

# **REGIONAL HIV/AIDS-GENDER WORKSHOP**



Workshop organised by  
**PELUM Association**

**Held at Capital Hotel, 7-12 June 2004**  
Lusaka, Zambia

## ACKNOWLEDGEMENTS

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## INTRODUCTION

The following report is based on a workshop organized by the Participatory Ecological Land-Use Management (PELUM) Association Regional Desk. As part of its activities, PELUM runs such workshops with a view to build member organization's capacity in responding and coping with various challenges and realities of their work and communities. One such area is that of HIV/AIDS, Gender and Development. The workshop was aimed at broadening participant's understanding of gender and HIV/AIDS and how they are interlinked, so as to raise their consciousness, motivation and initiative to influence change of policies and challenge oppressive power relationships for sustainable development. It also served to provide insight to member organizations in the process of deriving and shaping their own policies.

The workshop set out, as its objectives to; familiarise and socialise the participants with PELUM Gender and HIV/AIDS policies, promote discussion, sharing and learning among participants working on HIV/AIDS interventions, demonstrate the link between Gender and HIV/AIDS, develop a time and action plan detailing how the participants were to mainstream Gender and HIV/AIDS concepts in their day-to-day activities and contribute towards prevention and checking the spread of HIV/AIDS within the region.

Participants to the workshop comprised Development Workers involved in gender and HIV/AIDS activities.

# DAY ONE

## 1. WELCOME REMARKS

Mary Kabelele, Finance and Administrative Officer of the PELUM Regional Desk invited Assely Mwanza of PELUM Zambia to welcome the participants.

## 2. EXPECTATIONS

Participants were requested to record on small pieces of paper their expectations from the workshop. The facilitator then asked them to classify outcomes according to suitable categories and thereafter put them up on the wall. The following were the expectations under the themes discerned:

### HIV/AIDS-GENDER

Understand PELUM's position on the subject i.e. HIV/AIDS-Gender

To learn more on gender

Gender issues in HIV/AIDS (how to relate the two)

To learn how HIV/AIDS and gender can be integrated in different programmes

Learn more about gender mainstreaming process

To share the link between HIV/AIDS and gender

To learn more on how HIV/AIDS and gender can be strategised in communities

'Addressing role of men and women in development

Learn about what research has been done on gender and HIV/AIDS

To come up with strategies to improve gender relations in our community

### COUNTRY INFORMATION

- To share information on HIV/AIDS situation in countries in attendance
- Gather information on HIV/AIDS from other countries
- Share ideas on how to mitigate the impact of HIV/AIDS
- To know more on the impact of HIV/AIDS from an international-country perspective
- State of HIV/AIDS in the world: is it increasing or reducing? Where is Africa?
- To share with others how they are coping with HIV/AIDS
- To share experiences of how mitigation is being carried out in other countries
- To know how HIV/AIDS is influenced by gender

### HIV/AIDS PROGRAMMES

- To learn how to fuse HIV/AIDS into agriculture
- To identify an appropriate approach to mainstreaming of HIV/AIDS in our programmes
- Mitigation of the impact of HIV/AIDS in agriculture. How and why?
- Learn how others address HIV/AIDS in their programmes
- Learn more on HIV/AIDS interventions
- To know more about gender
- Relate gender to HIV/AIDS
- To learn more on the relationship between gender and HIV/AIDS

### SOLUTIONS AND SHARING

To learn different ways/methods to make HIV/AIDS interventions

Whether impacts and difficulties about HIV/AIDS are equally experienced in all countries

To discuss the working strategies on HIV/AIDS

To share how we can reduce the impact of the pandemic

To learn/find solutions to reduce HIV/AIDS pandemic

To come up with strategies for fighting against HIV/AIDS

To establish the main problem/fear that leads to stigma

To know the effects on livelihood of HIV/AIDS in relation to conservation agriculture

To learn why HIV/AIDS kills people earlier than the expected time

To find ways of helping individual country's health situation.

### SOCIAL /NETWORKING

To acquire international friends

## 3. CODE OF CONDUCT

The workshop went on to draw up the following as the agreed ground rules:

Avoid unnecessary movements during sessions

No ringing phones

Start and end with prayer

Time keeping (respect)

Respect every participant's view

Avoid abusive language

Respect each ideas/ freedom of expression

## 4. SMALL GROUP WORK ON PARTICIPANTS' VIEWS ON HIV/AIDS

Regis introduced Dr. Jay Buensuceso the first HIV/AIDS facilitator from CARE International. In recognising the fact that every participant had some basic knowledge about HIV/AIDS, he initiated a group exercise. The following guidelines were provided:

### *Guiding Questions:*

- 1) What do you know about HIV/AIDS that needs to be shared?
- 2) What are the issues and beliefs about HIV/AIDS that the people in your area/country believe in?
- 3) How does HIV/AIDS manifest or affect your locality?

## 4.1. FEEDBACK FROM SMALL GROUP WORK

The second facilitator on HIV/AIDS, Doras Chirwa also from CARE International asked each representative from the groups to walk the workshop through their findings after tea break.

### 4.1.1. Results

#### Group 1

1. –Its transmission
  - How to live positively
  - Its impact at various levels
  
- .2. –There is silence for fear of stigmatization
  - Beliefs that transmission is associated with immoral conduct
  - Families paying back the wrongs they did on other families in the past
  - That sexual cleansing is necessary for inheritance
  - That HIV/AIDS is a town disease
  - It was introduced deliberately on human beings
  - God's wish
  
- .3. –Low productivity due to absentism from work
  - Increased number of orphans and street children
  - Poverty; too many funerals and funerals, which are very expensive handle
  - Tension and stress resulting from seeing the sick all the time
  - High expenses
    - \*During sickness (food)
    - \*During funerals
    - \*Medical care
  - High responsibility of looking after orphans by surviving relatives
  - Change of death pattern (productive age group is dying more)
  - High incidences of child labour

#### Group 2

1. –Condoms should be distributed
  - Prevalence in Kenya is 9%
  - 700 people dying every day in Kenya
  - Policy to protect the affected and infected by HIV/AIDS
  - In Zambia in every six people one is infected
  - Most infected are between 15-40 years old (most productive age group)
  
2. –Belief that if the HIV/AIDS infected person sleeps with a virgin/minor gets rid of the disease

Prisoners' belief that HIV/AIDS cannot be found in people practicing homosexuality  
Belief that using a condom one cannot get satisfied  
Belief that AIDS is only found in urban areas

3. –High rate of street children  
Low productivity  
Increase in child-headed households  
Literacy level have gone down due to lack of support to orphans

**In Kenya:**

Straining of available resources e.g. 3 people sharing one hospital bed  
High dependence rate on government from the affected people  
Ignorance is a major problem  
There is moral change in Kenya as the prevalence rate has reduced from 13% to 91% in 2004.

**Group 3**

1. – Killer disease
  - No cure
  - “Hidden” disease
  - Approached differently in rural and urban areas
  - Fear of knowing status
  - Women more open
2. –Sleeping with virgin will cure you
  - Religious curse
  - Due to immorality
  - Curse-cultural belief
  - Positive if you have TB

Issues

- Abandoning victims
  - Home-based care
  - Improved availability of ARVs (Kenya)
  - Reduced life expectancy
  - High cost of insurance covers
  - Discourage negative cultural practices
  - No access to ARVs
3. –Dependence
    - Loss of insurance
    - Financial constraints
    - High rate of funerals and burials

**Group 4**

1. –It cuts across all sectors
  - Pandemic
  - No cure as yet
  - Majority sexually transmitted
  - Negative effects on development
  - It is controllable

## 2. Issues/beliefs

Witchcraft  
Curse from God  
Population control and reduction strategy by the western countries  
Spread through promiscuous practices  
Came from the monkeys  
Came from Africa  
Virgins are HIV free

## 3. –Stressfulness

- Increasing number of orphans and child-headed households
- Loss of productive manpower and other resources
- Stigma
- Poverty
- Increased crime rate
- Lineage in continuity broken
- Overstretched extended families
- Much resources are being diverted towards HIV/AIDS programmes
- Child defilement
- Sexual deviation

## 5. BASIC INFORMATION ON HIV/AIDS

With the foregoing background information on how participants viewed the pandemic, Doctor Jay went on to provide some basic facts about HIV/AIDS, covering such aspects as the nature of the HIV virus from a scientific point of view, how it invades the CD4+ T cells of the human immune system and the eventual breakdown of the defense system of the body, the modes of transmission, the molecular structure of the virus, its life cycle and most importantly its rapid level of replication that far outpaces the ability of the human body to replace/produce defensive T cells.

CD4 + T-Lymphocytes depletion = averages 50/mm<sup>3</sup>/ year over a mean of 8-10 years  
850-500 represents the normal levels of a healthy individual. As compared with HI virus whose replication rate = average 10 to the 10<sup>th</sup> virions/ day. 8-10 Years is the estimated length if time for destruction of immune system

## 6. THE STATE OF THE HIV/AIDS PANDEMIC

This was the focus of the second plenary session facilitated by Dr. Jay. The situation was presented at both the regional and global levels. Particular attention was however accorded to Africa South of the Sahara. In acquiring a better understanding of the state of affairs with regard to the pandemic, the facilitator stressed on the need to realise the following:

- Looking at what is behind the statistics presented (as opposed to taking a simplistic view of them as alarming or encouraging numbers)
- Interpretation of statistics to understand the real situation behind them.

-Taking statistics as a tool for analyzing past trends with a view to learning from the past, based on which we will be able to know the way forward in deriving strategies. At the end of the day, the aim was for the workshop to assign a human face to the statistics (of real people and their situation in our communities) and the purpose of statistics as a tool for planning interventions.

## GLOBAL SUMMARY OF THE HIV/AIDS EPIDEMIC DECEMBER 2003

<b>Number of people living with HIV/AIDS</b>	<b>Total</b>	<b>40 million (34 - 46 million)</b>
	<b>Adults</b>	<b>37 million (31 - 43 million)</b>
	<b>Children under 15 years</b>	<b>2.5 million (2.1 - 2.9 million)</b>
<b>People newly infected with HIV in 2003</b>	<b>Total</b>	<b>5 million (4.2 - 5.8 million)</b>
	<b>Adults</b>	<b>4.2 million (3.6 - 4.8 million)</b>
	<b>Children under 15 years</b>	<b>700 000 (590 000 - 810 000)</b>
<b>AIDS deaths in 2003</b>	<b>Total</b>	<b>3 million (2.5 - 3.5 million)</b>
	<b>Adults</b>	<b>2.5 million (2.1 - 2.9 million)</b>
	<b>Children under 15 years</b>	<b>500 000 (420 000 - 580 000)</b>

The ranges around the estimates in this table define the boundaries within which the actual numbers lie, based on the best available information. These ranges are more precise than those of previous years, and work is under way to increase even further the precision of the estimates that will be published mid-2004.

### 6.1. Why women in Africa?

It came out clearly in the presentation that women have been more adversely affected and infected. Both scientific and social factors were advanced in explaining this scenario.

#### a) Some Facts in the Third World

- Women are 1.2 – 2.5 X more vulnerable to HIV than men (refer to subsequent section on vulnerability and susceptibility).
- Heterosexual sex: main mode of transmission
- Biological fact that HIV is easily transmitted from men to women

**b) Reasons for High Exposure of Women**

Lower social, political and economic status

- a) Sexual activity starts earlier for women
- b) Women tend to have sex with much older partner
- c) Lack sufficient knowledge about HIV/AIDS
- d) Dependency (economic/social) leads to women having difficulty/impossible to negotiate for safer sex
- e) Wars (Concrete cases of abuse and rape of women and girls during wars in countries like Rwanda)
- f) Women look after the sick, thus more exposed to chance of infection
- g) Polygamy (one man, many women)
- h) Sexual cleansing/ wife inheritance
- i) Lack of economic empowerment
- j) Most women overstretched/overworked, with poor nutrition
- k) Men having multiple partners

## 6.2 Difference between HIV prevalence & HIV incidence

**HIV prevalence** – the most common measure of HIV/AIDS epidemic. It refers to the percentage of the adult population living with HIV. It is like a still photograph of HIV/AIDS. It is possible that countries could have the same HIV prevalence, but be experiencing very different impacts of the epidemics and even in terms of impact on the kind of prevention and care efforts.

“**Stable**” **prevalence** – could be – high rates of mortality & high rate of new infection

**HIV incidence** – completes the picture of current trend of new infections observed over a year among previously uninfected people.

\***Weakness** – expensive and complicated, not feasible at a national level & on a regular basis.

\***Proxy** – is to measure HIV prevalence among groups of young people on a regular basis (not perfect but acceptable)

## 7. REACTIONS TO THE PANDEMIC - group work

The facilitator for the HIV/AIDS session, Mrs. Chirwa, engaged the participants in individual and thereafter group reactions to the state of the HIV/AIDS pandemic. Four sets of pictures (each set comprising about six picture) were mounted for analysis and response.

### **7.1 Guiding questions**

1. Look at the picture
2. Write what your first impression is of the picture
3. As a group allow minimal discussion, arrive at consensus
4. Give one agreed expression of your set of pictures

### **7.2 Summary of reaction to the pandemic**

Every group placed under each picture, a series of individual reactions of what was depicted. One participant was chosen in each group to take the workshop through the outcomes and thereafter provide one underlying message or theme the whole set of was portraying, as agreed by the members. The four groups arrived at the following themes:

1. *CRISIS* of HIV/AIDS, of death and sickness. Pictures represented by this theme depicted a general sense of a crisis manifested by chronic illness, death, coffin production and the quest for health care.

2. *Hope for a brighter future in the midst of turmoil and helplessness.* This hope was shown in the faces of children who can be regarded as the window of hope for a better and brighter future. Pictures portraying children learning in school and playing were among others displayed.

3. *Campaign and advocacy.* It was concluded that the HIV/AIDS fight required good leadership and concerted efforts. In the final analysis, something is being done about it. One of the pictures on the group portrayed the first Zambian republican president, Dr. Kenneth Kaunda conducting HIV/AIDS awareness campaign. Other picture including condom advertisements, red ribbon campaign and peer education comprised this group.

4. *Survival and determination,* was the last theme on group four on the last set of pictures. This brought out the various acts of courage that are on going, particularly among the women, in *coping with the impact of the pandemic.* Various coping strategies being undertaken were portrayed among other images.

## **8. SUSCEPTIBILITY AND VULNERABILITY**

### **Definitions:**

**Susceptibility** – defenselessness / openness / exposure / liability

“A person’s risk of HIV infection”

**Vulnerability** – In the context of HIV/AIDS, this arise from circumstances that are beyond the direct control of the people involved. They include, poverty, low social status, inequality, gender discrimination, marginalisation, criminalisation.

These circumstances also reduce or deny a person’s access to HIV information, services, means of prevention and support. Also worth observing is that gender inequalities increase the vulnerability of both **men** and **women** to HIV infection.

