Turning the Tide on Gender Based Violence Summit Report

November 1st-3rd, 2011
Harare, Zimbabwe,
Acknowledgements

The SAfAIDS Regional Summit, Turning the Tide on Gender Based Violence, HIV and Culture in Southern Africa to share the evidence from successful models, strategies and approaches evolving around the SAfAIDS Changing the Rivers Flow programme, was made possible by SAfAIDS through support from its various funding partners. Special acknowledgement is proffered to Lois Chingandu (Executive Director), Sara Page (Deputy Director) and Ngoni Chibukire (Regional Head of Country Operations) for their overall guidance and support in hosting the summit.

SAfAIDS extends its appreciation to all the speakers for gracing the summit and for their invaluable inputs and insights on these most topical issues of our time. We would like to particularly thank all the participants and their various organisations who attended the summit and offered their experiences and rich reflections. Special thanks go to Seke Rural Home based Care for hosting the gala.

We would like to thank the consultant, Katrina Wallace-Karenga who laboured to write this summit report. The report was reviewed and edited by Kefilwe Koogotsitse and Vivienne Kernohan. Layout and design was done by Natalie Davies.
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**Acronyms**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
</tr>
<tr>
<td>ARVs</td>
<td>Antiretroviral Medicines</td>
</tr>
<tr>
<td>CARMMA</td>
<td>Campaign for the Accelerated Reduction of Maternal Mortality in Africa</td>
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<tr>
<td>CBV</td>
<td>Community-Based Volunteer</td>
</tr>
<tr>
<td>CTRF</td>
<td>Changing The Rivers Flow</td>
</tr>
<tr>
<td>GBV</td>
<td>Gender-Based Violence</td>
</tr>
<tr>
<td>HAART</td>
<td>Highly Active Antiretroviral Therapy</td>
</tr>
<tr>
<td>HBC</td>
<td>Home-Based Care</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>ICT</td>
<td>Information Communication Technology</td>
</tr>
<tr>
<td>IEC</td>
<td>Information Education Communication</td>
</tr>
<tr>
<td>ILO</td>
<td>International Labour Organisation</td>
</tr>
<tr>
<td>LGBT</td>
<td>Lesbian, Gay, Bisexual and Transgender</td>
</tr>
<tr>
<td>MCP</td>
<td>Multiple Concurrent Partnership</td>
</tr>
<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>PICT</td>
<td>Provider Initiated Counselling and Testing</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother-To-Child Transmission</td>
</tr>
<tr>
<td>PPTCT</td>
<td>Prevention of Parent-To-Child Transmission</td>
</tr>
<tr>
<td>PSI</td>
<td>Population Services International</td>
</tr>
<tr>
<td>PWD</td>
<td>People With Disabilities</td>
</tr>
<tr>
<td>REPSSI</td>
<td>Regional Psychosocial Support Initiative</td>
</tr>
<tr>
<td>SAFAIDS</td>
<td>Southern Africa HIV and AIDS Information Dissemination Service</td>
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<tr>
<td>SAN</td>
<td>STOP AIDS NOW!</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual Reproductive Health</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>UNESCO</td>
<td>United Nations Educational Scientific and Cultural Organization</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children's Fund</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>WWDs</td>
<td>Women With Disabilities</td>
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Executive Summary

The SAfAIDS Regional Summit, Turning the Tide on Gender Based Violence, HIV and Culture in Southern Africa, held from November 1st-3rd, 2011, in Harare, Zimbabwe, is the second such cross cultural learning conference to date\(^1\). This was a combined event which included the north-south annual conference, regional monitoring and experience sharing events.

The purpose of the summit was to provide a platform for participants to learn about and share evidence on successful models, strategies and approaches for integrating HIV prevention, gender and sexual reproductive health (SRH) interventions in communities in southern Africa. The Turning the Tide Summit brought together partner agencies from seven southern African countries in collaboration with a number of other researchers from the Netherlands and east Africa.

Recommendations

<table>
<thead>
<tr>
<th>Thematic area</th>
<th>Recommendations</th>
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</table>
| Leadership, HIV prevention and culture | • Support family units and not just individual household members  
• Recognise and include the voices of all groups of people in communities  
• Scale up engagement of community leaders and the judiciary  
• Push for the domestication of existing declarations and conventions  
• Integrate universal human rights in all HIV interventions  
• Build the capacity of leaders to advocate for and tackle prevention of gender-based violence (GBV) and HIV |
| Eliminating paediatric HIV and improving maternal and child health | • Make available and integrate age specific sexual and reproductive health (SRH) services and support in all HIV interventions  
• Intensify efforts to eliminate peri-natal transmission  
• Ensure provision and roll out of universal highly active antiretroviral therapy (HAART) for HIV positive pregnant women |
| Gender, sexual and reproductive health, HIV and gender-based violence | • Promote safer sex  
• Fully integrate HIV services in gender and SRH programmes  
• Act as policy development, implementation and monitoring watchdogs  
• Extend activism on violence against women from 16 days to 365 days  
• Adopt a holistic human rights approach  
• Improve access to one-stop services for rape survivors  
• Build capacity for greater community involvement in support for young people on HIV and SRH |

\(^1\)HIV and Culture Confluence: Experiences on HIV, gender and education, Johannesburg, April 2010
Quick Facts about the ‘Changing the Rivers Flow’ (CTRF) Programme

This programme is implemented in seven countries in southern Africa, working with more than 35 implementing in-country partners. The programme highlights the work and progress of their efforts to train and support community-based volunteers (CBVs) and Traditional Leaders in linking and taking initiatives on HIV and gender issues within their local cultural context. CBV resources have been produced, community dialogues held, and door-to-door campaigns on gender-based violence (GBV) and women’s rights conducted across the programme sites and countries.

Ultimately, the programme’s goal is to confront cultural practices, beliefs and customary laws to promote gender equality and prevent GBV against women and girls in southern Africa. The idea is to build and support local champions to take the lead in turning the tide on the links between culture, GBV and HIV culture.

Seven countries, seven stories

Presentations on the partners’ implementation of the CTRF in the seven countries are available in the annex to this report.

The table below highlights some quick key facts and figures from the programmes to date;

<table>
<thead>
<tr>
<th>CTRF Country</th>
<th>Number of partners</th>
<th>Number of CBVs trained</th>
<th>Numbers reached through door-to-door campaigns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malawi</td>
<td>5</td>
<td>208</td>
<td>24,898</td>
</tr>
<tr>
<td>Mozambique</td>
<td>4</td>
<td>432</td>
<td>28,800</td>
</tr>
<tr>
<td>Namibia</td>
<td>5</td>
<td>430</td>
<td>61,318</td>
</tr>
<tr>
<td>Swaziland</td>
<td>4</td>
<td>320</td>
<td>19,130</td>
</tr>
<tr>
<td>South Africa</td>
<td>4</td>
<td>362</td>
<td>2,824</td>
</tr>
<tr>
<td>Zambia</td>
<td>4</td>
<td>80</td>
<td>5,863</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>5</td>
<td>380</td>
<td>147,361</td>
</tr>
</tbody>
</table>
Introduction

The SAfAIDS Regional Summit, *Turning the Tide on Gender Based Violence, HIV and Culture in southern Africa*, was held from November 1st to 3rd, 2011, in Harare, Zimbabwe.

The Summit presented progress reports from seven countries from southern Africa and discussed 17 abstract papers from as far afield as Kenya, Uganda and Netherlands; held panel discussions around 14 research papers and projects; reviewed two documentaries; and introduced critical reflection sessions on the use of data in planning and the sustainability of programmes in a reduced funding environment. The information shared also included the importance of monitoring and evaluation in building evidence and measuring impact of community-based efforts.

By the third day of the summit, clear lessons and directions for the future were emerging. In a participatory session just before closing, the SAfAIDS rapporteur team, programmers, researchers, Traditional Leaders and guests negotiated and discussed the main issues and key recommendations under each of the summit’s five thematic areas. These are presented at the end of this report.

Community Dialogue

To take the learning and sharing of information to a higher level, SAfAIDS organised a field day in Seke District on Tuesday, November 1st, that brought together community members from Manicaland and Mashonaland Central, including local chiefs and headmen, kings and Traditional Leaders from across the region. The learning and sharing in Seke went on long after the departure of the summit participants.

Edutainment

Throughout the three day event, SAfAIDS wove in live drama and edutainment from Patsimeredu (a professional theatre group specialising in HIV messaging) and the Masovsava Drama Group, a local group from Seke. Mandedza High School in Mhondoro also provided entertainment, as did CBVs from both the Seke and Manica programmes in Zimbabwe.

During the summit, video documentaries were shown that included the voices and stories of CTRF programme participants from Namibia, Mozambique, Swaziland, South Africa, Zimbabwe, Malawi and Zambia as well as 20 brave Zimbabwean children and youth coping with HIV in their lives.

Who attended the Summit?

The summit attracted participants from a number of African countries including Traditional Leaders from Namibia (King Petrus Ukongo), Swaziland (Chief Sokhaya Fano Mdluli and Headman Zihute) and Zimbabwe (Chief Seke and Headman Richman Rangwani from Mhondoro) as well as organisations and activists from east and southern Africa.

In addition, a broad range of stakeholders attended. These stakeholders included representatives from STOP AIDS NOW! (SAN) and the Royal Tropical Institute (KIT) of the Netherlands.

The workshop also boasted a strong institutional presence from the University of Zimbabwe, as well as senior representatives from the local Zimbabwe offices of PSI (Population Services International) and UNESCO. There were also many representatives from civil society organisations, programme partners and the media.
Regional organisations in attendance included the ILO, Regional Psychosocial Support Initiative (REPSSI) programme and Gender Links. SAfAIDS media coordinated the communication efforts and focused on ‘real time’ reporting through the SAfAIDS website, Facebook and Twitter. Over 150 people attended the workshop over the course of the three days.

**This report**

This report captures key experiences and lessons learnt over the three days of the summit and focuses on the content of the summit from a ‘learning and sharing’ perspective.

As part of the annex, you will find the participants list together with a list of all the presentations by the different organisations. Copies of these are available electronically from SAfAIDS.

