**Symposium on:**

# Preventing and Coping with HIV/AIDS In Post-Conflict Societies:

## *Gender-Based Lessons from Sub-Saharan Africa*

**Hosted by:**
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**FINAL REPORT**

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## EXECUTIVE SUMMARY

There is an urgent need to address the formidable threats to human security posed by the twin crises of violent conflict and HIV/AIDS in Sub-Saharan Africa (SSA). It is now understood that conflict and HIV/AIDS can reinforce one another by deepening the conditions that breed violence and disease. Throughout, vulnerable populations such as women suffer the most.

There have been important gains made in preventing and coping with HIV/AIDS in some areas, and a rich body of research has emerged offering lessons from which to learn. Yet there are also gaps in knowledge and practice, one of which is limited understanding of the effective approaches to preventing and coping with HIV/AIDS in post-conflict environments. There are, however, many initiatives. Across Africa, women especially are engaged in efforts to prevent and cope with HIV/AIDS. Too often their voices are not heard, and their lessons are not learned by others. The overall objective of the Durban symposium was to provide a forum for African practitioners with diverse backgrounds to share and build upon their rich and complex, personal and professional experiences working on HIV/AIDS issues amongst conflict-affected populations. The specific goals were:

- (i) to strengthen networking among Africans drawn from government and PVOs who work in this field,
- (ii) build and augment African capacity for further work, and
- (iii) to draw any lessons and best practices that the participants are able to describe so that these may be utilized both by Africans as well as the international donor community to design and implement future programs.

In order to achieve the overall objective, participants authored narratives of their work and made oral presentations and discussed issues during the symposium. The symposium culminated with a consensus declaration.

Several common themes emerged from the discussion led by the African practitioners assembled in Durban.

- ◆ The need for a multi-sector, integrated, and gendered approach to HIV/AIDS prevention and psychosocial and economic rehabilitation in post conflict societies is the most powerful message that emerged from the symposium. The critical role of poverty reduction and developmental component of such programs was repeatedly stressed.

- ◆ In conflict situations women are the principal victims of violence and HIV/AIDS. Thus programs for conflict-affected populations must be designed with cultural sensitivity and gender sensitivity to overcome the disadvantages suffered by women.

- ◆ Stigma (HIV/AIDS) and shame (rape), the twin psycho-social scourges that afflict many women in post-conflict societies, can be overcome with collective action by women.

- ◆ A "Health as a Bridge to Peace" component that helps resolve or mitigate conflict and promotes peace building can be incorporated into both HIV/AIDS programs that are specially tailored to women as well as to more general programs in post-conflict societies.

- ◆ HIV/AIDS programs for the military would be more successful if they took gender into account and incorporated women.

# INTRODUCTION

*"The HIV epidemic rages in situations where power is exercised without regard of others, whether that power be economic, social, sexual, psychological or the power of force. It spreads where there is a disregard for life, an intolerance of difference, a devaluing of women, a lack of a will to live, and a breakdown of community values, violence and conflict. (…) What is required to respond to it is a way of perceiving and constructing social reality in its interconnectedness."*

Ever more Effective Responses to HIV/AIDS Discussion: HIV in Situations of Conflict[1]

## Background

There is an urgent need to develop an integrated approach to address the formidable threats to human security posed by the twin crises of violent conflict and HIV/AIDS in Sub-Saharan Africa (SSA). There is a rich and growing body of research on HIV/AIDS prevention/mitigation in humanitarian emergencies, particularly in refugee camp settings. Resources on best practices to guide policy and programming addressing HIV/AIDS in populations affected by violent conflict and other crisis/transition settings are less available. There are, however, many initiatives. All across Africa, people from all walks of life, women especially, are engaged in formal and informal initiatives that not only confront the scourge of HIV/AIDS in the context of crisis and reconstruction, but also contribute to environments that enhance human security in all its dimensions.

To tap into this experience, Tulane University's Payson Center for International Development and Technology Transfer and the African Center for the Constructive Resolution of Disputes (ACCORD), in collaboration with USAID's Africa Bureau Conflict, Mitigation and Recovery Division organized the symposium "Preventing and Coping with HIV/AIDS in Post Conflict Situations: Gender-Based Lessons," held March 26 – 28, 2001 in Durban, South Africa. Tulane University's Linking Complex Emergency Response and Transition Initiative (CERTI), the International Centre for Migration and Health-Geneva (ICMH), and World Bank – Pretoria also extended support. This report briefly outlines the background that led to this initiative and describes the principal findings of the symposium.

## Conflict

Violent conflict in some part of Sub Saharan Africa is protracted and almost endemic. Many countries and regions move in and out of conflict, making it hard to define precisely those which are in a stable post-conflict setting. Thus, it is more accurate to say that the focus of the Durban symposium and this report is on populations affected by conflict. This broader definition of populations permits us to include refugee populations in otherwise peaceful and stable countries such as Tanzania.

The number and nature of violent conflicts and related complex emergencies, coupled with the HIV/AIDS pandemic are now setting development in SSA back and negating many of the gains achieved over the last 50 years. Half of all the world's conflicts in 1999 were located in SSA, involving two-thirds of the countries in the region. Six high-intensity conflicts (causing over a thousand deaths per year) were still raging there in late 2000. Africa is also the part of the globe that has been hardest hit by HIV/AIDS. Nearly 70% of the world's infections (over 25 million

[1] http://rrmeet.undp.org.in/_disc4/0000000a.htm

infected people), and 90% of deaths from AIDS are to be found in a region that is home to just 10% of the world's population.[2]

Although little cross-country epidemiological data is available, there is evidence to suggest that conflicts increase the risk and impact of HIV/AIDS in several ways. Conflicts dislocate communities, create flows of refugees and internally displaced persons (IDPs), and seriously disrupt family life. They also bring soldiers and fighters into contact with civilians in situations where women and youths are highly vulnerable to sexual violence and sexual exploitation, and combatants, especially child soldiers, may have experienced intense traumas that make them particularly susceptible to violent and other high-risk behavior. Breakdown of basic services and psychosocial stress compound the situation. The magnitude of these problems has prompted efforts among national and international actors to mainstream HIV/AIDS prevention and control into humanitarian response, development efforts, and post-conflict reconstruction.

Despite the persistence of violent conflict, it is important to recognize that in the past ten years, some intra-state and regional wars have come to an end in Africa, and progress towards transitions have been made in others. Some post-conflict countries, like Mozambique, have gone on to sustained economic growth. A few others such as Uganda are considered to have achieved some success in preventing growth of HIV/AIDS rates. These experiences beg several questions:

- What are the factors driving the pandemic in post-conflict countries?
- What interventions make a difference in such countries?
- What conditions favor action?
- What hinders success in building the capacity of people affected by conflict, to prevent HIV infections and provide essential services to those who are directly affected by HIV/AIDS?
- Most importantly, what are the special considerations that must be taken into account in designing HIV/AIDS programs in post-conflict countries and conflict-affected populations that are confronted with problems such as demobilization of ex-combatants and single-parent families mostly headed by women?

These were some of the principal questions that were addressed at the Durban symposium.

**Why *Gender-Based* Lessons in Post-Conflict Societies?**

The importance of exploring gender-sensitive approaches to the HIV/AIDS pandemic is widely recognized, for in SSA, HIV/AIDS especially impacts women. Over 50% of new HIV infections in SSA occur in women; their vulnerability is compounded by lack of control over their own sexual health. At the same time, women also carry the main burden of care of family members with HIV/AIDS. In conflict and post-conflict contexts, the burdens on women escalate at the same time that their coping capacities are diminished. For these reasons, it is especially important that any HIV/AIDS prevention or mitigation approach for conflict-affected populations address not only the clinical health aspects of the disease, but the underlying social and economic determinants of vulnerability, of which gender is among the most significant.

There is also a need to understand better the impact of conflict and HIV/AIDS on African men, as they too are suffering and dying. Countries with a population "youth bulge," especially

[2] International Partnership Against AIDS in Africa: A Framework for Action at http://www.unaids.org/africapartnership/whatis.html

concentrations of young males who are out of school, also have higher risk of violent political conflict. Anecdotal accounts suggest that during high intensity conflicts boys and men are vulnerable to sexual violence as much as women. Furthermore, overall rates of infection among the military -- traditionally an almost exclusive male domain -- are significantly above the average rate of the general population. The needs of these young men are too often overlooked, to the detriment and danger of themselves and their communities. Sometimes they are even demonized, rather than having their needs respected or their suffering acknowledged.

In sum the symposium sought to identify the crosscutting issues and solutions in the HIV/AIDS-conflict-gender nexus through the eyes of African practitioners and to propose a set of "lessons learned" and "best practices" as guidance for policy makers, practitioners and others. In the next section we describe five major lessons learned and connected best practices identified by the participants with supporting case examples. The report ends with several appendices that provide additional information to the reader who wishes to know more about the symposium and follow up work.

## CROSSCUTTING LESSONS LEARNED AND BEST PRACTICES: KEY THEMES OF THE DURBAN SYMPOSIUM

Table 1 is a summary of the country projects that were presented to the symposium. Inevitably, a significant number of the lessons learned and best practices were of a generic nature. They ranged from using schools as an effective point of intervention for HIV/AIDS awareness programs for youth to the importance of closer cooperation between NGOs, host country governments and donors. The importance of these should not be underestimated. However, they are not unique to HIV/AIDS programs in the context of conflict and gender. Many are common issues concerning all HIV/AIDS programs, if not development aid in general. Some of the more important generic issues have been included in the *Durban Declaration* that is annexed (Appendix A) to this report. A summary of the symposium discussion is also included in Appendix D. We shall not repeat the more generic issues in the main body of this report that would dilute the principal message we wish to convey. Here we focus exclusively on the interrelated dimension of HIV/AIDS, Gender and Conflict. In what follows we report on the lessons learned and best practices that crosscut those three themes.

A few key issues emerged that were emphasized by participants throughout the symposium. Despite tremendous differences in the backgrounds of the participants and countries they work in, these common themes were returned to time and again. These have been presented below under five "Lessons Learned," with appropriate illustrations from case studies. It should be noted that the five lessons are not mutually exclusive. Some are closely connected to one another. For example, income-generating programs for women lead to women's empowerment while enhancing their choice and confidence in dealing with men. On the other hand literacy programs and skills development programs that empower women also create more economic opportunities for them.

### Lesson 1 – Multi-sector, integrated and gendered programs are the best.

**The need for a multi-sector, integrated and gendered approach to HIV/AIDS prevention and psychosocial and economic rehabilitation in post conflict societies is the most powerful message that emerged from the symposium.**

HIV/AIDS and conflict create a double jeopardy for women. As noted in the introduction to this report, women are more vulnerable to the disease in SSA. They (and children) are also the main victims of conflict. When the economy and the social infrastructure are destroyed, and male heads of

> **Box 1**
>
> **Rwanda has created an integrated polyclinic where HIV/AIDS Counseling and medical help combines with economic support programs to assist the female victims of genocide**
>
> ***Mary Balikungeri***
>
> Mary Balikungeri directs the "Polyclinic of Hope" that was established in 1995 to cater to the medical, psychological, and economic needs of the women victims of rape and other related crimes in **Rwanda**. Currently the center is handling five hundred and four women victims with members of their families totaling about 3,024 people. The major interventions of the center for the welfare of the women and members of their families include:
>
> - free medical services,
> - psycho-social support and counseling,
> - trauma counseling
> - referral of complicated medical cases,
> - HIV awareness programme,
> - Testing and post-testing counseling, and
> - special care & support to victims of HIV.

**Box 1 continued…**

Balikungeri reports that the experience of the Polyclinic confirms that

1. It is essential to create a "secure space" –not just in physical terms but in emotional terms" – that allows the victims of genocide and HIV/AIDS to seek through the sharing of experiences – "Looking Beyond Self" - the solidarity the women provide each other and the sense of belonging and security which they lost in the genocide.
2. It is essential to establish a system/institution(s) that go *beyond* mere awareness of HIV/AIDS and its consequences in the context of genocide/rape to develop economic support for victims by multiple, practical methods, including encouraging women to take care of each other in a practical way, especially when a victim of HIV/AIDS is physically disabled and is without resources or family support for care.

households are missing for war-related reasons, women carry a disproportionate burden as single-parent heads of families. This is compounded if they are victims of HIV/AIDS (a disease that spreads even more easily during times of war) and rape. An extreme form of female deprivation in such situations is seen in commercial sex workers (see, for example, Box 3 on Ethiopia) who rely on sex work as the only available means of support. In that context, one of the most powerful messages that emerged from the symposium was the need to have a multi-sector, integrated, and gendered approach to HIV/AIDS prevention and psychosocial and economic rehabilitation in post-conflict societies. What is meant by multi-sector, integrated and gendered approach is a women-focused program that combines HIV/AIDS counseling and testing, reproductive health, family planning, fertility checks, advice on and assistance with income generating ventures, life skills education, etc. in an integrated one-stop facility. It is especially important to note that the participants repeatedly stressed in the discussion that the income-generating aspect of these programs was essential to attract women and also to make the program meaningful and sustainable. This underscores the close link between HIV/AIDS prevention and poverty reduction. It also confirms the validity of the current thinking on the conflict to transition to sustainable development continuum that also emphasizes the importance of starting the

**Box 2**

**Tanzania's one-stop medical centre in a volatile conflict/refugee region provided a range of services from HIV/AIDS counseling and reproductive health services to income generating opportunities for women.**

***Daraus Bukenya***

Daraus Bukenya described a project undertaken by the African Medical and Research Foundation (AMREF) in Mwanza in northern **Tanzania** that experienced a large refugee influx and the usual public health and social problems such a situations entail. The project described as a "response to mitigate impact of conflict on gender based HIV vulnerability" delivered "women-centred reproductive health care within the framework of women's rights." Bukenya states that the program was "overwhelmingly successful in drawing the interest of women and many families to the issues that increase their vulnerability to reproductive ill health, including HIV/AIDS."