### **Vulnerable Population**

- 1) Those that have been denied their human rights and/or,

- 2) Have limited access to HIV information, health services and means of prevention (male & female condoms)
- 3) Have limited ability to negotiate safer sex

### **Vulnerability to STIs/HIV owing to biological make-up**

**Female:** It has been said that STIs are “biologically sexist”. This is because women experience a disproportionate amount of STI burden and complications and death. STIs in women are often asymptomatic, but the silent process is both infectious and damaging. Vertical transmission of the disease in the perinatal period places the baby at risk for illness, congenital anomalies, mental retardation and death. Studies have demonstrated that STDs, particularly infections that cause ulcerations of the vagina (for example, genital herpes, syphilis, and chancroid), greatly increase a woman's risk of becoming infected with HIV.

Women are particularly vulnerable to heterosexual transmission of HIV due to substantial mucosal exposure to seminal fluids.

Women suffer from the same complications of AIDS that afflict men but also suffer *gender-specific manifestations of HIV disease (?)*, such as recurrent vaginal yeast infections and severe pelvic inflammatory disease, which increase their risk of cervical cancer. Women also exhibit different characteristics from men for many of the same complications of antiretroviral therapy, such as metabolic abnormalities.

**Male:** Symptoms of STIs in males are early felt, seen, and therefore can be treated early.

### **8.1. Individual work on susceptibility and vulnerability to HIV/AIDS**

The facilitator engaged the workshop in conducting individual reflections on the specific ways in which one thought they were vulnerable and susceptible to HIV/AIDS. Responses were recorded on small pieces of paper and thereafter the facilitator went round with a box to collect results for reasons of confidentiality. These were later assessed by the workshop on day two and grouped according to perceived encompassing themes

Two volunteering participants facilitated the collection of evaluations of the day after which they would present them before the workshop at the beginning of the following day's business. Two pieces of paper were circulated, one for likes and the other for dislikes. The facilitator would then engage the workshop in finding remedies to address the negative aspects.

# **DAY TWO**

# 1. EVALUATION OF DAY ONE

## DISLIKES

- Poor lighting in the conference room
- Time not enough for thorough discussion
- Fire from the socket
- Cold water
- Time keeping
- Too much spices in the food
- Encouraging participants to intensify awareness campaigns on HIV/AIDS when communities are already sensitized
- Reality of HIV/AIDS in human race
- Sitting arrangement not good
- Not enough knowing each other provided for
- None

## LIKES

- Picture interpretation
- Group discussions and presentations
- Good facilitation
- Good participation
- Workshop contents
  - HIV/AIDS statistics
  - Incubation period of HIV
  - Vulnerability and susceptibility

Time keeping

# 2. GENDER (Conducted by Regis Gwaba.)

The HIV/AIDS team was delayed on this day and so Regis began the presentation on gender which was scheduled for the next day- three.

## ***Individual and group work.***

Participants were drawn into assuming that they had the power to determine the sex of an unborn child, and so were to give individual preferences of the sex of a child on behalf on their partners. Two were to be done at of individual level:

- Choose the sex of a child
- Justify (giving reasons for the decision)

Two groups were formed afterwards with the Pro- girls and Pro- boys in their separate groups. The following were the responses:

**Why choose a girl?**

1. More responsible than boys
2. Bring more friends to the family
3. We earn a son (the husband) and a daughter
4. Mature faster and good investment
5. They are compassionate and source of happiness
6. They are lovely especially to the parents
7. More appreciative
8. Share clothes
9. Continuity

**Why a boy?**

1. Continuity of the name and the clan
2. Boys are easy to maintain
3. There is security in the marriage and home
4. There are higher chances for boys to complete education
5. Less problems and confusion in the family

The exercise was aimed at establishing the fact that when dealing with gender, sex assumes the first consideration. We are all either born male or female and this forms the initial basic foundation when looking at gender. It is the sex of a child that works to determine the kind of roles that child will be expected to perform in the community and specifically the home. Next comes the socialisation process, which begins from the basic environment of a home where a mother begins to impart social values, beliefs and knowledge of society. The child begins to understand what is expected of him or her as either, male or female, the dressing, relations with members of the opposite sex several other aspects.

This process of socialization can either be positive (such as telling the girl child of their inability to do so much especially as compared to men, their inability to perform in particular subjects such as sciences and mathematics as a man's domain) or indeed positive such as enlightening the child of their abilities. In the final analysis, this socialization can either promote or hinder development.

Understanding the socialization process of a particular setting in question is cardinal to development work, because the inherent beliefs and values have the potential to either promote or inhibit development efforts. It is of utmost importance that this socialization aspect is not ignored, as doing so will translate in a waste of time and effort in attempting to improve peoples' lives. These values and beliefs have to be confronted at many stages of our work.

In concluding the exercise, the facilitator pointed out that all reasons advanced for choosing a particular sex over another were as a result/outcome of our socialization process (upbringing). They reflected an individual's background as shaped by a given environment in which one was brought up. It therefore follows that

1. We are born either male or female
2. We all undergo a process of socialization, in terms of the roles and behaviours that society expects from us.

The two components are what constitute gender

## **2.1. WHAT IS GENDER**

People are born male or female. They are taught what the appropriate behaviour, attitudes, roles and activities are for each sex, and how they should relate to other people. Through this process they learn to be boys or girls who grow up to be men or women. This learned behaviour is what constitutes gender and determines gender roles. Gender is therefore, learnt through the socialization process and through culture and norms of a given society.

### **2.1.1. Gender sensitivity**

This refers to the awareness that all our activities have an effect on existing gender relations. In being gender sensitive we strive to improve the position of the people affected by inequalities. In this marginalized group are women. In being gender sensitive we also become cognizant of the need to shift from viewing women in isolation from men, to examining the relative position of women and men in division of resources, responsibilities, rights, power and privileges.

### **2.1.2. Gender planning**

Within a process of change, a conscious attempt can be made to change the relationships between men and women in favour of the marginalized groups. This is what constitutes gender planning. The gender in development approach facilitates this planning through considering women as major players in development who do not have equal access to household, community and/or national resources. It also considers society and social relations as a whole, actively including men and women in the process of development as opposed to taking on women as isolated entities.

### **2.1.3. Practical gender needs**

These are responses to an immediate perceived necessity. They are needs arising from and reinforcing women's reproductive and productive role. The fulfillment of those needs should not conflict with existing division of labour in a given community.

### **2.1.4. Strategic gender needs**

These stem from the need to adjust the unequal relations between men and women in favour of an improvement in the position of women. Strategic gender interests are concerned with increased control over resources and the products they yield. The challenge is to improve the nature of relationships between men and women and when addressed they should lead to the transformation of gender based division of labour.

Work is divided into three categories, namely:

- Productive work, involving the production of goods and services for consumption
- Reproductive work, involving the care and maintenance of the household and its members
- Community work, which has to do with the collective organisation of social events and services such as community improvement activities.

Women's reproductive workload can prevent them from participating in the development project as intervention in one role may negatively affect the other roles.

### 3. STIGMA AND DISCRIMINATION (by Doras Chirwa-Care International)

As the workshop awaited the arrival of the Minister of Agriculture and cooperatives, Honourable Mundia Sikatana to officially open it, Doras began the topic on **Stigma and discrimination**.

The first step was to ask participants to reflect (while seated or in a corner of the conference hall) on a time when they or someone else got rejected, isolated or discriminated against and how they felt. The results of the reflections were shared in pairs after which they were brought to the attention of the workshop as a whole. The reverse, when an individual discriminated against, rejected or isolated someone was done. At the end of the exercise, it was concluded that everyone had stigmatized someone and also faced stigmatization of one form or the other in the past.

### 4. OFFICIAL OPENING OF WORKSHOP

PELUM Zambia's Information Officer, Assely Mwanza recognized the presence of the Minister and lead the workshop in reciting the national anthem. She thereafter handed over to the Chairman for PELUM Zambia, Mr. Jonathan Chisaka to give his speech.

Mr. Chisaka welcomed the Honorable Minister and thanked him for showing the importance that government attached to issues of gender and HIV/AIDS by leaving his busy schedule and be present at the event. After giving a brief background to PELUM's work since 1995, he made reference to the emerging challenges of the HIV/AIDS scourge which has negatively impacted not only on human resource base but also affected operations of agriculture productivity due to illness and death. He further pointed out that food security is threatened leading to increase in poverty levels among the farming community. He was however happy to report that in response to the situation, PELUM had embarked on learning processes by way of providing information on issues related to HIV/AIDS and Gender. The outcome of which has been the development of policies on HIV/AIDS and gender. Mr. Chisaka was proud to announce the completion of the policy development process. The Chairman expressed hope that the spirit of learning and sharing would characterise the workshop, in order that the knowledge gained would go a long way in mitigating the impacts of HIV/AIDS. Refer to annex 1 for the detailed speech.

The thrust of the Minister's speech was on his concern with the high levels of poverty due to past failure of the agricultural sector to provide sustainable livelihood for the rural poor and diminishing employment opportunities. He referred to the impact that HIV/AIDS has had in exacerbating poverty by undermining agricultural productivity and thereby increasing household food insecurity. Honourable Sikatana went on to outline how and why HIV/AIDS was a gender issue:

- Although HIV/AIDS affects both men and women, women are more vulnerable owing to biological, epidemiological and social reasons.
- HIV/AIDS is fueled by macro policies that have led to the increasing gender disparities such as mass population displacement resulting from external conflicts.
- The ability of concrete change in sexual behaviour of men to translate into rapid reduction of spread of HIV/AIDS among women.
- The feminisation of poverty as a key characteristic of the socio-economic impact of HIV/AIDS. He observed that the burden of care of the infected and sick invariably falls on women.
- Gender inequality was also cited as a key variable in HIV/AIDS incidence, as more and more women become negatively affected as a result of gender imbalances.

The minister posed a challenge before the workshop as to why Africa is so poor and continues to get poorer despite the abundance of natural resources and favourable climatic conditions as compared to the majority of industrialised countries. He stated that; “poverty is like dirt, if we don’t clean ourselves, no one will come from outside to clean us”. The Minister further observed that not much was being done in response to the pandemic. He indicated the existence of a budgetary allocation under his ministry aimed at identifying and assisting vulnerable groups as one example. He expressed hope that next time he attends such a gathering he will be on the listening end, taking note of the successes scored against HIV/AIDS.

Mary Kamau, one of the participants from Kenya, was called upon to give a vote of thanks to the Minister on behalf of the workshop. She expressed gratitude to the Minister for finding the workshop worthy of his presence. She also referred to him as a father whose presence at the gathering brought a sense of direction to the whole endeavor. Mr. Sikatana pledged his continued presence at the workshop to hear of the experiences shared. Doras led the minister to view the various group presentations on reactions to the pandemic before he left.

## 4.1. COUNTRY EXPERIENCES

### **i) Uganda**

Representatives from Uganda shared the following issues with the workshop:

- There is a great sense of openness about HIV/AIDS in Uganda. Referring to it as ‘an open secret’.

- Government determination and involvement in arresting the situation impressive. Useful has been success scored in areas of:
  - Dealing with HIV/AIDS at national level by earlier declaration of the pandemic as a national disaster in the late 1980s.
- Leadership in the fight, as exhibited by the continued personal commitment by the head of state in HIV/AIDS campaigns and other interventions.
- Improvement in health delivery system in response to the demands exerted by the scourge. And the recognition and incorporation of traditional medicine and indigenous knowledge in the existing system.
- Promotion of abstinence and faithfulness, indicating that the campaign had the full backing of the head of state and the first lady who, it was reported that the Head of State of that country had never been seen to engage in condom use campaigns in public. A significant part of the success registered in the fight was attributed to this approach which favours abstinence and mutual faithfulness.
- Reduction in prevalence rates from fourteen to the current seven percent. The figure was reported to have been stagnant at seven for the past three years. Also referred to was the crucial role that information dissemination and attitude change have played in improving the situation.
- It was also reported that HIV/AIDS was promoting fidelity in marriages due to fear of infection, reduced condom use with a further strengthening of alternative interventions such as abstinence and mutual faithfulness.

#### ii). Ugandan government intervention

On the role of the government of Uganda in the fight against HIV/AIDS, the first observation was the creation of a relationship and collaboration by the government with traditional healers as strategic partners in the battle. One of the participants from Uganda reported that previously, HIV/AIDS was widely regarded as a consequence of witchcraft in Uganda, until the government decided to engage traditional healers after realizing their influence in the local communities as figures whom the people turned to for a cure. A process of sensitizing the healers on the facts about HIV/AIDS was initially embarked on, after which the traditional healers relayed these facts to their clients. “Many people now have a correct understanding of the causes and effects of HIV/AIDS”, one of the Ugandans stated. Government has gone further to encourage the formation of *traditional healers’ associations* to facilitate liaison between the two parties.

This structure has seen these associations assume the position of an extension of the overall health delivery system of the Ministry of Health. The structure has also provided a strategic channel of information dissemination to and from the communities. Other than creating awareness in the shrines, traditional healers have formed groups of patients with related responses to treatment, with whom they share

experiences knowledge and information. This information is further disseminated to other people. “Key is information which is making a difference,” Josephine observed.

This has also seen the acceptance of both ARVs and traditional herbs as alternative measures. Various herbs aimed at immune boosting and improving appetite of patients cannot only be obtained from the traditional healers but also be cultivated in backyard gardens for easy access. Hospitals give patients a choice between ARV treatment or herbal drugs. Herbs have, therefore been recognized as alternative treatment and lists have been drawn of the various types known, and publicized. People are free to obtain seeds from a nearest health center to plant at their premises.

## **ii) Herbal medicine-From a personal experience perspective**

The Ugandan experience was ended with a moving personal experience of Dorothy, who spoke on the benefits of herbal medicine. Having been diagnosed HIV positive at one point she, Dorothy testified on how herbal medicine had facilitated the reversal of her HIV positive status. After being in a comma, she also spoke of the grace of God as vital. She explained to the workshop that she had been on ARV treatment for three months, which had caused her a lot of pain in the limbs with a resulting inability to walk even the shortest distance in her house. “AIDS is painful, but God is able”, she stated. She also reported that many other people had experienced a reversal in HIV status from positive to negative. In response to a question on side effects, Dorothy referred to the following as some of the main ones:

- ◆ Failure to walk due to painful limbs
- ◆ Excessive sweat in the night
- ◆ Drumming in the ears (which had resulted in her loss of sleep for three months)

She went further to explain that ARVs are still expensive despite being made available free in some clinical centers by government. In many hospitals, an estimated \$15 would be needed for a month’s treatment. The government of Uganda has also established a HIV/AIDS support organization in collaboration with cooperating partners offering such services as free medical attention and food once a person declared their status.

Dorothy also mentioned expressed gratitude to her organisation for the support rendered to her during her illness. She spoke of the attributed such support to the existence of a *good organisational policy* that enabled an environment free of stigma and discrimination that was responsive to the needs of an employee in her state. She appealed to Zambian and other countries to emulate this and implement such policies in their respective organizations.