**Workshop Publications and Book Launch**

On the evening of Wednesday November 2\textsuperscript{nd}, the summit also hosted the ‘Programme Materials Launch and Networking’ event. This occasion was officiated by SAfAIDS and the Netherlands Embassy, represented by Barbara Joziasse, the Dutch Ambassador to Zimbabwe.

In her opening address, Joziasse highlighted the Netherlands’ ongoing commitment to the southern Africa region (amounting to some 10 million Euros of funding currently) as well as to the Changing the River’s Flow programme.

Joziasse noted that ‘the Dutch are traditionally seafaring people, and in this regard knew much about changing tides and waters’. In the past Dutch people have had to defend their communities against the sea and the issue of protecting livelihoods is close to their hearts. The Ambassador thus drew a parallel between Holland’s struggles with livelihood protection and the struggle to overcome the negative impacts on livelihoods of HIV, gender inequality and gender-based violence in southern Africa.

Joziasse emphasised that such a change was only possible in Holland through strong leadership and that the CTRF programme cannot turn the tide on HIV, gender inequality and gender based-violence without a strong effort to gain support from policy and decision makers and other leaders. Joziasse commended the programme for the involvement and engagement of Traditional Leaders.

The following key books were launched;

**HIV and culture confluence: Experiences from the Johannesburg Cross-cultural Learning Conference:** This book captured key reflections and experiences from the cross-cultural learning conference held in Johannesburg, South Africa, in April 2010. The conference aimed at sharing experiences on implementing interventions to address HIV and AIDS, sexuality, gender and education, with culture as a cross-cutting issue. The book targets professionals involved in HIV programming, SRH, gender and education — primarily non-governmental organisations (NGOs), faith-based organisations and CBOs. However, it is also aimed at policy makers and programme managers in governmental institutions, international NGOs, UN agencies, media personnel, researchers and teachers. The objective of the book is to empower these target readers with skills to improve the way they implement their programmes.
Traditional Leaders on the Frontline: Addressing Harmful Cultural Practices to Reduce Gender-based Violence and HIV in southern Africa: This book was developed following the successful summit (Indaba) organised by SAfAIDS in Johannesburg, South Africa in April 2010. The summit was largely an opportunity to harness the experience of the increasing number of Traditional Leaders now taking a leading role in addressing gender-based violence (GBV), harmful cultural practices and HIV at community and national levels. The summit brought together Traditional Leaders from Malawi, Mozambique, Namibia, South Africa and Swaziland. The book aims to share widely the deliberations at the Indaba.

It targets Traditional Leaders in southern Africa and other African regions, SAfAIDS partners implementing the CTRF programme, policy makers in the fields of HIV and AIDS, sexual and reproductive health and GBV, academics and researchers. Its objective is to empower these target readers with deeper insights which can enhance their efforts in addressing HIV and AIDS and GBV.

The evening also saw the launch of the SADC 2011 Gender Barometer, presented by Coleen Lowe Morna of Gender Links. The publication has been running for the past three years and uses a Citizen Score Card approach on gender and development in the southern Africa region. It is available online.

This year the barometer does more than just gauge opinion. Through the introduction of the SADC Gender and Development Index, it gathers empirical evidence using data from 23 indicators in six sectors. Whilst citizens feel their countries are only half-way to achieving the 2015 MDG targets, the index scores progress a little higher at 64%.

To complement the ongoing summit, SAfAIDS also launched their CTRF Programme Best Practice Case Study Booklet which was part of a larger package of programme materials distributed during the evening. The package included: Turning the Tide on Gender-Based Violence: Best Practices of Organisations Applying the ‘Changing the River’s Flow’ Model in southern Africa and the ‘Turning the Tide’ Documentary DVD.

Why a second learning and sharing workshop?

SAfAIDS and its programme partners have an important role in creating opportunities for and making good changes for their client communities. Hence, all efforts that are geared towards turning the tide on gender-based violence, HIV and culture must be grounded in the experience and reality of the communities across the region.

SAfAIDS believes that planning must be supported by evidence and learning that ensures that the voices of beneficiaries and stakeholders are heard. The Turning the Tide summit uses this ‘time out’ to look at what works and what does not work, as a way of shaping future interventions.
To acknowledge the importance of using data, conducting evaluations and reviewing our efforts, the summit included key presentations that emphasised the need to continually refocus and utilise available data to inform programme development, implementation and monitoring going forward.

**Managing Change**

**Sustainability of HIV Programmes in Challenging Times**

In the wake of decreasing funding for HIV programmes, Simon Matsvai urged the organisations that partnered with SAfAIDS in implementing the Changing the River’s Flow programme to ensure their policies, vision and values remain relevant as the programme changes. He raised critical questions to NGOs and CBOs urging them to internalise and introspect in the face of the erosion of donor funding for HIV-related programmes.

*Who owns you? What drives you? Who do you serve?*

Matsvai asked participants to consider why their programmes should be sustained? He noted that if it was the clientele and their needs who were creating ‘effective demand’ then the sustainability of their efforts as organisations was more likely.

**Numbers for planning**

SAfAIDS Executive Director, Mrs Lois Chingandu noted that using numbers for planning programmes is now more important than ever. Chingandu took participants through a presentation on using numbers for planning. She highlighted the role of using existing data to inform necessary changes in programming for the next phase. Some of the key points from the presentation centred on:

- **Implications of new WHO treatment regulations:** Without a concerted effort, few countries would meet treatment targets by 2015 using the new guide of CD4 counts below 350.

- **The need to push harder on reaching prevention of mother-to-child transmission (PMTCT) targets:** A call was made to intensify efforts on PMTCT to reduce vertical infections. This is an area with potentially big wins, yet most countries in east and southern Africa have only met 50% of their targets.

- **Stubbornly high HIV infection rates in the region:** five people are infected for every one person put on treatment, making treatment as prevention an important focus.

- **Limited political leadership to invest resources in HIV and AIDS programmes:** There has been little progress on the Abuja commitment to allocate 15% of the total national budget spending to health. The bulk of all HIV responses in African countries (with the exception of South Africa) remain largely funded by donors.

Chingandu stressed that monitoring incidence rates across different groups, particularly among young women, was crucial for success in the HIV response - young women are five times more likely to get infected with HIV than young men. Mrs Chingandu reminded participants that there is ‘no magic bullet’ to address the multitude of issues in HIV programming. Unfortunately costs remain unacceptably high.

“The days of relying on external funding for HIV are over. African governments must look internally to fund HIV programmes - prevention, treatment and care”
Achieving MDG 3 – A must!
The CEO of Gender Links, Colleen Lowe Morna, discussed MDG 3 and the role of policy in turning the tide against GBV and HIV. Morna emphasised that achievement of this goal is a must in our programming efforts since ‘the face of HIV is a woman’.
Gender Link’s recent role with SADC began with work to develop the SADC Gender Protocol in response to MDG 3. Her presentation noted that 34% of all people globally who are living with HIV and AIDS, live in southern Africa.

‘Gender issues and domestic violence are playing a critical role in HIV prevalence.’

Morna emphasised that the SADC Gender Protocol extends the efforts of the MDGs with 28 ambitious new targets. She called upon the CTRF programme partners to intensify advocacy activities on the signing and domestication of the protocol. Key highlights from her presentation are;

• In most SADC countries women still remain minors all their lives, subject to their fathers, husbands, sons, brothers-in law and men in general, because of unwillingness to address inequality in customary practices

• ABC (abstain, be faithful and use condoms) for HIV prevention means little to women; home-based care (HBC) just means more unwaged work for women

• More women are needed at all levels of decision making, especially in helping to champion efforts to significantly reduce maternal mortality

• With very few women owning media companies (5%) and even fewer on the news floor (17%), the representation of women and the coverage of HIV and gender issues are purely sensational and often targeted at a male reader and male dominated market. Media advocacy and change is therefore needed. Gender media watchdogs should mushroom and lobby for minimum reporting standards to be applied.

Keynote address

The summit was supported and endorsed by the Honourable Thokozani Khupe, Deputy Prime Minister of Zimbabwe. Her speech was entitled, ‘No Woman Should Die While Giving Life: Opportunities and Challenges’ as a build up from the 2010 Maputo declaration and the campaign for the accelerated reduction of maternal mortality in Africa (CARMMA).

The speech was presented by Dr Henry Madzorera, the Minister of Health for Zimbabwe, and highlighted the need for good stewardship from all leaders and their critical role in turning the tide on HIV, gender inequality and gender-based violence. One critical example cited was that of traditional birth attendants who can play a key role in maternal and child health. Traditional Leaders have clear and direct roles in the support and function of traditional birth attendants. Dr Madzorera posed the following questions and reflections;

“With one in every three cases of HIV infection coming from our regions, what does this say about our Traditional Leadership?“
“Are traditional birth attendants getting support? How do they access information and resources? How can and do Traditional Leaders intervene? How can they work with clinics and health services? How do we revitalise this service?

Transport is a perennial issue and more importantly, emergency transport for pregnant women to arrive on time at health facilities. How do we address continuous availability of drug supply and good quality drugs? How is our referral system - is it functional?”

Dr Madzorera concluded his speech by highlighting the need for communities and individuals to “rid themselves of the victim mentality that holds back most communities”.

He urged communities to “move towards directing and shaping their own futures” which meant the need for more emphasis on empowerment rather than on relief support. Dr Madzorera called for a renewed and renegotiated partnership with Government, NGOs, Traditional Leaders and civil society to turn the tide on gender inequality, HIV and GBV.

Edutainment
The drama conducted by Patsimeredu Drama Group from Zimbabwe highlighted the plight of the girl child. It depicted the poverty that a lot of families face coupled with abuse by those in authority, which increases the girl child’s vulnerability and risk of GBV and HIV infection.

Field visit to Seke Rural Community Home Based Care Programme

Under such a scorching heat, Seke villagers usually take refuge in the cool shade of fruit trees dotted around their homesteads. However, this was not the case on Tuesday, November 1st, 2011, when scores of women and men marched from Dema Business Centre to the Seke Rural Home-Based Care complex. It was no ordinary march but one which villagers expressed as crucial to the survival of the younger generation. Young people attended the event, as well as high school majorettes, dressed in their beautiful shiny purple and white uniforms.

