Gender Programming and Practices: Practical Approaches for Integration with HIV and AIDS
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RUTH MURPHY: Thank you so much for coming. My name is Ruth Murphy and I'm with the office of the U.S. Global AIDS Coordinator in Washington. I'm just going to say a few words of introduction for Jantine Jacobi; Dr. Jantine Jacobi. Many of you know her and she probably needs no introduction, but I will say a few words.

Dr. Jacobi is currently heading the Women, Girls, and Gender Equality Team in the UNAIDS Secretariat Office and she's responsible for the roll out of the UNAS agenda on women and girls and the outcome framework priority area entitled, We Can Meet the HIV Needs of Women and Girls and Stop Sexual and Gender-based violence.

She also heads the Global Coalition on Women and AIDS. Dr. Jacobi coordinated development of the UNAIDS agenda for women and girls and earlier led country role out of universal access to HIV prevention, treatment and care and support. Previously Dr. Jacobi served as a UNAS country coordinator in Uganda, Ukraine, Moldova, and Belarus.

Before joining UNAIDS, Dr. Jacobi worked with WHO on child health, the reproductive health portfolio and AIDS in Nepal, Zambia, and Namibia.

A physician and public health specialist, Dr. Jacobi pursued advanced studies in gender and reproductive health;

applied epidemiology, health systems management and most recently a Masters in business administration at the universities in the Netherlands, South Africa, the United Kingdom and the United States. Please help me welcome Dr. Jacobi.

JANTINE JACOBI: Thank you very much and thank you very much for your kind words. I would like to welcome you all to this really exciting session where we will be discussion the PEPFAR strategy on how to integrate gender into HIV programming.

A lot has been done in the past, but I think we get much more strife and we need to have much bigger impact on the epidemic and on the lives of women and girls. So this is an opportunity it's for the first time that a women-centered approach has been adopted with so much commitment to improve the lives of women and girls. This session will specifically look at what are the practices for integrating gender into the HIV programs.

We will have a panel of five experts and eminent people and I would like to briefly introduce the panel members to you. First of all we have Michelle Moloney-Kitts who is well known to all of you. She is the assistant global coordinator in the OGAC office and has been a key architect in the design of the PEPFAR Program and its implementation.

She's well known for her work on women and girls health as well as HIV, has worked in many countries abroad as a foreign service officer and we're really welcoming her as the host of the session and as the main architect of bringing women and girls to the center of the PEPFAR response.

The second speaker is Elizabeth Mataka. Elizabeth Mataka is the Executive Director of the Zambia National AIDS Network and UN Special Envoy for AIDS in Africa. She's nominated by the Secretary-General, Ban Ki-moon, and she has been engaged in HIV AIDS and to be since many years – more than 20 years – worked with government, private sector and the civil society. She's a strong advocate for the health and rights of people living with HIV, women and girls, and we are thoroughly pleased to have her on the panel.

I'll quickly go through and then we have time to applause for everybody and welcome the and then I will briefly explain the procedures of the session and then we will go over to the introductory remarks.

The next speaker will be Rui Bastos. He's sitting next to me. He's a medical doctor working with the Minister of Health in Mozambique; one of the partner governments of PEPFAR. He has been involved in all aspects related to HIV/AIDS, but in particular working on treatment. The treatment is not only related to the adults, but also to adolescents and to pregnant

women. He has also been focusing on opportunistic infections and is building the capacity of the system in terms of training and in terms of roll out of the guidance.

Our fourth panel member is Pamela Barnes. Pamela Barnes brings more then 30 years experience in management and vision in both non-profit and for-profit sectors. She's currently serving as the co-lead for the UN and CDC working group to address sex and violence against girls and the relationship of HIV, particularly in South Africa. Of South Africa we have already very good results form the first countries.

Ms. Barnes recently serves as President and Chief Executive Officer of the Elizabeth Glaser Federation AIDS Foundation and we're really pleased to have her on the panel.

So and last but not least I would like to welcome Dunstan Bishanga from Tanzania. Dunstan Bishanga is a medical doctor working with engender health, specifically focusing on the engagement of men and boys in the prevention of HIV. This is being on the take and in the context of the Champion Project. It's an extremely interesting project and I believe he will share many of the experiences that have been gained so far.

He's an advocate for sexual and reproductive health rights, including for adolescents, men and women, and has a

range of experiences working as community health worker, facilitator, trainer, researcher and program manager. Please join me in welcoming all [applause].

This session will start with an introduction; introductory remarks by each of the panel members in the sequence I mentioned, then we will have an interactive dialog with the panel; what it means to integrate gender in HIV and what we can do to scale up the actions.

Then there will be an interaction with the floor. You are requested to fill in cards – I believe there are cards around that are completed and that are collected, and you can also make use of the mikes. We have the time until 3:20 I believe. We will then close and you're asked to complete an evaluation.

In addition to questions, you might also consider to add some recommendations for the PEPFAR Program because this is the unique opportunity to have the input from the floor. I would like to start with giving the floor to Michelle Moloney-Kitts. Thank you so much.

MICHELLE MOLONEY-KITTS: Let me just begin by first of all thanking our chairperson as well as the panelists, as well as everyone in the audience for participating in this session this afternoon. It's extremely important for PEPFAR. I really

don't have any slides, so I think we could have the lights up. Is that possible? Maybe not.

Anyway, let me just begin by saying that the focus of this session is really on practical approaches for integration of really trying to look at how we integrate gender programs in HIV. How we really make sure that that's central to what we're doing. The reason why I don't have to explain to this crowd, I think everybody here knows the data is now absolutely crystal clear of the incredible relationship between the role of women and girls in HIV and its role in the epidemic.

PEPFAR has really understood this really from the beginning and we've had a strategy to integrate gender into our programs that really focuses on five key areas. One is increasing gender equity in HIV/AIDS programs including through maternal and reproductive health. Another is looking at male norms and behaviors; reducing violence and coercion, increasing women and girls access to income and productive resources as well as education. And then increasing girls and women's legal rights and protection.

Although we've been working in this area for some time, we really haven't achieved the magnitude of results that we're really hoping for that we will need to really have effective prevention of HIV moving forward. This has really been recognized and the impact goes far beyond HIV.

I think that if you look at where the Obama administration is coming out right now, you see very clearly that women's access to reproductive health, their access to family planning, their ability to prevent and protect themselves against HIV and other sexually transmitted diseases, and most importantly the way to really engage women fully in a participatory manor moving in the development process I think is really critical to much of what we're trying to do.

That's well reflected in the Global Health Initiative which is the centerpiece of the Obama's response to health which actually has as one of its key principals that it would be a women and girls centered approach; improving outcomes for women and recognizing how central a role they play.

If you look at PEPFAR Programs up until now, what you see is that we've reached an enormous number of women in prevention and care program. There's over 1.5 million women on treatment. We've actually reached over 7.5 million women for HIV testing during pregnancy.

Through our care and platforms we really have the ability to reach people, but if you look at how we're doing in terms of prevention; how we're actually doing in some other areas, access to care is not enough so we really, in the reauthorization of PEPFAR and in the PEPFAR strategy for phase II, women and girls also play a very critical role.

One of the other things that we've noted, looking at our programs historically is that we have lots of really excellent examples across those five areas that I've named, but all of them are relatively small. We have not really figured out yet working together with our country governments, with civil society and others, how do we take this small idea and make it big?