The key features of the program were:

- **Collaboration** between AMREF and several local civil society and government partner organizations.
- Although the primary target was women, the program actively sought the **involvement of the male partners** ("those who caused the most trouble") of the women.
- **Provision of a variety of integrated services** including "HIV voluntary counselling and testing, gynaecological examinations, family planning, sexuality and reproductive health information, support counselling, fertility checks, advice on income generation, advice on relationships, life skills education and others, in a one-stop facility.
- **Training of culturally acceptable "para-professional counselors"** for community outreach support of women and families that suffered from violence and abuse.

developmental component from the very beginning of the process. Participants cited successful

**Box 2 continued…**

An evaluation of the program conducted three years after its commencement had revealed that:

- The most important lesson learned was that conflict resolution in order to be successful and lasting, must also have the involvement of the community that suffers most from the negative consequence of conflict. Conflict resolution that is limited to the higher political level is not adequate by itself.
- Culture has a very strong influence on conflict resolution. An understanding of what cultural values and beliefs are could help identify what could work, and the well-received para-counselling program was developed in a culture-sensitive manner.
- It was difficult to involve males in the program, and frequently women had to participate without the knowledge of their male partners. If and when males joined the program, the success was overwhelming.
- Much of the success of the program was attributable to the very high level of commitment of staff that truly believed in the cause
- At the beginning, it was difficult to convince the policy makers and "some" donors that this new approach would work.

examples from Rwanda (Box 1), Tanzania (Box 2), Ethiopia (Box 3) and Kenya (Box 7) among others.

**Box 3**

**In Addis Ababa commercial sex workers who were mainly the victims of the Ethiopia-Eritrea war benefited from an integrated program of counseling and assistance with income generating projects. It achieved success through the devoted commitment of the workers, who succeeded in winning the trust and confidence of the women.**

***Yene Assegid***

Yene Assegid describes an IEC, counseling and income generating project in Addis Ababa, **Ethiopia,** that reached approximately 1500 low-income commercial sex workers. The main goal was to educate the women in the practice of safer sex and to facilitate access to government STD health clinics. About 100 to 150 peer educators who were chosen from among the beneficiary community were trained and employed as counselors for a small monthly payment of $10. Assegid notes that the counseling made the women more aware of their rights, and the income-generating program allowed them a little more freedom and empowered them to negotiate in the use of condoms. She reports that, as a result of the intervention, at least 70% of the target group used the STD treatment facilities and primary health care offered by government clinics. Assegid observes that the sex workers were very suspicious of all outsiders. She attributes the success of the program primarily to the ability of a very dedicated team of workers who won the confidence of the target group and successfully retained that confidence throughout the program against considerable odds.

### Lesson 2: In conflict situations women are the principal victims of violence and HIV/AIDS. Thus programs for conflict-affected populations must be designed with cultural sensitivity and gender sensitivity to overcome the disadvantages suffered by women.

In the African family and the African community, the power of patriarchy is especially strong and places women at a disadvantage. Male domination over women is accentuated in the dynamic context of war and its aftermath through commercial sex, rape, and sexual violence and demobilized soldiers returning home with hardened and aggressive attitudes, and with HIV/AIDS. War is also a situation in which traditional coping and protection mechanisms for women breakdown. As the quotes from Burundi, South Africa and Tanzania (Box 4) indicate, several participants were very frank in their assessment of the second-class status of women in many parts of Africa, which they noted has worsened in the context of conflict. Thus they placed a great deal of emphasis on the importance of empowering women who have been either victims of HIV/AIDS and rape or belonged to vulnerable groups that required assistance to avoid being

victims of the disease. However, as section (d) listed below shows the empowerment programs were of a more general nature and not necessarily confined to HIV/AIDS and conflict situations.

The discussion in Durban also stressed the importance of integrating men into strategies and programs so that the approach is one of "gender" rather than one of "women." Such an approach also allows these programs to be mainstreamed. However, the participants conceded that this was not something that was widely practiced but one that should be encouraged.

From the discussion and the papers, four approaches could be gleaned as practical "best practices" to cope with the situation. Some recognised the need to assist women separately and others made a bid to integrate men and women:

(a) The first (e.g. Rwanda's Polyclinic of Hope – See Box 1) was **to create a facility that is exclusive to women** so that they could "unmask their pains, anguish, shame, guilt and their silence."
(b) The second, (e.g. the AMREF Centre in Tanzania – See Box 2) was to **observe "maximum privacy and confidentiality" for the women** who attended without informing husbands/partners but "encourage" them if possible to come with the latter. Tanzania reported that the latter approach, if possible, almost always produced better results.
(c) The third, which the Burundi military adopted (See Box 7), was when possible **"*not* to separate husbands and wives."** This, it is worth noting, was possible because the Burundi program was a "Fight against HIV/AIDS within the military community" that was subject to military discipline. A similar program for civilians that encouraged "partnerships with husbands" in HIV/AIDS awareness education was reported from Uganda at the symposium.
(d) The fourth were a limited number of women empowerment programs such as a legal aid program in Burundi, a program in DRC to enhance women's rights to inheritance of property, and literacy programs in the same two countries.

**Box 4**

**"Burundi woman are socially inferior to men"**

***Sophonie Niyondavyi***

"**Burundi** woman are socially inferior to men. They have no right to (inheritance) and have very limited economic power. Men have all the power including sexual power which encourages male adultery." —The socio political events of 1993 that led to thousands of death nearly a million of IDPs and increased insecurity has "increased promiscuity, prostitution, rape, epidemics, poverty and malnutrition" and helped intensify the spread of HOIV/AIDS.

**"South Africa is a deeply patriarchal society"**

***Carol Bower***

"**South Africa** is a deeply patriarchal and conservative society, with relatively rigid roles for men and women sanctioned both by religion and custom. Despite our Bill of Rights and Constitution, the position of the vast majority of women in South Africa is dictated by these two factors as inferior. "

**"Conflict has exacerbated violence against women in Tanzania"**

***Daraus Bukenya***

"Conflict has only exacerbated the violence that women in many parts of **Tanzania** already suffer and therefore the risk to HIV infection. Such violence includes female genital mutilation or cutting (FGM) among many others. Domestic violence including sexual and physical abuse is rampant, as is child abuse in several forms including defilement, rape and coerced marriage. Therefore, even in normal times, the woman (and child) in the Lake Victoria zone has been denied her rights; the rights to the universally accepted human rights, access to productive resources, ownership to property, access to information and freedom to take charge of her own livelih ood."

**Lesson 3: Stigma (HIV/AIDS) and shame (rape), the twin psycho-social scourges that afflict many women in post-conflict societies, could be overcome with collective action by women.**

**Box 5**

**The fight against the stigma attached to AIDS in Kenya was won by openly speaking out and reclaiming the humanity of those who suffered from the disease.**

***Asunta Wagura***

"Yes, it's true that I have the virus; a deadly virus: that I know, I detest the state that I am in. But I am not a case neither a number. I do not focus on dying of the virus, but rather I concentrate on living with it. Victims are weak and powerless. I am still able because I am advocating for my rights and the likes of myself. I am still myself and responsible because I am taking charge of my life and also taking care of my child. The virus has only weakened my immunity but not my humanity. I will never allow that to happen."

Since 1984, when the first case of Aids was discovered in Kenya, AIDS remained a mystery. Those suspected to be infected were taken to be sexually immoral members of the community. People were dying miserably, without support from their families, hospital staff, community at large. This was due to so much fear and stigma attached to HIV/AIDS.

It was against this background that in 1993, four women and I, all infected with the deadly virus, teamed up and humbly started a meeting-group. This group gradually grew in strength and determination, and in 1998 we established the Kenya Network of Women with AIDS (KENWA). Today we have 1,600 women members and 100 orphan children members.

The goal of KENWA is to assist women and children infected with the virus through counseling, psychosocial support, medical treatment, and income generating activities,

Outcomes and impact

- We have given AIDS a human face, and as a result we have seen more and more women coming out in the open and joining the network without fear or shame.
- We have earned respect and acceptance in our families and entire community, and today they involve us in any activities pertaining to HIV/AIDS.

We have managed to break the wall of ignorance by religious leaders and made them understand HIV did not even respect religious observers. They have now allowed us to talk about sensitive issues like sex, condoms, and AIDS. This was a breakthrough, as we see it.

Women are the principal victims of violent conflict in Africa. They contract HIV/AIDS at a higher rate than men, and significant numbers are victims of rape especially in extreme conflict situations such as the genocide in Rwanda. Stigma (HIV/AIDS) and shame (rape) are two major psychological scars that these women face in post-conflict communities. The two often are combined in one individual. Some of the participants reported projects that addressed this issue directly with considerable success primarily by encouraging women to speak out.

The Polyclinic in Rwanda (Box 1) encouraged women to speak out among themselves. It created a "total system of care both emotional and physical" that allowed them to speak freely to each other about their ordeal to find solidarity in each other, and to help each other materially.
Beatrice Murunga who wrote on the Map International Trauma Healing and Reconciliation Project for Women in **Rwanda** observed that women were willing to speak openly about trauma from killing but were reluctant to address the "more shameful" trauma arising from rape. This observation underscores the importance of adopting something akin to the Polyclinic approach described above.

Gladness Xaba reported that in **South Africa** RAP established groups where members similarly spoke out.

The Network of Women with AIDS in **Kenya** - KENWA - (Box 5) is perhaps the best example of open expression of the condition of those infected with the virus as a way of dispelling stigma and regaining dignity.

It is important to note that the success of this method of getting over stigma and shame appears to depend largely on collective action and collective strength of women.

**Lesson 4: A "Health as a Bridge to Peace" component that resolves conflict and promotes peace building can be incorporated into both HIV/AIDS programs that are specially tailored to women as well as to more general programs in post-conflict societies.**

Almost all the HIV/AIDS programs that were reported to the symposium explicitly recognized that conflict aggravated and compounded the HIV/AIDS problem. In response, many of the programs explicitly incorporated a peace-building/conflict-resolution component in them, underscoring the concept of "health as a bridge to peace"

In **Zambia,** the "Community Responses to Refugee Crisis" project designed primarily to enhance the capacity of the refugee host community to cope with the refugees has a peace-enhancing component to help communities understand the "nature, causes and effects of war." This has been done primarily to avert a conflict between the host community and the refugees.

The Polyclinic project in **Rwanda** (Box 1) encouraged the participating women to express their opposition to "war and brutality in society; the right to condemn all forms of violence (and) discrimination in society; the right to build solidarity of women for women as women, and the right to political freedom and participation."

In the Trauma Healing and Reconciliation Project of **Rwanda** "a larger aim was to reach the people at the grassroots level …… with the message of peace, and reconciliation. This was to be achieved through training of trainers at the prefecture (provincial) level in trauma counseling/trauma healing so that they could carry on the work within their own prefectures."

The AMREF project in **Tanzania** (Box 2) has a strong "community conflict resolution" component.

**Lesson 5: HIV/AIDS programs for the military would be more successful if they took gender into account and incorporated women.**

Given the number and scale of internal and regional wars in Sub Saharan Africa,

**Box 6**

**The HIV/AIDS program of the Burundi Military reaches out to both men and women**

***Sophonie Niyondavyi***

The "Fight against HIV/AIDS within the military community" program of Burundi has two declared goals. The first is to "improve the knowledge of armed forces on HIV/AIDS and sexually transmitted diseases." The second is to make the military personnel and their partners move away from "risky" sexual practices and adopt "non-risky" sexual practices. The three strategies adopted were (a) sensitize the military community at all levels - political authority and high command, health personnel, and military personnel and their families, (b) promote the use of condoms, and (c) promote early diagnosis and treatment of sexually transmitted diseases.

**Box 6 continued…**

One of the striking features of the program is that, using military command powers, both husbands and wives were required to attend together the "sensitization" sessions. Further to breakdown the sense of "inferiority" that wives feel in relation their husbands, leaders were chosen from among the former to conduct some of the sensitization sessions. The program also incorporated non-military women (not wives) who had been sexual partners of soldiers.