Participation
Seke Rural Home Based Care Hospice is an institution largely comprised of women who provide care for AIDS patients. Prominent in the gathered crowd were pre-school children in their bibs and hats, the home-based carers and community-based volunteers (CBVs). The carers were identified by their bright blue bags and brown checked uniforms carers, while black bags and white cotton t-shirts reading ‘Nyora wiri kubatsira kupambwa kwefuma’ (write a will to avoid plunder of inheritance/estate by relatives) identified the CBVs.

The event was planned as an opportunity for the Seke programme’s participants to take stock of the work they have been doing for the past five years on the Changing The River’s Flow programme. This day of discussion and reflection was deepened by the participation and sharing of experiences from visitors from other CTRF programmes in the region and summit delegates.
Chief Seke opened the proceedings and spoke of the role Traditional Leaders have to play in preventing GBV and HIV. He informed the gathering that in Seke, women are now part of the traditional court. He urged others communities to do the same and emphasised that, “this involvement of women in traditional decision making has assisted to ensure that justice is delivered for women. This has also helped women to open up about the challenges they face.”

Dialogue and Discussion
SAfAIDS Executive Director, Mrs. Lois Chingandu informed those in attendance that although there was nothing wrong with socially prescribing the way people should live, some cultural practices were no longer progressive. She indicated that commitment to stopping new HIV infections means change from the top leadership.

Some of the key issues raised and discussed throughout the day were:
- Deceased estate management and HIV
- Wife inheritance
- Property inheritance
- Power imbalances between widows and male in-laws
- Family communication and resolution of family disputes
- Rights of women and girls to inherit from parents
- Wills and inheritance and the increase in cases of GBV.

Leadership
When Chief Zihute Mangwende of Murewa addressed participants, he informed the gathered crowd that he attends to many complex domestic violence cases. He reminded participants that before modern court systems, all issues were settled by traditional courts. He indicated that today, cases with a criminal element, such as violence in a marriage or family, were now referred to the police, showing that traditional systems can be wedded to modern systems for everyone’s benefit.

Using the Law
The local constabulary have been an important part of the Seke programme. When Police Assistant Inspector Gilbert Kaswa addressed the group, he added that women usually suffered unimaginable violence in silence when action could be taken against offenders. He highlighted that aspects of culture and the ‘skewed’ belief that domestic matters are better resolved behind closed doors, are still a major concern.

Country perspectives
Supporting women’s rights: As part of the discussions, a participant from Kenya was concerned that the gatekeepers of culture at community level were also acting as law enforcement agents. He asked, “Is this not a conflict of interest? Does this not hold back change?” He emphasised that GBV cases need to be entrusted to people who can help communities to change. He called for programmes to keep working with and engaging cultural gatekeepers to focus on protecting women’s rights and preventing GBV.
The rights of women and children: In Mozambique the law recognises only one type of marriage, between a man and a woman. Where a couple stays together for a year, they are allowed to register their marriage. Children, whether born within this marriage or not, can benefit from their father’s estate, but their mothers cannot be beneficiaries.

Culture and the law: In Zimbabwe Traditional Leaders are paid by Government to preside over cases. There is however, little coordination between customary and common law. Traditional Leaders must be the first and effective point of call for women seeking justice.

Learning and sharing
The dialogue from a broad range of state and civil society stakeholders helped to showcase the key elements of the CTRF programming in Zimbabwe and from across the region. Many of the regional programmes share common elements: community involvement and engagement, integrated service provision linking clinics, police, voluntary testing and counselling (VCT) and other services (in the case of Seke, both CD4 count testing and legal advice centres have been established locally). Such partnerships and integrated services were moving communities forward in the recognition of broader human rights.

Tracks to ‘turn the tide’ on gender-based violence and HIV

1) The Summit presented six tracks;
2) Gender-based violence and women’s rights
3) Linking HIV and sexual and reproductive health
4) New strategies towards achieving zero transmission of HIV
5) Leaders taking the bull by the horns
6) Young people and sexual and reproductive health
7) Media and information and communication technologies (ICTs)

Track 1: Gender-Based Violence and Women’s Rights

Gender Links opened the discussion with reflections on the interaction between gender inequality, HIV and GBV. The clear message that resonated throughout was the acknowledgement that even though the three issues are linked, programmes to address them remain fragmented and unlinked. On the issue of supporting women’s rights and promoting gender equality, the presentation highlighted how the media continues to negatively contribute to the advancement of gender equality necessary to ‘turn the tide’. Men and women continue to be stereotyped, with the greater damage being done to women in the media - branding them as the source of HIV and as sex objects.

Women Fighting AIDS in Kenya (WOFAK) focused their presentation on the positive outcomes of providing comprehensive care for women and children. Successes recorded by WOFAK were based on strong local coalition and referral networks that were key to affordable and achievable capacity to support women and children. Traditional Leadership was also an
important focus for this presentation. Participants were informed that women in Kenya have begun to take up Traditional Leadership positions and roles, with examples given of female chiefs and chiefs’ assistants.

Women’s Action Group (WAG) of Zimbabwe presented on their work with communities in Mudzi district. Their findings revealed that a large number of women experience abuse from their intimate partners. Over 60% of all women surveyed in the area reported that they had suffered abusive behaviour from partners and spouses. WAG noted that GBV is also occurring in schools and other institutes of learning.

Reports of ‘sex for marks’ incidents at local tertiary institutions were said to be on the increase. A key solution offered to combat abuse of authority at homes and institutions was to support schools, colleges and university programmes to strengthen gender issues in the curriculum and enhance life skills efforts. This will in turn protect, support and empower girls and young women to prevent and report abuse.

The International Labour Organisation (ILO) presentation introduced the role of policy and legislation in turning the tide on gender inequality, HIV and GBV. It focused on the new workplace standard on HIV, the ‘ILO Recommendation 200 Concerning HIV and AIDS and the World of Work, 2010’. This was noted as the first of its kind and its purpose was to highlight responses to HIV and AIDS in the world of work. The recommendation covers all workplaces and calls for the adoption of organisational policy that covers workers, families and their dependents, and the need to work in partnership to build capacity to implement and police its application and success.

Track 1 Conclusions:
The participants in attendance in this session noted several issues of concern including:

- The need to expand the 16 days of activism against violence against women to 365 days and harness the power of new policies together with lobbying for the domestication of other policies, in support of year round activism and affirmative action for women.
- **Policy gaps** that require further attention as well as follow through to implementation, especially those that support and enhance a rights-based approach for all efforts.
- The need to integrate HIV, GBV and women’s rights across all programming efforts.
- The need to target the media as a major barrier to change in the region and have more female editors and newspaper owners; media watchdogs who contribute to advocacy and lobby efforts to better enforce already existing regulations around responsible reporting.

Several resources to support comprehensive care of women and children can be found at www.whatwomenwant.org

To counter negative socialisation, re-socialisation must take place and take into consideration all age groups

The community must have the opportunity to identify and assess its own weaknesses and they must be given the platform to dialogue on the identified issues
Track 2: Linking HIV and Sexual and Reproductive Health

A study of policies, actions and commitments in African countries was presented by local Zimbabwean researcher, Delight Moyo. The presentation focused on the need for universal access to sexual and reproductive health, making the point that people with disabilities are also part of this commitment. Some daunting facts shared on disability and women included:

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>POP SIZE</th>
<th>DISABILITY PREVALANCE</th>
<th>DATA COLLECTED BY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malawi</td>
<td>12.1 million</td>
<td>2.9%</td>
<td>1997 UNDP survey</td>
</tr>
<tr>
<td>Nigeria</td>
<td>151 million</td>
<td>0.5%</td>
<td>1997 UNDP survey</td>
</tr>
<tr>
<td>South Africa</td>
<td>49.1 million</td>
<td>5%</td>
<td>2001 National census</td>
</tr>
<tr>
<td>Uganda</td>
<td>32.4 million</td>
<td>3.5%</td>
<td>2002 Population and housing census</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>12 million</td>
<td>2.9%</td>
<td>2002 National census</td>
</tr>
</tbody>
</table>

- Worldwide, ten million women per year are disabled as a result of pregnancy or child birth (WHO)
- 80% of people with disabilities live in poverty in the global South
- Disability prevalence in Uganda is 3.5% and 2.9% in Zimbabwe.
- Despite representation and a supportive policy environment in both countries, there remain minimal levels of consideration for people living with disabilities.

Can Service Providers Change? was the key question asked by Delene van Dyk in her presentation that focused on sexuality and different sexual orientation. A taboo for many, it is one that negatively affects the delivery of health care. This happens primarily when service providers show their fear, prejudice and stereotypical understandings when assisting individuals of different sexual orientation. Dyk highlighted that SRH support is neither straight forward nor homogenous because different people have different needs. A rights-based approach requires everyone to be treated the same, without judgement.

“Unlearning literally requires us to discard our old eyes and acquire a new set with which to see the world”
Sylvia Tamale, African Sexualities – A Reader

Track 2 Conclusions:
- Discussion stemming from the presentations in this track highlighted:
- The need for service provision on HIV and SRH and inclusive health support services for everyone, including lesbians, gays, bisexuals and trans sexuals (LGBT) and those living with disabilities
- Better understanding of sexuality for everyone involved in programming for HIV, gender inequality and GBV.
Track 3: New Strategies towards Achieving Zero Transmission of HIV

A study on epilepsy looked at the struggle of women with epilepsy within the HIV epidemic. Critical in this struggle is that epilepsy is often seen as a condition in need of ‘traditional remedies’ and is linked to numerous cultural factors. The Presenter, Nyakanyanga pointed out that encouraging women with epilepsy to get tested for HIV and enrol on antiretroviral therapy (ART) requires more than just a targeted approach. There is also a strong need to better understand how ART interacts with epilepsy medication.

Text to Change from Uganda highlighted the supportive role that cell phones can play in HIV programming. This is a powerful channel that can promote more direct information sharing and encourage service uptake. In this project, mobile phones are being used to send at least ‘one message a day’ that encourages people to access essential services. Through the project, increased uptake of services has been recorded.

Ambassadors of Change from Kenya, focused on testing and treatment as an HIV prevention strategy. The presentation highlighted the results of a study involving about 300 people in Nakuru District. Several important findings on behaviour were reinforced through this study:

- HIV prevalence is high among married couples, combined with low condom use
- Women still require permission from their husbands to access health services including HIV testing
- The majority of men included in the study did not test for HIV, but preferred to have their wives test during PMTCT. Based on their wife’s results, they extrapolate their own HIV status.