## **Challenges of ARV treatment.**

Doras, the facilitator came in addressing some of the challenges of ARV treatment. Because ARVs are new drugs, they are also new to many people in the medical field who are yet to have a full understanding of the nature of the drugs, especially with regard to side effects.

In the absence of proper explanation from the doctor on possible side effects of a drug, most patients have tended to abandon treatment after experiencing side effects.

It was concluded that the majority of people are giving preference to herbal medicine because of perceived minimal side effects, despite the bulky nature of the fluid intake. It was also clear that the herbal medicine was more widely used by people in the rural areas owing to affordability.

## **b. Kenya**

The major issue regarding HIV/AIDS in Kenya was the perceived contradictory and sometimes-conflicting nature of the law in responding to the challenges of condom use or abstinence and faithfulness. Other areas included confidentiality of HIV test results and deliberate infection with the virus by an individual.

Home-Based Care has also been identified as one of the strategic points of entry into the HIV/AIDS problem. Various measures, including training caregivers and traditional birth attendants have been embarked on in responding to the challenge. Such training is further tailored in a manner that attempts to reduce the chances of infection of the caregivers and Traditional birth attendants.

## **5. RESPONSES ON INDIVIDUAL WORK ON VULNERABILITY AND SUSCEPTIBILITY**

The participants went back to the previous day's exercise on Vulnerability and susceptibility. The Minister was present during the initial stages of this activity before excusing himself. PELUM 's National Chairman also said his concluding thanks giving remarks to the participants and left. Responses from the previous individual reflections were classified and displayed. The following came out as the major areas of vulnerability and susceptibility to HIV/AIDS:

- ◆ Sexual violence
- ◆ Cultural practices
- ◆ Self control
- ◆ Economic status
- ◆ Misconceptions
- ◆ Biological
- ◆ Unfaithfulness
- ◆ Inadequate information
- ◆ Woman's role
- ◆ Power relations

## **6. STIGMA AND DISCRIMINATION –CONTINUED**

### **6.1. Definition:**

**Stigma:** -A quality that significantly discredits an individual in the eyes of others  
-An attribute that is deeply discrediting that reduces the bearer from a whole and usual person to a tainted discounted one. Stigmatization is process that continually adheres to reducing a person's self esteem.

## **Stigmatisation and HIV/AIDS**

Stigma is associated with diseases that:

- Have severe disfiguring effects
- Are incurable or have progressive outcomes

As such, stigma is also associated with other diseases such as TB and leprosy.

When transmitted is perceived to be under the control of individual behaviour perceived to result from transgressions of social norms. Stigma is a powerful tool of social control that can be used to marginalize, exclude and exercise power over individuals who show certain characteristics. Stigma in the final analysis leads to discrimination, exclusion, or restriction affecting a person by virtue of personal characteristics.

### **6.2. Effects of stigma**

Is associated with:

- Pain and suffering of PLWHAs and families
- Refusal to participate in VCT and MCT
- Sero prevalence increasing. Which are:
- Discrimination-strained, ended relationships
- Depression-denial, fear
- Fuels the spread of HIV/AIDS

Factors that contribute to HIV/AIDS related stigma:

- HIV/AIDS is a life-threatening disease
- People are scared of contracting HIV
- The disease's association with behaviours such as sex between men and injecting drug-use that are already stigmatized in many societies.

In describing the destructive nature of stigma and discrimination, the facilitator referred to the three phases of the pandemic. She used the example of a family that suffered all the three:

**AIDS:** the husband dies of AIDS

**HIV:** the wife tested positive. She decides to come out in open by declaring her status, leading to:

**Stigma:** which resulted in the son's discrimination at school as coming from " a family of AIDS". The child disappeared from the community and was never seen again.

### **6.3. What can you do?**

Advocate for legal protection for PLWHAs (e.g. at workplace)

Promote life skills

Community mobilization-to enable change take place alongside interventions

Action to tackle stereotypes

Continuing advocacy- lobby governments top provide HIV/AIDS drugs for all.

Doras moved on to providing a framework for planning against stigma and discrimination and also how we all can get involved, through the leadership of PELUM in ultimately bringing about a better life for all in society.

Arising from the deliberations were the following concerns:

- The need for the implementation of favorable organizational policies to respond to among other challenges, stigma and discrimination was also highlighted.
- The need for people to know their entitlement to information related to HIV/AIDS and ARV treatment from medical practitioners (including the possible side effects of ARVs)
- Awareness of and demand for right against discrimination at place of work. For example in the face of dismissal due to HIV positive status.
- Unfriendly nature of some doctors in dealing with patients. Further analysis attributed part of the situation to:
  - An overstretched health system which amounts to overstressed medical personnel as they strive to attend to as many people as possible
  - Medical ethical considerations that sometimes do not allow the divulgence of certain types of information to patients.

The challenge posed at the end of the session was for all present to provide leadership in both their organizations and communities by being examples themselves. “In order to change others, we may need to change ourselves first. HIV/AIDS is about behaviour change and there is need for people to see it in us first”, added the Facilitator.

The session ended with a personal experience of the damaging effects of stigma and discrimination from the facilitator. She gave a real life experience where, while on a tour to a local hospice in Zambia, she accidentally found her niece dying of AIDS. The girl had experienced suffering not only from her denial of the illness because of her age and that she had not slept with a man, but mainly due to the isolation and rejection from the members of the community she lived in.

## 7. FORMATION OF WORKSHOP COMMITTEES

The workshop put in place two committees, namely, coordination and newsletter committees. The general terms of reference drawn by the *coordination committee* were to:

- See to it that participants have the best of their stay
- Coordinate/link up participants with the organizers of the workshop
- Attend to the welfare of the participants

All housekeeping issues were to be handled by the coordination committee.

The *newsletter committee* on the other hand was given the mandate to guide and collect articles written by the workshop participants and plan for its subsequent production. The two committees reported to the workshop at the beginning of every morning's session on updates and other issues that needed to be addressed.

### **Composition of committees**

**Coordination:** - Mary Kamau (Chairperson)  
Fr. Jovenale Ayelangom (Secretary)  
Sara Goma (Welfare Officer)  
George Simuyemba (Entertainment Officer)  
- Asselly Mwanza

**Newsletter:** -Joe Mzinga (Chairperson)  
Lillian Hamusiya (Secretary)  
Josephine Kasande  
Chilufya Chileshe  
Eneya B. Maseko (production)

# 1. GROUP WORK ON GENDER MYTHS AND FEEDBACK FROM GROUP WORK

## 1.1. Guiding questions on the MYTH exercise

Myths are ideas and beliefs people hold about men and women which are generally accepted as truths.

1. In small groups prepare two lists, one about women and the other about men
2. Where possible site the origin of the myth
3. Give ONE EXAMPLE of the implication of the myth for each of the sexes

## 1.2 Results of group work on: Myths (implications refer more specifically to their interpretation in present time)

### Group 1

Myth/Men	Origin	Implication
-Grinding on the grinding stone	Grandmother	-Harm on body parts -Girl were overburdened with duties
Man with one woman is not man enough	-Grandfather	-Polygamy -Infidelity -Spread of STIs -Women's position weakened
Removal of pubic hair on the dead by surviving spouse	Grandparents	Oppression on surviving souse
No shaving of pubic hair when spouse is away from home		Hygiene
A man has no place in the kitchen		-Overburdened duties on women -Kitchen becoming poorly equipped and structured due to lack of attention from husband
<b>Myths/Women</b>		
Pregnant women not eating eggs	Grandparent	-Pregnant women and developing foetus denied protein -Control developing baby weight and mother craving for eggs
Dry sex is good (dry vaginal lining)	Grandmother	-Cervical cancer -Susceptibility to contraction of STIs and HIV -Women denied sexual pleasure
No adding of salt to relish during menstruation	Grandmother	Means of checking if a woman is pregnant
Women should not eat goat's testicles	Grandmother	Sexual desires encourages extramarital affairs by men
Women not allowed to across a fishing net	Grandmother	Reducing economic empowerment of women
A newly wed bride should be sampled by the father-in-law before her groom		-Spread of disease -Oppressive -Woman becomes wife of clan (where any man belonging to that clan needs only put a spear at the door step to the woman's house as a sign of his presence)

<b>Group 2</b>		
Men	Origin	Implications
Should not step in a groundnut field		-Productivity low -More labour demand on women
Should not eat from a pot No shading of tears Should not be served three pieces of food	-Grandparents -Friends -Society	-Promotion of good table manners -Unfair distribution of food -He comforts the woman -Suffers emotionally Men are over/under fed
Beat wife as sign of love		-Promotes domestic violence -Low self esteem among women
Women/myth		
Should not eat gizzard, chicken and pork	-Grandparents -Friends -Society	Deprives women of highly nutritious food
Pregnant women should not eat eggs (boiled)		-May lead to birth of a malnourished child -Ill health for mother
Should not put salt in relish when menstruating		-Saltless food -Lack of calcium in food
No sitting on a mortar or pounding empty mortar		Promotion of good manner
Widow should not sleep before being cleansed		Promotes spread of STIs and HIV
No chewing sugar cane		-Denied pleasure of sugar cane -Denied freedom of expression

<b>Group 3</b>		
Men/myth	Origin	Implications
Do not touch pots or else develop breasts	Friends (Zambia)	Men not involved in cooking
No whistling at night	Friends (Uganda/Zambia)	Discipline
Do not eat the neck of a chicken	Grandfather (Kenya)	-Would eat the fleshy part of the chicken and leave small parts for women and boys -For men to eat quickly in order to return to work promptly
Do not shed tears	Friends (Zambia/Uganda/Kenya)	Men to be strong
Do not sit on burnt bricks or become impotent	Friends (Zambia)	Discouraging laziness
Women		
Do not eat cowpeas. Leads to barrenness	Grandfather (Zambia)	High protein and delicious reserved for men
Pregnant women not to eat eggs. Child will grow big (inability to deliver)	-Friends -Great aunt (Kenya/ Uganda/Zambia)	Women denied importantly source of protein
Do not hold spear	Grandmother (Uganda)	Women no defensive skills
Do not eat birds will bear hairless children	Society (Zambia)	Women denied high protein
Girls not to climb trees	Grandmother (Kenya/Uganda/Zambia)	Protection
Do not stand when cultivating	Mother (Kenya/Uganda)	Discourage laziness, work too hard
Do not sleep with boys will grow long nails	Grandmother (Zambia)	Protection

<b>Group 4</b>		
Myth/women		
Women not supposed to eat meat meant for a man to qualify as a real man	Kikuyu-Kenya	Women were denied protein intake, while favouring men

Women not supposed to eat eggs, milk, meat		Women denied protein intake
Women were not supposed to sit on mortar because sexual feelings would disappear	Tanzania/Zambia/Zimbabwe	Hygiene
Beating of a woman by man regarded as an expression of love		Respect, love and attention
Wives should be ready to have a good time (sex) with the husband at any time		To maintain zero-grazing
Myth/Men		
Men not supposed to sleep with women on their periods	Zambia/Tanzania/Zezulu	Hygiene
Men not supposed to sleep with women their senior		To encourage hard work
Men were/are not supposed to be circumcised because it makes them loose sensation	Tanzania	-Maintaining the naturalness -Vulnerability
If men went to the kitchen, would grow breasts	Zambia	-Define chores between sexes -Protecting the privacy of men.

Findings of the group work indicated that most of these myths are common to the countries represented at the workshop. It was also discovered that not all myths are destructive, as they worked to restore proper moral conduct and harmony in the socialisation process, particularly the social division of labour. The ultimate need to design interventions in community development work in consideration of myths and beliefs was established as necessary for registering any success.

# **DAY THREE**

## 1. EVALUATION OF DAY 2

The day was begun with presentation from the coordination and newsletter committees. This was followed by evaluation of the previous day and the reactions to address the areas of concern.

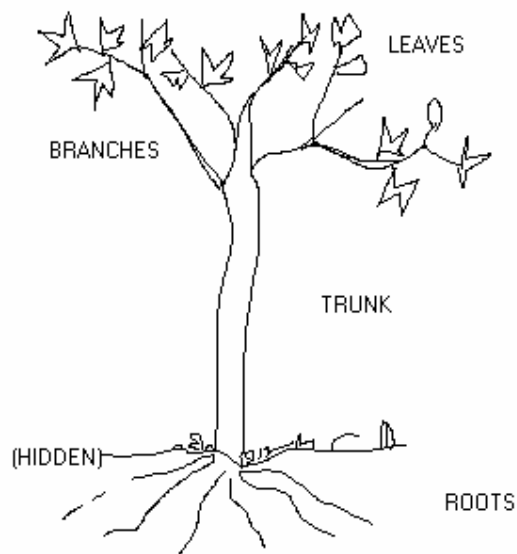
### DISLIKES

- The way gender was introduced
  - Late coming of the HIV/AIDS team (facilitators)
  - Feeling of being stigmatized
  - Food not well prepared
  - Minister's speech was not related to the workshop objective
- Workshop evaluation of day one
- No freelance photographers to take photos, especially of the official opening
  - None

### LIKES

- Speech by the minister
- Returning of the money by the Minister
- Facilitators kept time
- Introduction to gender
- Liked the food
- Full contributions from the participants
- Participatory facilitation
- Openness of the Ugandan participants to share their experiences

## 1.2. ATTITUDES and VALUES Tree



The first session was a continuation of the previous day's deliberations on myths. Attention was directed at moving from the abstract to a more specific perspective. The facilitator introduced the 'attitude and beliefs tree' in explaining the topic at hand. The tree provided a clearer view of the interaction between the various aspects that reinforce attitudes and beliefs and the institutions that perpetuate certain values and the power relations at play. These are helpful in deriving intervention strategies. Society's value system and the power relations therein have to be understood. The absence of women at certain public discussions does not necessarily entail their exclusion and marginalisation. Instead they indicate the role of women as consultants of their husbands when faced with important decisions to make on issues at hand.

There are good and bad value trees. If one says that women cannot be leaders, is it a good tree or a bad one? If it is bad, at which part (branches, trunk or roots) should we enter in as development workers in addressing the situation?