I'm going to talk just for a moment about an area in particular with is gender-based violence. If you look at the statistics in the WHO report about the number of girls whose first sexual encounter around the world is forced, about the percentage of women in countries and the magnitude of physical and sexual violence that they have experienced either in a lifetime or in the last 12 months.

From a public health lens you would say this is an epidemic of absolutely massive proportions. If it was an infectious disease we would have the greatest minds of the world working every aspect to try to resolve this issue.

One of the things that PEPFAR is going to try to do is really see if there are practical ways that we can show how you can scale-up gender-based violence programs in a couple of countries. We've dedicated specific resources to three; The Democratic Republic of the Congo, Mozambique, and Tanzania.

We've also set aside funding for research to help show us what it is that can make the difference. I think in our programs we're going to be looking at two main areas. One is how can you make sure that you use PEPFAR platforms for services as the availability for quality post-rape care and support. But also how can we really learn from the many experiences in HIV about changing social norms around gender-based violence.

We also – to move forward – our broader-gender portfolio have established a gender challenge fund, where in fact OGAC will match country funds to look at innovative approaches across the five areas that we're working on. There's also a lot of other innovations that are happening and I know Pam is going to talk about a private/public partnership that PEPFAR has also recently just joined.

This is going to be great because we're going to have the opportunity for a lot of discussion so I don't want to take up too much time right here but I do want to say that this is really so critical for us moving forward.

It's a central piece of our platform and our portfolio and we really are looking forward to your input to help us think through are there ways that we can be doing better programming; that we can really reach more and more women and

really changed this very key, central driver of the AIDS epidemic.

I will say just one last comment that the momentum around this issue right now is enormous. I think that we've learned so much from the epidemic and how to respond to it and some of the challenges, including in fact the multi-sectorial challenge. That is really a rare opportunity that we have and I look forward to hearing from you [applause].

JANTINE JACOBI: This commitment is extremely important because we need first a commitment before we can have the amount of money following it and then making sure that it reaches all the implementing partners so that we can indeed make a big movement. Ms. Elizabeth Mataka is already moving to the floor, so please Elizabeth go ahead.

ELIZABETH MAKAKA: Let me begin by thanking the organizers who invited me to make a few comments and also to appreciate the U.S. government's new strategy on gender, and appointing an ambassador to focus specifically on the issue.

I think this is indeed very timely because it presents an opportunity to link up to other strategies such as the UNAIDS Accelerated Action Plan, country action plan for women and girls and gender and HIV, which I have the privilege to contribute to under the leadership of Michel Sidibé, the ED of UNAIDS.

I think speaking as an African woman, it is very evident that unless we really make an impact into gender as it relates to women and girls in HIV, we'll continue to have very limited success in terms of reversing the trends in new infections and mitigating the impact of AIDS on women and girls and families as well.

I think I want to say that if we don't address the issue of women and girls, gender and HIV/AIDS, it's like we keep on mopping the floor without really fixing the top. I want to say that this is a very welcomed development.

In relation to this topic, I think that a lot of issues that really stand in the way for women to fulfill their basic human rights, and also to protect themselves and decrease their vulnerability to HIV and AIDS.

For me, I would like to say, like I say, coming from where I come from and having worked with communities for many years, I've seen it first hand how the deep-rooted social, economic, legal, and cultural affairs really contribute to women and girls vulnerability to HIV. Unless we address that I think we'll continue to have limited success.

I think what it takes is really a very well-targeted, well-focused process of community mobilization because it's all these bias's against women; all these disadvantages against

women. All these negative attitudes against women are really deep-rooted in the society.

As long as we are addressing this from the level—even of this conference — we need to go right back into the communities and engage with communities to see how we can catalyze the communities to have a change of mindset. It simply has to happen.

Communities have to look at the way we socialize our children; it starts from the cradle. It starts from there. What values are we imparting on our children? On the boys, is it mature to beat your wife? Is it mature to have multiple sexual partners?

And for the girls, is it acceptable to be beaten? Why must you take this? I think, like I say, I really advocate for very intense commitment [inaudible]. But even for this to happen, as I say working with communities I have noticed that there's a total lack of well developed women's organizations. What we need here is leadership, development and capacity building in women's organizations specifically.

We do have little pockets of women's organizations but truly I think from my experience working with communities, we face a serious shortage of women leadership at the grass root level who can encourage women to speak for themselves, to let their voices be heard, to claim their basic human rights.

I say so because I'm also privileged to work for the Zambia National AIDS Network and we do have funding and around eight of the global funds that specifically targets women and girls. But you go out there with the funding and you find the weak structures in women's organizations. If we continue to have these weak structures, what it means is that women and girls are not going to access these funds and yet these fund were specifically, after a lot of negotiation to actually make a difference to the lives of women and girls.

For me, I'm coming from Africa again; I need to say that we need to have a way to hold governments accountable to the commitments they make. We need to translate the political commitment into action and I feel that this is perhaps one way we could find a way to drive this agenda forward. I'll stop there for now and look forward to contributing later. Thank you.

JANTINE JACOBI: Thanks very much Elizabeth this is the current reality. It's the women underground that need to determine for themselves what they need and how they can make sure that they can have access to the services. It requires leadership; it requires resources and in due course I hope we can each hold each other accountable. Thank you so much.

Can I invite Rui Bastos from Mozambique to provide a perspective from a government official?

RUI BASTOS: Thank you. I want to thanks to the organizers to invite me to be in this symposium and I want to also apologize for my English language. So if you agree with me I feel more comfortable if I can read it in my notes. Thank you.

In Mozambique, the HIV prevalence in the adult population among the age group from 15 to 40 years old is 11.5-percent; being 13-percent for women and 9-percent for men. Girls are three times more infected than boys at the same age group.

The higher prevalence of the HIV infection among women reflects the gender-based inequalities caused by the social, cultural values as well as the economic environment that develops the relationships and the sexual behavior of men and women, and puts women and girls at greater risk for the HIV infection. Poverty, illiteracy and employment, immobility, lack of access to health information are also contributing to the vulnerability of women.

Women in general don’t have the power to decide regarding their sexual life. They can’t refuse sex or demand protected sex to their partners. Women are subsequently victims of psychological, physical and sexual abuse and violence.

Basic women's right are subsequently violated, increasing the risk of unsafe sex. Multiple and concurrent partnerships and protected sex, low and inconsistent condom use, lack of access to female condoms and some cultural and traditional practices are driving the epidemic in our region.

Also the national, legal framework guarantee women's rights and the equality among men and women, there is still along way to go in all the death, disease and the reality and the women rarely enjoy their rights.

The access of women to the anti-retroviral treatment is significant in the country. Among patients on an ART, 60-percent are women, 32-percent are men and 8-percent children. This is good news and bad news. Good news because women are more infected but also more women are in treatment. But it is also bad news because the number of men in treatment are so low and the men continue to transmit HIV so this is a problem. We must increase demand on treatment.

What we should continue doing? Challenge the social and cultural norms that change men and women's sexual behavioral, promoting the debate of gender issues at all levels, including the schools curriculum. This is a point very important for us in my opinion because we must start to discuss early in the life of our people regarding the future and this can reduce the risk of the infection in women.

Implement the national action plan for the prevention and the response to the violence against women. Place gender issues and women's rights in the agenda of government, including plans and strategies as transversal and priority issues and involving all of society and implementation.