The program started in 1999, and it is halfway through. No comprehensive evaluation has been done to assess its impact. However, Dr. Sophonie Niyodavyi, who is Director of the National Health Service of Burundi, asserted that the results were encouraging.

addressing the problem of HIV/AIDS in the African militaries is an essential part of the solution. Two reports were presented to the symposium that explicitly addressed this issue.

The report from Burundi (Box 6) underscored the importance of making use of military discipline and command structure to overcome some of the constraints that a civilian program may face, while reaching out beyond the narrow confines of the military to the larger community, especially women, to make the program more effective.

The report from Ethiopia (Box 7) highlighted the need to treat demobilized, infected soldiers humanely, with understanding and compassion, as a part of the *vulnerable community* and *not* as dangerous infected persons out to harm family and community.

**Box 7**

**Treating demobilized HIV/AIDS infected soldiers with compassion in Ethiopia**

***Bogalatech Gebre***

Bogalatech Gebre has developed and manages a program in **Ethiopia** to assist demobilized soldiers from the Ethiopia-Eritrea war, their families and communities cope with HIV/AIDS. She made a valuable psychological point in the design and approach of her program by pointing out that the soldiers must not be treated as "dangerous infected individuals bringing a disease home to be spread to others" but as "vulnerable persons who needs assistance and understanding just as much as those at home and their community." This, she noted, required a humane approach in the design of the program that in turn made it more appealing to the soldiers. She also pointed that in a male-dominated and patriarchal society such as that of Ethiopia and Africa in general, such an approach would also be more practical.

## CONCLUSION

In this brief conclusion we want to highlight a few salient issues that synthesize some of the Lessons Learned and Best Practices that have been cited in the report. First, the discussion in Durban placed a great deal of stress on the value of what the participants called the "intangible qualities" of programs such as compassion and commitment that made a crucial contribution to success. These, they noted, were essential because of the very nature of the issues – HIV/AIDS, rape, stigma, shame, psycho-social illness etc. - that the programs addressed

Second, the participants stressed the importance of community involvement for success, again taking into account the peculiar characteristics of the problem. They noted that in Africa the sense of community, especially in rural areas, still remains strong and should be viewed as an asset to fight HIV/AIDS in the context post-conflict transition. Many of the best practices that have been cited in the report have successfully used the community as a resource.

Third, every participant stressed the importance of a multi-sector and integrated approach to HIV/AIDS prevention in conflict-affected populations, placing special emphasis on poverty reduction and income generation.

Fourth, as one would expect, different countries and different regions within countries often adopted different strategies and programs that best suited their needs and resource endowments. For example, in South Africa and Zimbabwe street dramas were used as a medium to promote HIV/AIDS awareness, whereas in DRC and Burundi radio was being used to spread the message. In Rwanda a polyclinic also became a "political" platform to advocate women's rights. The implication of this is that strategies and programs have to be very situation specific to ensure success.

## FOLLOWUP

The participants emphasized the importance of networking within Sub-Saharan Africa and declared that the symposium was useful for that purpose alone. They appealed to the donors to finance continuing dialogue among such inter-sectoral groups. Several of the participants have written back to the organizers of the symposium indicating how they are making use of the information they gathered and the networking they did in Durban in their work at home. For example, Mary Balikungeri of Rwanda reported that she found the symposium useful for her network planning. Barbara Jaeggi of the ICRC, Geneva reported that she shared the symposium findings with her colleagues working on HIV/AIDS in Sub-Saharan Africa.

The participants also requested a list serve that Tulane/CERTI has now provided. To subscribe to the listserv please send a message to listserv@tulane.edu and in the body of the message type: SUBSCRIBE AIDS_SYMP-L

Tulane/CERTI is disseminating the Durban Declaration, Symposium Report and related documents through the website www.certi.org. The website also contains full audio and limited video record of the symposium. Hard copies of the report together with the Durban Declaration will be forwarded to relevant donors and humanitarian/development agencies. The full report also can be downloaded from the CERTI website from the following URL: www.certi.org. An announcement of the availability of the report, website and list serve will be made through several humanitarian electronic communities.

A State Department unclassified cable drafted by USAID/AFR/SD/CMR was sent out to all USAID missions in Sub Saharan Africa as well as Washington-based staff working in projects related to the symposium in order to ensure maximum dissemination.

## TABLE 1: A Summary of the Country Projects Presented to the Symposium

| Country | Organizations | Program Name | Description | Key Lessons Learned & Best Practices |
|---|---|---|---|---|
| Burundi | Burundi Military | Fight Against HIV/AIDS Within he Military Community (1999–03) | Improve the knowledge of the military on HIV/AIDS and STD, inform on non-risky sexual practice, and promote condom use, early diagnosis and treatment of STD. | • Sensitize the military and political authority at the highest level on the importance of the program<br>• Include both men and women partners in awareness programs |
| Ethiopia | Medecins Sans Frontieres (Belgium), Addis Ababa | HIV/AIDS and STD Prevention Among Commercial Sex Workers in Addis Ababa | An IEC program for low-income sex workers in Addis Ababa many of whom were directly or indirectly connected to the Ethiopia-Eritrea war situation | • The critical importance of developing a strategy to win and retain the confidence of the women<br>• Given the nature of the project, the strong commitment of the staff to the work that they were doing proved decisive for success. |
| | Promotion of Reproductive Health in Ethiopia Project and German Technical Cooperation (GTZ) | Mainstreaming HIV Prevention, AIDS Care and Support at the Workplace (1999) | HIV/AIDS training for Focal Persons in business establishments | • Business establishments were very reluctant to draft an internal policy for health and benefits focusing HIV/AIDS<br>• Team effort proved to be a key factor in success. |
| Kenya | Kenya Network of Women with AIDS (KENWA) | Advocacy, Education, and Community Mobilization Program to Fight HIV/AIDS and Help Victims of the Disease | Care and support for infected women through counseling, treatment, homecare and income-generating activities<br>AIDS Orphans Support Program through psycho-social and material support | • Stigma can be overcome and infected people can lead regular lives by being open and fearless about the disease and ones condition<br>• Group support is vital for success |

| Country | Organizations | Program name | Description | Key lessons learned & Best practices |
|---|---|---|---|---|
| Rwanda | 1. Map International, Nairobi, Kenya | Trauma Healing and Reconciliation Project in Post-Genocide Rwanda (1999– ) | 330 women church and community leaders were trained on HIV/AIDS and rape trauma counseling | Female victims were more willing to address trauma from killing than trauma from rape (shame was the constraint). |
| | 2. Rwanda Women's Network | Polyclinic Of Hope (1995) | Free medical service, trauma counseling, HIV/AIDS awareness, legal/human rights awareness, psycho-social support and economic support for female Genocide victims | • Collective discussion/communication among female victims is a necessary part of the healing process<br>• Importance of economic support for women in post-conflict situations<br>• Emphasis on women's rights in post-conflict situations |
| South Africa | 1. Resources Aimed at the Prevention of Child Abuse and Neglect (RAPCAN) and collaborating CBOs | School and Community Workshops on Sexual Abuse of Children (6-14) | Awareness programs for youth, teachers and children on the link between sexual violence and HIV-AIDS | • Teachers are an effective means of reaching children for awareness programs on sexual abuse and HIV/AIDS<br>• Community-based organizations are an effective collaborating partner to reach the school community, parents and neighborhood. |
| | 2. Religious Aids Program (RAP) | HIV/AIDS Awareness/Empowerment Program in Natal | Target groups: women, youth and farm workers and their families | Cooperation and commitment of members were key to success |
| | 3. Medical Research Council of South Africa | Social and Behavioural Research on Adolescent Sexuality and HOV Prevention in Natal 1998-2000 | Research on a sample of secondary school children | • School based interventions in HIV/AIDS awareness programs must include teachers and parents.<br>• HIV/AIDS awareness programs for youth must be located within a broader reproductive/sexuality education program prevention |

| Country | Organizations | Program name | Description | Key lessons learned & Best practices |
|---|---|---|---|---|
| Tanzania | African Medical and Research Foundation | "One-Stop" Demonstration Medical Centre for Women-Centred Reproductive Health Services in a Conflict-Affected Refugee Area of Northern Tanzania | Provision of an integrated reproductive health service including HIV voluntary counselling and testing and advice on income generation. | • Attendance of male and female partners together for counseling sessions produced better results than woman only sessions.<br>• Emphasis on gender roles in conflict situations was important to ensure respect for women's rights.<br>• Conflict resolution must be made the responsibility of the community<br>• A culturally sensitive community para-counseling service was successful |
| Zambia | Society for Women and AIDS in Zambia (SWAAZ) | Community Responses to Refugee Crisis: A Better Way to Cope | Raise community awareness of refugees and their plight in north and northwestern Zambia by conducting programs that educated the host community on refugees, social responsibility of community living and sharing with refugees, and HIV/AIDS in refugee communities and how to cope with it. | Inclusion of a peace-enhancing behavior module in the awareness program that help communities understand war. |

**Note**: This table is limited to projects that have been implemented. It excludes projects that have been planned but not yet implemented, as well as papers presented on the general HIV/AIDS country situation.

# Appendix A: Durban Declaration

## Preventing and Coping with HIV/AIDS in Post Conflict Societies: Gender-Based Lessons from Sub-Saharan Africa

*WHEREAS* Sub-Saharan Africa is home to 630 million people of diverse racial and ethnic groups with a long and proud history and culture and has one of the richest natural resource bases in the world, with potential to be one of the most prosperous regions, nevertheless:

1. The twin scourges of violent conflict and HIV/AIDS have mutually reinforced each other though a multiplicity of mechanisms including large-scale population dislocation, the destruction of the public health infrastructure and the weakening of governance and economy. These twin scourges are destroying families, communities, nations and the African continent as a whole.

2. More than 50% of the world's active violent internal and regional conflicts are in Africa. These conflicts have directly or indirectly affected over 75% percent of the region's countries and populations, conscripted over 300,000 child soldiers, displaced over 30 million people from their homes, caused the deaths of over one million people, destroyed social and economic infrastructure, damaged the environment, weakened institutions of governance and generally retarded equitable, sustained and sustainable development.

3. More than 75% of the world's HIV/AIDS cases are found in Africa. More than 11 million Africans have succumbed to AIDS over the past decade and the social and economic consequences are profound.

4. Gender roles play a crucial role in both the evolution of the problem and in the way forward to solutions. Women are disproportionately affected by the physical and psychological consequences of conflict and HIV.

5. Poverty is a key contributing factor to the spread of HIV/AIDS.

6. While there is recognition of these problems, and resources have been devoted to their solutions, current approaches are inadequate in both magnitude and scope. HIV, conflict and gender roles crosscut all development concerns and should be mainstreamed into all sectors.

7. Current financial resources are also inadequate to address the scope and magnitude of these complex social problems.

***Noting that*** throughout the continent, every single day, women and men are actively preventing and coping with HIV/AIDS, conflict, and gender-based violence and that there are particularly remarkable lessons to be learned from African women who through a series of grass-roots efforts have evolved unique approaches towards these challenges;

***Further noting that,*** there are growing networks, initiatives, and partnerships to address these intertwined challenges in Africa and that these efforts, already generating momentum towards creative solutions, need to be recognized and supported;

***Now therefore*****,** we the undersigned African members of the international development and health community who assembled in Durban South Africa and deliberated for three full days, at the invitation of the African Centre for the Constructive Resolution of Disputes (ACCORD) and the Tulane University Payson Center for International Development and Technology Transfer and sponsored by the United States Agency for International Development (USAID) in association with the Linking Complex Emergency Response and Transition Initiative (CERTI), the International Centre for Migration and Health (ICMH-Geneva) and the World Bank (Pretoria),

***Taking special*** account of the community, national and regional experience and lessons learned of African strategists and implementers of programs and projects, especially at the sub-national and community level, to cope with and combat HIV/AIDS in conflict affected countries;

***Acknowledging that*** conflict, HIV/AIDS and gender inequalities are inextricably related and therefore solutions to these problems must take in to account this complex interrelationship which requires interdisciplinary and inter-sectoral approaches.

***Request that*** national governments, national NGOs, and the international community, including all bilateral and multilateral donors and international NGOs, must revisit their policies, strategies and programs to fight the twin scourges of violent conflict and HIV-AIDS and achieve sustainable peace based on:

1. Mainstreaming interventions to address HIV/AIDS, conflict prevention, mitigation and resolution/reconciliation and women's empowerment into all sectoral programs;

2. Empowering women as key actors and community mobilizers to both address both HIV/AIDS and conflict resolution/peace building. Empowerment requires action at the policy (including legal framework), strategy and program levels at local, sub-national, national and international legal levels;

3. Devising a conceptual framework that:
    - Is holistic, integrated, and gendered;
    - Takes into account the needs of both women and men;
    - Incorporates the importance of poverty as a determinant of high-risk behaviours related to HIV and conflict.
    - Takes into account the importance of security, governance and socioeconomic development;
    - Contextualizes the pandemic within determinants including poverty, gender socialization and access to resources.