The programme called for more support for use of microbicides for women since behaviour change seems to be taking too long, whilst women continue to be at high risk of infection.
Track 3 Conclusions:
Participants in this session agreed that:

- There is an ongoing research gap in understanding the link between HIV and other health conditions.
- There is still a research gap on epilepsy. The focus has largely been on HIV and TB, whereas epilepsy and other chronic illness are not yet being fully studied in relation to ART which is being scaled up across Africa.
- Since the use of technology goes hand-in-hand with the content it transfers, relevant and targeted messages are critical. Technology is there to help in turning the tide and there is a need to be creative in using it.

Track 4: Leaders Taking the Bull by the Horns

Zimbabwe Community Health Intervention Research (ZiChire) Behaviour Change Programme delivered a presentation on leadership, HIV prevention and culture. The presenters highlighted the role of Traditional Leaders in the CTRF programme. In terms of traditional practices, the work with Traditional Leadership is about, in the words of one programme participant, ‘creating a way for the people to contribute meaningfully to their community’.

The presenters urged programmers to include all key stakeholders and local leaders, especially religious leaders and traditional healers.

“A panel discussion was led by Traditional Leaders from Zimbabwe, Namibia and Swaziland. Overall, the Traditional Leaders concurred that programmes supporting HIV prevention need to address issues of food security as well. Traditional Leaders have to focus at the whole family unit when offering their support and guidance and not on individual members who may be programme participants. A question was posed on whether HIV programmes are able to take on a more household or family centred approach? Traditional Leaders highlighted that safer sex is an area of concern and polygamous relationships cannot be ignored. Traditional Leaders stated that men were not yet ready to abandon this practice. A practical step forward, ahead of men’s full understanding and realisation of women’s rights, is an emphasis on safer sex and the direct involvement of young people, rather than just as recipients of information.

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Track 4 Conclusions:
- Traditional Leaders have an important role to play in the support of the family unit and may assist families by facilitating life skills, as well as bridging intergenerational issues.

“I can inherit responsibilities not my brother’s wife”

“When we pray for you, you will be healed of HIV, and you should stop taking ARVs immediately.” — what some traditional healers tell their followers

Chief Seke called for for all Traditional Leaders to have HIV tests
UNESCO Zimbabwe focused on the ‘limited’ readiness of schools to facilitate programmes on the sexual and reproductive health rights of young people. The presenter noted that many gaps still exist. Most important of these was the need for greater awareness of issues related to HIV and AIDS and youth, and capacity building for teachers and administrators in the education system generally. UNESCO reported that stigma remains high in schools and resources are needed to support the education system. The health and education systems must work together to implement programmes within and around schools and to jointly evaluate the response.

The Royal Tropical Institute (KIT) of the Netherlands discussed their work in KwaZulu Natal in South Africa. The study captured the experiences of young people who attended an urban HIV clinic in KwaZulu Natal. Feedback from those who attend the clinics is critical to inform service provision and care. Some of the key feedback issues were:

• “We want to be involved and have a say in our sexual health and not always be told what we should do”
• “We need information and advice - not judgement, clinic staff must not be like parents. Their job is to keep us safe”
• “Respect us”
• “Be honest- Tell us about our HIV status, it is better that we know”
• “Understand that we are young and like fun - we don’t want the clinic to take over our lives – we want to still live our lives!”

Track 5 Conclusions:
- Service providers need training and resources to support young people; need to budget for young people in health and education and bring them together to maximise the funds available.

Track 6: Media and ICTs

Drama, medics and straight talking: Using DVD-led discussion to challenge HIV and AIDS stigma amongst health workers was the title of the presentation by researchers Katrina Philips and Betty Chirchir from Kenya.

DVD clips were used to communicate key messages to health workers and others. This approach highlighted the role and value of visual communications for change.

The DVD clips used responded to challenges in the health workplace on dealing with issues of HIV testing and disclosure, as well as stigma and discrimination. Using video clips provided opportunities to encourage health workers to take up the services that they normally provide to the public, including HIV testing and treatment. The DVD clips focused on health care workers who were aware of and comfortable with their own HIV and TB status, these health workers’ testimonies and how this improves their service delivery and support.
The study revealed that it is still a challenge for health professionals to confront their own fears around HIV and AIDS. In discussions following the viewing of the video clips, feedback indicated that the clips assisted health professionals to open up and talk.

"If you know your TB and HIV status, it makes you more effective."

"I and my family (wife) will visit a VCT within a week's time"

"If I'm going to help TB and HIV patients I have to empathize with them and learn a more positive attitude towards colleagues who are infected with TB and HIV."

"It is time I disclose my status to my husband to facilitate him to be tested and my teenage girl and boy"

**SAfAIDS Zimbabwe** presented the digital stories of 20 young people from projects across Zimbabwe. The children in the digital stories were all living with or affected by HIV and the stories depicted the challenges they face in their daily lives.

The powerful use of voice and testimony from the youth was the key message for the group. Their role and participation was acknowledged as critical in sustained behaviour change. Some of the issues that came out of the stories were; stigma experienced within the extended family, difficulties faced by some children in taking medication at school; and the plight of grandmothers taking care of positive grandchildren, which raise issues of how to and when to disclose to the children.

**The Kubatana Trust of Zimbabwe** gave a presentation on how audio edutainment is a powerful behaviour change tool for young people. Kubatana showcased their project using ‘Freedom Fone’ technology (www.freedomefone.org). Their mobile phone ‘audio drama’ project has to date received 2,800 ‘call backs’ and queries. Some emerging issues from young people who took part in the project are;

- the lack of understanding from parents on issues of their sexuality and rights
- Newspapers and traditional media are not effective at reaching young people AND they often give conflicting and stereotypical messages
about sex and gender. The barriers they face on safer sex (girls still feel they cannot be seen having condoms as they would be branded as sex workers)
• the ‘safe space’ offered by the project to discuss the issues.

Young people and technology go together. This is an area worth investing in, in order to effectively reach young people with SRH messages. SAfAIDS in partnership with Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) is implementing an online HIV workplace programme that seeks to link people and organisations to exchange information, experiences and knowledge on HIV and AIDS in the workplace - the AIDS Prevention and Health Promotion Workplace Programmes in southern Africa (AWiSA) Network. The network began in South Africa in 2003 and has so far expanded through Malawi, Mozambique and Zambia, with SAfAIDS as a partner. The programme uses face-to-face workshops and training, together with online networking in its toolkit for turning the tide in the workplace. The network is accessible to everyone; employers, employees and peer educators. It is, however, targeted at small and medium-sized enterprises. The online network has a strong technical advisory support to ensure that the information available on this online ‘community of practice’ is always available and relevant.

Nine out of every ten people living with HIV will get up today and go to work, making the workplace a key location for HIV and AIDS-prevention and effective care programmes.

Juan Somavia, Director-General of ILO

Track 6 Conclusions:
• The use of technology is ensuring delivery of HIV programmes that are relevant, inspiring and accessible.
• The role of voice and visual communications that reach individuals in their homes and places of work are a critical expansion of traditional programme delivery systems.

The Research: Multiple Concurrent Partnerships (MCPs)

The Summit wove in research findings with practical programming outcomes. Four discussion sessions on research are summarised here.

SAfAIDS presented on MCPs as a key driver of HIV infection. The research highlighted that MCPs accelerate HIV transmission in southern Africa because of the following;
• When one intimate partner forms a concurrent partnership, the monogamous or faithful partner is vulnerable to HIV infection facilitated by the partner’s behaviour
There is a positive correlation between declines in concurrency and declines in HIV transmission. This can inform programming, care and support if the issues can be moved from research findings to programming.

Polygamy and the issue of courtship. Research into polygamous relationships has shown that it is very hard to ensure a polygamous network is closed. Thus the network remains open to HIV transmission.

STOP AIDS NOW! presented a risk analysis of MCPs. The presentation further emphasised that working on MCPs is difficult and poses a risk of doing greater harm, when the context in which MCPs occur is not understood. The discussion explored issues around communication on MCPs, indicating that very often the messages used in communicating MCP risk are too general, not properly targeted to high risk groups, and do not help define what concurrency means to the target audience. The research found that understanding of both of these terms varies from place to place and group to group.

Studies in Kenya and Tanzania show that not all young people understand catchphrases about ‘faithfulness’ the same way. Some thought faithfulness referred to the importance of trust in relationships and others thought it referred to the value of being a good or honest person. The links to ‘how we have sex’ were not clearly made.

Population Services International introduces the role of good local research into the work around MCPs. Local research on MCPs that links it to HIV, gender inequality and GBV needs especially to select, adapt and use the correct definitions, measures and indicators. Very often existing indicators are not localised. Local operational research is needed to inform programmers on what works. In this effort, research has so far yielded the following important information:

- Disaggregate your investigations by sex to avoid research bias
- Use a range of indicators covering the following
  - Type of partner
  - Duration of overlap of intimate partners
  - Frequency of sex
  - Consider the definitions used before making conclusions on MCP issues

<table>
<thead>
<tr>
<th>Method</th>
<th>All</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;1 partner in past 6 months</td>
<td>13%</td>
<td>18%</td>
<td>8%</td>
</tr>
<tr>
<td>&gt;1 partner in same month during any of the last 6 months</td>
<td>19%</td>
<td>26%</td>
<td>12%</td>
</tr>
<tr>
<td>Point prevalence (‘still having sex with’ &gt;1 of last 1-3 sexual partners at time of survey)</td>
<td>15%</td>
<td>18%</td>
<td>10%</td>
</tr>
</tbody>
</table>

Some highlights of definitions of MCPs used
- % reporting extra-marital sex in the past 12 months among married/co-habiting
- % of 15-49 year olds with more than one regular partner/spouse
- % reporting having sex w/ someone else while in a sexual relationship w/ a partner from the last 12 months/during last partnership
- % reporting 2+ partners in the last 4 weeks/3 months
- % of men and women aged 15-49 years with more than one ongoing sexual partnership at the point in time six months before the interview
- % of adult population with overlapping partnerships in the past year.
The University of Zimbabwe gave a brief presentation title ‘MCP is our Culture - True or False’. This took a dramatic line around how Africans position themselves within their own culture and more broadly globally, noting that much of the research on MCP was driven by northern agencies wishing to understand behaviours in the south. This skewed findings and he urged that more locally led research be encouraged and supported.