Commitment and leadership at all levels for the implementation and funding of the national agenda for the full respect of human rights. Address the specific needs of women and girls in the national program for the HIV prevention and AIDS treatment. Involve men and boys in the debate of gender issues and for the respect of women's right.

Facilitate and increase the access of human to health information and health care. Increased access of girls and women to formal education. Increased access of women to income generation activities. Increased access of women to female condoms at affordable prices and finally increase access of men to health information particularly regarding sexual and reproductive health for those on HAART and for those on HAART information for treatment evidence. Thank you for your attention [applause].

JANTINE JACOBI: Thank you so much Rui, and thank you for presenting these statistics. It demonstrates that we need to much better understand what is going on at the country

level. We see this a lot that women are more accessing treatment; not necessarily for themselves.

So we don't know exactly what is going on, but it's clear that there should be a better division of men; male/female in the access to the treatment according to the needs that is present.

I would now like to invite Pamela Barnes to take the floor. Thank you.

PAMELA BARNES: Thank you Jantine for your introduction and for your role today. It's a pleasure to have this opportunity to work with you again. And Michelle I want to congratulate you and your colleagues at PEPFAR for putting this issue on the table early here during this week of many meetings.

I did sit in on the meeting this morning also sponsored by PEPFAR around country ownership and I really think that the gender-based issues belong at the same level of importance as country ownership. What we heard this morning was the importance of some cross-cutting issues as we look to really continuing the work in HIV and AIDS and I think that gender-based programming is really at the top of that list as a cross-cutting issue.

Michelle, in inviting me to participate today asked me to talk a little bit about the work I've been doing over almost

the last year as co-lead of a partnership really trying to address sexual violence against girls.

Just a moment of history on this young partnership; it was created just about a year ago at a Clinton Global Initiative meeting and brought together some public/private people who really were interested in the issue of sexual violence against girls and how that is really impacting the work that we're doing in HIV and AIDS.

Being very specific, there were some private donors. We heard a presentation earlier to day from someone from BD and Gary Cohen, who's an Executive Vice President at BD and a private donor, Amy Robins, who heads the ENDUNA Foundation, came together with a group of UN agencies including UNICEF, UNAIDS, UNFPA, UNIFEM and CDC – Center for Disease Control – and now PEPFAR are a part of this partnership. So it truly represents public and private; both implementers as well as policy people with respect to sexual violence against girls.

The goals of that partnership were set out very early and were really catalyzed around the publishing of a survey that was done in 2007 specifically looking in Swaziland at data – developing data – on sexual violence against girls.

It was the publication of that in collaboration with the government of Swaziland that really catalyzed the members of this particular partnership to come together to really look

at bringing forward data, country-by-country. And I think what we've heard here already is that while there is some data, it is not specifically developed to address sexual violence against girls. It's really data that is trying to link sexual violence or gender-based violence; two issues that are related to HIV and AIDS.

So number one, it's the really developing and presenting data; doing surveys and presenting data to countries with counties, on a country-by-country basis.

Number two is looking at this issue of trying to coordinate. Based on the number of partners that I mentioned so far, and there are many others who've now come into this partnership, it's really trying to coordinate very good work that is already being done, and trying to elevate that to both a policy as well as program implementation in a much more coordinated way.

Number three, we're really trying to demonstrate the value of partnering in this way. In this very young organization, those are the goals and I will tell you that we're still really trying to work hard at how we're going to be able to achieve those goals. Let me tell you a little bit more about what the partnership has been able to do in just the past year.

Based on the work that was done in Swaziland, several other countries have now asked for surveys to be done on sexual violence against girls. Based on what was heard and learned in Swaziland, a lot of that work is now really being focused on the survey side in being able to develop programmatic plans with multiple partners in each country. We've already begun to move to aligning countries with understanding that more data is necessary.

Let me just back up for a second and I know some folks already mentioned some of the statistics on sexual violence and specifically let me go to the Swaziland data. Again, I think many of you may know this but I'll repeat it here. The specific results in Swaziland show that 30-percent of the respondents indicated that they had experienced some for of sexual violence prior to the age of 15.

I think one of the things that was most shocking to people was that the perpetrators generally were known to the girls who were victims of sexual violence and that the most common venue for sexual violence was frankly within the homes of the victims. These are very deep-rooted societal issues and certainly not issues that are easy for any government or health system or social service network to really begin to deal with.

However, in Swaziland, with the leadership of the government and lead program implementation by UNICEF, the

government actually undertook a whole series of programmatic changes from legal reform.

That actually meant passing additional laws and enforcing laws that were on the books to providing the kinds of services that are necessary to victims. But also moving within the education system to an entire program of trying to motivate the voices – bring forward the voices of children and educating them in terms of how to protect themselves; so very cross-sectorial and very focused in terms of trying to address the issues of sexual violence against girls.

Let me go back and talk about the importance of data. Again, the survey tool that's been developed by CDC is really just now beginning to be used in a number of countries. There is very little data on sexual violence against girls.

In order to be able to move to some of the other issues we've been talking about in the PEPFAR contacts for several years in HIV and AIDS, we need to be able to measure impact. What this partnership is trying to do is to create the opportunity for governments to really take on the issue of looking at this through the lens of data; good data; good survey data across the board.

Working in this partnership, not only putting data out there, and I've heard many people say over the course of this last year in particular, how many times did we have surveys and

people don't know how to implement with the data they've gotten.

There is no follow-through on program implementation. While it is having the partners for program implementation at the same table that we're really trying to address that issue. So moving from data to policy to program implementation; this is not new. This is certainly not a new paradigm. What we're trying to do is do it in a coordinated way.

Let me just say one more thing about management efficiency that is a part of this particular partnership. One of the things that the donors have asked is that we not move to create a new entity. At the moment the partnership doesn't have a name and part of that is because we're really trying to develop some operating principals so that we don't create another structure.

There is already extraordinarily good work being done. There is at least a belief on the part of the donors and the partners at this table that we don't need another structure. In fact, learning from the lessons of PEPFAR and HIV and AIDS over the last several years, the focus here is to integrate any and all program implementation with work that's already being done.

I just want to go back to the key principals. It's additional data. It's using that data under country leadership to influence policy. And with the same partners around the

table and multiple partners in the countries with country leadership being able to move to program implementation integrated in work that's already being done.

So while this is a new and incubating partnership, the goal here is to be able to move quickly and I'm very anxious to hear some of the questions in discussion today to see if we can further inform that work. Thank you [applause].

JANTINE JACOBI: Great. Thanks Pamela. First of all I would like to thank you for highlighting what you call in a business sector the Blue Ocean Strategy adopted by PEPFAR. It is so simple; it's so real to make women and girls the center of the approach and yet it is completely innovative in the thinking of many development partners. It's really a great movement and a great development that this is happening.

I wish to thank you also for highlighting the data on sex and violence against adolescents. We on our side, in UNAIDS, we are extremely excited about this undertaking. We know that violence against, in particular young girls, young women, is going on for years and years; everywhere around the world.

It is only because we have the data that we can start talking about it. In Swaziland, together with the UNICEF representative, the UNAIDS team, and in particular the role of CDC started the discussion collecting the data and starting a

public dialog about the unacceptability that women or young girls are victims for their life in sense, carrying the trauma for the rest of their life. So this is something that needs to stop and I hope we can work much more together with all of you here to make sure that this is ended.