### 1.3. SMALL GROUP WORK ON ATTITUDE TREE

#### Guiding questions on the VALUES and ATTITUDES exercise

In your small groups draw and label the various parts of the tree (as explained during the plenary session). Please also identify those aspects that provide ideal environment for the spread of the HIV virus and for perpetuation of conditions that promote the HIV virus

1. Roots: values, beliefs, attitudes about men and women
2. Trunk: social institutions that transmit and perpetuate values and attitudes
3. Branches: forces that reinforce attitudes and values
4. Leaves: practical outcomes

#### Group 1

ROOTS	TRUNK	BRANCHES	LEAVES
1. Female genital mutilation	-Family -Parents -In-laws	-Fear -Recognition	-Exposed to high chances of HIV/AIDS -Pain and trauma -Infection using some tools
2. Dry sex	-Family -Aunt -Grand parents	-Insecurity -Fear of not being accepted	-Oppressed -High chances of HIV/AIDS -Infection in both partners
3. A man with one woman not man enough	-Friends -Society -Grand father	-Pride -Recognition -Pride -Lusts and selfishness -Social status	-High exposure to HIV/AIDS and infection -High rate of spreading HIV to many women -Moral decay
4. Sexual cleansing	-Family -Society	-Fear of ghost -Acceptance	-HIV/AIDS infection -Promiscuity -traumatisation -Humiliation

5. Bride price	-Family -Society -Clan	-Security -Pride -Status	-Submission -Slavery -Eternal bondage
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### Group 2

ROOTS	TRUNK	BRANCHES	LEAVES
1. wives are supposed to have sex with their husbands anytime the husband feels like irrespective of her state	-Society -Acceptance by latter to seeing to it that wife has to submit -Extended family	-Fear of being divorced -Status of marriage (for women) has more regard	-Oppression (women's vies are not respected) -Sexual dissatisfaction on the part of women -"Out-sourcing" by women for sexual encounters
2. Dry sex is enjoyable	-Society -Friends -Traditional doctors, media	-Insecurity -Rejection from husband	-Dissatisfaction on the part of women -Bruises increase exposure to HIV, STIs infection
3. Virgin cure	-Traditional doctor -Friends -Media	-	-Defilement -Child abuse -Mental torture -STIs
4. Uncircumcised men	-Society	-Rejected by society	-Vulnerability to STIs, HIV/AIDS

### Group 3

ROOTS	TRUNK	BRANCHES	LEAVES
1. Wife denying husband sex	-Extended family	-Economic dependence -Fear -Shame	- Marital rape - -Promiscuity - Divorce - Separation
2. 'A cock cannot have one hen`	-Religion -Peers	-Prestige -Peer pressure -Economic status -Biological make-up (sexual dissatisfaction)	-Disease -Death -Stress on woman -Poverty -Unhappy families -Illiterate children

3. a woman cannot approach a man for sex	-Traditional setup -Clan	-Ignorance -Fear	-Oppression -Loss of dignity -Lack of sexual satisfaction -Extra marital affairs -Divorce
4. A woman has no right to pick a marriage partner	-Parents -Tradition	-Lack of exposure -Social economic -Social classes	-Unhappy -Affairs -Broken marriage -Disease

### **Additional responses from above group work**

#### ***Group 1:***

- Very high exposure to infection during circumcision in villages by use of unclean instruments
- Genital mutilation, especially in Uganda
- Sexual cleansing
- Dry sex and associated increased chances of infection

#### ***Group 2***

Marital rape

#### ***Group 3***

Beliefs and common practices of sleeping with 'perceived' virgin girls for cure of HIV/AIDS.

In all the group work, it was clear that power relations were at the center of all concerns. And so the issue of who has power becomes critical.

In looking at the three types of power:

- Power over
- Power within
- Power with,

In the final analysis, the desired state is that of power with, where there is equity among men and women. Recognizing who has power is important in formulating workable strategies and interventions aimed at realizing equity. Targeting those possessing power in a community, for example would be useful in as far as transforming certain negative values and beliefs that impede development.

Much as it is important to target where the effects of an intervention will yield the best impact, there is an added need to adopt a holistic approach which takes into account another relevant factors at play in a given community. The following analytical model can be assessed in deciding on the possible strategy of approaching a problem (deciding the entry point):

**Question:** what is causing HIV/AIDS?

*Cause:* Get HIV in body

*Effect:* CD4 count reduces

*Cause:* Infect spouse

*Effect:* HIV

*Cause:* Sickness

*Effect:* Low productivity and low income

In making the decision on the possible entry point, the following questions ought to be addressed:

- ◆ At which stage do we enter/intervene?
- ◆ How feasible would this be?
- ◆ Do we have the required capacity?

## 2. LINKAGES BETWEEN HIV/AIDS AND GENDER

### **Group work**

Having analysed and discussed gender and HIV/AIDS, it was time to establish the linkages between the two. Group deliberations were recorded and presented on flip charts, after which the workshop made comments, posed questions or clarifications.

### **Linkages**

- ◆ Women are submissive to men
- ◆ Men and women have sex with each other
- ◆ Women tend to take care of the sick
- ◆ There are gender issues in HIV/AIDS related the cultural, social and economic setting
- ◆ Addressing these issues= mitigating the impact of HIV/AIDS
- ◆ HIV/AIDS affect women and men, girls and boys
- ◆ Communication
- ◆ Conjugal expressions
- ◆ Socialisation (leisure)
- ◆ Sex roles
- ◆ Church perpetuates submission
- ◆ Economic disadvantaged position of women encourages men to misbehave
- ◆ HIV/AIDS cannot be separated from gender because it takes two to tangle
- ◆ Home-based care in HIV/AIDS –its women who are care givers and this exposes them to vulnerability
- ◆ Socialisationn of boys and girls, girls are taught how to submit at kitchen parties while boys are not.

### 3. SOCIAL –ECONOMIC IMPACT OF HIV/AIDS IN ZAMBIA

(Host country presentation by Dr. Kanyanta Sunkutu-World Health Organisation)

#### Summary of presentation

- Overview
- Geographical spread
- Demographic spread
- Modes of transmission
- Heterosexual transmission
- Peri-natal
- Health problems associated with HIV
- Impact-People Living with HIV/AIDS (PLWHAs)
- Impact-Children/Orphans
- Impact-Families
- Impact-Economic
- Summary of gender specific impact
- Summary of high risk groups

#### 3.1 Question and answer session

The following comprised the salient features during the session:

1. Maximum age reached by HIV positive child in Zambia so far -17 years after being on ARVs since the age of five years. Some adults have been on ARV treatment for 15 years
2. HIV/AIDS –related disease have greatly challenged/ stretched the health services. Example has been the 500 percent increase in TB cases since the onset of HIV/AIDS in the country.
3. Stigma and discrimination resulting in
  - Reluctance to accessing VCT facilities
  - People’s lack of knowledge of their status
  - Inappropriate behaviour
  - People not seeking medical attention
  - Exacerbating HIV/AIDS
4. Potential for inappropriate behaviour due to reduced viral load as a result of ARV treatment. According to the Doctor, such behaviour should not be viewed as a disadvantage of the drugs as it is individual conduct.
5. The doctor indicated that there is never going to be a cure for HIV/AIDS. Asserting that until the present time, there exists no single cure for viral diseases other than vaccines. He was therefore optimistic that on-going research in the medical field would amount to a vaccine for HIV/AIDS.

6. Currently government of Zambia supporting promoting of ARVs.

7. Condom still very safe as prevention (went further to demonstrate to the workshop the proper use of it condoms)

In terms of effectiveness of measures against HIV/AIDS infection, the Doctor outlined the following in their order of effectiveness:

I. Abstinence

II. Faithfulness

III. Condom use

He observed, however, that for the HIV/AIDS fight to succeed, not one method should be emphasized over the other.

8. Traditional medicine can be unreliable due to refusal by traditional healers to test it. World Health Organisation (WHO) is currently funding studies in traditional medicines

9. Encouraged treatment by ARVs, referring to concerns about negative side effects as being applicable even to other forms of drugs and that peculiar to individuals. However, admitted failure on the part of the health system to provide proper advice and sufficient information on ARVs to the public. Informing the people on how to access ARVs was cited as one example.

10. On patents and question of access, Dr. Sunkutu identified two channels in which ARVs are currently being acquired, namely:

Generic and

Brand names (patented and under trade marks)

With regard to the majority of developing country governments, *generic drugs* remain the major form of drugs being accessed because they are cheaper as compared to brand names.

11. Spouse inheritance was one of the great areas of concern in increasing exposure to infection.

12. Prevalence of STIs high (STIs increase vulnerability and susceptibility to possible infection) higher exposure to infection, especially among women, because of larger surface area exposed to infected body fluids.

13. Older men sleeping with young girls

14. Appeal to work with the 'window of hope' –the children of 5-14 years

### **3.2. Benefits of ARVs**

Dr. Kanyanta concluded by outlining the benefits of ARVs as follows:

He went further to make reference to the following benefits of ARVs.

- ◆ Delayed clinical progress of the disease
- ◆ Reduced risk of disease transmission

- ◆ Return to productive work capacity by AIDS patient
- ◆ Improved quality of life
- ◆ Reduced income poverty levels
- ◆ Reduced number of HIV/AIDS orphans
- ◆ Improved economic productivity and thus economic performance across the country
- ◆ Decreased number of hospitalization for HIV related illnesses
- ◆ Prolonged life of many people with HIV enabling them to contribute to the national economy
- ◆ Controlled rural replication
- ◆ Reduced incidence of opportunistic infections

One of the biggest challenges in ensuring wider access to ARV treatment is testing. Most people still shun VCT, which is a pre-requisite for accessing treatment. Doctor Sunkutu appealed to influential persons in society to come out and declare their status as an indicator of the crosscutting nature of the pandemic and encourage more people.

Yet of utmost importance is to legislate into law the protection of HIV positive people at places of work to prevent stigma and discrimination. It was observed that HIV positive people need jobs even more because of added costs that arise such as treatment.

Dr. Sunkutu made reference to the vicious cycle associated with HIV/AIDS; Parents dying from HIV/AIDS, leaving children unskilled due to lack of support, lack of skills entails that ssyoung girls engaging in commercial sex activities, leading high exposure to HIV infection. He also reported of the on going Studies aimed at establishing the linkages between food security and HIV/AIDS. A connection he said was still unclear.

#### 4. SMALL GROUP WORK ON SOCIAL ECONOMIC IMPACT OF PANDEMIC AMONG THE PEOPLE WE WORK WITH.

What has been the **impact at the level of the communities** we work in? Groups according to country of origin were formed in which experiences were shared and recorded. Because Zambia had the largest representation, the group was broken up into two allow for more fruitful deliberations. Results to be presented on day 4. The day was ended with a closing prayer from Sara Goma Sikota of Monze Diocese.

# DAY FOUR

# 1. EVALUATION OF DAY 3

## LIKES

- The linkages gender and HIV/AIDS
  - The traditional treat
  - Dr. Kanyanta's presentation very educative (4 participants)
  - Delicious Zambian dish (2 participants)
- Everything including the Zambian dish (2 participants)  
Exercise on values, myths and beliefs very practical  
Group work presentations on value and attitude tree  
Better food  
Workshop proceedings especially during feedback from group work  
Energizer from Mary  
Good information pertaining to the impact of HIV/AIDS  
No dull moments  
Everything  
The topic on gender, the way it was presented  
More information on gender  
Managed to put a human face to statistics about AIDS

## DISLIKES

- Rooms not arranged by morning
- Too much group work
- No toilet paper in ladies toilet
- The hall set up: management e.g. weeping in the morning, falling table clothes etc
- Expensive photographer
- Did not keep time after lunch (2 participants)
- The issue of religion, vis-avis Christianity debate
- Mother-to child transmission in womb (explanation not explicit)
- Changing of secret friends
- Dr. kanyanta's presentation-too fast (4 participants)
- Attitude
- Limited time for questions and answers
- Ignorance of people's feelings (behaved as though knew everything)
- None
- Zambian group in last session's group work too large, discussion not easy

## 2. IMPACT OF HIV/AIDS IN THE COMMUNITIES: COUNTRY EXPERIENCES

### **Feedback from group work: (effects of the pandemic on the people we work with)**

#### **a. UGANDA**

##### **Economic**

Impoverished communities and families  
Low productivity  
Women overwhelmed by the load of work  
Rise of pseudo organizations to tap money  
Job opportunities

##### **Psychological**

1. Stigmatization
2. High rate of school dropouts
3. Increased number of street children
4. Child labour
5. Alcoholism/ drug abuse
6. Health facilities are congested, especially among children (referred to the mental torture arising from sharing of beds with patients of differing ailments, especially highly infectious ones)
7. Health facilities are expanded and multiplied
8. Suicide
9. Defilement
10. Bestiality
11. Positive behavioral change
12. Education/ change of some cultural practices (particularly use of one instrument to conduct several circumcision acts).
13. Apathy for self, others and even God
14. Emergence of many traditional healers/ exploiting clients
15. Mushrooming of associations of widows and single mother unions

#### **b. ZAMBIA**

1. Increase in orphans
2. Female-headed households have increased
3. Low income (due to absence of bread winner, especially that men tending to die earlier)
4. Old people taking care of grand children
5. Oral traditional and skills transfer lacking/hampered
6. Deforestation
7. Diversion of funds for development projects
8. Increased illiteracy levels

9. In absence of parents, useful knowledge and traditional skills are being prevented from being passed on to subsequent generations.
10. Deforestation due to increased coffin production and extraction of herbs perceived to mitigate or remedy HIV/AIDS, in the final analysis reducing quality of the environment.

Emerging issues from the Zambia report further attracted the following reactions with regard to why men were perceived to be dying faster than women.

Also mentioned was the lack of opportunities in rural areas and stress arising from such social factors as “*men are not supposed to cry*”, excessive alcohol intake and other male –dominated vices that may fuel already deteriorating health condition after infection.

The notion that women live longer than men who are infected due to loss of blood during menstruation was also disputed. It was observed that mere loss of blood does not entail reduced levels of the virus in the blood stream.

It was also observed that young girls tend to engage in sex at an earlier stage than boys (estimated 12-15 years), they chances of contracting the disease from older men are higher. And when the time comes for marriage, they fall back on men in their age group.

### **c. TANZANIA**

#### Negative

- Increased orphans/ street children
- High rate of school dropout among children
- Family breakage (especially when father dies)
- Family income decrease
- Overstretched extended family (most families live with HIV/AIDS orphans of their relatives)
- Reduced involvement/ participation of people/ farmers in training programmes offered by the organization

#### Positive

1. Free talks between parents and children about HIV/AIDS/STIs and other issues
2. Most women rights are discussed/ demanded
3. Employment/ grants flow in the country

#### **d. KENYA**

1. Huge financial resources diverted to meet funeral expenses, average cost estimated at 150 thousand shilling with some going as high as half a million shillings.
2. Funerals being used as opportunity for displaying wealth of a family, through long fleets of vehicles, video cameras and other possessions.
3. Loss of working hours while attending funerals
4. Labour diverted from productive work to attending the sick
5. Loss of skilled man-power affecting project implementation
6. Some level of behaviour change
7. Creation of employment and income generating activities

On the positive side, it was reported that men are becoming more cautious of the HIV/AIDS pandemic and therefore seen to be spending more time at home. When at drinking places, they tend to be in company of other men as opposed to girl friends. A final submission was made from Zimbabwe where it was observed that the dignity with which death was treated in the past has been lost as a result the routine nature of funerals due to too many deaths.