4. Recognizing that conflict and HIV/AIDS will require behavioural change at the individual, institutional, community, national and international levels;

5. Necessitating that approaches must address the problems of stigma and shame, which are underlined by fear on the parts of both, infected and affected. There is also a need to promote self-esteem and healthy relationships and hope, including hope for a cure;

6. Including as a priority psychosocial care for those affected by conflict and HIV/AIDS, with special attention given to trauma management and reintegration into communities for ex-combatants, especially former child soldiers;

7. Giving special consideration to vulnerable groups such as women, children, young adults, people with disabilities, orphans, refugees and internally displaced persons, child soldiers and ex-combatants;

8. Requiring broad and strategic partnerships, including the military sector, women's groups, civil society groups, spiritual institutions and the private sector;

9. Embracing the importance of regional and locally-tailored solutions that are based on the common principals of women's empowerment, inter-sectoral approaches, analysis of the needs of vulnerable groups, gender analysis, and peace;

10. Promoting national, regional, and international networking, dialogue and cooperation;

11. Mainstreaming conflict, gender and HIV/AIDS strategies and programs in the broader post-conflict development and democracy and governance framework;

12. Enhancing present programmes in areas of care and support for people living with HIV/AIDS, particularly in making medical treatment affordable and accessible and providing services that alleviate their suffering and protect their human rights.

*We therefore recommend that:*

1. As conflict, HIV/AIDS and gender are now inextricably linked in Sub-Saharan Africa; all conflict programs must adequately address the issues of HIV/AIDS, poverty and gender.

2. The proceedings of this forum be widely disseminated to the practitioners and policy community, including donors, international organizations, Non-Governmental Organizations (NGOs), including religious organizations, and governmental sectors, including the military;

3. Practical tools be developed to support the programming approaches articulated above for addressing the problems of HIV/AIDS and conflict/crisis through gender-based strategies;

4. Donors increase resource levels in support of programs to address these critical problems through a process of regular consultation that facilitates strategic partnerships, community ownership and mutual accountability;

5. There be increased donor coordination and programming and streamlined requirements;

6. All of the actors involved in addressing these problems utilize inter-sectoral approaches that address the complex inter-relationship between conflict, HIV/AIDS, poverty and gender roles;

7. Mechanisms be put in place to build a learning network of professionals and workers in order to improve the quality and efficacy of programs as well as to increase advocacy for these issues;

8. Empowering women and addressing the root causes of their vulnerability is key to preventing and coping with HIV/AIDS.

In witness, whereof, we the undersigned, being duly representative of African members of the international development and health community have assented to the declaration here in, concluded in Durban, Republic of South Africa on the 28th day of March 2001.

# Appendix B: Cable Summary of the Symposium

UNCLASSIFIED

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SUMMARY
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1. SUMMARY:  A THREE DAY SYMPOSIUM ON PREVENTING AND COPING WITH HIV/AIDS IN POST-CONFLICT SOCIETIES: GENDER-BASED LESSONS FROM SUB-SAHARAN AFRICA WAS HELD FROM 26-28 MARCH 2001 IN DURBAN, SOUTH AFRICA.  26 AFRICAN PARTICIPANTS FROM EAST AND SOUTHERN AFRICA ATTENDED.  COUNTRIES INCLUDED WERE BURUNDI, DEMOCRATIC REPUBLIC OF THE CONGO, ETHIOPIA, KENYA, MOZAMBIQUE, NAMIBIA, REPUBLIC OF THE CONGO, RWANDA, SOUTH AFRICA, TANZANIA, UGANDA, AND ZAMBIA.  THESE HIV/AIDS PRACTITIONERS, LARGELY INDIGENOUS AND NON-GOVERNMENTAL WITH SOME GOVERNMENTAL PARTICIPATION, DEVELOPED A #DURBAN DECLARATION# STATING THAT CONFLICT, HIV/AIDS AND GENDER INEQUALITIES ARE INEXTRICABLY RELATED. SOLUTIONS TO THESE PROBLEMS REQUIRE MULTI-SECTORAL, CROSS-SECTORAL AND SYNERGISTIC APPROACHES. PARTICIPANTS PLAN TO DEVELOP A STRATEGIC PLAN THAT LINKS HIV/AIDS, CONFLICT, AND GENDER FOR THE NATIONAL AND REGIONAL LEVELS BY DEVELOPING AN EFFECTIVE DIALOGUE WITH GOVERNMENT AT COMMITTEE AND CABINET LEVELS, CIVIL SOCIETY ACTORS, THE PRESS, AND OTHER SALIENT ACTORS SUCH AS FIRST LADIES. THE SYMPOSIUM DEMONSTRATED THAT WE LIVE IN AN ERA WHERE AIDS IS NOT SIMPLY A DISEASE OR AN EPIDEMIC, BUT A FACT OF LIFE AND A COMPLEX SOCIAL DYNAMIC THAT IS INTRICATELY TIED TO ISSUES OF GENDER AND CONFLICT. THE DURBAN DECLARATION TEXT IS REPORTED IN PARAGRAPHS 23-31.

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WORKSHOP METHODOLOGY
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2. METHODOLOGY OF SYMPOSIUM: OVER THE THREE DAYS, PARTICIPANTS SHARED THEIR STORIES FROM THE TRENCHES THAT ELUCIDATED THE LINKS AMONG HIV/AIDS, CONFLICT, AND GENDER.  PRIOR TO THE SYMPOSIUM, EACH PARTICIPANT PREPARED A PAPER ILLUSTRATING THEIR ORGANIZATION'S OR COUNTRY'S EXPERIENCES.  PARTICIPANTS SHARED THESE STORIES IN A SERIES OF PANEL PRESENTATIONS AND SMALL WORKING GROUPS.  THESE LESSONS LEARNED WILL BE PART OF A BEST PRACTICES DOCUMENT THAT WILL BE PREPARED BY TULANE UNIVERSITY OVER THE NEXT FEW MONTHS. PARTICIPANTS SHARED THESE IDEAS WITH INTERNATIONAL AND USAID COLLEAGUES FOR CREATING AN EFFECTIVE AND COGENT PLATFORM FOR ACTION AND ADVOCACY.

3. STRATEGIC FRAMEWORK SETTING: PARTICIPANTS PLAN TO BEGIN THEIR STRATEGIC ANALYSIS BY MEETING WITH USAID MISSIONS IN AFRICA TO BRIEF MISSIONS ON THE WORKSHOP. THEY THEN PLAN TO DEVELOP A STRATEGIC PLAN THAT LINKS HIV, GENDER, AND CONFLICT FOR THE NATIONAL AND REGIONAL LEVELS FOR EFFECTIVE DIALOGUE WITH GOVERNMENT AT COMMITTEE AND CABINET LEVELS, OTHER CIVIL SOCIETY ACTORS, THE PRESS, AND OTHER SALIENT ACTORS SUCH AS FIRST LADIES.

4. WORKSHOP GOALS: (A) TO PROVIDE A QUICK OVERVIEW OF GENDER-SENSITIVE PRACTICES AND KNOWLEDGE IN PREVENTING AND COPING WITH HIV/AIDS IN THE AFTERMATH OF VIOLENT CONFLICT; (B) TO EXPAND THIS KNOWLEDGE BASE BY SHARING AND DISSEMINATING THE EXPERIENCES OF AFRICANS WHO ARE CONFRONTING THESE ISSUES IN THEIR COUNTRIES; AND, (C) TO IDENTIFY RECOMMENDATIONS AND STRATEGIES FOR PRACTITIONERS, POLICYMAKERS, AND DONORS ON HOW THESE EFFORTS CAN BE BEST SUPPORTED. THEMATIC AREAS INCLUDED: (A) DEMOBILIZATION AND REINTEGRATION OF ARMED FORCES, (B) GIRLS' EMPOWERMENT, (C) CARING FOR ORPHANS AND PEOPLE LIVING WITH HIV/AIDS, (D) REHABILITATING OR REBUILDING HEALTH SERVICES, (E) HEALTH AS A BRIDGE TO PEACE, (F) LOCAL, NATIONAL, AND REGIONAL RESPONSES, AND (G) GRASS ROOTS LESSONS LEARNED AND RECOMMENDATIONS FOR PRACTITIONERS, AFRICAN GOVERNMENTS, AND DONORS.

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BACKGROUND TO WORKSHOP
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5. BACKGROUND: STATISTICS ON HIV/CONFLICT/GENDER: PARTICIPANTS AGREED WITH THE INITIAL OBSERVATIONS OF USAID/AFR/SD/CMR (REF. CABLE STATE 044234): VIOLENT CONFLICT AND HIV/AIDS POSE FORMIDABLE THREATS TO HUMAN SECURITY IN AFRICA. THE NUMBER AND NATURE OF VIOLENT CONFLICTS AND RELATED COMPLEX EMERGENCIES, COUPLED WITH THE HIV/AIDS PANDEMIC IS NOW IMPEDING DEVELOPMENT IN AFRICA, AND NEGATING MANY OF THE GAINS ACHIEVED. HALF OF ALL THE WORLD'S CONFLICTS IN 1999 WERE LOCATED IN SUB-SAHARAN AFRICA (SSA), INVOLVING TWO THIRDS OF THE COUNTRIES IN THE REGION. SIX HIGH INTENSITY CONFLICTS (CAUSING OVER A THOUSAND DEATHS PER YEAR) WERE STILL RAGING IN THE REGION IN LATE 2000. AS OF JANUARY 2001, AFRICA HAD 3.5 MILLION REFUGEES AND 1.7 MILLION INTERNALLY DISPLACED PEOPLE (IDPS). AFRICA IS ALSO THE PART OF THE GLOBE THAT HAS BEEN HARDEST HIT BY HIV/AIDS. OVER 25 MILLION PEOPLE, OR NEARLY 70 PERCENT OF THE WORLD'S 34.5 MILLION AFFLICTED WITH HIV/AIDS, AND 90 PERCENT OF DEATHS FROM AIDS ARE TO BE FOUND IN A REGION THAT IS HOME TO JUST 10 PERCENT OF THE WORLD'S POPULATION. OVER HALF OF THE AFRICANS AFFLICTED BY HIV/AIDS PEOPLE ARE WOMEN.

6. BACKGROUND: LINKS AMONG HIV/CONFLICT/GENDER: ALTHOUGH THERE IS LITTLE CROSS-COUNTRY EPIDEMIOLOGICAL DATA AVAILABLE, THERE IS EVIDENCE TO SUGGEST THAT CONFLICTS INCREASE THE RISK AND IMPACT OF HIV/AIDS IN SEVERAL WAYS. CONFLICTS DISLOCATE COMMUNITIES, CREATE FLOWS OF REFUGEES AND INTERNALLY DISPLACED PERSONS, AND SERIOUSLY DISRUPT FAMILY LIFE. THERE IS AN INCREASE IN THE NUMBER OF WOMEN HEADED HOUSEHOLDS. SOLDIERS AND FIGHTERS COME INTO GREATER CONTACT WITH CIVILIANS IN SITUATIONS WHERE WOMEN, YOUNG GIRLS AND BOYS ARE HIGHLY VULNERABLE TO SEXUAL AND GENDER-BASED VIOLENCE, SEXUAL EXPLOITATION, AND RISKY SEXUAL BEHAVIOR DUE TO INCREASED PSYCHOSOCIAL TRAUMA AND BREAKDOWN OF BASIC SERVICES. THE MAGNITUDE OF THESE PROBLEMS HAS PROMPTED CONSIDERABLE WORK AMONG NATIONAL AND INTERNATIONAL ACTORS TO MAINSTREAM HIV/AIDS PREVENTION, SCREENING, EDUCATION, TREATMENT, AND CONTROL INTO HUMANITARIAN RESPONSE AND POST-CONFLICT RECONSTRUCTION. GENDER SENSITIVE APPROACHES THAT AFFECT THE EFFECTIVENESS OF RESPONSES TO THE AIDS PANDEMIC ARE KEY IN AFRICA, GIVEN WOMEN'S DUAL ROLE AS CARE GIVERS AND HOUSEHOLD INCOME EARNERS. NOTING THAT OVER 50 PERCENT OF NEW HIV INFECTIONS IN AFRICA OCCUR IN WOMEN, YOUNG WOMEN SEEM TO BE PARTICULARLY VULNERABLE. FOR EXAMPLE, ONE IN FOUR SOUTH AFRICAN WOMEN IN THE 20-29 AGE GROUP CARRY THE VIRUS TODAY. THE NUMBER ONE FORM OF TRANSMISSION OF HIV AMONG WOMEN IN AFRICA IS SEXUAL INTERCOURSE. WOMEN'S INCREASED RISK FOR HIV HAS BEEN ASSOCIATED WITH PROSTITUTION, TRAFFICKING OF WOMEN AND CHILDREN, DOMESTIC VIOLENCE, FORCED MARRIAGES, RAPE AND INCEST, POOR HEALTH, (PARTICULARLY ACCESS TO QUALITY REPRODUCTIVE HEALTH SERVICES) AND LIMITED POWER TO AFFECT THESE RISKS. WOMEN ALSO CARRY THE MAIN BURDEN OF CARE OF FAMILY MEMBERS WITH HIV/AIDS. IN SITUATIONS OF CONFLICT AND POST-CONFLICT, WOMEN ARE NOT ONLY MORE EXPOSED AND VULNERABLE TO HIV/AIDS, THEY ALSO HAVE LESS COPING CAPACITY, NOT LEAST BECAUSE THEY ARE NOT USUALLY INVOLVED IN PLANNING THE ALLOCATION OF RESOURCES FOR RECONSTRUCTION, INCLUDING THOSE FOR HIV/AIDS PREVENTION AND MANAGEMENT. AT PRESENT, NO ESTABLISHED SET OF BEST PRACTICES TO GUIDE POLICY AND PROGRAMMING FOR ADDRESSING HIV/AIDS IN POST-CONFLICT COUNTRIES EXISTS. THERE ARE HOWEVER, MANY INITIATIVES. ALL ACROSS AFRICA, PEOPLE FROM ALL WALKS OF LIFE, AND ESPECIALLY WOMEN, ARE ENGAGED IN FORMAL AND INFORMAL INITIATIVES THAT NOT ONLY STRENGTHEN THE COPING CAPACITIES OF FAMILIES, COMMUNITIES, AND COUNTRIES IN THE FACE OF THESE CRISES, BUT ALSO CONTRIBUTE TO CREATE ENVIRONMENTS THAT ENHANCE HUMAN SECURITY IN ALL ITS DIMENSIONS. WOMEN HAVE WORKED ON BOTH DIPLOMATIC AND DEVELOPMENT EFFORTS, AT THE NATIONAL/INTERNATIONAL LEVEL, AND AT THE GRASSROOTS LEVEL.

