time to be with us and I want a special thanks to Julie Gijourno [misspelled?], the Coordinator of Information Media Group, for kindly moderating

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this [inaudible] for us, so thank you very much and join me in a big applause to her and to all the panelist for their kind support and ambitions on these big issues and I will ask everyone to remain in the room for the next plenary session. You have 10 minutes to stretch, we are working hard, thank you very much.

[END RECORDING]