I would now like to invite the last speaker who is heading a very interesting project on male engagement, on addressing the role, the social norms in relation to HIV transmission. Please Dunstan Bishanga.

DUNSTAN BISHANGA: Thank you. I'd like to take this opportunity to thank the organizers for inviting me and for inviting us, and I would like also to pass our thanks to the U.S. government, in particular PEPFAR Program for the support we are receiving at Engender Health, planning a number of initiatives including the [inaudible] Project which is out of the area of addressing the male gender norms.

We also thank, on behalf of the country, that we are one of the countries that are going to receive the money for this get up of GBV work in our country and I remember a couple months ago we are part of the Global Collective Meeting in DC to see how best we work on that. I also thank our government for the support they are providing to our project, the Champion Project.

Now the previous speakers have talked a lot about the importance of transforming the community. The importance of having males being involved, the importance of changing male norms and the importance of getting men involved in the services.

Now Champion is doing some of those things and to give you a sense of our problem and how we do employ the agenda transformative approach to bring about the change at both individual and community level. We've put together a video clip that I'll invite you to review and we'll have a discussion afterwards. If the technology doesn't let me down, you'll see that in a second.

[VIDEO PLAYED]

DUNSTAN BISHANGA: Thank you.

JANTINE JACOBI: Thank you so much Dunstan, this was really a pleasure to look at to bring music to our work. I think we might sometimes feel overwhelmed with all the challenges we face; the deeply rooted social norms and yet we can make a change. That's extremely important to spread the good message, so thanks very much for that. And as always it's beautiful to hear the music from Africa.

I would now like to go over to the dialog with the panel members and I would like to ask you already to think about if you would like to ask a question and to put it down on a piece of paper so it will be collected. There will be also time to open the mics, so please make use of those as well. But first it's the session for the panels to ask them some questions.

First of all, Michelle you were already eluding that a lot of work has been done already. Maybe not to the scale we would like to see, but yet a lot has been done and a lot has been achieved. Can you explain a bit what were the achievements so far, and how were they achieved do you think?

MICHELLE MOLONEY-KITTS: I think that there are numbers of examples of things that have been achieved. First of all I mean I think we have heard that we've done an extraordinarily good job in terms of making sure that women do have access to treatment.

I think that was a big concern in the beginning of PEPFAR because we know that access to healthcare is sometimes quite difficult. I think the fact that women are much more comfortable accessing healthcare usually than men, has actually had that as a consequence.

The second thing where I think that we've had a lot of discussion about data; I actually think over the last five

years we've made a lot of headway in terms of the data. Not obviously to the level it needs to be, but unquestionably nobody's asking two questions that thank goodness they're gone. One is, are women adversely affected by AIDS and why? I think we understand that very well now. The second is, is there a link between gender-based violence and HIV? Again, we don't need to talk about those anymore. I think that platform has been established and we're starting to have very good methodology in looking at some of these other issues.

The third thing I would say is if you look across the five areas that PEPFAR has focused on, you will find in each of those areas nuggets of success. We have nuggets of success in terms of legal reform or national policy. I would like to highlight both Mozambique and Tanzania as countries that at the very highest level.

Now how it gets implemented may be a question, but certainly people are starting to look at policies for women and really insuring they have equal rights. I think if you look at, let's talk about education, we have some lovely, really fabulous models through safe schools and recognizing that girls need to have places to go and creating those safe spaces for girls; that's another really good model.

We have economic growth models where women have access to resources and we do find that when they have access to

resources a lot of these issues kind of go away. We have some good experience now with post-rape care even though hopefully we'd like to move to prevention.

Those are some of the successes we've had, and as I said earlier, I don't think we would be where we are today on gender issues if we hadn't learned what we've learned from the AIDS epidemic about how to engage community, how to engage faith organizations. The incredible importance of stigma, how essential it is that you figure out how to get a person from point A to point B. We have a very rich foundation I think to take this to the next level.

JANTINE JACOBI: Mm-hmm thank you very much. Pamela could I invite you to come in and share a bit of your experience from your earlier life?

PAMELA BARNES: Yes thank you Jantine. Thank you for that question. As Michelle was speaking I was thinking about the early epidemic of HIV and AIDS and the fact that frankly, in the early days children were often left behind. Certainly that happened in the U.S.; in the early days of the epidemic and then frankly globally.

It wasn't really until we understood more about the impact of the disease on children that we really got a better focus on making sure that children are included in our programs; both for prevention as well as for treatment.

This is an anecdotal link between the work that we've done so well, or worked at so hard over these many years in HIV and AIDS and where we need to go. Again, a personal anecdotal experience, but I had an opportunity late last year in December I actually worked at a camp for kids in South Africa and I met a young woman who was 16 years old and in the course of spending camp time with her over several days, she shared with me that she was HIV positive. She became HIV positive as the result of a gang rape.

I thought not only was that an extraordinarily difficult story for a young woman to share with me, but she also told me that she was actually the daughter born to a woman who was HIV positive and she was born negative. Again in my work at Elizabeth Glassier, a great deal of our work was focused on prevention of mother to child transmission.

In the moment of trying to absorb the incredible story this young woman was sharing with me about her life, I thought my goodness, here we have a young woman who in fact was born HIV negative of a positive mom only to become positive through sexual violence.

So I realized that is not data, that is a very poignant life story of a young woman. But that's I think the lessons learned. Let us not ignore, not only the continuity of the work we need to do in the health system, but also what are the

lessons that we need to now really put into these programs about prevention. We've heard a lot about prevention here even in this very early set of discussions today. But let us keep that in mind when we talk about the sexual violence issue.

PEPFAR hosted a meeting in Washington just a few weeks ago around gender-based violence. For those of us who've been working in HIV and AIDS through the health lens, again, if we start to look at gender-based violence only through a health lens, we wind up on the side of treatment and not on the side of prevention.

If we only look at gender-based violence through an adult lens, we're going to leave the children behind. Children are incredibly hidden when it comes to issues of sexual abuse. Again, I think those are all lessons learned, as Michelle has said very well. Let's just keep reminding ourselves that we need to address those issues going forward.

JANTINE JACOBI: So hearing what has been achieved; hearing the challenges as well from the previous speakers, what do you think? How should an effective gender HIV/AIDS response look like? First maybe could you express it in a broader context? Gender and HIV, how can it be brought together?

RUI BASTOS: I'm sorry for my English is not so good. Sometimes I can't express what is going in my mind. We know in the context actually, in relationships between men and women

and if we don't change that the women will continue to be more exposed to the HIV infection and other sexual diseases, not only HIV but others.

This is true, what we need is not to retire the power to the men, but is to give power to the women. I think we must be liberated, the relationship. This is not easy because this is social and cultural aspects are from long, long time ago; 100 years. So it's not easy to change but perhaps programs as Champion, programs in Tanzania, our colleague showed us can help to change.

Perhaps also we can try to give for youth not only for girls but for boys together. Health service in the health system for sexual and reproductive program; both men – boys and girls and not only about the girls arrive already infected because our program is when the girls arrive in their adult life, they are already infected. So this is too late to do something. Only what we can do is give a good treatment, but what we need to do is look for the prevention to avoid that infection.

In that point of view, I think we need to start here when they don't have yet sexual activity. So start at 10 years old in the schools. But it is not easy because we have already this program in our schools and the critics comes from the parents. The don't accept very well to talk with the children

about sex because they think perhaps they are open to start sex anywhere so we hand out protection. This is not easy. Even some teachers don't accept very well this program. So this is a struggle we need to look for and try to improve that program but we continue to struggle.