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SUMMARY OF WORKSHOP SESSIONS
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7. DURING THE OPENING SESSION OF THE WORKSHOP, STATISTICS (SEE PARAGRAPHS FIVE AND SIX ABOVE) WERE PRESENTED AND LINKAGES EXPLORED WITH QUESTIONS THAT HAVE BEEN RAISED ON HIV AND CONFLICT. SUCH QUESTIONS INCLUDE WHETHER KNOWINGLY HIV POSITIVE SOLDIERS DELIBERATELY RAPE WOMEN IN CONFLICT SITUATIONS. THE LINK AMONG THE THREE AREAS WAS SET IN THE CONTEXT OF PUBLIC INTERNATIONAL HUMAN RIGHTS LAW AND PRACTICAL EXAMPLES FROM THE FIELD.

8. SESSION ONE OVERVIEW: WORKSHOP PARTICIPANTS HAD PREPARED SUMMARY PAPERS PRIOR TO THE WORKSHOP. KEY THEMES WERE THE FOLLOWING: (1) NEED FOR A SOLUTION BEYOND A NARROW TECHNICAL APPROACH, (2) AGREEMENT THAT HIV HAS BEEN IDENTIFIED AS AN EXPLICIT WEAPON OF WAR, (3) THE EXTRAORDINARY URGENCY OF THE VULNERABILITY OF WOMEN, CHILDREN, REFUGEES, AND IDPS, (4) CONNECTION WITH LOCAL CULTURE THAT CAN BE EITHER HARNESSED OR DETRIMENTAL TO PROGRESS, (5) NEED FOR FOCUSING ON PSYCHOSOCIAL AND SOCIO-ECONOMIC DETERMINANTS, AND (6) RECOGNIZING THAT WOMEN AND MEN HAVE DIFFERENT ACCESS AND POWER OVER RESOURCES. CHALLENGES ARE INTANGIBLES SUCH AS FEAR, IGNORANCE, LACK OF POWER TO MAKE INDIVIDUAL SEXUAL HEALTH DECISIONS, AND COMMUNITY-LEVEL COMMITMENT.

9. MILLICENT MALAZA-DEBOSE OF SAVE AFRICA ESTABLISHED THAT GENDER ROLES AND EXPECTATIONS TAKE DIFFERENT FORMS IN CONFLICT SITUATIONS. TRADITIONALLY, WOMEN HAVE BEEN SEEN AS CARETAKERS AND MEN AS PROVIDERS AND PROTECTORS; IN CONFLICT THESE ROLES ARE HEIGHTENED. THE GROUP QUESTIONED HOW SECURITY, GOVERNANCE, AND DEEP-ROOTED POVERTY CAN BE ADDRESSED TO MITIGATE THE POTENTIAL FOR WEAKENED GENDER ROLES AND INCREASED HIV TRANSMISSION. GROUP CONCURRED THAT THERE IS A NEED FOR BEHAVIORAL CHANGE, INCLUDING MEN AS PARTNERS IN THE HEALTH PROCESS. GLOBALIZATION WAS RAISED AS BOTH A POSITIVE AND NEGATIVE IN PROVIDING INFORMATION TO STEM HIV TRANSMISSION. THERE WAS AN AGREEMENT THAT THE MILITARY NEEDS TO BE PART OF A BROADER HIV STRATEGY, RATHER THAN AS A TARGET GROUP.

10. SESSION TWO - LIVING WITH HIV/AIDS: ASUNTA WAGURA, AN HIV POSITIVE KENYAN WHO IS THE EXECUTIVE DIRECTOR OF KENYA NETWORK OF WOMEN WITH AIDS, GROUNDED THE WORKSHOP BY PRESENTING HER PERSONAL LIFE HISTORY WITH AIDS. HER GRIPPING PRESENTATION REMINDED PARTICIPANTS THAT HIV POSITIVE PEOPLE CANNOT BE CONSIDERED AS VICTIMS; VICTIMS ARE CONSIDERED WEAK AND POWERLESS; HIV POSITIVE PEOPLE HAVE CAPABILITIES DESPITE THEIR STATUS. CLAUDINE MUYALA TAYAYE BIBI OF THE UNIVERSITY

OF KINSHASA AND THE NGO PLATFORM PAAF FOLLOWED WAGURA'S PRESENTATION, ARGUING THAT WITHOUT PEACE IN THE DRC, THERE WILL BE NO SECURITY IN CENTRAL AND SOUTHERN AFRICA AND THE AFRICAN RENAISSANCE WILL REMAIN A DREAM, FORESTALLING FUTURE PROGRESS ON HIV. NZAMA CHIKWANKA OF THE SOCIETY FOR WOMEN AND AIDS IN ZAMBIA ARGUED THAT AFRICAN CULTURE ENCOURAGES SILENCE; YET EFFECTIVE HIV EDUCATION CALLS FOR A HEALTHY DISCUSSION OF AN INDIVIDUAL'S RESPONSIBILITY FOR MAKING HEALTHY SEXUAL DECISIONS.

11. SESSION THREE - WOMEN'S STRUGGLES AGAINST HIV/AIDS AND VIOLENCE: SMALL GROUP DISCUSSIONS CRITIQUED THE DUAL EXPECTATIONS OF WOMEN AS CAREGIVERS (PILLARS OF CULTURE AND CUSTODIANS OF COMMUNITY) AND AS BREAD-WINNERS. PARTICIPANTS ARGUED THAT WOMEN CANNOT AUTOMATICALLY BE CONSIDERED AS PROGRESSIVE INDIVIDUALS; WOMEN, LIKE MEN, ARE REPRESENTATIVE OF BROADER SOCIETAL ISSUES. HOWEVER, PARTICIPANTS CONCURRED THAT HIV, VIOLENT CONFLICT, AND POVERTY DISPROPORTIONATELY AFFECT WOMEN. NGO PARTICIPANTS SHARED PRACTICAL CHALLENGES OF DESIGNING EFFECTIVE EDUCATIONAL CAMPAIGNS WHILE BEING RIDICULED FOR PROMOTING HIV. PARTICIPANTS STATED THAT CRISIS CHANGES THE NATURE OF PERSONAL RELATIONSHIPS AND WOMEN TAKE ON NEW ROLES. WOMEN CANNOT ESCAPE THE CYCLE OF MALE DOMINATION AS THE LOSS OF ONE MAN USUALLY MEANS THE REPLACEMENT WITH ANOTHER. NGOS STRESSED THAT THEY HAVE A CHALLENGE OF BRINGING WOMEN'S GROUPS TOGETHER TO ACHIEVE A COMMON PLATFORM, ESPECIALLY WHEN SOME OF THEIR AGENDAS ARE DRIVEN BY DONOR INTERESTS.

12. SESSION FOUR - HIV/AIDS, VULNERABLE POPULATIONS, AND THE MILITARY: NSAMA CHIKWANKA OF THE SOCIETY FOR WOMEN AND AIDS IN ZAMBIA DISCUSSED THE ROLE OF POST TRAUMATIC STRESS DISORDER AND THE PARTICULAR REACTIONS OF HYPERACTIVITY AND DEPRESSION THAT ARE LINKED TO VIOLENCE AND RISKY SEXUAL BEHAVIOR. DOROTHY GATERA WIBABARA OF THE PRESBYTERIAN CHURCH OF RWANDA ARGUED THAT FAITH-BASED HIV/AIDS INITIATIVES NEED TO WORK WITH AN ON-THE-GROUND FAMILY SUPPORT NETWORK TO ENCOURAGE CAPACITY BUILDING IN FAMILIES AND COMMUNITIES SO THAT INDIVIDUALS CAN MAKE HEALTHY CHOICES ON SEXUAL BEHAVIOR. TRAUMA COUNSELING IS SEEN AS AN EFFECTIVE INTERVENTION POINT. ANNE-MARY SHIGWEDHA OF THE NAMIBIAN MINISTRY OF DEFENSE REMINDED THE GROUP OF SECURITY COUNCIL RESOLUTION 1308 THAT STATED THAT HIV IS A HUMAN SECURITY ISSUE. UGANDAN PARTICIPANT CAROLINE ODONGO TURYATEMBA NOTED THAT UGANDAN VETERANS HAVE NOT UNIFORMLY ENJOYED ACROSS THE BOARD SUCCESS IN ECONOMIC REINTEGRATION. PARTICIPANTS ITERATED THE NEED FOR EFFECTIVE INTEGRATION OF HIV PROGRAMMING IN CONFLICT SETTINGS OF DEMOBILIZATION (DDRR) ACTIVITIES AND HIV/AIDS EDUCATION FOR EX-COMBATANTS

13. SESSION FIVE - THE SECURITY SECTOR AND GOVERNANCE: THIS SESSION FOCUSED ON THE ISSUE THAT DEVELOPMENT IS IMPOSSIBLE WITHOUT SECURITY AND JUSTICE. SECURITY AND GOVERNANCE ARE SEEN AS THE UNDERPINNINGS OF ECONOMIC GROWTH.

14. SESSION SIX - HEALTH CARE IN POST CONFLICT ENVIRONMENTS: DARAUS BUKENYA OF THE TANZANIA-BASED AFRICAN MEDICAL AND RESEARCH FOUNDATION (AMREF) STATED THAT PRESERVATION OF HEALTH SYSTEMS INCLUDES BUILDING SELF-RELIANCE AND REHABILITATING HEALTH INFRASTRUCTURE, YET BEING AWARE OF THE POTENTIAL TO RECREATE DETRIMENTAL GENDER AND HEALTH ROLES. BEATRICE MURUNGA OF MAP INTERNATIONAL SPOKE ABOUT PSYCHOSOCIAL SERVICES FOR SURVIVORS OF VIOLENCE. SHE NOTED THAT SEXUAL VIOLENCE RESULTING IN POSITIVE HIV STATUS CREATES LOW SELF-ESTEEM AND SELF HATRED IN WOMEN. THIS PSYCHOLOGICAL TRAUMA IS TIED TO LOSS OF ECONOMIC STATUS AND SELF-ESTEEM. CULTURALLY, RAPE CONTINUES TO HAVE A NEGATIVE STIGMA ATTACHED TO IT. FOR THIS REASON, IN AFRICAN CULTURE, THERE IS A GREAT DEAL OF SILENCE AROUND RAPE, ESPECIALLY AMONG WOMEN; PARTICIPANTS WANT TO BREAK THIS SILENCE TO MORE EFFECTIVELY ADDRESS THE INTERSECTION AMONG HIV/AIDS, CONFLICT, AND GENDER. PROGRAMS IN TANZANIA THAT HAVE USED A TRAINING OF TRAINERS MODEL IN WHICH SURVIVORS WHO THEN RETURN TO THEIR COMMUNITIES AND WORK WITH CLIENTS.