### **3. MITIGATION OF IMPACT OF HIV/AIDS (Dr. Jay)**

Mitigation measures do not have to be great, but aimed at addressing the most urgent problems at hand. Helping a child retain a sense of identity with his/her past by keeping a photo album of the family, for example, can reduce the impact on a child of the death of parents. In Uganda, some organisations were reported to have started encouraging their employees to draw up wills and, in collaboration with the superiors at work, entrust the document in the custody of a bank. This has helped in addressing the economic impact on children after the death of their parents.

#### **3.1. Mitigation (Working definition):**

Mitigation has to do with reducing, alleviating, easing or diminishing the impact rather than the entire removal of the problem.

The impact of HIV/AIDS on individuals, families and societies transcends physical illness and death. No clinical effects of HIV/AIDS include socio-economic effects, including poverty and hunger; increase of orphans and vulnerable children; burnout among caregivers looking after the sick, orphans and vulnerable children, stigma and discrimination and other human rights concerns.

#### **3.2. HIV/AIDS mitigation interventions**

##### **a. TANZANIA**

HIV-associated violence studies have found out that young HIV positive women (18-29) were almost 10 times more likely to report partner violence than young HIV negative women.

Recommendation: Training HIV counselors to ask questions about partner violence and to encourage disclosure when appropriate.

## b. UGANDA

Refining interventions to improve the well-being of AIDS –affected children. “Succession planning” has led to increase in the proportion of parents who appointed guardians, disclose their HIV status and wrote wills.

Suggestions: the need to protect women’s and children’s property rights, assist children affected with HIV/AIDS before parents die, and foster adult-child communication. Support HIV positive parents in Uganda to overcome taboos about “planning for death” and put wills and guardians in place to promote the future well-being of their children.

## c. ZIMBABWE

Microfinance programmes and HIV/AIDS: small loans to start a business helped clients respond to the resulting economic impact of chronic illness and death in small yet important ways- through improved savings and gender income diversification.

Caution: Microfinance is not a panacea for dealing with economic shocks caused by HIV/AIDS and that additional safety net and poverty alleviation strategies are needed.

Institutions spearheading the above studies include:

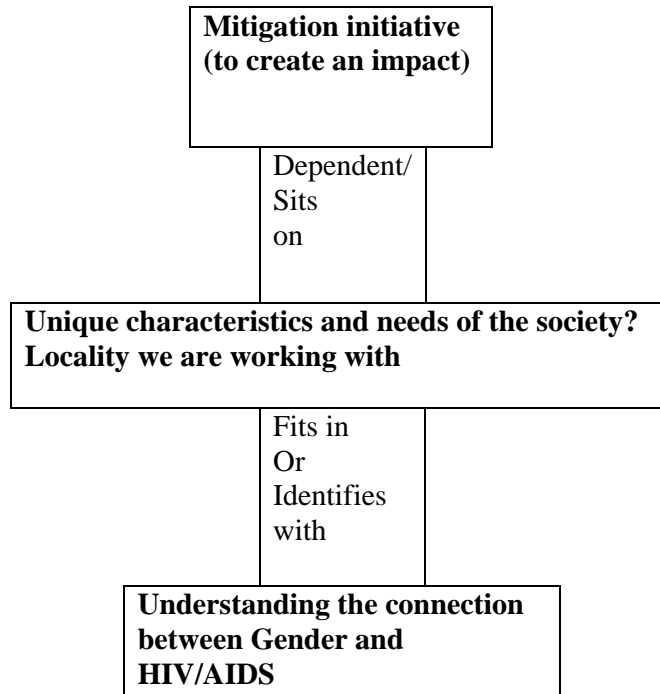
Tanzania: Muhimbili University College of Health Science

Uganda-Makerere University Department of Sociology

Zimbabwe- Zambuko Trust Zimbabwe

-Association of Micro-Finance Institutions

In formulating an effective mitigation strategy, the following factors in the model should be taken into account:



#### 4. SMALL GROUP WORK ON MITIGATING THE IMPACT OF HIV/AIDS

Participants were engaged in group work, according to core business organizations represented.

##### **Guiding questions**

- i. What are the indicators (signs) of the effect of HIV/AIDS in your sector?
- ii. What is being done?
- iii. What are the gaps (what has been done and what should or needs to be done)
- iv. Plan =solution=gap filling (use your knowledge) from the workshop

#### 4.1. FEEDBACK FROM GROUP WORK.

##### **a. Capacity building and advocacy in agriculture and rural development**

###### **Indicators**

- Decline/erosion of knowledge and skills among farmers,, extension staff, researchers, etc
- Increase in the cost of recruitment and placement of personnel
- Health facilities, budgets systems failing to cope with demand
- More tension/fight over the estates of the deceased

###### **What is being done**

- Some NGOs have adopted a multi-skilling approach
- Not much is being done about “capturing” the knowledge and skills among farmers (documentation)
- Countries in the south are begging even more now
- Promotion of local and alternative medicines and private hospitals
- State subsidies of health coming back
- “Depositing” of the sick in rural areas
- Inheritance (and wills) laws are being revised to support surviving spouse and children
- HIV/AIDS policies developed at national and organizational levels
- HIV/AIDS information sharing and sensitization
- People/citizens advocating their governments to allocate more resources to alleviating HIV/AIDS and poverty
- Governments in the south demanding debt cancellation, fair trade, community rights over biodiversity and the right to import generic drugs
  
- Countries are paying more attention to international arrangements

###### **Gaps**

- Not enough research (coordinated) in Africa
- No clear policies on HIV/AIDS in many organizations especially among NGOs
- Inflexibility of donors
- Knowledge about the disease and how to mitigate its spread and impact
- Limited knowledge about national policies and budget by th citizens especially service providers
- No cure/vaccines
- African countries not producing generic drugs!
- No or limited monitoring of policy implementation
- Fragmented approach /compartments

###### **Solutions**

- NGOs that provide services should link their activities to policy for sustainability
- Governments should allocate more money to health
- African governments should make concerted efforts to collectively research as well as to produce generic drugs

Governments should further subsidies on ARVs and provide a safer/more conducive working environment for health workers  
Macro and micro-economic policies should address the concerns of the poor and marginalised

## **b. Capacity building Group**

### *Question 1*

- i. Declining productivity
- ii. Overstretched (work overload)
- iii. Emotional stress
- iv. Policy formulation for some organizations (application of the policy)
- v. Loss of working hours due to:
  - Sickness
  - Visitation to the sick on hospitals
  - Seeking medical attention

### *Question 2*

Development of a policy  
Mainstreaming of HIV/AIDS and gender  
Encouraging counseling  
Networking with other organizations that have HIV/AIDS as core business  
Support to traditional medicine associations

### *Question 3*

Lack of HIV/AIDS policy  
Lack of budgeting allocation for HIV/AIDS  
Inadequate information on research i.e. right kind of food, ARVs  
“Stigma” to access of information on HIV/AIDS; considered women’s disease  
(people will consider me as one of them)

### *Question 4*

- i) Assurance of job security i.e. policy
- ii) Providing more information on HIV/AIDS
- iii) Encouraging VCT
- iv) High support from high management of organization
- v) Advocacy and campaigns to “distigmatise” the issues on HIV/AIDS
- vi) Networking with organizations providing home-based care and other services
- vii) Forums that will help in sharing of experiences and information on HIV/AIDS on drugs e.g. ARVs
- viii) Side effects of HIV/AIDS drugs, etc.
- ix) Collection of material on HIV/AIDS

## **c. Sustainable agriculture group 1**

### **Indicators**

Increased number of funerals in the communities

Reduced number of productive man hours  
High cases of sick people  
Increased number of orphans living with extended families/ street children  
Increased number of child-headed households  
Increased number of female-headed households  
Reduced number of productive households  
Decreased food production

#### **What is being done?**

- Promotion of organically grown crops
- Promotion of less time/ labour consuming technologies e.g. agro forestry near home stead for firewood, medicinal use, conservation farming
- Household trainings in taking care of the sick
- Assisting households keeping orphans with agricultural inputs and loans to start small businesses
- Free education in primary school (in Kenya it is not only free but also compulsory)
- Programmes that help orphans to reunite with their extended families
- Local food processing programmes
- Awareness creation programmes in the communities/ schools

#### **Gaps**

- Most mitigation measures are addressing the effects not the root causes
- Guardians personalize property e.g. land and cattle
- Don't have programmes that deal with orphans' needs
- Little networking with other NGOs and government institutions dealing with HIV/AIDS pandemic

#### **Solutions**

programmes addressing root causes should be introduced

Reinforce networking and information sharing among organizations working with vulnerable communities

3. Come up with strategies that address the needs of orphans

### **d. Sustainable agriculture 2**

#### **Indicators-negative**

- Low production
- Low turn-up for meetings
- Less energetic people for agriculture

- Project implementation destructed due to death
- Loss of skilled labour
- Untilled land is increasing due to loss of energetic labour
- Increased number of children out of school
- Increased child prostitution

#### **Positive**

- Slight change in behaviour
- Communities openness in discussing HIV/AIDS
- Number of income generating activities related to deaths

#### **Done**

- Open discussions
- Programmes are set up for people living with HIV/AIDS

#### **Gaps**

- Monitoring indicators
- Stigmatization
- No adequate training on HIV/AIDS
- Inadequate facilities for VCT and ARVs
- HIV training mostly offered to health workers
- Limited funds to fight HIV/AIDS

#### **What we need to do**

- Come up with organization policy on HIV/AIDS
- Multisectoral approach reinforced for information sharing

### **e. Rural livelihood empowerment in the midst of HIV/AIDS Group**

#### **Signs of effect of HIV/AIDS**

Absentism of staff

Illness prevents flow of information

Financial resources are diverted to treatment instead of other productive ventures

Consumption patterns at household level change e.g. purchase of ARVs

Delayed programme implementation as funerals cannot be delayed

Participation in development is minimal

Loss of highly skilled personnel and replaced with inexperienced staff.

#### **What is being done**

- Training more trainers
- The trained should represent a variety of groups/ peers
- Invite all couples for the training
- Allocation for miscellaneous and HIV/AIDS itself

- Packages have been introduced for farmers to grow food for food security
- There is double costing so that funeral could be done side-by-side other programmes
- Double commitment (working overtime)

### **Gaps**

- Inadequate finances
- Lack of coordination
- Lack of commitment by implementers
- Conservatism/ denial by communities

### **Plans (solutions)**

- Mainstreaming gender/ AIDS in a participatory way
- Promote open attitude towards HIV/AIDS e.g. testing
- Collaborative effort by churches, government, NGOs and CBOs
- Lobbying and advocacy

In consolidating the issues covered by the workshop, it was concluded that establishing linkages between HIV/AIDS and gender with the aid of statistics, it becomes possible to possess guidelines on how to create the most impact from a given mitigation strategy/initiative. This, however, is dependent on the following factors:

- Political will
- Commitment
- Donor support (most of which has strings attached)
- The unique characteristics (comprising, among other things, the social relations of a given environment, beliefs and values) and the needs of the society under consideration.

It was discovered from deliberations in the sustainable agriculture group 1 that:

-Credit facilities were seen as a useful tool being used in the area of agriculture to affected and infected members of the communities in mitigating HIV/AIDS through poverty reduction. Poverty has been identified as one of the major factors fueling the disease. Skills training is also provided in different areas in an attempt to raise income levels in the local communities.

-The Food security pack is also being used to enhance household food security, through such activities as kitchen gardening. It is hoped that this will help to cushion the impact of HIV/AIDS. It was noted by participants in this group that these measures are not new, but have just involved an emphasis on more vulnerable groups affected and infected by HIV/AIDS.

-Agricultural practices emphasizing the use of organic manure and organically made pesticide use have also been adopted to not only promote affordable and sustainable agriculture, but also in reducing the possible negative health implications on HIV/AIDS patients of chemicals. Furthermore, organizations are careful not to approach the communities as experts in HIV/AIDS.

They begin by making known to the people the core business of their organizations and then explain of their concern with HIV/AIDS and the need to address it. This enables the organization to also assume the role of a bridge between the communities and government health service delivery. It was observed, however that HIV/AIDS is still being treated only as a health issue in some countries. Training in the area of HIV/AIDS, is mostly offered to personnel in the medical field.

-In order to be true agents of change, the group resolved to take the lead in such activities as going for VCT.

The facilitator posed the following challenges in wrapping up the session:

- How do we advise our organizations as to where and how to tackle the problem area identified?
- Who should we work with?
- Whose reality counts? Ours or that of the people in the community? (Thus the need -understanding gender relations and how they are linked to HIV/AIDS).
- Do we have the capacity?
- Where can we make the most impact and how? By attacking the leaves, the trunk or the roots. The leaves are usually easy to deal with as mostly outcomes of the real source of the problem, whereas the roots are difficult as they have to do with challenges such things as power relations, beliefs and values.
- A bottom up approach becomes crucial in the final analysis

One organization shared with the workshop how they had identified the local traditional chiefs and headmen as an effective point of entry (the trunk). They were regarded as the trunk because of the great influence and respect they command in their communities. And so they are virtually the institutions they represent, which are capable of re-enforcing or perpetuating undesirable practices and values. Particularly those that have a direct bearing on HIV/AIDS like as sexual cleansing. These leaders have, therefore been brought on board as key participants and stakeholders in both not only implementing strategies, but most importantly being part of the solution formulation process.

## 5. MONITORING AND EVALUATION (M&E)

### 5.1. Overview of Monitoring and Evaluation

Monitoring and evaluation (M&E) is about having information and the ability to utilize the information. Viewed in this summary form, it implies the existence of a clear logic in the design of a project. The logic should encompass the following in descending order:

#### Framework for individual organizations

What problem are you trying to address? What sustainable change do you want to achieve? (IMPACT)

What behaviour change are you hoping to achieve? (OBJECTIVE)

What system change are you trying to achieve? (OBJECTIVE)

What are you doing to achieve the above 3 changes? (OUTPUT)

The questions above refer to the goal, the objectives and the outputs and activities of the intervention

#### Evaluation:

The one most important issue is that of **information**. What information? When is the information needed? What and above all what is the information going to be used for in order to address a particular shortcoming should the initial objectives not have been realized? In emphasizing this aspect, Regis stated that M&E is about having information and using it. Once what you want has been defined given adequate information, then M&E is halfway done, She observed.

**Behavioral change** is core in gender work. It is a crucial tool with which HIV/ AIDS can be eradicated. It could be considered as good as the impact itself.

**System**, in looking at the system in place, it is also important to analyse it in relation to behavioural change. This is due to the interrelated nature of the two.

**Output**, the above three points are very important in M&E because they constitute the part which we have no control over. The output can be altered with little difficulty. In M&E it is important to consider what is being used as a signal (indicator) to monitor change.