JANTINE JACOBI: Dunstan do you want to come in from your perspective?

DUNSTAN BISHANGA: Okay. I think that question you asked is very relevant to why we are here because I guess the issue of gender and the general relations and the dynamics between the men and the women is all about HIV infection. HIV, most of it is from relationships and the relationships there is power within the relationships.

If there is this power imbalance between the relationships it is most likely that there will be much effect to one side. We're not only about gender equality and if a panelist says about there being some sort of community tendencies to turn to the gender norms.

The expectations of the community do affect the way men do behave. And they also affect the way women behave. If the community do expect that a woman should be submissive. If the community do expect that a man should always be strong. All this would determine the dynamics within the relationship of the two and that we know all this directly will also affect the

decisions that is made in the relationships in terms of sexual relations between the two, and then putting one party at the risk of HIV infection.

Now, how do we approach this problem? You know that being about gender equality. That's where gender transformative programming comes in. Whether you are looking at the gender norms and are trying to change, lets people be aware of what is happening in the social norms. Let them question if these social norms are good or bad for them, and then let them find the solutions and that's the way you can get a long-lasting solution. So, when you are talking about bringing gender equality, when you are challenging gender norms, it is not only for men. It is about men, women, and the children, and the family, and the community and the nation. So, that relationship becomes very clear.

JANTINE JACOBI: Wonderful. Thanks so much. And Liz, do you want to come in from your side?

ELIZABETH MATAKA: You know, I think prevention should be very comprehensive and broad-based. And I think when you deal with young people — I remember many years ago when I used to work for an anti-AIDS project and we were targeting very young children in schools. These kids were about eight, nine, ten, but with them, we are dealing with other issues. We are dealing with issues like assertiveness, self-worth and so

forth. Because we've heard that those were other issues and values if the kids adopted for themselves would do them and stand them well against HIV.

But I also think that time has come now to have a broad-based sexuality education, very comprehensive, in schools because it's not about just sex. It's sexuality. It's a much broader thing. I think kids need to realize that it's normal to have the feelings that they do and also look at strategy of how to manage those feelings. I think this is what we are talking about.

And when we now come to the broader community and talk about violence against women, what I think is that apart from, we must accept that changing behavior, changing norms, is a long haul. It's not going to happen overnight. But what we need, perhaps, are safety nets to catch the victims of gender-based violence.

I mean, in my country for example, what happens to a woman who is battered overnight? You know, there simply isn't anything to go to. There is no safe house. You may go and report to the police, but the environment in the police service has not been created to receive a victim of gender-based violence.

Somehow, you are made to feel you must have asked for it. Or did you wait? Maybe their schedule is too short. So we need to deal even with the law enforcement officers.

So I think prevention is really a very much broad-based prevention of gender-based violence has to start with the attitudes that boys and girls have from a very early age. And also I think that apart from saying the society must change, you must create support systems for gender based violence victims. Thank you.

JANTINE JACOBI: You moved us already, and I will come to you soon sir. Thank you so much. But I would like to have one question first to my neighbor because Ms. Mataka moved already to the gender-based violence, and I would just like to hear from Mozambique how they see gender-based violence as far to being addressed through the HIV and then I will come to you sir. If you have one moment. Yes?

RUI BASTOS: Thank you. We have already a plan is approved by the government, is a national plan against violence against women and their objective is expand and improve the service to the victims and that includes medical assistance, includes justice and psychologic aspects and reinforced institutional capacities and a location from the people in general about violence against human issues.

And we have prepared in the police, there are specific service with people trained on these issues and these aspects so as not any police can receive these. The department is there to receive that victims of violence and they are prepared for that. And the people can also phone to that department to ask for help. So we can also have some strategies of advocacy, information, civilization for prevention and struggle against violence against women. So this is what we are doing more or less right at [inaudible].

JANTINE JACOBI: Yes, excellent. Okay, sorry, my panelists, the boss. If Pamela could come in first and then you are after that.

PAM BARNES: Sorry. I just, and I really appreciate the efforts that you just outlined. Again, I think the legal system, the education system, all need to be partners if we use that term.

But again, and one of the things I heard Ambassador Goosby say earlier today is also, let's learn from what didn't work well in the HIV/AIDS world here. And I think that, if I can use that terminology, sort of a top-down approaches, we need national plans.

We need levels of coordination at the highest areas of ministries and partners and implementers. But at the same time, to your point about let me go back to this Swaziland data

I mentioned, at least in the Swaziland surveys, the perpetrators were often known to the victims. And a great deal of the violence against girls in this particular survey was shown to happen in the home.

So we can think about and work on and must work on issues of legislation, enforcement, treatment, education, all those things. But, the real issue of what's accepted in the home environment. Okay? What has become acceptable? What is acceptable? And I wanted to say something I omitted earlier in this context.

This issue, at least from the sexual violence against girls perspective that I have been working on, this is not an issue only in countries where there's HIV. This is a global issue. It is a silent, global issue in developed and developing countries. I just want to make sure we keep that in context while we talk about this.

So, again, I think lessons learned of things that have worked, but let's also remember things that it took us a long time to come back around to. And I think the mobilization at family and community levels is critical here. Thank you.

JANTINE JACOBI: Yes, no. Thanks for highlighting that. And it is indeed critical that you make sure that it is a country-led effort and that it is based on accountabilities. That's extremely important and similarly that we adopt and

integrate its approach like is promoted now, but I think we have reached a stage where we say we can no longer work in isolation, in political ways, we need the ways to convene together.

I hope sir, please, take the mic. I hope you can speak a bit more about how each of you can addressing gender-based violence, if that's okay.

MORAMBA JIASOM: Thank you. My name is Moramba Jiasom [misspelled?], I'm from Engender Health, New York. I would like to share with you what is Engender Health implementing as a PEPFAR program in Cáte D'Ivoire. We, as an organization, have been supporting the program with a champion in Tanzania which you have seen.

In South Africa we are working with uniform police as our partners and we extend to the community because we know as Elizabeth says that people in uniform must be trained, must be part of the program to resolve. Obviously in South Africa they've got loads, they've got everything in place, but you need that acceptance.

We've been working with these countries and these police force for the last five years. And then, in Ethiopia, we are implementing the same program, PEPFAR program, with mobs and with gender.

Okay, what we are doing in Cáte D'Ivoire is to combine all the structures, uniform, we need certification, have department and community. So we approach all aspect. We educate with teachers so that they can understand. We revise the curriculum so that they can teach, and we train them. We support one of our partner, PEPFAR partner, to implement the same approach for uniform. I mean police, [inaudible] and military.

We support our colleagues, Elizabeth Glaser, at the facility to train the health workers so that they can have that dimension and gender have, so that they can actually support the victim coming like Grassi Center [misspelled?] victim and so on so forth.

Then we work with gender, Minister of Gender and Equality to implement those aspect in the community. So we are at the level of working on a police drafting implementation and as well as communities and we combine champion approach. We combine police as a partner from South Africa. We combine men as a partner with a three dimension, all together as a package under PEPFAR in Cáte D'Ivoire.

We believe that by moving towards implementation as we are doing now with all the partners, PEPFAR partners, and others, non-PEPFAR, the U.N. AIDS support and so on, we will manage to actually come to some palpable impact. We believe in

that. So that we can start to see what we can come out with a reduction of sexual and gender based violence as we've already got in Ethiopia.