Agencies’ Reflections on Achieving Gender Transformations

Sonke Gender Justice Network of South Africa showcased their work on the One Man Can Campaign. The campaign takes a human rights approach as it seeks to build men’s confidence and rationale for participation in gender programming. It is further aimed at breaking down the stereotypes of men, finding and sharing the lives of role models that support gender equality and are rooted in today’s modern values as well as traditional practices.

PADARE from Zimbabwe highlighted their adoption of a culturally sensitive community entry strategy through engaging relevant community authorities i.e. Provincial and District Administrators, chiefs and other key stakeholders. This has helped their work with local leaders and work with young men in local schools.

People Opposing Women Abuse (POWA) focused on the intersection of women, HIV and poverty. The group uses radio drama to get across key messages and a phone-in strategy for feedback. Each episode received at least 200 calls with 60% of the callers being women. The project is part of the wider global Raising Her Voice project. The presentation made the following three core points:
- HIV and AIDS and poverty are a form of violence.
- Poverty sets the stage and context for HIV and GBV
- Poverty and HIV are gendered and continue to have the face of a woman.

Coalition of Women Living with HIV and AIDS (COWLHA) from Malawi noted that 58% of people living with HIV in Malawi are women. COWLHA is a membership organisation of women and girls who are openly living with HIV in Malawi. The coalition currently has 15,000 members.
Testing and Treatment as HIV Prevention

STOP AIDS NOW! challenged participants as they took a bold stance to say, ‘We have reached a tipping point’. New infections have fallen by nearly 25% over the past 10 years. AIDS-related deaths have dropped by nearly 20% over the past five years. Now, 6.6 million people receive life saving treatment, which is nearly a 22-fold increase since 2001! The global fight against AIDS has reached a tipping point. The end of the pandemic may be in sight in the next decades, provided we do not slide back to the days when the challenge seemed too vast to tackle.

The presentation promoted the use of treatment as prevention, because research has shown that treatment is the most effective option and in combination with other prevention measures can help turn the tide on HIV in southern Africa. The following table outlines new evidence, clearly showing the role that ART plays in prevention, with efficacy of 96%.

<table>
<thead>
<tr>
<th>Study</th>
<th>Effect size (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antiretroviral treatment for prevention Pape Nova, Asia, Americas</td>
<td>94% (73-99)</td>
</tr>
<tr>
<td>PEP for discordant couples</td>
<td>72% (49-85)</td>
</tr>
<tr>
<td>PEP for heterosexual men and women TDF Botswana</td>
<td>63% (21-84)</td>
</tr>
<tr>
<td>Medical male circumcision</td>
<td>54% (38-66)</td>
</tr>
<tr>
<td>PEP for MSMs</td>
<td>44% (15-63)</td>
</tr>
<tr>
<td>PreEX Americas, Thailand, South Africa</td>
<td>42% (21-58)</td>
</tr>
<tr>
<td>Sexually transmitted disease treatment Nwanzu Tanzania</td>
<td>35% (6-60)</td>
</tr>
<tr>
<td>Microbicide</td>
<td>31% (3-51)</td>
</tr>
</tbody>
</table>

Figure: HIV prevention technologies shown to be effective in reducing HIV incidence in randomised controlled trials.

Elimination of Paediatric HIV

Botswana-Baylor Children Clinic of Excellence in Botswana presented on the lessons and challenges of treatment for adolescents on ART. The key issue highlighted was the critical stage of adolescence which can be affected by ART.

The presentation also highlighted the challenges of adherence among 15 - 19 year olds. Key amongst them are:

- Adolescents vary considerably in their response to treatment – some respond positively to what is required of them; many however do not adhere to treatment consistently and in a few extreme cases abandon it
REPSSI made a presentation focusing on paediatric HIV. In this session the gap in providing psychosocial support to children and mothers was noted.

The presentation emphasised a child-centred, family-oriented approach that takes services to children and focused on meeting the entire range of needs of families affected by the epidemic.

In their presentation focusing on comprehensive prevention of mother-to-child transmission (PMTCT), EGPAF highlighted the decline in prevalence amongst children under 15 years of age. This decline is in tandem with overall HIV prevalence declines, with sub Saharan Africa recording declines from 500,000 new cases to the current new cases standing at around 330,000, according to UNAIDS. The presentation noted that this was in some way linked to progress achieved against targets. Some of the main progress issues highlighted were:

- Antiretroviral medicines (ARVs) for women on PMTCT increased from 58% in 2008, to 68% in 2009
- Infant prophylaxis increased slightly to 45%
- Only 50% of pregnant women received HIV counselling and testing, up from 43% in 2008
- Only 15% of HIV-exposed infants received an HIV test within the first two months of life
- Only 32% of children in need of ART were receiving it.

EGPAF called for an increased effort to deal with key gaps on PMTCT. The role of men was highlighted and men’s excitement and enthusiasm for healthy wives and babies should be capitalised on for gaining support.

Overall, the call was for 100% health facility coverage with HIV services as part of all ante-natal and maternity care services.
The Big Issues

This section captures some of the feedback and voices of summit participants during the final discussion and debate that contributed towards the formulation of the recommendations and helped highlight the important from the interesting.

**Thematic recommendations**

The summit came up with 22 recommendations for programming that emerged from the many and diverse presentations, discussions and debates. The recommendations were discussed, and after a consultative process, endorsed by participants.
Leadership, HIV prevention and culture

Support Family Units
The summit acknowledged that family units have changed a lot in our communities, yet remain the building blocks of our societies. Implementing programmes that target individuals in a homestead is making less sense, when the issues being tackled are complex and require good support networks.

Supporting family units helps align programmes more closely with the roles of Traditional Leaders and put back on the table the need to integrate food security in any health- or rights-related intervention.

Recognise and include the voices of all groups of people in our communities
With a focus on Traditional Leadership support, local and national governance structures must work harder to listen to and include the voices of others on HIV prevention issues, such as those of young people, people with disabilities, men who have sex with men and the LGBT (lesbian, gay, bisexual and transsexual) community. All voices must be heard in order to better protect the community. Ignoring the voices of the LGBT community, for example, only limits a community’s capacity to turn the tide on GBV, HIV and negative cultural practices.

Scale up engagement of community leaders and the judiciary
The programme has shown that when Traditional Leaders, local authorities, religious leaders and localised legal advisory services work together in tackling GBV, HIV and negative cultural practices, communities become safer places.

Reaching more community leaders, including faith-based organisations, and working to ensure that basic health and legal services are available locally is an important focus for programmes.

Push for the domestication of existing documents, declarations and conventions
Meeting MDG targets is important but targets set under these broad policy guidelines at times do not go far enough to support change at community level.

The SADC Gender policy has worked hard to localise and surpass MDG 3 for the southern African region. It creatively offers 28 targets to work towards, as a deliberate move to guide practice locally to help achieve MDG 3.

Focus on Universal Human Rights
Focusing only on the rights of individual groups such as women, young people or people living with disabilities, in isolation, has limited the capacity for change. A universal human rights approach considers the rights and dignities of all people and provides a concept that everyone can relate to. Rights-based approaches are critical for the voices of the marginalised to be heard. Without everyone’s voice and participation, HIV programming is not complete.

Tackle GBV from the top
Summit participants acknowledged that a lot still needs to be done to overcome GBV in our communities. Empowering women remains an important strategy. Male engagement strategies need to include stronger and sustained support from local and national leaders, who remain largely male.

Programmes should develop male engagement strategies that acknowledge the important roles and responsibilities of men, and work to lobby leadership to ensure and enforce protective laws.
Eliminating paediatric HIV and improving maternal and child health

**Make available and integrate age-specific SRH services and support**

Summit participants acknowledge that young people are sexually active. Including comprehensive SRH services and psychosocial support for HIV infected and affected children, youth, families and care-givers is a gap that still needs to be addressed, if HIV programmes are to be effective.

Being proactive in supporting age-specific children’s, adolescents’ and youth rights should also include comprehensive sexuality education for these different groups.

The capacities of schools and the expansion of the school curriculum in areas of life skills and sex education are areas that also need to be supported.

**Eliminate peri-natal transmission**

Summit participants acknowledged that programmes need to push for CARMMA to be integrated into all national strategies.

Beyond this, reaching PMTCT targets is critical and possible with adequate resources.

**Universal HAART for HIV positive pregnant women**

Participants acknowledged the need for capacity building and training of service providers if targets under this whole thematic area are to be achieved. The efforts of the Global Fund were acknowledged in relation to the provision of ART; however breaks in funding pipelines are a cause for concern.

Overall health care systems need improving. Greater community involvement in eliminating paediatric HIV and improving maternal and child health is important. The inclusion of patient experts (e.g. mothers with infants who are responding well to ART), support groups linked to health facilities for the newly treated, and associated service provider training on interpersonal skills and paediatric ART issues, can help.

**Gender, sexual and reproductive health, HIV and gender based violence**

**Promote safer sex**

Moralising about sex and behaviour has not worked to support gender equality and eliminate HIV and GBV, but has resulted in a preoccupation with sexual intercourse, at the expense of safe sex and protection from HIV. Summit participants acknowledged that practicing safe sex is about HIV prevention and protection should be the primary message and aim.

Legislation is also an important issue. Participants acknowledged that there is a need to advocate against the criminalisation of unintended transmission of HIV as this was likely to affect women the most. Laws that prohibit free sexual expression also make it harder for risky sexual behaviour to be eliminated, as lifestyles/behaviours are simply pushed underground.

**Fully integrate HIV services**

Stigma and discrimination is reducing across programme areas. Stand alone HIV services should now become a thing of the past. HIV, SRH and GBV care and support need to go hand-in hand, calling for a closer working relationship between health facilities, schools, legal services, churches and local police services.
**Policy watchdogs**
Auditing policy at all levels, and ensuring allocation of adequate resources to strengthen support structures addressing GBV, is an important move for programming.

Auditing the cost of GBV in societies and its links with HIV and TB is a must.