The signs, it was concluded, were usually difficult to detect, especially when under pressure by the funding organisation to see results in a short period of time. This point was made vivid when referred to the case of intervention aimed at addressing the problem of HIV/AIDS in a Kenyan prison, where it was difficult to isolate indicators of behavioural change among the prisoners towards homosexuality. It was assumed that homosexuality was fueling the spread of HIV/AIDS among the prisoners. This is especially a great challenge considering the fact that behavioral change, as a process is sometimes is very slow. Selecting which indicators to use and how to collect the information were other great challenges in a prison setting.

After tea break, the case of Cinci Wa Babili, (*what it is*), was used in understanding the concept of M&E. A specific intervention measure recently embarked on by the organization was used. The following were the details of the project:

**Goal:** reduce illiteracy among orphans and vulnerable children (OVCs)

**Objective:** sustainable agricultural activities, resulting in food and income security

**Activities:** -Register guardians (of OVCs) with corporatives in the area  
-Training in farming skills  
-Provision of first package of subsidized inputs

**Factors:** - Rainfall distribution in the area  
-Lack of understanding for training provided  
-Diversion of inputs from intended purpose (e.g. by selling them)

These are factors that Cinci has no control over.

**Monitoring:** having looked at the issues outlined above, how does the organization know it is achieving what it set out to do? First is to consider the initial targets that were set. In which case 20 guardians, either male or female, were targeted.

**Data:** -Number of guardians training in specific skills  
-Number of guardians registered at the corporatives  
-Number of guardians caring for OVCs who had received material support  
-Type of materials obtained (uniforms, books or other school requirements)

The last two points also help in knowing the cost which is sometimes ignored. The facilitator observed that it is easy to control the system.

The second level is that of **indicators**. What do you want to know?

-Number of OVCs from the participating households that are in school  
-Number of children from participating household that have reached at least four years in school  
- The trend in agricultural yield at household level

It is important also to look at that part of the environment that can have a bearing on the results, such as rainfall distribution. This is helpful in explaining the situation should there be an inability to realize the intended target (impact).

Other questions to be posed are

-What system of data collection have you put in place? and  
- The source of that data.

# DAY FIVE

## 1. FIELD TRIP (FRIDAY 11<sup>TH</sup> JUNE 2004)

In order to make the field experience more fruitful, participants were encouraged to consider the following during the visit:

What the center was all about

What the strategy for the project/center was

Was there a similar facility within the area that they worked in (in respective country)? If so sharing with everyone (at the site) the details of a similar project?

Sharing with the center management on what suggestions the participant (s) thought could assist in improving the services of the center

To facilitate effective sharing of experiences during the visit, the participant were advised to take note of the things/activities that had impressed/affected them most

### 1.1. UMOYO CENTRE

#### **Organisational profile**

The organizational visited during the field trip was Umoyo center. Umoyo means “life”. Established in 1996 by Kara Counseling, the center attempts to respond to the plight of orphans and vulnerable children in society, particularly girls (aged 13-18 years). Most of the girls are identified through the Fountain of Hope. Umoyo also works closely with home-based care organizations. The girls are accepted on the basis of recommended age and vulnerability. Umoyo also works with girls on the understanding that girls tend to be the most vulnerable in society. Compared with girls, at the ages between 13 and 18 years, most boys would have already started fendng for themselves.

Umoyo works at equipping the girls with life skills such as tailoring, knitting and capentry to enable them be useful to society and enhance the quality of their lives. Sporting activities are also undertaken. These skills are also important in improving food security. As such, the girls have a garden for the practice of agricultural activities. This is also designed for the economic empowerment of the girl child.

#### **Strategies:**

Umoyo works closely with home-based care, NGOs and other organisations working whose focus is on orphans and vulnerable children. Strategic partnership also exists with organisation in the area of with HIV/AIDS. Such organizations play an important role of helping Umoyo in identifying legible girls and also in the subsequent process of monitoring their lives after Umoyo.

The Centre is currently attempting to increase the capacity from the present 45 to 65 children.

**Way forward/future plans:**

- Have peer educator groups from those who have successfully gone through Umoyo
- Target girls (10 to 14 years)
- Incorporate boys in the system
- Enhance income generation for the girls after Umoyo

Umoyo has counselors from outside who help the girls in dealing with life matters. Their encounters with the counselors were described as beneficial as they talk openly. The girls are also encouraged to go for VCT.

Participants in the workshop freely interacted with the girls during the visit. The girls were undertaking marketing on what is referred to as “marketing day”, aimed at enabling them understand the various businesses they might be undertaking in future. The participants took time to purchase some clothes and vegetables from the girls.

## 2. WORKSHOP DINNER PARTY

A long day’s field trip and shopping was ended on a relaxing note with a diner party. It is according to PELUM tradition to end a workshop of this nature with a dinner for the participants. Father Jovenale, Secretary of the Coordination Committee gave his welcome remarks at 20 00hours, after which he invited Chairperson of the committee, Mary Kamau. Speaking on behalf of the participants, Mary thanked the organisers of the event for the courtesy extended to them and described the workshop as a success. She was particularly motivated by the active participation of everyone in the process especially PELUM Officers Mary said brought themselves down to interact. She pledge support to PELUM by the organisations present and called for continued networking. Fr. Jovenale then requested the Secretary General of PELUM, Mr. Mutizwa Mukute to call upon PELUM Zambia Chairperson Mr. Jonathan Chisaka for his remarks. A common feature among the three was the call for the implementation of the fruits of the workshop learning and sharing experience in the local communities and organisations back home. The Secretary General further noted that this was the first workshop of its kind that had the participation of four PELUM Officers from the Regional Desk. Other activities that characterized the evening were country-specific presentations in form of traditional dances. The host country, Zambia was the first to perform.

# **DAY SIX**

## 1. REACTIONS ON FIELD EXPERIENCE

- Monitoring productivity and lifestyles of girls after Umoyo impressive
- Girls have a vision and a bright future
- Interaction between the girls and boys living in the compounds undesirable as boys' behaviour still risky.
- Openness of girls in sharing their experiences and backgrounds was encouraging (e.g. prostitution before coming to Umoyo)
- Any intervention has loopholes i.e. some pregnancies reported despite teachings on condom use.

## 2. EVALUATION OF DAY 4

Since the previous day was spent in the field, day 4 was evaluated on the last day (6)

### DISLIKES

1. There were few people in the afternoon such that contributions were not as rich as previous day's
2. Participants seemed to be tired
3. M&E did not come out well thus people became tired
4. The day was dull
5. The brief stay of doctor Jay
6. No water in the afternoon
7. French fries for lunch were not dry
8. The use of words that excluded woman (manpower, man hour)
9. None

### LIKES

1. Presentation of M&E X4
2. Dr. Jay's presentation
3. How to design a suitable project and preparing measurable indicators
4. The afternoon sessions
5. Vivid and practical examples in the M&E session
6. Everything for the day
7. Sharing experiences on the impact of HIV/AIDS, interventions, gaps and solutions
8. The day's sessions
9. The information on monitoring of projects
10. The information on the impact on HIV/AIDS
11. The analysis of the negative and positive impact on HIV/AIDS

## 1. PELUM HIV/AIDS POLICY (Presented by Mary Kabelele)

Policy is intended to address gaps/limitations in our work and also in providing the organisation with direction based on our needs and goals. Constitutional pronouncements can sometimes be inadequate in terms of according a particular area the due attention it deserves.

### 1.1. REACTION TO THE POLICY

The following were the main areas of concern in the policy:

**Immune-enhancement** did not come out clear. It could be interpreted as an example, a specific mechanism involving the elderly counseling boys in a village hut while girls, on the other hand undergo the same in their respective settings with elderly women. Or creating huts detached from the main house for boys to sleep in while old men continue to monitor their conduct.

**Prevention:** Of concern was the uncondusive and compromising sanitary conditions in many hospitals where chances of infection are higher because of limited facilities and space for cleaning up after delivery of children (many people using same facilities). This exposes women to higher risks of infection. The same concern applied to traditional birth attendants in terms of exposure to possible HIV infection due to the absence of proper facilities or even gloves for protection. Other issues that needed to be addressed included:

- Development of policies at organisational level (majority of organizations yet to do so)

- Lack of HIV/AIDS expert knowledge (and so need for close collaboration with the experts in the field)

- Tendency to jump on the bandwagon without due consideration of the issues involved (just because everyone is doing it). This results in mere copying of what others have done as opposed to deriving and implementing policy that responds to peculiar needs of an organization;

- Operationalising the policy

- Ability to adapt policy to prevailing local /organizational needs

- Linking interventions at national level to policy

- PELUM to see to it that there is no duplication of effort which makes impact assessment difficult. The need to sometimes cooperate when deemed necessary for effectiveness of interventions

- Mainstreaming

- PELUM to visit organizations other than its members to help interpreting interventions at local level which might sometimes be regarded as unuseful by the organization involved

- The Need for sharing experiences and strategizing

- Advocacy at all levels.

## 2. PELUM GENDER POLICY

-Historical background: described as one of the oldest policies in PELUM. The process was embarked on as early as the 1980s and 90s.it was adopted at the 1999 BGM in Lusaka-Zambia and finally received consensus in Uganda-2003.

1.The gaps it is trying to address

2.Who is in the policy?

3.How (the strategy)

- organisational culture
- Constitution and other policies
- Structures

4.Policy socialization and application

### 2.1. Reaction to policy

-No.11 point 5 (policy management), the role of networking and learning in discussing the progress made on gender policy whereby reports will be sent to the regional desk, which will in turn disseminate the information.

-Need to link our activities to the gender policy

-The need to strengthen policies after their adoption.

-Policy helps in bringing out priority areas. For example the health policy of Uganda and its emphasis on HIV/AIDS

After all said, the facilitator posed the following questions for consideration by the participants in their gender policy development endeavours:

- What values are we going to promote through these policies? Taking cognizance of the existence of traditional values (positive and negative). Within traditional values, therefore, which ones are to be retained and which ones to do away with?
- Whose values?

### **3. PELUM ON ADVOCACY (LINKING HIV/AIDS AND GENDER)-PRESENTED BY *MZINGA JOE L.E***

#### **3.1. Introduction**

Since HIV was diagnosed in the world in early 1980s, now 42 million people are infected with the virus worldwide.

Among them 29.4 million are living in sub-Saharan Africa. In 2002 New infections 3.5 and death 2.4 million (why?)

58% PLWA are women and girls in 5 yrs 70%

To date East and Southern Africa is at the epicenter of the epidemic

#### **3.2. What is advocacy**

Involve putting a problem on the agenda, providing a solution to that problem and building support for building on both the problem and the solution

#### **3.3. Why HIV/AIDS affects more poor countries and poor people?**

Marginalized groups in the society are further impoverished due to existing international, national and societal arrangements.

They cannot own, access or benefit from resources or economic gains.

They cannot fight HIV/AIDS effectively as to prevention, support, care and treatment

For the majority catching HIV is like getting a death sentence and the beginning of suffering

#### **3.4. HIV/AIDS a Gender Issue**

Women and Men all can get AIDS.

But women are affected by HIV/AIDS differently: **-Socially-** Illiteracy, Poverty, Blame as cause of misfortune, denied right to inherit, and gender violence.

**Biological-** Fertility and age limit, large area of exposed, coerced sex, FGM and Rape. Also in danger of infecting their babies.

**Gender Roles-** Higher burden of care for the sick, the dying and during funeral.

### 3.5. What may be our campaign's goal?

- To see a society whereby women and men have access to and are able to benefit from national and international resources that enable them to address effectively and challenge HIV/AIDS; in its prevention, care and treatment so that to ensure food security and better life in rural areas

### 3.6. What may be our issues for advocacy?

#### **At organizational level;**

To advocate for HIV/AIDS and Gender Policy & projects

At local level;

To mobilise community to participate in the budgeting/policies processes and hold leaders accountable

To ease the burden of women and girls; by demystifying harmful myth and practices

Mainstream gender and participatory democracy (promote women to leadership)

### 3.6. The campaign objectives

At National Level

To generate a public debate on poverty, gender and HIV/AIDS

Demand gender, HIV/AIDS policies or laws

Vigilance on resource allocation (budgets)

To advocate for the increased budget for the health, PMTCT/ARVs programmes, Post Exposure Prophylaxis PEP-

To pressurize public and private companies to care for the their infected employees  
Right to information and proper nutrition

### 3.7. Steps, strategies and tactics

- i. Identify problem
- ii. Gather more information, understand other policies and initiatives
- iii. Identify actors
- iv. Coalition Building and roles
- v. Identify targets
- vi. Implementation strategies: action plan, messages, publicity materials, letters, position papers, media etc.
- vii. M & E and Restrategising

#### 4.0. REACTION TO ADVOCACY PRESENTATION

- Statistics are useful in adjusting our intervention strategies
- Compilation of statistics can sometimes misrepresent the prevailing situation within the total population
- Adequate advocacy in some areas has already been done and what national governments want to hear more is what is being implemented on the ground.
- A lot of advocacy has been done, but question is on the quality of that advocacy. What is the outcome of people outcry? Thus need for advocacy that is backed by the people in the communities. (Who lobbies?) Real change, as evidenced in history, begins from below. Need to include those who are affected and infected in the advocacy. An example of the campaign against GMOs in Kenya which began with a small group of SACDEP members and thereafter had acquired a national following.
- Advocacy is a long-term process in as far as discerning its results/impact
- Advocacy requires clear understanding of the problem area before engaging in it.
- Advocacy should be based on clear objectives and principles.
- Advocacy is usually out of our control in terms of the results it is intended to yield

#### 5. FINAL WORKSHOP EVALUATION

##### **Guiding questions for final evaluation**

What did you like (in the 6 days of the workshop)?

What didn't you like?

How can a similar workshop be improved?

What can PELUM do to improve similar workshops in future?