15. SESSION SEVEN - PREVENTING HIV/AIDS IN POST CONFLICT AFRICAN SOCIETIES: PRACTICAL APPROACHES TO DEALING WITH HIV PREVENTION WERE DISCUSSED. AN EAST AFRICA GROUP SUGGESTED THAT THE MAIN ENTRY POINT SHOULD BE DEMOBILIZED SOLDIERS AND THE HIV EDUCATION ENTRY POINT SHOULD BE COORDINATED AT THE NATIONAL LEVEL AND INCLUDED IN THAT LEVEL OF POLICY. THE CENTRAL AFRICA GROUP FOCUSED ON DEVELOPING RADIO PROGRAMS THAT ARE TARGETED FOR ADULT AND ILLITERATE WOMEN SO THAT THEY ARE BETTER INFORMED. THIS GROUP ALSO FOCUSED ON DEVELOPING WOMEN'S ECONOMIC CAPACITIES. THE SOUTHERN AFRICA GROUP DISCUSSED THE TOOL OF DRAMA FOR DISSEMINATING HIV/AIDS EDUCATION IN A SAFE WAY THAT USES LOCAL LANGUAGE AND CULTURE. IT WAS CLEAR FROM THIS SESSION THAT EACH AFRICAN SUB-REGION REQUIRES A LOCALLY GENERATED AND RELEVANT APPROACH THAT MEETS THE MOST CRITICAL NEEDS IDENTIFIED. THESE INTERVENTIONS MUST WORK WITH THE LOCAL POPULATION.

16. ONE SIDE GROUP DISCUSSED NETWORKING AND POSSIBLE FOLLOW ON ACTIONS FOR THIS WORKSHOP. IT WAS ENVISAGED THAT THE GROUP RECONVENES IN TWO YEARS TO SEE HOW THEY HAVE IMPLEMENTED THE HIV/CONFLICT/GENDER APPROACH INTO NATIONAL-LEVEL POLICY. SECONDLY, THE GROUP SUGGESTED THAT THEY CONVENE QUARTERLY DISCUSSIONS TO SHARE LESSONS LEARNED. THIRD, SPECIFIC THEMES WERE RAISED INCLUDING

RAPE, DONOR COMMUNICATION WITH COMMUNITY-BASED ORGANIZATIONS, PSYCHOSOCIAL ISSUES, THE ROLE OF MEN IN PREVENTING HIV/AIDS, LITERACY AND HIV/AIDS, AND THE CONNECTION BETWEEN DONORS AND HIV/AIDS POLICY.

17. SESSION EIGHT - COPING WITH HIV/AIDS IN POST CONFLICT AFRICA: THIS SESSION FOCUSED ON INCREASING ACCESS TO RESOURCES (ECONOMIC, EDUCATIONAL, AGRICULTURAL, HEALTH, FINANCIAL) IN EAST AFRICA, PSYCHOSOCIAL SERVICES AND HEALTH CLINICS IN CENTRAL AFRICA, AND ORPHANS IN WEST AFRICA. IN EAST AFRICA, THE EMPHASIS IS AT THE GRASS ROOTS LEVEL, ADULT EDUCATION PROGRAMS, AND INCLUDING WOMEN'S GROUPS IN ALL STAGES OF PLANNING AND IMPLEMENTATION DESIGN. TWO APPROACHES SUGGESTED WERE FOCUSING ON WOMEN'S INHERITANCE AND ENSURING WOMEN'S EQUAL RIGHTS IN A COUNTRY. THERE WAS A CLEAR FOCUS ON IDENTIFYING TALENTED WOMEN IN THE SUB-REGION AND DRAWING ON THEIR SKILLS TO DESIGN EFFECTIVE PROGRAMS. THE CENTRAL AFRICA GROUP FOCUSED NOT ONLY ON PSYCHOSOCIAL AND HEALTH CLINICS, BUT LEGAL CLINICS WHERE WOMEN ARE ABLE TO HAVE ACCESS TO LEGAL REMEDIES. THE SOUTHERN AFRICA GROUP FOCUSED ON COMMUNITY-BASED RESPONSES TO ORPHANS GIVEN DIFFERENT COMMUNITIES' LEVELS OF RECEPTIVITY TO ORPHANS.

18. SESSION NINE - HEALTH AS A BRIDGE FOR PEACE: MARY BALIKUNGERI OF THE RWANDA WOMEN COMMUNITY GROUP ARGUED THAT STORY TELLING AND SHARING OF STORIES IN A TRUSTING ENVIRONMENT ASSIST WOMEN IN DEALING WITH ISSUES OF DOMESTIC VIOLENCE. BALIKUNGERI DESCRIBED THE POLYCLINIC THAT SHE RUNS WHICH INCLUDES PSYCHOSOCIAL SUPPORT, LEGAL SUPPORT AND WITNESS PROTECTION, MICRO FINANCE, AND POLITICAL EMPOWERMENT. THE CLINIC IS AN EXAMPLE OF AN MULTI-SECTORAL APPROACH TO ADDRESSING HIV/AIDS. CAROLINE ODONGO TURYATEMBA OF REACH UGANDA DISCUSSED HOW HER PROGRAM EMERGED FROM LOCALLY GROWN FOCUS ON FEMALE GENITAL MUTILATION (FGM). AS THE CLINIC STARTED TO TACKLE FGM WITHOUT THREATENING LOCAL CULTURE, THE KEY LESSON LEARNED WAS DEVELOPING A PROGRAM IN CONJUNCTION WITH THE COMMUNITY THROUGH SENSITIZATION AND DEVELOPING RAPPORT WITH EACH PATIENT SO THAT S/HE IS COMMITTED TO CHANGE. SUSTAINABILITY HAS BEEN A FUNCTION OF FAMILY AND COMMUNITY LEVEL INPUT. A SECOND LESSON FOR THE SUCCESS OF THE CLINIC WAS COORDINATION WITH THE MILITARY. THE MILITARY WAS SEEN AS AN ORGANIZATION THAT COULD PROVIDE SERVICES AND ALSO PROTECT A BENEFICIARY GROUP.

19. SESSION TEN - EMPOWERING WOMEN: PROVIDING SEX WORKERS WITH INCOME GENERATING SKILLS AND LEGAL KNOWLEDGE HAS BEEN SUCCESSFUL IN ONE COMMUNITY IN ETHIOPIA AND HAD A SPILLOVER EFFECT THAT HAS WORKED IN OTHER COMMUNITIES. THE ETHIOPIAN FEDERAL GOVERNMENT BACKED THIS PROGRAM, WHICH ENSURED ITS SUCCESS. GIVEN THE SENSITIVE NATURE OF WOMEN'S PROGRAMS, PARTICIPANTS QUESTIONED WHETHER HOST

GOVERNMENTS WOULD SUSTAIN ACTIVITIES IN THE LONG TERM. BULIKUNGERI STATED THAT THE USG-FUNDED WOMEN AS PARTNERS FOR PEACE IN AFRICA HAS BEEN A SUCCESSFUL NETWORKING MODEL FOR AFRICAN WOMEN. WHILE THESE EFFORTS HAVE BEEN SUCCESSFUL INTERNATIONALLY, PARTICIPANTS QUESTIONED THE SUSTAINABILITY OF LOCAL LEVEL INVOLVEMENT AND SUPPORT.

20. SESSION ELEVEN - LESSONS LEARNED AND ISSUES FOR CONSIDERATION BY PRACTITIONERS: PARTICIPANTS NOTED THAT LOCAL NEEDS AND COMMUNITY EMPOWERMENT ARE CRITICAL TO ADDRESSING ISSUES. EXAMPLES INCLUDE USE OF LOCAL LANGUAGE AND THE MEN-AS-PARTNERS HEALTH APPROACH. PRACTITIONERS ARE CHALLENGED BY LACK OF STAFF COMMITMENT TO KEEPING THE MESSAGES ON HIV/AIDS SERIOUS, AND NOT REDUCED TO JOKES OR INAPPROPRIATE/INSENSITIVE COMMENTS. PARTICIPANTS DISCUSSED THE EMERGENCE OF HIV/AIDS IN THE UNITED STATES LARGELY IN THE GAY MALE COMMUNITY AND DREW A PARALLEL THAT HOMOPHOBIA IS PREVALENT IN SUB-SAHARAN AFRICA. IN DISCUSSING GENDER ROLES BETWEEN MEN AND WOMEN, PARTICIPANTS NOTED THAT THE PARADIGM SHOULD BE BROADENED TO NON-TRADITIONAL ROLES. AGE IS A CRITICAL FACTOR IN GENDER ROLES AND PRACTITIONER SUCCESS; ACTIVITIES NEED TO BE SENSITIVE TO YOUTH. BESIDES GENDER ROLES, ANOTHER ISSUE IDENTIFIED WAS THE LACK OF COMMITMENT ON THE PART OF THE STATE TO ADDRESS THE ROOT CAUSES OF GENDER INEQUALITY AND CONFLICT WHICH CAN LEAD TO HIGHER HIV/AIDS TRANSMISSION (E.G. INHERITANCE AND LAND RIGHTS). COUNTRIES' CONSTITUTIONS DO NOT REFLECT THE GROUND LEVEL REALITY IN COMMUNITIES AND IN THE PERIPHERY. INTERNATIONAL COVENANTS, E.G. THE CONVENTION TO ELIMINATE ALL FORMS OF DISCRIMINATION AGAINST WOMEN (CEDAW) OR THE CONVENTION ON THE RIGHTS OF THE CHILD (CRC), OR OTHER HUMAN RIGHTS CONVENTIONS, ARE EITHER NOT SIGNED AND RATIFIED BY HOST GOVERNMENTS, POORLY IMPLEMENTED, OR THE EDUCATION DOES NOT TAKE PLACE IN THE FIELD SO COMMUNITIES ARE EMPOWERED TO MAKE DECISIONS.

21. SESSION TWELVE - LESSONS LEARNED AND ISSUES FOR CONSIDERATION BY POLICYMAKERS: THIS SESSION RAISED DIFFERENCES AMONG DONORS, DONOR INTERESTS, AND APPROACHES. SOME PARTICIPANTS SUGGESTED THAT EUROPEAN DONORS ARE MORE CONSULTATIVE THAN AMERICAN DONORS ARE. ISSUES WERE RAISED REGARDING HOW BEST TO IMPLEMENT DECENTRALIZATION ACTIVITIES TO MITIGATE CORRUPTION AND OTHER PROBLEMS IN LOCAL GOVERNMENTS. PARTICIPANTS CALLED FOR AN EFFECTIVE PARTNERSHIP WITH DONORS AND FOR TRANSPARENT NATIONAL-LEVEL UMBRELLA ORGANIZATIONS THAT COORDINATE EFFECTIVELY. SOME PRACTITIONERS RAISED MANAGEMENT CHALLENGES SUCH AS THEIR DIFFICULTIES WITH HAVING DIFFERENT FINANCIAL SYSTEMS FOR DIFFERENT DONORS AND FULFILLING A MYRIAD OF REPORTING REQUIREMENTS FOR EACH DONOR. THERE WAS UNANIMOUS AGREEMENT THAT DONORS NEED TO REDUCE

REPORTING REQUIREMENTS SO THAT GRANTEES CAN DEVOTE MORE TIME AND RESOURCES TO IMPLEMENTATION. DONORS COULD ALSO CONSIDER PROVIDING MORE INSTITUTIONAL SUPPORT SO THAT NGOS ARE BETTER EQUIPPED TO ADDRESS ISSUES IN THE LONG TERM, AND HAVE THE FINANCIAL, ADMINISTRATIVE, AND MANAGEMENT CAPACITY TO DEAL WITH DIFFERENT DONORS' AGENDAS, REQUIREMENTS, AND ACTIVITIES. LINKING THE THREE AREAS OF HIV/AIDS, CONFLICT, AND GENDER, PARTICIPANTS AGREED THAT WOMEN'S EMPOWERMENT, FOCUS ON CROSS-CUTTING APPROACHES, CONSULTATION, OUTREACH, AND PARTNERSHIP ARE ALL CRITICAL, WHILE TAKING ACCOUNT OF LOCAL CONDITIONS, CULTURE, AND LANGUAGE.

22. PARTICIPANTS CONCLUDED WITH A CONSENSUS ON A #DURBAN DECLARATION#THAT STATED THEIR VIEWS, AND COMMITTED THE GROUP TO CONTINUE THEIR NETWORKING AND NATIONAL LEVEL ADVOCACY.

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DURBAN DECLARATION
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23. DURBAN DECLARATION BEGIN TEXT: WHEREAS SUB-SAHARAN AFRICA IS HOME TO 630 MILLION PEOPLE OF DIVERSE RACIAL AND ETHNIC GROUPS WITH A LONG AND PROUD HISTORY AND CULTURE AND HAS ONE OF THE RICHEST NATURAL RESOURCE BASES IN THE WORLD, WITH POTENTIAL TO BE ONE OF THE MOST PROSPEROUS REGIONS, NEVERTHELESS:

A. THE TWIN SCOURGES OF VIOLENT CONFLICT AND HIV/AIDS HAVE MUTUALLY REINFORCED EACH OTHER THOUGH A MULTIPLICITY OF MECHANISMS INCLUDING LARGE-SCALE POPULATION DISLOCATION, THE DESTRUCTION OF THE PUBLIC HEALTH INFRASTRUCTURE AND THE WEAKENING OF GOVERNANCE AND ECONOMY. THESE TWIN SCOURGES ARE DESTROYING FAMILIES, COMMUNITIES, NATIONS AND THE AFRICAN CONTINENT AS A WHOLE.