**Move activism on violence against women from 16 days to 365 days of activism**
Summit participants agreed that programmes should begin to move away from the 16 days of activism against GBV to 365 days of activism, which means sustaining activism throughout the year. Preventing GBV is not an event. HIV programmes need to refocus and innovate ways of maintaining activism efforts directly or through partners, all year round.

**Do no harm - adopt a holistic human rights approach**
During the summit, the experience from Namibia highlighted that bringing issues together under a single national human rights campaign can shift the frame of the important issues of tackling GBV, HIV and women’s rights outside of activism and within the scope of individual and collective responsibilities.

Support from national governments and leadership is critical and understanding individual rights is a crucial first step for everyone.

**Improve access to one-stop services for survivors of rape**
Participants at the summit noted the efforts of holistic programming and emphasised the need for one-stop services to include PEP (post-exposure prophylaxis), legal services and psychosocial support among others. Support for child survivors is also critical.

Experience has shown that providing 'child friendly' services reduces children's trauma. This includes the provision of victim friendly units in police stations and courts specifically for children.

**Build capacity for greater community involvement in HIV and SRH care and support for young people**
Strengthen the role of local protection agencies and committees for children at the local level to address child sexual abuse. Include creating safe spaces for young people, especially young women, to speak on issues of abuse.

Youth friendly services are critical and should go hand-in-hand with training of CBVs and service providers in age appropriate support and methods, to improve the response to issues of abuse and advocacy.

**Testing and treatment as an HIV prevention strategy**

**Implement WHO CD4 350 standards**
Moving treatment initiation to a higher CD4 count means more people are eligible for treatment. This requires more resources as well as that people know their status earlier.

Programmes need to focus on lobbying for resources, ensuring access to treatment, as well as VCT and PICT (provider-initiated counselling and testing) that helps ensure individuals and couples come forward for early testing.

**Increase funding for treatment for prevention**
Research has shown that access to and correct and consistent use of the full range of ARVs is a very effective strategy in preventing new infections. Increased funding for treatment also requires increasing funding for treatment literacy and continued research into the efficacy of treatment strategies.
An important issue acknowledged by participants was the availability of cheap and affordable generic ARVs and the need to lobby for trade and supply barriers to be removed and local production accelerated.

**Move programmes to a combination treatment approach**
Participants acknowledged that research in this area encouraged the use of multiple strategies for HIV prevention. Treatment alone cannot eliminate new infections.

**Monitoring, evaluation, reporting and accountability tracking**

**Monitor new infections**
Monitoring new HIV infection rates, especially among young women, is the critical bio marker for HIV prevention.

Programmes need to use data around universal access and other global and more localised data to help focus their programmes and better direct increasingly limited funding streams.

**Integrate new technologies**
Youth are both a vulnerable group and a resource in turning the tide. Young people use and enjoy new technologies and evidence is emerging that simple technologies, such as cell phones and community radios, are expanding among this group and within communities.

These new technologies offer cheap and effective ways of communicating and monitoring (especially when used together e.g. cell phones and community radio).

**Increase the use of appropriate IEC**
Summit participants were reminded time and again in discussions and presentations that messages are not reaching everyone in the communities. Information is often not trickling down and Traditional Leaders called for assistance in getting accurate and up-to-date information about the links between HIV, gender inequality and GBV to their communities.

Language, distance and cost barriers still persist. Cheap and effective communications were noted to be important.

- IEC materials developed in local languages, after consultation with the target group, is critical.
- IEC materials tailor made for people living with disabilities still remain a gap
- Messages that reach and teach men, engage LGBT, faith-based groups and other marginalised groups are critical – ask them, get them involved.
- ‘Movable’ IEC such as community radio, DVD/CD and cell phones work!
Conclusion

Mrs Lois Chingandu, the SAFAIDS Executive Director, concluded the summit with some key reflections.

She emphasised that knowing what works is critical to move our programme activities forward and brought participants back to her Data for Planning presentation on the first day of the conference. She indicated that activities implemented under the CTRF programme are contributing to meeting the real needs of communities today and tomorrow.

“A lot has been done and a lot still needs to be done. Reaching the MDG targets is a MUST. The answers to doing so lie within our communities, hence investing in them makes sense.”

Mrs Chingandu reminded participants that they were ‘leaving footprints’ that should lead to empowerment. These footprints must be left side by side with building capacities at the local level and strong involvement of leadership and law to ensure sustainability.

“Lead by example”, she encouraged participants, and challenged them to reflect on their own practice and values and to introspect on whether they are able to practice what they preach.
## Annex 1 - Summit Programme

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<td>Country Success Stories from the <em>Changing The River’s Flow Programme</em></td>
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<td>Sustainability of HIV Programmes in Challenging Times</td>
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<td>Achievement of MDGs by 2015 – A Daunting Task or a Fantasy</td>
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<td>Drama performance on the Vulnerability of the Girl Child in southern Africa</td>
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<td>Key Note address - No Woman should Die While Giving Life: Opportunities and Challenges</td>
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<td>TRACK 1: Discussing Gender Based Violence and Women’s Rights</td>
<td>Colleen Lowe-Morna, Gender Links CEO, Hellene Otieno, WOFAK, Kenya, Gamuchirayi Mandangu, WAG, Zimbabwe, Evelyn Serima, ILO</td>
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<td>TRACK 2: Linking HIV and SRH – Beyond Rhetoric</td>
<td>Delene van Dyke, 2nd Sight Consultants, Delight Moyo, Local Researcher</td>
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<td>TRACK 4: Leaders taking the Bull by the Horns</td>
<td>ZICHERE Behaviour Change in Zimbabwe, Traditional Leaders from Namibia, Swaziland and Zimbabwe</td>
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<td>Researching MCPs as a key HIV driver: Presentation of Current Debates and Implications for Programming</td>
<td>Sara Page-Mtongwiza, Deputy Director, SAfAIDS, Jenifer Bushee, STOP AIDS NOW!, Dr Noah Tarubereka, PSI, Professor C. Mararike, University of Zimbabwe</td>
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<td>Gender Transformations working with Women and Men to Address HIV and GBV</td>
<td>Desmond Lesejane, Sonke Gender Justice Network, Padare/Enkundleni/Men’s Forum of Zimbabwe, Nonhlanhla Sibanda, POWA, South Africa, Stephen Iphani, COWHLA Malawi</td>
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<td>Testing and Treatment as HIV Prevention from Research to Practice</td>
<td>Louise van Deft, Director, STOP AIDS NOW!</td>
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<td>Day 3</td>
<td>Elimination of Paediatric HIV</td>
<td>Grace Karugaba, Botswana - Baylor Children’s Clinic</td>
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<td>Noreen Huni, REPSSI</td>
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<td>Young People and Sexual Reproductive Health</td>
<td>Dr Patricia Machawira, UNESCO</td>
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<td>Alice Armstrong, KIT</td>
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<td>Media and ICT in HIV Programming</td>
<td>Katrina Phillips, Communication for Social Change Consultant,</td>
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<td>Juliet Mkaronda, SAfAIDS</td>
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<td>Lisa Mildes, AWISA Programme</td>
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ANNEX 2 – LIST OF CONFERENCE PRESENTATIONS AND ABSTRACTS

All presentations made at the Summit are available on CD from SAfAIDS. The CD ROM contains the following power point presentations.

Presentation by Dr Simon Matsivayi
Using Numbers for Planning Presentation
Presentation by Colleen Lowe-Morna
Participants’ list and contacts sheet
Malawi country presentation
Mozambique Country Presentation
Namibia Country Presentation
South Africa Country Presentation
Zambia Country Presentation
Zimbabwe Country Presentation
Gender Links Presentation
Presentation by Hellene Otieno
Presentation by Gamuchirayi Mandangu
Presentation by Delene van Dyk
Presentation by Delight Moyo
Presentation by Paul Moses Mutiga
Presentation by Eunice Namirembe
Presentation by Walter Chikanya
Presentation by Dr Patricia Machawira
Presentation by Alice Armstrong
Presentation by Katrina Phillips
Presentation by Juliet Mkaronda
Presentation by Lisa Mildes
Presentation by Sara Page-Mtongwiza
Presentation by Jennifer Bushee
Presentation by Dr Noah Tarunereka
Presentation by Desmon Lesejani
Presentation by Kelvin Hazangwi
Presentation by Nonhlanhla Sibanda
Presentation by Stephen Iphani
Presentation by Louise van Deft
Presentation by Grace Karugaba
Presentation by Dr Makunike
Presentation by Noreen Huni
Changing the River’s Flow Country programmes

Malawi programme milestones

Implementing partners in Malawi are: Chitani CBO; Kasalika; Manet+; Gender Support Programme and Friends of AIDS Support Trust (FAST). The programme addresses the issue of GBV

Why GBV?

- Violence against women is a major health and human rights issue
- Violence against women and HIV are mutually reinforcing, making GBV a key development constraint
- GBV and HIV both fall within a vicious cycle, fuelling each other with the existence of one perpetuating the other.
- Forty-eight percent of women in Malawi have reported some form of intimate partner violence
- The relationship between HIV and violence against women has resulted in physical injury, unwanted pregnancies, unsafe abortions, gynaecological complications and a high prevalence of sexually transmitted infections (STIs) in the country, as well as reduced productivity across economic sectors
- It is reported that approximately 3.1 million children have witnessed and experienced the effects of domestic violence, with 65% of girls and 35% of boys reporting experiencing some form of violence in their lives
- Twenty-four percent of children have experienced sexual violence and exploitation in their lives.

The CTRF methodology involves community dialogue and engagement and the involvement of Traditional Leaders and gatekeepers of culture.

Case Study 1
Annie attended a community gala. During the gala, she got tested for HIV and found she was HIV positive. She tried to get her CD4 count done at the local hospital but the machine was not working for months. She was very sick. She came to the Chitani CBO office to seek advice on where she could go for her CD4 count. Chitani wrote a referral letter to their partner, DREAM, and she was assisted. She has now started taking ARVS. Annie said ‘The Community Gala saved my life because I got to know my HIV status. It was difficult for me to pay for transport to Queens Hospital for the CD4 count but the networking between Chitani CBO and DREAM has shortened the distance.