	<b>Likes</b>	<b>Dislikes</b>	<b>How a similar workshop can be improved in future</b>	<b>What can PELUM do to improve similar workshops in future?</b>
<b>Participant 1.</b>	Togetherness of the participants and facilitators	Bathing of cold water in the morning in the rooms	Time allocation to sessions to be increased (e.g. M&E, Advocacy and lobbying and Impact of HIV/AIDS)	Topics which the participants feel are of great use to them should be allocated enough/adequate time
<b>Participant 2</b>	The presentations and the atmosphere in the class was very much conducive for learning	The venue was not good enough in terms of having cold water in the morning and food was monotonous	Next time PELUM should try to take us to a better place than this one	
<b>Participants 3</b>	<ul style="list-style-type: none"> <li>-Information on HIV/AIDS</li> <li>-Gender concept</li> <li>-Linkages between gender and HIV/AIDS</li> <li>-Conceptualising the HIV/AIDS and gender in view of how to plan/target and intervention</li> </ul>	<ul style="list-style-type: none"> <li>-The statistical representation of HIV/AIDS impact done swiftly</li> <li>-Arrogance of the presenter for the statistical impact of HIV/AIDS</li> <li>-Some of the food cooked, quality not impressive</li> <li>-The low lighting of the conference facility and dusty</li> </ul>	<ul style="list-style-type: none"> <li>-Need for more assignments to research on certain issues would have been helpful</li> <li>-More time allocated to some very conceptual presentations</li> <li>-Teasing out of certain unnecessary issue would be great help</li> </ul>	<ul style="list-style-type: none"> <li>-The association should follow up with member associations on certain concepts</li> <li>-Monitoring and evaluation system to be incorporated in the check of what work is being done</li> <li>-Information flow to individuals to be improved selection of a good site for such a function/ good facilitated committed to the work output</li> </ul>

<b>Participant 4</b>	The workshop has been very educative and I have really learnt a lot from it. The presentations were well done and the facilitation excellent. I have now acquired more knowledge especially on the interventions of HIV/AIDS and the identification of entry points when mainstreaming gender and HIV/AIDs in programmes and activities.	Can't really point out one activity that could have made me dislike the workshop except to say that sometimes we overshot the time and this could have caused some people not to concentrate on issues, especially in the afternoon sessions	PELUM needs to come up with more such activities so that we could be afforded a chance of getting abreast with issues as they happen. To wait and concern a workshop only when we see alarming statistical figures may be costly as issues need to be tackled when the problem is still in its infancy. So please more such workshops are needed. PELUM also needs to find out more about the venues of the workshops to avoid situations that may be detrimental to the well being of the participants. - Cold water in the rooms may be an example here.	PELUM should continue sourcing experienced facilitators such as the ones we had for this workshop.
<b>Participant 5</b>	<ul style="list-style-type: none"> <li>- Group works allowing all to participate</li> <li>-Representation from many countries allowed rich examples and sharing</li> <li>-The very excellent way in which the participants related to each other</li> <li>-Very flexible programme</li> <li>-Resource persons who were brought in for more technical work</li> <li>-Fieldwork brought the reality before us</li> </ul>	<ul style="list-style-type: none"> <li>-The food! Very few choices, same type day in day out</li> <li>-Resource persons with no participatory methods, e.g. doctor Sunkutu</li> <li>-Poor planning towards the workshop, kept on postponing. - No pre-workshop notification, last letters came very late. So I did not know about the weather</li> </ul>	<ul style="list-style-type: none"> <li>-More African dishes or a mix</li> <li>-Prepare early and communicate faster</li> <li>-Bring people who know the background of participants and who have participatory methods.</li> </ul>	

<b>Participant 6</b>	<ul style="list-style-type: none"> <li>-Topics on demographic trends of HIV/AIDS and gender</li> <li>-Susceptibility and vulnerability</li> <li>-In-country statistics</li> </ul>	Missed the topics on policy due to office demands	Hold it outside town. Should have invited a PLW Aids working in a pro-HIV organization to talk about programming and issues at both the organizational and individual levels	<p>Informed us about possible funding opportunities, nationally, regionally</p> <p>- Beyond the workshop, how can you assist us in developing organizational HIV/AIDS policies? Accessing funds for integrating HIV/AIDS activities</p>
<b>Participant 7</b>	HIV/AIDS and gender policy presentations		To have full-time facilitators for HIV/AIDS workshop for the whole workshop days, like Madam Regis	To increase the days of the workshop; one week is not enough to learn better the issues
<b>Participant 8</b>	<ul style="list-style-type: none"> <li>-The impact of HIV/AIDS and gender in development (Communities)</li> <li>-The participatory approach by the facilitators</li> <li>-The interaction of group members/PELUM leaders</li> </ul>	<ul style="list-style-type: none"> <li>-The one-sided presentation by Dr. Sunkutu</li> <li>-We were told to bring pictures/or anything for presentation from our organizations, but the presentation was not given time</li> </ul>	-The association to try to use flexible facilitators that are not one-sided	-By allowing participants to facilitate in one community to see whether they have captured or not.
<b>Participant 9</b>	- Every topic and exercise of the workshop in the six days of the workshop. We were able to socialise and have learnt a lot by sharing as individuals and countries	<ul style="list-style-type: none"> <li>-What I did not like is the venue. This place is not fit to be called a hotel but either a guesthouse or to be fair as a motel.</li> <li>-Cups were usually dirty and not properly cleaned, tables were not cleaned and services too slow.</li> <li>-Table clothes were not washed</li> <li>-Too much dust in the conference room</li> </ul>	<ul style="list-style-type: none"> <li>-Similar workshops can be improved by censoring on the facilitators. -Dr. Sunkutu's is not a good one.</li> <li>-Involve also very much the Secretary General for PELUM.</li> </ul>	For improvement in future, PELUM needs to go down to the communities we are serving so that they get a wide idea of what exactly is on the ground. Lip service at time is there to impress people when in actual fact not the ground truth.

<b>Participant 10</b>	-The workshop deliberations went on very well and they were fruitful. To improve on the quality of such a workshop in future, ensure that all deliberations for a particular day are printed on the very day and distributed to participants so that they can serve and a starting point for the next day.	PELUM should prepare enough articles for every participant and also the Regional Desk should send reports on the deliberations of the workshop to our various organizations so as to tally with our reports which will be submitted		
<b>Participant 11</b>	The encouragement from PELUM staff, their involvement and concern in the workshop deliberations.	. Repetition of certain topics of the course and some facilitators did not answer some questions adequately	Inform the resource persons in advance for them to prepare adequately to avoid "management by crisis	Perhaps PELUM could communicate to its members on the type of courses being run so that certain areas could also be included before the course contents are out.
<b>Participant 12</b>	-The group work and the presentations on stigma and discrimination. -Presentations on mitigation and the impact of HIV/AIDS	Disliked the presentation by Doctor Kanyanta Sunkutu. He was very fast.	Talk to consultants early before workshop due because they seem not to know what they want to achieve (Dr. Kanyanta)	-Invite consultants that are willing to facilitate people like Gwaba, Doctor Jay and doctor Chirwa. -Choose good facilitators for the workshop sessions. -The conference room was not all that conducive for training.
<b>Participant 13</b>	-Networking and experience sharing		More time to be given to working out of the way forward	
<b>Participant 14</b>	-Participation from the various countries; Zambia, Tanzania, Zimbabwe, Kenya, Uganda -The sessions of the workshop -The socialisation of the participants. They got on so well	- The absence of other media organisations	-Invite more media organizations to the workshop -Participation from all countries in Africa (invite) Incorporation of youths in the workshop	
<b>Participant 15</b>	-The dynamic facilitation -Active participation -Choice of content -Accommodation Interactions	Some participants were in a hurry	-Well ventilated room	-Could afford outdoor pocket allowance

<b>Participant 16</b>	<ul style="list-style-type: none"> <li>-Topics on HIV/AIDS and statistics</li> <li>-On gender evaluation and monitoring</li> <li>-A meal with traditional dishes</li> <li>-Field trip on HIV/AIDS-mitigation strategy</li> </ul>	<ul style="list-style-type: none"> <li>-Lack of clarity by the workshop on what values will gender promote.</li> <li>-The doctor's (Sunkutu) outcome on local initiatives (traditional medicines)</li> <li>-Workshop duration was short hence many other challenging issues were not brought out.</li> </ul>	<ul style="list-style-type: none"> <li>-Increase on the number of days i.e. 14 days</li> <li>-Invite people in research on HIV/AIDS who can give views on both conventional and traditional initiatives.</li> </ul>	
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## 6. ACTION PLANS

### **Points for plan of action**

To help participants in deriving systematic action plans, Regis requested them to reflect on the following points to consider both at individual and organizational levels. The points were recorded on pieces of paper and submitted –bearing name of participant and the organization they were representing.

#### *Individual*

1. What activities will I undertake to incorporate HIV/AIDS and gender in my work?

#### *Organisational*

2. With the skills and knowledge acquired from the workshop experience, how/what will you do to promote the incorporation of HIV/AIDS and gender in your organisation?

3. How will you feedback your experiences into PELUM?

## 7. PRESENTATION OF CERTIFICATES AND CLOSE OF WORKSHOP

After the discussion, Mary called upon the Secretary General to award of certificates to the participants. In his closing remarks, he appealed to the participants to be able to make a difference in their communities and families. “ The richest place in the world is found in the graveyard”, he said. Implying that the wealth of talent and ability there cannot be exploited or put to use. He, therefore, advised the workshop that it is the little contributions that change the world. After the awarding of certificates, Mary made her closing remarks by thanking all the participants and the organizations they represented for the wonderful response. She mentioned how humbled she and PELUM as an organization were at the overwhelming response to the call.

She also thanked PELUM Zambia for the support rendered towards the workshop. Tim from PELUM Zambia was called upon to say a few words.

She went on to convey sincere thanks to the facilitators during the workshop. When called upon to say her final remarks, Gegis Gwaba acknowledged the wealth of information possessed by the workshop and expressed hope that the participants would put it to use back in their respective communities of operation.

## APPENDIX 1

### **ACTION PLANS**

#### **IREEN C. BANDA – MINISTRY OF AGRICULTURE AND CORPORATIVES (KAFUE – ZAMBIA)**

I will mainstream the community problem (gender/HIV/AIDS) into a particular government programme (agriculture). In a purposeful integration of activities designed for mitigating that problem into the intended development programme under consideration by government, such that the resources available are also used to benefit the community in addressing its concerns in a holistic way (as you know governments have no fixed or promissory funding which donors make most of the time).

In this case since gender and HIV/AIDS affects the productivity of affected individuals and communities the accrued benefits for mainstreaming also affect the availability of the development programme itself and its overall impact may be enhanced. In government, the HIV/AIDS – gender are yet to be funded.

#### **NJIRA MTONGA – WOMEN FOR CHANGE**

Activities:

1. Advocacy on gender issues, human rights, democracy and development.
2. District human rights workshops for districts and village Head Persons in all districts in Zambia. WFC advocates for the five basic pillars of life visa-viz food, water, health, education and shelter to be enshrined in the Zambian constitution. The bill of rights has to be protected and respected by all.
3. Train both male and females in communities on what gender is. Currently, WFC is using a gender in development approach which entails that both men and women must be equal partners in development.
4. HIV/AIDS has been mainstreamed in all development programmes of WFC and currently communities in our remote rural parts of the country are pressurizing government to provide them with ARVs just as their counterparts are doing in towns.
5. Traditional leaders (chiefs) are being trained on issues of advocacy and lobbying and currently some chiefs have banned those cultural practices which perpetuate inequalities and risky behavior e.g. sexual cleansing, brewing if illicit beer and the virgin cure.

Feedback:

1. Information has been disseminated and currently there was news article that Chief Sikufele of Kabompo has banned the brewing of illicit beer and sexual cleansing.
2. People are now aware of their human rights and have started demanding for the enshrining of the Bill of rights in the constitution as can be evidenced from submissions in the constitutional review commission.
3. People now aware that HIV/AIDS is now a human right and everyone has a right to treatment and care regardless of town or rural dweller, race, creed and tribe.
4. On gender, all our communities are well versed with the concept gender and are working towards realizing an equal representation in all decision-making levels.

**SARA GOMA SIKOTA – Monze Diocese, Zambia**

<i>Activity</i>	<i>When</i>	<i>Where</i>	<i>Assumptions</i>
- Hold a re-training workshop for members of staff for the organisation with emphasis from issues learnt from here	20-23/06/04	Monze Home-craft Centre	Resources will be made available
a) Mainstream HIV/AIDS and gender in all our agriculture activities making sure that all men and women, boys and girls are exposed to the same empowering environment in terms of quality and quantity. This will be reflected first in our strategic plan	By July 2004	Monze Diocese	Influential leaders are made aware and accept our ideas
b) Develop a gender and HIV/AIDS by December organisation policy for the organisation 2004 Monze leaders accept	By December 2004	Monze Diocese	Organisation leaders accept
Report writing to PELUM on all the activities being done on the issues of gender and HIV/AIDS	Wherever an activity is done	Monze Diocese	

**MUKAMBA MWANGALA – Community-Based Natural Resource Management and Sustainable Agriculture (Kalomo, Zambia)**

<i>Individual</i>	<i>Organisational</i>	<i>Feedback of experience into PELUM?</i>
<ul style="list-style-type: none"> <li>- Workshops</li> <li>- Meetings</li> <li>- Training meeting</li> <li>- Enterprise skill development</li> <li>-</li> </ul>	<ul style="list-style-type: none"> <li>- Hold an organisational workshop where I will be a key resource people in order to disseminate the acquired skills</li> <li>- Lobby for gender consideration in all the organisational work</li> </ul>	Update PELUM through the country desk which is hosted in SACDEP-Kenya

**KOTATI JUSTIN NONDE - Archdiocese of Lusaka**

<i>Individual</i>	<i>Organisational</i>	<i>Feedback of experiences into PELUM?</i>
	To lobby for the inclusion of HIV/AIDS and gender in the rural development programme. This will also ensure that a desk is created to deal with this matter	By contributing articles and necessary reports on HIV/AIDS and gender to PELUM

**ROSEMARY V. G'OMA – Programme Against Malnutrition (Lusaka-Zambia)**

<i>s</i> <i>Individual</i>	<i>Organisational</i>	<i>Feedback of experiences into PELUM?</i>
Talking to my children on the myths negativeness leading to acquisition of HIV/AIDS and gender. Sharing with my neighbors and fellow church congregants on facts that make the use of condoms and abstinence helpful for all.	Train trainers on more nutritious recipes for people living with HIV/AIDS. Advocate for interventions that will address the root causes of HIV/AIDS and gender, I have noticed in the workshop deliberations that my organization is mostly looking at the <i>leaves</i> of the problem tree i.e.the affected	Send in quarterly reports to PELUM through Internet and contributions to the magazine.