B. MORE THAN 50 PERCENT OF THE WORLD'S ACTIVE VIOLENT INTERNAL AND REGIONAL CONFLICTS ARE IN AFRICA. THESE CONFLICTS HAVE DIRECTLY OR INDIRECTLY AFFECTED OVER 75 PERCENT OF THE REGION'S COUNTRIES AND POPULATIONS, CONSCRIPTED OVER 300,000 CHILD SOLDIERS, DISPLACED OVER 30 MILLION PEOPLE FROM THEIR HOMES, CAUSED THE DEATHS OF OVER ONE MILLION PEOPLE, DESTROYED SOCIAL AND ECONOMIC INFRASTRUCTURE, DAMAGED THE ENVIRONMENT, WEAKENED INSTITUTIONS OF GOVERNANCE AND GENERALLY RETARDED EQUITABLE, SUSTAINED AND SUSTAINABLE DEVELOPMENT.

C. MORE THAN 75 PERCENT OF THE WORLD'S HIV/AIDS CASES ARE FOUND IN AFRICA. MORE THAN 11 MILLION AFRICANS HAVE SUCCUMBED TO AIDS OVER THE PAST DECADE AND THE SOCIAL AND ECONOMIC CONSEQUENCES ARE PROFOUND.

D. GENDER ROLES PLAY A CRUCIAL ROLE IN BOTH THE EVOLUTION OF THE PROBLEM AND IN THE WAY FORWARD TO SOLUTIONS. THE PHYSICAL AND PSYCHOLOGICAL CONSEQUENCES OF CONFLICT AND HIV DISPROPORTIONATELY AFFECT WOMEN.

E. POVERTY IS A KEY CONTRIBUTING FACTOR TO THE SPREAD OF HIV/AIDS.

F. WHILE THERE IS RECOGNITION OF THESE PROBLEMS, AND RESOURCES HAVE BEEN DEVOTED TO THEIR SOLUTIONS, CURRENT APPROACHES ARE INADEQUATE IN BOTH MAGNITUDE AND SCOPE. HIV, CONFLICT AND GENDER ROLES CROSSCUT ALL DEVELOPMENT CONCERNS AND SHOULD BE MAINSTREAMED INTO ALL SECTORS.

G. CURRENT FINANCIAL RESOURCES ARE ALSO INADEQUATE TO ADDRESS THE SCOPE AND MAGNITUDE OF THESE COMPLEX SOCIAL PROBLEMS.

24. NOTING THAT THROUGHOUT THE CONTINENT, EVERY SINGLE DAY, WOMEN AND MEN ARE ACTIVELY PREVENTING AND COPING WITH HIV/AIDS, CONFLICT, AND GENDER-BASED VIOLENCE AND THAT THERE ARE PARTICULARLY REMARKABLE LESSONS TO BE LEARNED FROM AFRICAN WOMEN WHO THROUGH A SERIES OF GRASS-ROOTS EFFORTS HAVE EVOLVED UNIQUE APPROACHES TOWARDS THESE CHALLENGES;

25. FURTHER NOTING THAT, THERE ARE GROWING NETWORKS, INITIATIVES, AND PARTNERSHIPS TO ADDRESS THESE INTERTWINED CHALLENGES IN AFRICA AND THAT THESE EFFORTS, ALREADY GENERATING MOMENTUM TOWARDS CREATIVE SOLUTIONS, NEED TO BE RECOGNIZED AND SUPPORTED;

26. NOW THEREFORE, WE THE UNDERSIGNED AFRICAN MEMBERS OF THE INTERNATIONAL DEVELOPMENT AND HEALTH COMMUNITY WHO ASSEMBLED IN DURBAN SOUTH AFRICA AND DELIBERATED FOR THREE FULL DAYS, AT THE INVITATION OF THE AFRICAN CENTRE FOR THE CONSTRUCTIVE RESOLUTION OF DISPUTES (ACCORD) AND THE TULANE UNIVERSITY PAYSON CENTER FOR INTERNATIONAL DEVELOPMENT AND TECHNOLOGY TRANSFER AND SPONSORED BY THE UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID) IN ASSOCIATION WITH THE LINKING COMPLEX EMERGENCY RESPONSE AND TRANSITION INITIATIVE (CERTI), THE INTERNATIONAL CENTRE FOR MIGRATION AND HEALTH (ICMH-GENEVA) AND THE WORLD BANK (PRETORIA),

27. TAKING SPECIAL ACCOUNT OF THE COMMUNITY, NATIONAL AND REGIONAL EXPERIENCE AND LESSONS LEARNED OF AFRICAN STRATEGISTS AND IMPLEMENTERS OF PROGRAMS AND PROJECTS, ESPECIALLY AT THE SUB-NATIONAL AND COMMUNITY LEVEL, TO COPE WITH AND COMBAT HIV/AIDS IN CONFLICT AFFECTED COUNTRIES;

28. ACKNOWLEDGING THAT CONFLICT, HIV/AIDS AND GENDER INEQUALITIES ARE INEXTRICABLY RELATED AND THEREFORE SOLUTIONS TO THESE PROBLEMS MUST TAKE IN TO ACCOUNT THIS COMPLEX INTERRELATIONSHIP WHICH REQUIRES INTERDISCIPLINARY AND INTERSECTORAL APPROACHES.

29. REQUEST THAT NATIONAL GOVERNMENTS, NATIONAL NGOS, AND THE INTERNATIONAL COMMUNITY, INCLUDING ALL BILATERAL AND MULTILATERAL DONORS AND INTERNATIONAL NGOS, MUST REVISIT THEIR POLICIES, STRATEGIES AND PROGRAMS TO FIGHT THE TWIN SCOURGES OF VIOLENT CONFLICT AND HIV-AIDS AND ACHIEVE SUSTAINABLE PEACE BASED ON:

A. MAINSTREAMING INTERVENTIONS TO ADDRESS HIV/AIDS, CONFLICT PREVENTION, MITIGATION AND RESOLUTION/RECONCILIATION AND WOMEN'S EMPOWERMENT INTO ALL SECTORAL PROGRAMS;

B. EMPOWERING WOMEN AS KEY ACTORS AND COMMUNITY MOBILIZERS TO BOTH ADDRESS BOTH HIV/AIDS AND CONFLICT RESOLUTION/PEACE BUILDING. EMPOWERMENT REQUIRES ACTION AT THE POLICY (INCLUDING LEGAL FRAMEWORK), STRATEGY AND PROGRAM LEVELS AT LOCAL, SUB-NATIONAL, NATIONAL AND INTERNATIONAL LEGAL LEVELS;

C. DEVISING A CONCEPTUAL FRAMEWORK THAT:

- IS HOLISTIC, INTEGRATED, AND GENDERED;
- TAKES INTO ACCOUNT THE NEEDS OF BOTH WOMEN AND MEN;
- TAKES INTO ACCOUNT IMPORTANT DETERMINANTS AT THE INDIVIDUAL, COMMUNITY, NATIONAL AND INTERNATIONAL/GLOBAL LEVELS;
- INCORPORATES THE IMPORTANCE OF POVERTY AS A DETERMINANT OF HIGH-RISK BEHAVIORS RELATED TO HIV AND CONFLICT.
- TAKES INTO ACCOUNT THE IMPORTANCE OF SECURITY, GOVERNANCE AND SOCIOECONOMIC DEVELOPMENT;
- CONTEXTUALIZES THE PANDEMIC WITHIN DETERMINANTS INCLUDING POVERTY, GENDER SOCIALIZATION AND ACCESS TO RESOURCES.

D. RECOGNIZING THAT CONFLICT AND HIV/AIDS WILL REQUIRE BEHAVIORAL CHANGE AT THE INDIVIDUAL, INSTITUTIONAL, COMMUNITY, NATIONAL AND INTERNATIONAL LEVELS;

E. NECESSITATING THAT APPROACHES MUST ADDRESS THE PROBLEMS OF STIGMA AND SHAME, WHICH ARE UNDERLINED BY FEAR ON THE PARTS OF BOTH, INFECTED AND AFFECTED. THERE IS ALSO A NEED TO PROMOTE SELF-ESTEEM AND HEALTHY RELATIONSHIPS AND HOPE, INCLUDING HOPE FOR A CURE;

F. INCLUDING AS A PRIORITY PSYCHOSOCIAL CARE FOR THOSE AFFECTED BY CONFLICT AND HIV/AIDS, WITH SPECIAL ATTENTION GIVEN TO TRAUMA MANAGEMENT AND REINTEGRATION INTO COMMUNITIES FOR EX-COMBATANTS, ESPECIALLY FORMER CHILD SOLDIERS;

G. GIVING SPECIAL CONSIDERATION TO VULNERABLE GROUPS SUCH AS WOMEN, CHILDREN, YOUNG ADULTS, PEOPLE WITH DISABILITIES, ORPHANS, REFUGEES AND INTERNALLY DISPLACED PERSONS, CHILD SOLDIERS AND EX-COMBATANTS;

H. REQUIRING BROAD AND STRATEGIC PARTNERSHIPS, INCLUDING THE MILITARY SECTOR, WOMEN'S GROUPS, CIVIL SOCIETY GROUPS, SPIRITUAL INSTITUTIONS AND THE PRIVATE SECTOR;

I. EMBRACING THE IMPORTANCE OF REGIONAL AND LOCALLY-TAILORED SOLUTIONS THAT ARE BASED ON THE COMMON PRINCIPALS OF WOMEN'S EMPOWERMENT, INTERSECTORAL APPROACHES, ANALYSIS OF THE NEEDS OF VULNERABLE GROUPS, GENDER ANALYSIS, AND PEACE;

J. PROMOTING NATIONAL, REGIONAL, AND INTERNATIONAL NETWORKING, DIALOGUE AND COOPERATION;

K. MAINSTREAMING CONFLICT, GENDER AND HIV/AIDS STRATEGIES AND PROGRAMS IN THE BROADER POST-CONFLICT DEVELOPMENT AND DEMOCRACY AND GOVERNANCE FRAMEWORK;

L. ENHANCING PRESENT PROGRAMMES IN AREAS OF CARE AND SUPPORT FOR PEOPLE LIVING WITH HIV/AIDS, PARTICULARLY IN MAKING MEDICAL TREATMENT AFFORDABLE AND ACCESSIBLE AND PROVIDING SERVICES THAT ALLEVIATE THEIR SUFFERING AND PROTECT THEIR HUMAN RIGHTS.

30. WE THEREFORE RECOMMEND THAT:

A. AS CONFLICT, HIV/AIDS AND GENDER ARE NOW INEXTRICABLY LINKED IN SUB-SAHARAN AFRICA, ALL CONFLICT PROGRAMS MUST ADEQUATELY ADDRESS THE ISSUES OF HIV/AIDS, POVERTY AND GENDER.

B. THE PROCEEDINGS OF THIS FORUM BE WIDELY DISSEMINATED TO THE PRACTITIONERS AND POLICY COMMUNITY, INCLUDING DONORS, INTERNATIONAL ORGANIZATIONS, NON-GOVERNMENTAL ORGANIZATIONS (NGOS), INCLUDING RELIGIOUS ORGANIZATIONS, AND GOVERNMENTAL SECTORS, INCLUDING THE MILITARY;

C. PRACTICAL TOOLS BE DEVELOPED TO SUPPORT THE PROGRAMMING APPROACHES ARTICULATED ABOVE FOR ADDRESSING THE PROBLEMS OF HIV/AIDS AND CONFLICT/CRISIS THROUGH GENDER-BASED STRATEGIES;

D. DONORS INCREASE RESOURCE LEVELS IN SUPPORT OF PROGRAMS TO ADDRESS THESE CRITICAL PROBLEMS THROUGH A PROCESS OF REGULAR CONSULTATION THAT FACILITATES STRATEGIC PARTNERSHIPS, COMMUNITY OWNERSHIP AND MUTUAL ACCOUNTABILITY;

E. THERE BE INCREASED DONOR COORDINATION AND PROGRAMMING AND STREAMLINED REQUIREMENTS;

F. ALL OF THE ACTORS INVOLVED IN ADDRESSING THESE PROBLEMS UTILIZE INTERSECTORAL APPROACHES THAT ADDRESS THE COMPLEX INTER-RELATIONSHIP BETWEEN CONFLICT, HIV/AIDS, POVERTY AND GENDER ROLES;

G. MECHANISMS BE PUT IN PLACE TO BUILD A LEARNING NETWORK OF PROFESSIONALS AND WORKERS IN ORDER TO IMPROVE THE QUALITY AND EFFICACY OF PROGRAMS AS WELL AS TO INCREASE ADVOCACY FOR THESE ISSUES;

H. EMPOWERING WOMEN AND ADDRESSING THE ROOT CAUSES OF THEIR VULNERABILITY IS KEY TO PREVENTING AND COPING WITH HIV/AIDS.

31. IN WITNESS, WHEREOF, WE THE UNDERSIGNED, BEING DULY REPRESENTATIVE OF AFRICAN MEMBERS OF THE INTERNATIONAL DEVELOPMENT AND HEALTH COMMUNITY HAVE ASSENTED TO THE DECLARATION HERE IN, CONCLUDED IN DURBAN, REPUBLIC OF SOUTH AFRICA ON THE 28TH DAY OF MARCH 2001.