Case Study 2
One group village headman explained that before the project, he had five wives. “But since I have learnt the danger of multiple and concurrent partnerships I have left four of my wives. I have encouraged my family to go for HIV tests and we are all negative. With this I am taking the lead to encourage my fellow Chiefs not to take advantage of being the traditional leader in order to have more wives, because HIV is real.
Numbers reached

Chitani
For the baseline survey, 110 households were visited (40 female headed and 70 male headed). HIV testing and counseling — 1,210 women and 650 men were tested and 451 women and 150 men receive HIV counselling per month.
Sensitisation meetings were held and attended by 106 community leaders and stakeholders (73 women and 33 men).

The community dialogues were attended by 124 men, 125 women and 102 custodians of culture. Thirty-four government representatives also attended. Forty-two CBVs were trained — 19 men and 23 women. The Gala was attended by 850 community members and the CBVs have reached over 4,537 individuals through door-to-door activities.

Achievements

• Improved couple communication regarding sexual matters
• Formation of referral networks among Traditional Leaders, Government, NGOs and CBOs in the area to support women and girls.
• The project has generated demand from other Traditional Leaders e.g. Chitani expanded the catchment area from 11 villages to 65 villages through the Lunzu CBOs network
• Modification of harmful cultural practices that expose women and girls to HIV e.g. widow cleansing in Nsanje.
• Custodians of culture taking a leading role in addressing the issues of women and girls who face abuse.

There are opportunities to build onto work done this far through mobilising Traditional Leaders to be custodians of preventing HIV and GBV at community level

Mozambique programme milestones

In Mozambique, the CTRF programme involves four partners; Associacao Kindlimuka, Muleidi, Magariro and AMMCJ.

Positive changes as a result of the CTRF

• Changes in cultural practices and beliefs
• Increased awareness about the linkage between cultural practice and HIV infections
• Local government and Traditional Leaders committed to influencing changes in negative cultural practices, such as widow cleansing and others
• Sex is no longer a taboo subject within beneficiary communities
• Women’s voices are heard more than before
• Beneficiary communities are more aware that HIV is among us and is not something ‘over there’.

Successes

• Mr Lundo, the local leader of Nhacafula in Tambara District, Manica province, offered to provide traditional treatment of pita Kufa, as a way of avoiding widow cleansing via sexual practices
• Beneficiary communities and their leaders are all involved in changing the negative practices that spread HIV and violate women’s rights
• Women are now refusing widow cleansing trough sexual practices because they know the consequences.
Lessons Learnt

• The CTRF is a very powerful approach. It touches the local reality and raises awareness about the epidemic and our real problems.
• Mixing young and old woman in one dialogue was not very effective, as younger women did not feel free to participate in the presence of the older women. Participation of younger women improved when the women were separated by age.
• The inclusion of community leaders as CBVs helped motivate community members to participate in the dialogues.
• High participation by men showed a lot of interest on their part and gives an indication that men are willing to bring about behavioural change through dialogue rather than confrontation.
• To achieve the desired sustainable changes, the implementation timeframe and project budget are important elements that must be designed according to the real situation.

Recommendations

• The project timeline needs to be realistic about the minimum time necessary to implement the CTRF to influence negative changes in cultural beliefs and practices within communities. Six months is not sufficient.
• The project budget must include both staff and volunteer costs.
• Monitoring and support need to be strong at the beginning to ensure the success of the project.
• The Mozambique office needs programme staff reinforcement to enable SAfAIDS to provide direct support to partners when requested.

CASE STUDY - Califiana Fulede Malacha

Califiana is 37 years old and lives in Nhamalema village. She is a widow and the mother of six sons. Her husband died in April of 2010 following an illness. He was a CBV within the CTRF pilot project in Tambara District. When the husband was very sick, he called his wife and brothers and made the following request.

• “If I die, nobody should be involved in pita Kufa ceremony with my wife, or marry her. I want to ask my brothers to keep her at my house. She will need your support to take care of the children”.
• “Pita Kufa is very big and dangerous. You know nowadays, we have the problem of HIV and AIDS - if you get involved in pita Kufa, you will be at risk of HIV infection”.

The brothers followed these recommendations and used traditional treatment using 'green medicines' for widow cleansing instead of sexual practice. Califiana is still living in the same place and she is taking care of the children. This result was possible as result of the increased knowledge of the impact of HIV and AIDS through the CTRF programme.

Namibia programme milestones

Namibia has a population of approximately two million and an HIV prevalence of 18.8% and cases of sexual and gender-based violence have been reported. The project in Namibia was implemented by five agencies: NAPPA, ACT, TONATA, PoH and NWHN in five of the 13 regions of Namibia; Ohangwena, Oshana, Omusati, Kunene and Khomas. A total of 430 CBVs were trained and over 2,500 community members were reached, among them 500 traditional and other community leaders.
Positive Changes as a result of CTRF Interventions

- Increased awareness of existing gender-related laws at community level
- Reduction in reported numbers of GBV cases
- Increased uptake of TB and ARV treatment
- Positive changes in the attitudes of CBVs towards the issues of GBV and HIV
- Greater involvement of custodians of culture in the fight against GBV and HIV
- Creation of an enabling environment for PLHIV to report stigma issues to traditional authorities.
- Empowerment of women to negotiate safer sexual practices in Kamanjab.

A paradigm shift for men

It was felt by men who were part of the community dialogue that is very important to uphold women’s rights.

- A senior Headman said “I understand where some of us are coming from, culture will justify beating a woman if she fails to cook for her man. But through these dialogues, looking at what makes both women and men vulnerable HIV, I came to understand that women have rights and needs to be treated with love and respect. We never dialogue about these issues but CTRF gives a platform to talk about them, not just to talk, but to change in a positive way. Most importantly, dialogue about this and leading an exemplary life will help our young men and women to be responsible citizens who uphold each other’s rights. We are not saying all culture is bad but it gives us power to carefully scrutinise the bad parts”.

Success Stories

- Women and men gave testimonies at Community Galas regarding their experiences living with HIV as well on GBV
- Traditional Leaders were successfully engaged
- The project enjoyed support from political leaders within project areas
- Improvement in the reporting of GBV cases was noted
- The impact of the project has been recognised by partners implementing similar projects in the regions.

Lessons Learnt

- The project was an eye opener as it brought all community stakeholders together: Traditional Leaders, women, men and youth.
- The vastness of the country makes implementation expensive
- The involvement and commitment of Traditional Leaders proved to be a powerful tool in the success of the project.

Case study

“I used to get STI’s every time I had sex with my husband but I was so scared to ask him to use a condom. But when I started taking part in the community dialogues I felt it was important to talk to my husband about condom use. I encouraged him to attend the male dialogue and that has changed everything. When I bring up the issue of condom use he doesn’t fight with me as he used to do, but agrees that we use a condom. My greatest victory came when he agreed to be treated for STIs as well”.

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- The project was an eye opener as it brought all community stakeholders together: Traditional Leaders, women, men and youth.
- The vastness of the country makes implementation expensive
- The involvement and commitment of Traditional Leaders proved to be a powerful tool in the success of the project.
Recommendations

- The project should be replicated in other parts of the country, especially those with high rates of HIV and GBV
- There is also need for the project to be continued in the implementation areas – taking advantage of the interest generated
- Sustainability of the intervention – need to integrate the project into implementing partners’ existing programmes
- Need to improve CBV incentives
- IEC materials should be translated into local languages.

South Africa programme milestones

Background

HIV, AIDS and GBV are among the multiple oppressions that South African women experience and are a far cry from the country’s progressive constitution. South Africa has the highest number of people infected with HIV globally – 5.3 million (UNAIDS, 2009). One in four South African men admitted to rape (Medical research Council study, 2009). Urgent and ongoing action is required as these oppressions affect the health and security of individuals, families, communities and the country as a whole.

The CTRF partners in South Africa are; REACH, POWA, GAPA & Kitso Vutivi Institute. The CTRF project runs across Cape Town farming areas, townships, villages and communities south of Johannesburg. All partners followed the CTRF programme carrying out training of CBVs; meeting with custodians of culture/community leaders/indunas and holding multiple dialogues for individual groups of women, men, and the youth, as well as joint community dialogues.

Three-hundred and sixty-two CBVs were trained and more than 7,000 door-to-door visits made with numerous referrals. IEC materials were translated into local languages where appropriate and distributed.

Case Studies

GBV: After disclosure of domestic violence in a household by a victim of abuse, the CBV informed the victim of her rights with regards to the Domestic Violence Act and arranged for her to see a social worker. At follow-up, the woman reported that the abuse had stopped and that she and her husband were going for counselling.

HIV support: A CBV learnt that an HIV positive woman had stopped taking her ARVs. She provided the client with education on HIV and discussed the importance of the medication. REACH assisted the CBV and the woman was transported to the clinic. At follow-up, the woman had regained her strength and was taking her medication regularly.

Xenophobia: The REACH trainer and CBV were called on to assist in xenophobic attacks and threats by youths against Somalis and Zimbabweans. The CBV assisted shopkeepers in protecting themselves, recovered some stolen goods with the help of a local councillor and supported the collection of donations to reimburse one of the victims. Several youths were arrested.

Child abuse: REACH was informed of a case of child abuse. Contact was made with the children but after organising a meeting with social worker, the children refused to talk of sexual abuse. However, the father was found to be neglectful and steps were taken to send the children to a children’s home.
Positive changes

- CTRF provides spaces for introspective discussions on culture. The term “culture” has been misused and lost, and was never questioned or challenged. CTRF allowed for revitalisation of positive aspects of culture through the concept of interlinkages.
- Dialogues allowed participants to voice and share concerns and opinions and allowed them the realisation that they all (women, men and youth) played a role in the current status quo of an environment that is stifled by GBV, HIV and AIDS, substance abuse, teenage pregnancies, etc.
- Many realised that they faced similar problems and that if they stood together they could create positive change. Participants were able to verbalise their needs and explore strategies to improve their communities.
- Community members acknowledged that *ukuthwala* of young girls for older men should end.
- Spaces were created for holding local based government institutions accountable for lack of service delivery.
- The notable willingness of men to speak openly about their vulnerabilities regarding HIV during several men’s dialogues is an indication of the value of the intentional involvement of men in responding to HIV.
- Youth want to be more involved, as well as calls for the replication of CTRF e.g. youth groups for one of the partners are strategizing youth dialogues to address youth issues; young men are committing to hold *umrhabulo* sessions where discussions on medical male circumcision versus traditional male circumcision will be conducted.
- Increased demand for services.
- Involvement of other CBOs and local stakeholders such as police and clinic workers, through CTRF programmes strengthened project impact e.g. for one of the partners, the police were not aware of the positive impact of CBV work and sometimes disregarded the urgency of cases. The South African Police Service now recognises the role of CBVs in the community and will take up cases more urgently. The police are also grateful to have the CBVs as support references.
- Door-to-door campaigns allowed community members to openly discuss problems and be honest about issues in a way that doesn’t ordinarily happen.
- Home-based care workers will provide gloves to women carrying out virginity testing.
- Traditional Leaders are supportive of the project and open to it e.g. Traditional Leaders working with one project partner were empowered to strive to decrease the availability and accessibility of alcohol, thus decreasing GBV and HIV infection.
- CBVs capacity was strengthened (knowledge, attitudes, uptake of services) and as a result, they took the initiative e.g. CBVs from one project partner used media and a road show to talk about issues of women’s rights, culture and HIV during 16 Days of Activism.
- CBVs reported a more peaceful Christmas and New Year and reduced incidences of violence in communities.