JANTINE JACOBI: Thank you so much sir. And it's encouraging to see that the program is already expanding to other countries. It is for us, for U.N. AIDS and our co-sponsors a great priority to address. We believe that the HIV response is well-suited to address the issues related to gender-based violence, in particular for young girls. And so it's encouraging to see that more things are happening.

I would like to invite the speaker –

FEMALE SPEAKER: Jantine, why don't you ask people to just come to a microphone.

JANTINE JACOBI: Yes, maybe you could line up. But I would like to invite Aso Aphne [misspelled?] from WHO to say a few words after the first speaker. Aphne, could you come and share what you have done in Swaziland. Okay, please.

MAURI KLANHEIM: Good afternoon. My name is Mauri Klanheim [misspelled?] and I'm representing Norwegian Church Aid. I would like to thank you for all the valuable inputs. We have recently undertaken a global evaluation on our program on gender based violence which is one of our priorities. Another one is HIV and AIDS.

And related to what Pamela Barnes said, that gender based violence is not only related to health. I think that one of our main findings actually is that gender-based violence is first and foremost human right abuse, and it has to be treated like that.

In our program, we are addressing female genital mutilation. And if you only look upon that as a health issue, it becomes very dangerous because then they will only tell you you can do it in a more personable way, you can go to the hospitals and so on. Still, it's not acceptable.

Gender-based violence could also take the form of early marriages and, of course, rape.

Now I'd like to put another issue on the table because we tend to talk about gender-based violence as violence against girls and women, which is correct. But men are not only perpetrators, they're also victims. And you may have heard men boast about their rapes of women, but you don't hear them boast about being raped, because that is very shameful, even more shameful than for the women. So they don't talk about it, but it happens.

And unless we are willing to talk about this as well, I think we will not be able to get the men on board in the best possible way. And, of course, we are aware that there are violence, sexual-based violence between men which is also a

possible driver to the epidemic. So the link is very clear. Whether it is men raping women or men raping men, it is still a possible driving force to the epidemic and it has to be addressed accordingly.

JANTINE JACOBI: Thank you. Could we have two speakers more and then we will answer the question.

Yes, please.

MARION BUNCH: Hi. I'm Marion Bunch, founder and CEO of Rotarians for Fighting AIDS. Hi Michele. I want to reply and kind of play off of what Elizabeth Mataka talked about.

Rotarians for Fighting AIDS focuses on mobilizing Rotarians all over the world to focus on helping the children that are the trailing consequence of AIDS, right? And we're talking about children's rights. Pam Barnes brought it up. Elizabeth was calling for needs such as grass roots leadership. She was calling for influence to hold the government accountable. That is rotary.

Rotarians are the business leaders all throughout your grass roots community and we're talking about Africa. They are there. Twenty thousand of them. And they're sitting and wanting to be invited to the table, to the planning table, with the NGO's with USAID, CDC.

I implore you to get your business leaders involved through Rotary and ask them to come to the planning table.

They will provide influence in making things happen behind closed doors that public health experts will not be able to do, and we proved it in polio.

That's my request. Thank you.

JANTINE JACOBI: Excellent. This is really music to my ear coming from an organization that we work together with, a most right group of partners.

The next question please.

REJINZA MENDA: Thank you so much all the panelists for that excellent presentations. Rejinza Menda [misspelled?], DOD, PEPFAR Rwanda.

I would like to commend Pam for the excellent work at ending violence against women, and I'm particularly happy that you mentioned child abuse. I was very worried at the beginning because I never heard of it but you literally talked of child abuse. And the previous speaker talked of neglitive boys. So I'm very concerned to include sexual violence against boys. So those are my comments. And you talked about experience from other countries. I would like to share with you what we do.

We've been dealing with some community awareness about gender issues. Of course, some are socially culturally imbedded, so we do sestacize [misspelled?] communities, local leaders and the police.

In my country, most victims are gender are various go to the police first instead of going to the medical aspect. And the process, there is a risk of losing some vital forensic evidence.

So we have been telling some police officers to be mindful of this gap so that they don't delay and they can have that crucial forensic evidence that they can get from the medical facilities. And there has been, of course, training on the health providers themselves on the physical examinations and the ability of the post-exposure prophylaxis issues.

So there is quite a lot going on, and I can't share in this short period. But congratulations to all the panelists for this very important topic in our efforts to combat HIV and AIDS. Thanks very much.

JANTINE JACOBI: Okay. Those waiting, if you can just bear with us. If you can have a brief reflection from the panel members starting with Michele, please.

MICHELE MOLONEY-KITTS: Thank you and thank you very much for raising the issue of boys and their vulnerability as well. The data that we do have does show that in fact, as we all know, boys are indeed also suffering from gender based violence as in some cases are men.

I will say the percentages are lower. It's not nearly — I mean, that doesn't make it any less horrible, but it is in terms of magnitude a little bit smaller of a problem.

But I think the one issue that we haven't really got to. I mean, Pam keeps alluding to it, but I think we're going to have to really understand better is really what does happen to children between the ages of 10 and 14.

I mean, this is such an incredibly vulnerable time for them. This is when your cute, little girl that you were absolutely just chuckling with at her antics outside her house, suddenly has breasts. And she doesn't know what to do with them and most of the people around her don't quite know either.

And what we've seen from the data, and there's some really compelling data out there, is that's the age that girls disappear. Excuse me.

And in fact, one of the things that Judith Bruce, a population council researcher, has done, is really looked at friendship networks and one of the things that's extraordinary is that you find that boys maintain friendship networks all through their kind of adolescence and on.

But girls, and particularly girls who, at this particular age, they start to get pulled out of their societies and their communities and they become hidden and they lose

their friendship networks, w in and of itself is highly protective if not physically, at least emotionally.

So I think that these are really complex interactions that we need to look at but, of course we care about boys.

And on the Rotarians, I hear you entirely and I, honestly, I'll say this again. For me, the only reason why we've achieved the successes we have with the AIDS epidemic is because of our ability to mobilize all levels of society from the president to the general to the wise woman in the community that had a huge amount of influence to a PTA to the business community. I mean, that's what's made the difference for AIDS.

And if we want to fight this particular epidemic, which in fact – and I'd like to reiterate this from the PEPFAR perspective – we are fighting not only because of its relationship with AIDS, but primarily because it is a human rights issue and it affects not only public health but it affects the ability of women and girls to contribute to developing their countries. So, I hear you about the Rotarians, and you can be sure that we'll take that under advisement. Thank you.

JANTINE JACOBI: Yes, please. Please go on.

PAM BARNES: And thank you for your patience. I'll be very brief. Okay, but I just wanted to make one comment on Rwanda. Where did the gentleman who spoke – thank you. It's

very impressive to hear that in Rwanda there seems to be a very high level of reporting to authorities.

Not health authorities necessarily, but legal authorities on sexual abuse. The global statistic is that probably only 10 to 20-percent of child sexual abuse cases are reported and/or receive services. So that's a very small number. So I just wanted to make a comment in support of the work that's apparently taking place in Rwanda.

But the other thing I did want to add to what Michele was saying and back to my soon to be colleague from Engender Health, that I think the work that's being done is, and again I said it earlier, I think there's great work being done. Whether we put it under the human rights umbrella or the health umbrella or an education umbrella, how do we develop outcome measures? One of the reasons why PEPFAR has continued to get support in the U.S. context is because we've been able to talk about results. Okay?