**Fr. JOVENALE AYELANGOM – CARITAS-NEBBI (Uganda)**

<i>Individual</i>	<i>Organisational</i>	<i>Feedback of experiences into PELUM?</i>
Talking to peers at leisure joints about HIV/AIDS and gender <ul style="list-style-type: none"> <li>- Being available always to give HIV/AIDS and gender training to people/organizations when called upon</li> <li>- Plead for those stigmatized and denied rights e.g. OVCs and widows</li> <li>- Living an exemplary life for other to emulate</li> <li>- Increase HIV/AIDS and gender issues in sermons and homilies</li> </ul>	Initiate gender and HIV/AIDS training for staff or organization <ul style="list-style-type: none"> <li>- Giving a detailed report of the training/workshop to the Caritas-Coordinator including other staff members</li> <li>- Initiate more gender and HIV/AIDS training to communities</li> </ul>	<ul style="list-style-type: none"> <li>- Regular writing of articles on HIV/AIDS and gender activities to PELUM Newsletter</li> <li>- Submitting records of work to PELUM Country Desk</li> </ul>

**MUTIZWA MUKUTE – PELUM Association Regional Desk**

<i><b>Individual</b></i>	<i><b>Organisational</b></i>	<i><b>Feedback of experiences into PELUM?</b></i>
<ul style="list-style-type: none"> <li>- Support orphans to the tune of US dollar per year</li> <li>- Exercise responsible behavior</li> <li>- Explain top others about the pandemic</li> </ul>	<ul style="list-style-type: none"> <li>- Finalise the HIV/AIDS incorporation into personnel policy process</li> <li>- Encourage PELUM member organizations and other NGOs to develop HIV/AIDS gender policies and programmes through ground up and other media</li> </ul>	

**JOSEPHINE KASANDE – Environment and Sustainable Agriculture Project, Fort-Portal Diocese (Fort-Portal, Uganda)**

<i><b>Individual</b></i>	<i><b>Organisational</b></i>	<i><b>Feedback of experiences into PELUM?</b></i>
<p>-Creation of understanding and commitment in my organization, by creating/raising awareness about the need to focus on HIV/AIDS and gender</p> <p>-Carry out a situation analysis to assess the scope and scale of the pandemic</p> <p>-Plan and priorities, looking at how we will get funds, time and human resource issues</p>	<p>-Develop a team (focus team) in the organization and implement</p> <p>-Analysis our M &amp; E system so as to get tools that incorporate the HIV/AIDS issues</p> <p>-Continue the process of developing a health policy (HIV/AIDS inclusive) and a gender policy which programmes are being facilitated by CDRN currently</p> <p>-Network with other organizations</p> <p><b>How:</b></p> <p>-Advocacy skill in explaining the rationale</p> <p>-Explain how HIV/AIDS links with my organization e.g. does it show in our mission, vision and values</p> <p>-Allow a participatorial process where all staff regardless of gender and position participates</p> <p>-Network with other</p> <p>-Get people on the decision level to push the issues forward i.e. allies within and without</p> <p>-Pray and trust that in everything God is able.</p>	<p>-Communication every month to the PELUM country desk at CDRN as we are already in the same process</p> <p>-Direct communication to the regional desk on lessons learnt, challenges and success at least every two months</p>

**GEORGE SIMUYEMBA MUNYAMA – Cinci Wa Babili Rural Development Project (Malole – Kasama, Zambia)**

<i>Individual</i>	<i>Organisational</i>	<i>Feedback of experiences into PELUM?</i>
-Provision of ARVs to identified PLWHA -Advocacy for a sound policy that addresses the issues of HIV/AIDS, gender and environment	Identify the “point of entry” in intervention that will cut across HIV/AIDS and gender in your programming	Write articles on achievement. Constraints, lessons learnt and way forward and circulate to collaborating partners and other stakeholders

**JOSEPH KANJOLO – Kaluli Development Foundation (Choma, Zambia)**

<i>Individual</i>	<i>Organisational</i>	<i>Feedback of experiences into PELUM?</i>
Discuss openly the issues of gender and HIV/AIDS with friends and family	<ul style="list-style-type: none"> <li>- Meetings with management team, project staff and communities</li> <li>- Agree with all stakeholders on how to incorporate gender and HIV/AIDS in our activities</li> </ul>	Documenting the activities (Video, photographs, reports) and sending the documentation to the country desk

**DOROTHY SITUMA – Community Development Resource Network (CDRN) (Kampala, Uganda)**

<i>Individual</i>	<i>Organisational</i>	<i>Feedback of experiences into PELUM?</i>
Write a brief report from those training because it has been a big problem in our organization to integrate gender and HIV/AIDS in programmes	Work with focal people “gender/HIV/AIDS” when they are drawing up programmes	The country desk officer

**GRACE MKETTO – INADES Formation Tanzania (Dodoma, Tanzania)**

<i>Individual</i>	<i>Organisational</i>	<i>Feedback of experiences into PELUM?</i>
Feedback session to staff team and share with them the contents/issues discussed during this issues	Revise the existing activities and try as much as possible to actually dig out the real roots and trunk and add other important things that were left behind that need to be focused	

	<p>on in our HIV/AIDS training as far as gender relationships are concerned</p> <p>-Share and disseminate the skills and knowledge gained from country desk –organised workshops (as a resource person)</p>	
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**MARY WANJIKU KAMAU – SACDEP (Thika, Kenya)**

<i>Individual</i>	<i>Organisational</i>	<i>Feedback of experience into PELUM?</i>
<p>-Briefing the organisational management team in the issues that need to be taken up</p> <p>-Sensitizing the communities through extensionists, on cultural issues that could be propagating the disease</p> <p>-Advocate for a gender and HIV/AIDS policy in the organisation</p>	<p>– Hold an organisational workshop where I will be a key resource people in order to disseminate the acquired skills</p> <p>– Lobby for gender consideration in all the organisational work</p>	<p>Update PELUM through the country desk which is hosted in SACDEP-Kenya</p>

**ESTHER CHIKANGA – Kaluli Development Foundation (Choma, Zambia)**

<i>Individual</i>	<i>Organisational</i>	<i>Feedback of experience into PELUM?</i>
<p>– Have meeting in the communities targeting all age groups (13-65 years) and to identify problems</p> <p>– Involve the target group in agriculture, HIV/AIDS and gender activities</p>	<p>Form a drama group that will be talking/performing HIV/AIDS and gender plays in agriculture during field days, meetings, workshops and training</p>	<p>– Through forums that PELUM will conduct in future or by writing to them about experiences</p> <p>– PELUM should visit its colleagues to their various places</p>

**ORAN NDELEKI – Kaluli Development Foundation (Choma, Zambia)**

<i><b>Individual</b></i>	<i><b>Organisational</b></i>	<i><b>Feedback of experience into PELUM?</b></i>
<ul style="list-style-type: none"> <li>- Sensitizing meetings in communities on HIV/AIDS and gender</li> <li>- Promotion of income generating activities with female headed households (goat multiplication; small scale irrigation)</li> <li>- Training of communities in processing, utilization, storage and nutritive values of locally available foods in linkage with PAM/EDRP</li> </ul>	<ul style="list-style-type: none"> <li>- Awareness meeting at organization level on the workshop objective</li> <li>- Also on the impact of HIV/AIDS and gender in the already existing activities (on development)</li> </ul>	Report writing

**MUKAMBA MWANGALA – Community-Based Natural Resource Management and Sustainable Agriculture (Kalomo, Zambia)**

<i><b>Individual</b></i>	<i><b>Organisational</b></i>	<i><b>Feedback of experiences into PELUM?</b></i>
<ul style="list-style-type: none"> <li>-Workshops</li> <li>-Meetings</li> <li>-Training meeting</li> <li>-Enterprise skill development</li> <li>-HIV/AIDS group support</li> <li>-Natural resource management awareness</li> <li>-Campaigns and skills development</li> <li>-Livelihood skills development</li> </ul>	<ul style="list-style-type: none"> <li>-Promote the distribution of HIV/AIDS material through HIV/AIDS talks</li> <li>-Support staff with some basic knowledge on HIV/AIDS and gender for incorporation in some activities</li> <li>-Support local extension staff/community in basic skills on HIV/AIDS</li> <li>-Provide support for linkages of activities that target women and youth skills development and HIV/AIDS prevention promotion</li> </ul>	<ul style="list-style-type: none"> <li>-Documentation of lessons learnt</li> <li>-Report</li> </ul>

**LILIAN H. HAMUSIYA** – Kaluli Development Foundation (Choma, Zambia)

<i>Individual</i>	<i>Organisational</i>	<i>Feedback of experiences into PELUM?</i>
<ul style="list-style-type: none"> <li>- Share the PELUM policy on mainstreaming HIV/AIDS and gender with fellow senior management staff at organizational level</li> <li>- Form HIV/AIDS discussion and drama groups</li> </ul>	<ul style="list-style-type: none"> <li>- Openly talk about the link between gender and HIV/AIDS in drama and HIV/AIDS discussion groups</li> <li>- Have discussed with the community leaders who are custodians of the traditional beliefs and attitudes</li> </ul>	Through a report to the manager on to PELUM on experiences

**GODWIN BANDA** – Catholic Center for Justice Development and Peace (Lusaka, Zambia)

<i>Individual</i>	<i>Organisational</i>	<i>Feedback of experiences into PELUM?</i>
<ul style="list-style-type: none"> <li>- I will incorporate HIV/AIDS and gender by going through all the programmes at the center and diocesan level to evaluate their activities and see whether the activities in the programmes do address the issues of HIV/AIDS and gender. Where these issues will be lacking recommendations will be made that they may be incorporated</li> <li>- The second approach will be to facilitate discussions at the Center and in Diocese to enable participants come up with ways and suggestions of how best to incorporate gender and HIV/AIDS in their programmes</li> </ul>	Will use my knowledge and skills by participating fully in the formation of the HIV/AIDS policy paper which my organization is trying to come up with.	Feedback to PELUM will be through sharing of activity reports which can be circulated to all association members through e-mails for example.

**ROSE HAAMBAYI – Harvest Help UK (Lusaka, Zambia)**

<b><i>What</i></b>	<b><i>When</i></b>
<b><i>Individual level</i></b>	
1. Discuss openly with spouse on vulnerability and susceptibility	June onwards
2. Discuss openly with my children/dependants (age range 4-9)	June onwards
3. Go for VCT	By December
<b><i>Organizational</i></b>	
1. Facilitate formulation of HIV/AIDS policy <ul style="list-style-type: none"> <li>- Identify experienced facilitators/organizations</li> <li>- Sensitize staff and management</li> <li>- Sensitize partner organizations</li> </ul>	September 2004 June 2004 July 2004 August 2004
2. Secure funding for integrating HIV/AIDS activities among five partner organizations	September onwards

## APPENDIX 2

**OPENING SPEECH BY HON. MUNDIA SIKATANA, MP,  
MINISTER OF AGRICULTURE AND CO-OPERATIVES, DELIVERED AT  
THE PELUM REGIONAL GENDER/HIV WORKSHOP HOSTED BY  
PELUM- ZAMBIA**

**8<sup>TH</sup> JUNE 2004**

Mr. chairman,  
Distinguished Guests  
Participants,  
Ladies and Gentlemen

It is my pleasure to officiate at this very important regional Gender/HIV workshop designed to broaden participants' understanding of the underlying concepts of gender and HIV and their inter linkages so as to raise their consciousness, motivation and initiative to influence policies to promote sustainable development.

Mr. Chairman,  
Poverty remains an endemic problem in Zambia and the sub region as a whole being more severe in rural than urban communities.

Some of the major driving factors to the current poverty levels are the failure of the agricultural sector in the past years to provide sustainable livelihoods for the rural poor and diminishing employment opportunities in urban areas.

Mr. Chairman,  
I wish to point out here that my government has worked tirelessly to facilitate increased agricultural production among the rural small scale farmers through improved input provision and produce marketing. I am proud to reiterate, once again, that this has resulted in bumper harvests we have witnessed in recent seasons.

Mr. Chairman,  
Besides the many driving factors, the impact of HIV/AIDS has exacerbated the poverty situation in rural areas by undermining agricultural productivity and thereby increasing household food insecurity.

In addition, the inter-relationship between HIV/AIDS and poverty is complex. The manifestation of HIV/AIDS leads to poverty and poverty directly or indirectly creates vulnerability to HIV/AIDS.

Mr. Chairman,  
I do not wish to over emphasise that issues of gender play a very important role in developing a sustainable strategy for poverty reduction.

I however wish to emphasise that even HIV/AIDS, which is fuelling poverty in our communities, is a gender issue. this is because:

1. Although HIV/AIDS affects both men and women, women are more vulnerable because of biological, epidemiological and social reasons.
2. The HIV/AIDS epidemic is fuelled by situations where macro policies have led to an increase in gender disparities such as mass population displacement due to internal or external conflicts.
3. The rapidity of the spread of HIV/AIDS among women can be slowed down only if current changes are brought about in the sexual behaviour of men. It is, for instance, not uncommon in African society for women to experience sex against their will.
4. The feminisation of poverty is a key characteristic of the socio-economic impact of HIV/AIDS. The burden of care of the infected and sick invariably falls on women in the family. Thus in households where women are responsible for subsistence farming, this leads to reduced productive time, food insecurity and withdrawal of the girl child from school among other consequences.

Mr. Chairman,

To sum this up, gender inequality is a key variable in the incidence of HIV/AIDS, as gender disparities increase, the pandemic is affecting more and more women who bear the negative consequences of the gender imbalances.

## APPENDIX 3

### **OPENING SPEECH BY PELUM ZAMBIA CHAIRPERSON JONATHAN CHISAKA AT THE OFFICIAL OPENING OF THE PELUM GENDER AND HIV/AIDS WORKSHOP.**

**CAPITAL HOTEL- 8<sup>TH</sup> JUNE, 2004-LUSAKA-ZAMBIA.**

Honourable Minister of Agriculture and Cooperatives, Hon Mundia Sikatana, MP,  
Distinguished guests, workshop participants, Ladies and Gentlemen.

May I take this opportunity to welcome the Hon Minister of Agriculture, who has left his busy schedule to come and be with us at this event. This goes a long way to show the importance the Government of the Republic of Zambia attaches to issues of gender and HIV/AIDS.

Sir, the Network of Pelum in the East and Southern Africa has since 1995 been engaging with small scale farmers, facilitating learning, networking and advocacy in sustainable agriculture, natural resource management and household food security so as to achieve community development among smallholder families in the region. This has been a process of leaning through shared experiences and exchanged knowledge.

This work has not gone without challenges, our members have faced challenges especially that there are now emerging issues like the scourge of HIV/AIDS which has negatively impacted not only on the human resource base but has also affected operations of the agriculture sector reducing productivity due to illness and death, food security is threatened leading to increases in poverty amongst the farming community.

To respond to this situation Pelum has embarked on learning processes by way of providing information on issues related to HIV/AIDS and GENDER and the outcome of this has been the development of policies on HIV/AIDS and GENDER.

Pelum's policies on HIV/AIDS and gender places great emphasis on mainstreaming of HIV/AIDS and gender in all its programmes taking into account the devastating impact of the pandemic on food security of the small scale farmers. During the 1999 Biennial General Meeting members took time to reflect on the involvement of Pelum Association, the idea of policy development was conceived. I'm happy to mention here that although the process of developing a policy document on HIV/AIDS took long the document is now ready. The workshop you are gracing this morning has participants from Kenya, Tanzania, Uganda, Zambia and Zimbabwe. All have come in the spirit of sharing and learning.

It is my sincere hope that this workshop will be characterised by the spirit of learning and sharing, so that knowledge gained from this workshop will go a long way in mitigating the impacts of HIV/AIDS. We are all infected and affected; therefore it's our problem.

Honourable Minister Sir I find this also to be an opptune time to inform you that the Pelum Association Board decided at the Morogoro board meeting in May this year to open a Pelum Association REGIONAL OFFICE here in Zambia to be based in Lusaka. The process of registration has already began. This is an opportunity we cannot afford to miss as a country, as it will further strengthen our Pelum Zambia.

It is now my privilege and Honour to call upon the Honourable Minister of Agriculture to come and officially open the workshop.

## APPENDIX 4

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