Lessons Learnt

- Despite positive changes, spaces where there are both women and men are still dominated by men.
• Although their existence in the community was acknowledged, the health concerns of lesbians and sex workers were not entertained in discussions.
• Despite the drive for de-stigmatisation of HIV, stigma is still very prevalent and caution was needed not to place persons living with HIV at risk, e.g., an HIV positive CBV had disclosed her status to the community. This, however, affected her work during the door-to-door campaign, as some were afraid she would pressurise them to disclose their status. To deal with this, CBVs swopped areas and paid extra attention to raising awareness of the effects of stigmatisation and assurances of confidentiality.
• Apathy predominates as most people are unemployed. While CBVs are very excited about creating change, expecting them to give of themselves and their time without compensation for an extended period of time is difficult. This is a great challenge for a project largely reliant on volunteers to fulfill its targets.

Impact
• Positive short-term impact was observed – long-term impact will require greater assessment. It is clear however that CTRF has gone a long way to breaking the silence which surrounds domestic violence and HIV.
• Community members now refer their friends and neighbours to CBVs. This is a strong indication that CBVs are seen as a community resource and as agents of support.
• The community now has greater awareness of the services available around GBV, HIV and AIDS and poverty in their community.

Positive changes
• The project has contributed to the four priority areas under the National Strategic Plan 2007-2011 (Prevention; Treatment, care and support; Human rights and access to justice).
• This also contributed to the sustainability targets by improving community-based volunteers’ knowledge, attitudes, and ability to deliver services.

Recommendations
• The CTRF project is excellent but needs further strengthening by including a component that empowers CBVs with basic crisis counselling/containment skills. This is especially necessary due to the lack of services in areas where projects are working and to the seriousness of the issues raised.
• CBVs need further training to enable them to deal with other health issues, e.g., sexual and reproductive health, chronic diseases, etc.
• Innovative strategies to involve men more in health issues.
• The CTRF programme should consider including volunteer stipends to retain and motivate CBVs.
• More funding and opportunities have been sought to continue working with and further strengthening the skills of CBVs.
• CTRF project goals have been met but there is a great need to continue the work. More funding is needed to continue the project.

Swaziland programme milestones

The Swaziland programme was implemented together with four partners; the Swaziland Network of People Living with HIV and AIDS (SWANNEPHA), Women and Law in Southern Africa (WLSA) and Nhlangano AIDS Training Information Counselling Centre (NATICC).

Successes
Twelve communities/chiefdoms were reached under the programme and a total of 320 CBVs were trained. Each CBV reached approximately 10 people each week, resulting in over 10,000 people being reached. In the areas engaging in the programme, there was an increase in reporting of
cases of domestic violence, with over 100 cases being reported to the nearest police station and still others being reported to Traditional Leaders. Local Traditional Leaders participated in the programme fully and four attended the regional CTRF meeting. All four partners attended both the national and regional meetings.

Since the beginning of the programme, the partners conducted 33 community dialogues in total. Of these, 12 were set aside for women only, which enabled women to discuss the issues that affect them without fearing reprisals from men. This also gave the women a forum to voice their ideas.

A young chief, Mbilaneni, has become a role model in his community by participating in and taking the lead in HIV prevention dialogues and encouraging his community members to prevent HIV. He says, “I know my HIV status and I've undergone medical male circumcision. I use condoms always. At the moment, I do not have any child outside marriage”.

Challenges
The programme was very popular and created great demand among nearby community members and leaders that it would one day be rolled out in their areas. Unfortunately due to resource constraints this has not been possible.

Lessons learnt
1. If Traditional Leaders are involved at an early stage they will fully support community programmes
2. The strategy of community dialogues attracted more men to begin using services that were traditionally used only by women
3. The collaboration between stakeholders such as police, the domestic violence department, and partners working on the GBV programme was strengthened. This helps with future planning and ensures teamwork.

Zambia programme milestones
The Zambia programme is run by the Society for Women and AIDS in Zambia (SWAAZ) a non-governmental organisation established in 1989 and a Zambian chapter of a Pan African organisation called the Society for Women and AIDS in Africa (SWAA). Partners in the project are: the Network of Zambian People Living with HIV and AIDS (NZP+), Family Health Trust (FHT) and the Young Women’s Christian Association (YWCA).
A national training of trainers was conducted in 2009 training 20 trainers, and in 2010, 80 CBVs, drawn from two districts namely Choma, in the Southern Province (29 females and 11 males), and Chingola (in the Copperbelt), 23 females and 17 males were trained in the CTRF methodology.

The CBVs began doing the door-to-door sensitisations and reached a total of 6,168 people. In Chingola 305 people, were reached, of whom 173 were female and 132 male, while in Choma, 5,863 people were reached of whom 3,297 were female and 2,566 male. The CBVs in this district are very enthusiastic and they continue to do the work on the ground.

After the training of CBV’s, SWAAZ conducted a Traditional Leaders’ sensitisation meeting on culture, gender and HIV. The meeting was conducted in Choma district and targeted 10 Traditional Leaders and senior Traditional Leaders, of whom three were Head Women from the surrounding villages.

Lessons Learnt
- In some areas harmful cultural practices are still being done secretly, e.g. wife inheritance, early marriages and widow cleansing. Therefore there is need for more sensitisation.
- Traditional Leaders find it difficult to intervene in GBV cases, since cultural norms support acts of GBV, e.g. wife beating.

Positive changes
- There has been an increase in the number of GBV cases reported at local police stations, especially in Choma district.
- The project has strengthened the referral system between the community and structures such as the church, victim support units, VCT centres and health centres.
- More people in Mwapona village of Choma district are aware of the harmful cultural practices which increase the vulnerability of women and girls to HIV.
- The project has scored success in involving men, as this is key to reducing the incidence of GBV.

Challenges
- Inadequate support for CBVs to conduct the door-to-door sensitisation, due to lack of incentives such as identification materials, i.e. T-shirts and badges.
- Need to have materials translated in the local language.
- Some people are very conservative and not receptive to issues of gender.

Recommendations
- More funds should not be made available to implement the outstanding activities such as community (women, men and youth) dialogues and community galas.
- Refresher courses should be held regularly as a way of motivating CBVs.

Despite the challenges mentioned above, the project is well on course and SWAAAZ is grateful for the trust that SAFAIDS has in the organisation. The participants were motivated upon receiving their certificates and look forward to more activities under the project.

Zimbabwe programme milestones

The implementing partners in Zimbabwe are; Christian AIDS Taskforce (CAT), Padare Men’s Forum, Seke Rural Home Based Care SRHBC (pilot), Students and Youth Working on Reproductive Health Action Team (SAYWHAT), Women’s Action Group (WAG).
The CTRF is a unique programme that employs persuasive strategies to change behaviour in line with the National Behaviour Change Strategy. Communities targeted are: rural communities (WAG & SRHBC); men (Padare); the religious sector (CAT); young people (SAYWHAT).

**Positive changes**

- Increased knowledge on harmful cultural practices, HIV, GBV and on the existence of laws e.g. Domestic Violence Act
- Respect for women's rights in traditional courts
- Recognition by Traditional Leaders that HIV is a factor to be considered when presiding over matters
- Increased interrogation of sensitive and/or taboo issues such as sex, sexuality and condom use by people of different religious backgrounds (Orthodox, Pentecostal, Zionist and more)
- Collaborative efforts by religious and Traditional Leaders in addressing GBV, HIV and Culture
- Young people have a sense of belonging to community through cultural activities
- Traditional Leaders are now supporting young people by addressing their challenges in an informed and objective manner
- Men are beginning to support their wives in PMTCT programmes by going for couple counselling and taking steps towards ensuring the healthy survival of the child.

**What the people said**

“Programme ye CTRF yatirerutsira basa redu nekuti hatichagaronzwa vanhu vanoita zhowezhowe mudzimba” (The CTRF programme has lessened our burden of work as cases of domestic violence have gone down) Traditional leader, Guruve

“Kushandiswa kwedrama kunobatsirachaizvo nekuti zvinoita hurukuro dzedu dzireruke uye dzinakidze” (Focus Group Discussion respondent)

“Ndikanzwa kuti munyika mako maita mhirizhonga nekushungurudzwa kwemadzimai kwakanyanya, husabhuku hwapera”

A Mhondoro Ngezi chief warned village heads that they will be dethroned from their positions should their communities experiences more cases of violence and abuse of women.

**Lessons learnt**

- Use of drama makes it easy to discuss sensitive issues
- Voluntarism should be reconsidered, as CBVs still expect incentives
- Including men in programmes removed the stigma people express against women's organisations
- Traditional Leaders can contribute to behaviour change and so they are a critical target group.

**Recommendations**

- This is a behaviour change project and therefore it needs to run over a longer period to ensure sustained behaviour change
- There is need to consider giving CBVs incentives
- A mechanism for continued monitoring of the programme (e.g. collection of door-to-door forms) needs to be put in place.
## ANNEX 4 – SUMMIT DELEGATES

**SAfAIDS Regional Summit: Turning the Tide on GBV, HIV & Culture in Southern Africa**  
1-3 November 2011, Rainbow Towers, Harare

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