So again, I applaud the work the human rights colleagues have been doing for many years in the issue of gender equality. What we're trying to get to now is through a health lens or others, how do we show impact, number one. And number two, can we bring these programs to scale? Right?

So I just want to make sure that on the program implementation side, we don't lose sight of, again, those

lessons learned from the PEPFAR programs. Thanks Jantine. [Interposing]

JANTINE JACOBI: Please do comment.

ELIZABETH MATAKA: Yes. Okay. I know that all we are saying really it's long-term. But I just can't forgive myself to leave this panel without saying that I believe maybe some quick gains we can make in regards to gender-based violence against women, and I'm talking specifically on women this time, is the development of tools that women can use without the knowledge of their sexual partners. And I'm here saying I believe that the day we will have an effective and safe microbicide for women to use is the day that we can expect to see a reduction in gender-based violence.

Secondly, I wanted to comment on things that have been said about reporting to the police. We do have a similar situation in Zambia, but the problem is – those services are there at policy level – but on the ground are they victim-friendly.

In other words, when a woman reports, it's about like, who invited it? I'll keep on going back to this point because women are asked, okay, what were you doing in the street in the dark? Well, women have a right to walk like everybody else any time of the day. Like, your skirt must have been too short, you attracted the men. I think the men must be in total

control of their emotions. So really, I need to say those things. Thank you.

JANTINE JACOBI: Thank you so much. Can we invite the next —

ROSA MAWLAR: Next, okay. My question and/or comment, it's about something that Elizabeth Mataka said earlier, which is women's organizations lack the structures. And because of that, I know and I have seen in many situations where especially the grass roots groups have been left out of programming.

I didn't introduce myself, first I'm Rosa Mawlar [misspelled?], I'm from SEDPA, and we have traditionally worked with the very grass roots organizations. And this has been sometimes a problem because when it comes to some of the specifications that a lot of organizations require in order for you to engage the grass roots organizations, the grass roots organizations are not going to meet those requirements. They're not going to see that advertisement in a newspaper for the global fund and what have you.

And so, one of the questions I have for the panel here, if we have to address the issues that women go through, the sexual violence and things like that, we have to be able to enable them and empower them to expand the little activities that they do within their communities. In every community in

Africa, you will find women organizing in their own ways to support themselves. How do we help them do that if we're not willing to take risks to fund these organizations?

I am in the process of working with a lot of organizations, especially in northern Nigeria. It takes a lot of work. It's not easy to get the results and the outcomes that [inaudible] is talking about because it always looks like you're not doing a good job. But it takes a long time, and I want us to look at that.

And then the second one is the behavioral component. Yes, I'm just, the behavioral component in all of these things. When people rape, when people do that, those kind of oppressive activities, there is a behavioral component of it. Are we targeting the right people? In many of our communities, the mother-in-law, the grandmother, is actually the most influential person on the man. Have we targeted these groups of people? Because those are the people who would influence the kind of behavior. Thanks.

JANTINE JACOBI: Okay, thanks. Please be brief because we are getting closer to the end, and I would like to invite you also to bring specifically out those practices, approaches, recommendations for the program. Thanks.

MARY BETH HASTINGS: Hi, I'm Mary Beth Hastings. I'm with the Center for Health and Gender Equity in Washington, DC.

Thank you to all the panelists. Those were excellent presentations and Michele, especially thank you. I really appreciate you being up there to respond to questions because one of my complaints about this morning's session is that there was no one from PEPFAR to respond to questions that we — asked panelists questions, but not the people from PEPFAR. So I really appreciate you putting yourself out there.

And I want to be a little bit challenging here but it's a friendly challenge because we feel like so much of what has changed in PEPFAR has been constructive for women and gender integration. The woman-centered approach, the change to an emphasis on comprehensive prevention especially, that was in the five-year strategy that was released in December. And so we're very excited about that.

What is frustrating is to see that there is a continuation of policies that are not constructive to gender integration, particularly funding of abstinence and faithfulness programs.

And I know that PEPFAR's intention is to get away from that but — and that some of those are contracts that have existed for years and are continuing — and but then in May of this year in Nigeria, there was an RFA release that asked for abstinence and faithfulness only programming.

And so there are still some contracts out there that are being signed where PEPFAR is saying we want you to do this kind of programming and it's not constructive for women and girls.

So I don't believe that anyone should leave a PEPFAR funded prevention program without knowledge of female and male condoms. And so I'm hoping that we can move away from that soon and just asking for that commitment.

JANTINE JACOBI: Yes. Thank you very much. The next speaker please.

ANN STARRS: Thank you. I'm Ann Starrs from Family Care International in New York. And I wanted to ask just a question. Perhaps Pam might be the best one to answer it which is, I wondered if somebody could comment on the issue of PMTCT programs and the extent to which they are globally and in-country addressing all four elements of the PMTCT team model.

In particular, how much they're looking at, of course, prevention of HIV infection among women of reproductive age. How much they're looking at prevention of unintended pregnancy for HIV positive women and the issue of ongoing treatment and care for mothers.

I was at the AIDS conference for the first time two years ago in Mexico and was struck by presenter after presenter after presenter who would stand up and talk about the success

of PMTCT programs because they had provided the ARVs to prevent infection of the newborn and through six months of breastfeeding and then they stopped. And the question of course is so what happens to the mother after that time. Thank you.

JANTINE JACOBI: Great. Okay. Please go ahead.

MANCHE THERFROMAZABE: Okay. Thank you for the opportunity. I'm Manche Therfromazabe [misspelled?] from Population Council South Africa. I'm excited that at least the main involvement has been addressed but I just would like to request that we also target our community traditional leaders because we know that they're custodians of culture and definitely don't have the best resources available. So if we could start from that for GB HIV.

And we as Population Council in South Africa were looking at post-exposure prophylaxis for adult and children and occupational. One of the things that we're looking at is system strengthening, capacity building, and you would develop tools to ensure that we look at current-level data. So these are part of our targets.

And we are also looking at the Department of Correctional Services because we know that MSM will happen, voluntarily or involuntarily.

But what I'd like to highlight is that it's important when we engage the very police to highlight to them the emergency for health, for PDP. Say, don't only focus on justice per say. Get this person to treatment and then you can deal with other things later on. So the 72 hour is very critical and when you highlight it, they really appreciate it.

And then for the forum for PEPFAR, as we're looking at ensuring that we put programs that are cost-effective and add service delivery, we also need to take care of the carer. Let's look at the carer because we're coming with the integration of HIV into family planning, into GBV. It's the same carer that's who we need, the carer that might be suffering from gender-based violence themselves or HIV positive. So as we come up with programs, let's also take care of the carer in more ways than one. Thank you.

JANTINE JACOBI: Yes. Thanks very much. First of all, I would like to ask Michele to comment for the questions directed to PEPFAR.

MICHELE MOLONEY-KITTS: Yes. Just quickly on the AV question. There really is no guidance to the field that requires anybody to implement AV programs at this time. The guidance for the field for PEPFAR in terms of prevention is to please design the best, comprehensive program and approach that

will address the particular population, target group that you are really trying to reach.

Now there are certain, that does not mean to say that there is never going to be a rule for abstinence or for either A or B, with the right people in the right time, looking at their context, their situation, that may be indeed and, in fact, we know that delaying the age of first sex, in many cases, and here we are talking about girls who really don't want to have sex.

It's quite a little bit different from abstinence I think the way it's been historically thought of. But these are all related things. So just so you know that that's really what the fact is. We're looking at comprehensive behavior change and that's not a requirement. And thank you for the feedback about Nigeria. I imagine that some of us will be checking back in. Because they may have had a very good reason to do it that we don't know about.

I do want to just briefly maybe mention something on the question of PEP because it's come up a lot. And I actually am a bit worried about PEP because, and again we'll have to look at what the data is, but the reality is, is for PEP to be effective, it has to be given within the first 72 hours following a rape.

Now my, – and I'll grant you I'm not an expert although it's amazing how quickly one learns about these things – the number of people who come forward and get themselves to a health center after a first rape within 72 hours, I'm almost willing to say particularly for children, is going to be highly unusual and unlikely.

Doesn't mean to say that we don't need to get PEP out there along with emergency contraception, but I do think that we have to be realistic that for PEP to work, every single civil society and community organization needs to know the 72 hours piece. And it also puts a new urgency on really trying to fight the stigma around these particular things.

RUI BASTOS: It's an emergency.

MICHELE MOLONEY-KITTS: It is an emergency.

JANTINE JACOBI: Yes. Thanks so much. Pamela, would you like to comment?

PAM BARNES: And thank you for the question on PMTCT. I'm going to try to do this sort of the then and the now and where I think we're going here, but I do think that the standards of care, I mean just out of WHO the standards of care around prevention of mother to child transmission we know have evolved and it's terrific. It's really great.

I mean, from the early days of trying to provide prevention mother to child transmission services when the

ability to deliver a single does of Nevirapine was certainly a challenge, to now really having the protocols from WHO, not only complex prophylactic treatment, but also treatment for the mom and the mom's disease.

And so, that evolution, I think, of PMTCT can also be looked at as another example of really now the urgency of integrating services that were thought of perhaps more in parallel even a short time ago.

The integration of family planning services with PMTCT is the standard of care. Okay? It is the standard of care. And as someone mentioned, it's not only family planning to an HIV positive woman, but also an HIV positive woman who might want to have another child, right?

So again, it's integration of these services across the spectrum is really the standard of care. And I do think that many of the providers of PMTCT services funded by PEPFAR and others are really moving to try to provide that standard of care. Again, realizing in all settings not entirely possible.

But there's another step to take and I sound sort of like one note Johnny here. All of that is not yet really measuring impact. I mean, the ultimate impact of PMTCT is, is that mom living well with her disease, taking care of her either HIV negative or positive child. And what's the health outcome for the child?

That's the real impact. Not there yet in terms of being able to do that, but in trying to sort of set the stage from single does of Nevirapine to being able to look forward and talk to what we need to do to really measure impact.

I hope that answered the question.

JANTINE JACOBI: I would like to have one round for all the speakers. And I will start with Dunsten. If you could start with making one recommendation for PEPFAR what it should consider for the roll-out of the plan.

DUNSTAN BISHANGA: Roll-out of?

JANTINE JACOBI: Of the PEPFAR strategy.

DUNSTAN BISHANGA: [Inaudible].

JANTINE JACOBI: Yes.

DUNSTAN BISHANGA: Okay. I think that most of the things that have been said in this symposium is they do have — can you hear me?

FEMALE SPEAKER: No. [Interposing]

DUNSTAN BISHANGA: Okay, I was saying most of the things that we have discussed in this symposium, most of them are embedded themselves within their social gender norms. So, if we really were willing to bring about sustainable change in the communities, in our community, to have a more gender equitable community or to have more of the gender-based or

gender-related problems addressed, then gender-transformative programming is required.

So this should not be about how it is implemented but it comes from when the program was being designed. How is it implemented? How is it monitored and how is it evaluated? So if there could be a way that we could come together and of a framework of how does a gender transformative program look like based on the experience that we already have like champion and the other programs that use that approach, it will be of —

JANTINE JACOBI: Thanks so much. Rui, could you comment? What would you recommend to PEPFAR?

RUI BASTOS: I don't know. Is not easy for me to recommend, give them recommendation. [Interposing]

JANTINE JACOBI: Would you like a bit more time to think?

RUI BASTOS: Perhaps, yes.

JANTINE JACOBI: Okay. Pamela, please, could you make one recommendation.

PAM BARNES: Yes. You know, I think it's keep our feet to the fire. I think that cross-sectoral work is really going to be critical in order to break through to really being able to bring programs to scale on an integrated basis.

And I don't want to attribute this wrongly to you, Michele, as a quote, but I think you said in a meeting not too

long ago, we don't have very strong examples of success in multi-sectoral coordination in programs where we really can show that that's worked. And I thing we must do that.

So I think keeping our feet to the fire in terms of working in a multi-sectoral way with multiple partners is really going to be an important issue for us.

JANTINE JACOBI: Excellent. Thanks so much. Liz?

ELIZABETH MATAKA: If I have to have a recommendation, I would implore PEPFAR to invest more in capacity building of women. I share the frustration of my sister, but I will talk to her about how I went around that frustration.

And, you know, you said one, but I'm going to steal a minute for another one and that is to implore PEPFAR to invest on facilitating these community dialogues because it is important for activists and others to target the right people. You target government for policy, but it has to trickle down and you target the traditional leaders.

I agree with my sister over there. These are the people who can be successful agents of change. And they have, they've all got good examples to prove that. So those are my two recommendations.

JANTINE JACOBI: Wonderful. Yes. Rui?

RUI BASTOS: So perhaps it’s recommended to the country ownership especially the leadership at two levels to the

implementation and national agenda for the full respect of women rights. Push the leadership on these issues.

JANTINE JACOBI: Thanks so much. Michele, would you like to comment before closing.

MICHELE MOLONEY-KITTS: Yes, just one quick plea maybe to all of our implementing colleagues. This is such a complex issue, and I think there's a lot of motivation around it and we have to start somewhere, and I think it can be overwhelming. But like most things, I actually think, although this may be a little bit different, there are some groups that we know are actually more vulnerable than others.

And I would really encourage people to look at those groups first. And for me, there are two that I just think are desperate. One is orphans and vulnerable children, street children, children who really don't have a real, solid nurturing, loving, caretaking relationship. And the other is 10 to 14 year old girls.

And I think, I mean, this is a big issue. We've got a lot to do. But usually it's good to also, when you have to start somewhere and think about these, and those would be groups I would implore us to think about.

JANTINE JACOBI: Excellent. We have come to the closing of our session. First of all, I would like to thank

all of you for your participation, for your interest, and for being present here.

And I would like to thank the panel for all your advice, interventions, and your sharing of experiences. It has been really a great experience. It's clear that we cannot do political programming any more. It has to be an integrated way. It has to be centered on the women, on the needs of women and girls.

We cannot do it differently. If you're going to make progress, and particularly in the area of PMTCT, if you don't address the specific needs of women and girls, we will go nowhere. It's a complex issue but, at the same time, I think like Michele said, we can start with groups where we can make the easiest impact or maybe the most visible impact.

And at last point is, we need to measure what we are doing. We need to document. We need to monitor and evaluate what we are doing because only then we will learn from what we are doing and we can convince others to invest in these interventions.

Thank you so much for all your enthusiasm and presence and may I please invite you to complete your evaluation of the session. Thank you. [Interposing]

[END RECORDING]