DURBAN DECLARATION END TEXT.

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WORKSHOP PARTICIPANTS
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32. PARTICIPANTS: (1) YENE ASSEGID OF EVERYONE ADVANCED HEALTH COMMUNICATION TRAINING AND TECHNICAL SUPPORT IN ETHIOPIA, (2) MARY BALIKUNGERI OF RWANDAN WOMEN COMMUNITY DEVELOPMENT NETWORK, (3) CALUDINE MUYALA TAYAYE BIBI OF THE UNIVERSITY OF KINSHASA AND THE NGO PLATFORM PAAF IN THE DRC, (4) CAROL POWER OF RAPCAN IN SOUTH AFRICA, (5) DARAUS BUKENYA OF THE AFRICAN MEDICAL AND RESEARCH FOUNDATION IN TANZANIA, (6) NSAMA CHIKWANKA OF THE SOCIETY FOR WOMEN AND AIDS IN ZAMBIA, (7) ANNA VANESCH OF THE FUTURES GROUP IN SOUTH AFRICA, (8) EMMANUEL GASAKURE OF THE FACULTY OF MEDICINE OF THE NATIONAL UNIVERSITY OF RWANDA, (9) BOGALETCH GEBRE OF THE KEMBETTA WOMEN'S SELF HELP CENTER IN ETHIOPIA, (10) SUSAN KAJURA OF WORLD LEARNING IN UGANDA, (11) BEN KATAMILA OF THE COMMUNITY BASED AIDS PROGRAM AND THE AIDS CARE TRUST OF NAMIBIA, (12) SERAPHINE

MANIRAMBONA OF THE SUPPORT TO RURAL WOMAN ADVANCEMENT PROJECT IN BURUNDI, (13) GUILHERMINA LANGA MILICE OF THE MULEIDE STD/HIV/AIDS PROJECT IN MOZAMBIQUE, (14) NESTOR MOUSSOKI OF THE INFORMATION, EDUCATION, AND COMMUNICATION BRANCH OF THE NATIONAL PROGRAM FOR THE CAMPAIGN AGAINST AIDS (PROGRAMME NATIONAL DE LUTE CONTRA LE SIDA PNLS) IN THE REPUBLIC OF THE CONGO, (15) BEATRICE MURUNGA OF MAP INTERNATIONAL FOR EAST AND SOUTHERN AFRICA IN KENYA, (16) SOPHONIE NIYONDAVYI OF THE BURUNDI MINISTRY OF NATIONAL HEALTH SERVICES, (17) JOSEPH NTAGANIRA OF THE DEPARTMENT OF PUBLIC HEALTH OF THE NATIONAL UNIVERSITY OF RWANDA, (18) PATIENCE NELISIWE NTULI OF THE SOUTH AFRICA MEDICAL RESEARCH COUNCIL, (19) AIRAH SCHIKWAMBI OF THE COMMUNITY BASED HEALTH CARE PROGRAM IN THE NAMIBIA MINISTRY OF HEALTH AND SOCIAL SERVICES, (20) ANNE-MARY SHIGWEDHHA OF THE PRIMARY HEALTH CARE STD/HIV/AIDS PROGRAMME IN THE NAMIBIA MINISTRY OF DEFENSE, (21) EMMANUEL B. SSEMPA OF THE HIV/AIDS PREVENTION AND POVERTY ERADICATION PROGRAM IN UGANDA, (22) JOHN TESHA OF THE INTERNATIONAL ORGANIZATION FOR MIGRATION IN PRETORIA, (23) CAROLINE ODONGO TURYATEMBA OF THE JOOINT CLINICAL RESEARCH CENTRE IN UGANDA, (24) ASUNTA WAGURA OF THE KENYA NETWORK OF WOMEN WITH AIDS, (25) DOROTHY GATERA WIBABARA OF THE AIDS PROJECT OF THE PRESBYTERIAN CHURCH OF RWANDA, AND (26) GLADNESS LINDIWE XABA OF THE RELIGIOUS AIDS PROGRAM IN SOUTH AFRICA.

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CONCLUSION
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33. COMMENT: USAID/AFR/SD THANKS USAID/SOUTH AFRICA FOR ENCOURAGING THIS WORKSHOP TO TAKE PLACE IN SOUTH AFRICA. THE OFFICE APPRECIATES THE COLLABORATIVE WORKING RELATIONSHIP ESTABLISHED AMONG ITS GRANTEES, TULANE UNIVERSITY AND ACCORD, FOR THEIR PERSEVERANCE IN DESIGNING AND IMPLEMENTING THIS WORKSHOP. THE OFFICE ALSO APPRECIATES USAID AFRICA FIELD MISSIONS AND USAID WASHINGTON OPERATIONAL UNITS IN THEIR ASSISTANCE IN THE THINKING AND PLANNING OF THIS SYMPOSIUM. FULL WORKSHOP PROCEEDINGS WILL BE AVAILABLE THROUGH THE FOLLOWING WEBSITE: HTTP://WWW.USAID.GOV/REGIONS/AFR/CONFLICTWEB/WHATSNEW.TML. END COMMENT.

UNCLASSIFIED

# Appendix C: Agenda

**DAY 0: SUNDAY 25 MARCH 2001**

**7:00 – 9:00 EVENING REGISTRATION**

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**DAY 1: MONDAY 26 MARCH 2001**

**8:00 – 8:30 REGISTRATION**

**8:30 – 9:40 OPENING OF THE SYMPOSIUM**

*Chair: Vasu Gounden, ACCORD*

- Welcome – *Vasu Gounden, ACCORD*
- Post-Conflict Reconstruction, Gender, and HIV/AIDS: Frontiers for USAID – *Ajit Joshi, USAID*
- Introduction to Symposium – *Sam Samarasinghe, Tulane*
- Participant Introductions – *Pravina Makan-Lakha, ACCORD*

*Facilitators: Pravina Makan-Lakha, ACCORD and Colleen McGinn, Tulane*

**9:40 – 10:45 SESSION 1 – OVERVIEW OF HIV/AIDS AND CONFLICT-AFFECTED POPULATIONS**

*Chair: Sam Samarasinghe, Tulane*

- Gender Based Experiences in Preventing and Coping with HIV/AIDS in Post Conflict Sub-Saharan Africa – *Millicent Malaza-Debose, Save Africa*
- HIV/AIDS, Conflict and Reconstruction in Sub-Saharan Africa – *Manuel Carballo, ICMH*
- Common Ground: Themes from Participants' Writings – *Colleen McGinn, Tulane and Pravina Makan-Lakha, ACCORD*
- Plenary discussion, summary, and wrap-up

**10:45 – 11:15 Break**

**11:15 – 12:15 SESSION 2 – OVERCOMING THE CHALLENGES: LIVING WITH AIDS, LIVING WITH WAR**

*Chair: Susan Kajura, World Learning (Uganda)*

- Participant Panel:
  - Life Story: Living with AIDS, *Asunta Wagura, Kenya Network of Women with AIDS*
  - Life Story: Living with War, *Claudine Muyala Tayaye Bibi, University of Kinshasa*
  - Plenary discussion, summary, and wrap-up

**12:15 – 12:25 INTRODUCTION TO SESSION 3** – *Pravina Makan-Lakha, ACCORD and Colleen McGinn, Tulane*

**12:25 – 1:25 LUNCH**

**1:25 – 2:45 SESSION 3 – FROM VICTIMS TO ADVOCATES: WOMEN'S STRUGGLES AGAINST HIV/AIDS AND VIOLENCE**

*Plenary Chair: Asunta Wagura, Kenya Network of Women with AIDS*

- Small Group Activity
  - Group work to identify consensus and prioritize issues
  - Plenary reports and working towards consensus

**2:45 – 3:15 BREAK**

**3:15 – 5:15 SESSION 4 – HIV/AIDS, CONFLICT, AND VULNERABLE POPULATIONS: CASE STUDIES**

*Chair: Nelly Ntuli, South African Medical Research Council*

- Participant Panel
  - HIV/AIDS and Refugees, *Nsama Chikwanka, Society for Women and AIDS in Zambia*
  - Caring for Orphans, *Dorothy Gatea Wibaya*, *Presbyterian Church of Rwanda AIDS Project*
  - HIV/AIDS and the Military, *Anne-Mary Shigwedha, Namibia Ministry of Defense*
  - Plenary discussion
  - Working towards consensus

**5:15 – 5:30 DAY ONE WRAP-UP**

*Closing and Summary of Consensus*

**7:00 – 8:30 DINNER**

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**DAY 2: TUESDAY 27 MARCH 2001**

**8:45 – 9:00 INTRODUCTION TO DAY TWO**
*Sam Samarasinghe and Colleen McGinn, Tulane*

**9:00 – 10:00 SESSION 6 – HEALTH CARE IN POST-CONFLICT ENVIRONMENTS**
*Chair: Joseph Ntaganira, National University of Rwanda*

- Participant Panel
  - Rebuilding Public Health Systems in Post-Conflict Contexts, *Daraus Bukenya, African Medical and Research Foundation (Tanzania)*
  - Psychosocial Services for Survivors of Violence, *Beatrice Murunga, Map International (Kenya)*
  - Plenary discussion
  - Working towards consensus

**10:00 – 10:10 INTRODUCTION TO SESSION 7** – *Pravina Makan-Lakha, ACCORD and Colleen McGinn, Tulane*

**10:10 – 10:40 BREAK**

**10:40 – 12:00 Session 7 – Preventing HIV/AIDS in Post-Conflict African Societies**
*Plenary Chair: Paul Ntulya, ACCORD*

- Small Group Activity
  - Group work to identify consensus and prioritize issues
  - Plenary reports and working towards consensus

**12:00 – 12:10 INTRODUCTION TO SESSION 8 –** *Pravina Makan-Lakha, ACCORD and Colleen McGinn, Tulane*

**12:10 – 1:10 LUNCH**

**1:00 – 2:30 SESSION 8 – COPING WITH HIV/AIDS IN POST-CONFLICT AFRICAN SOCIETIES**
*Plenary Chair: Millicent Malaza-Debose, Save Africa*

- Small Group Activity
  - Group work to identify consensus and prioritize issues
  - Plenary reports and working towards consensus

**2:30 – 3:30 SESSION 9 – HEALTH AS A BRIDGE TO PEACE**
*Chair: Airah Schikwambi, Namibia Ministry of Health and Social Services*

- Participant Panel
  - Health and Peacebuilding Case Study, *Mary Balikungeri, Polyclinic of Hope (Rwanda)*
  - Health and Peacebuilding Case Study, *Caroline Odongo Turyatemba, Joint Clinical Research Center (Uganda)*
  - Plenary discussion
  - Working towards consensus

**3:30 – 3:40 INTRODUCTION TO SESSION 10 –** *Pravina Makan-Lakha, ACCORD and Colleen McGinn, Tulane*

**3:40 – 4:10 BREAK**

**4:10 – 5:30 SESSION 10 – EMPOWERING WOMEN IN POST-CONFLICT AFRICA**
*Chair: Sam Samarasinghe, Tulane University*

- Plenary Dialogue

**5:30 – 5:45 DAY TWO WRAP-UP**
*Consensus and Close*

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## DAY 3: WEDNESDAY 28 MARCH 2001 – TOWARDS CONSENSUS

**8:00 – 8:15 INTRODUCTION TO DAY THREE**
*Sam Samarasinghe and Colleen McGinn, Tulane*

**8:15 – 9:15 SESSION 11 – LESSONS LEARNED AND ISSUES FOR CONSIDERATION BY PRACTITIONERS**
*Chair: Sam Samarasinghe, Tulane University*

- Plenary Dialogue

**9:15 – 10:15 SESSION 12 – LESSONS LEARNED AND ISSUES FOR CONSIDERATION BY POLICYMAKERS**
*Chair: Paul Ntulya, ACCORD*

- Plenary Dialogue

**10:15 – 10:45 BREAK**

**10:45 – 11:45 SESSION 13 – LESSONS LEARNED AND ISSUES FOR CONSIDERATION BY THE INTERNATIONAL COMMUNITY**

*Chair: Sam Samarasinghe, Tulane University*

- Plenary Dialogue

**11:45 – 1:00 SYMPOSIUM CLOSING**

*Co-Chairs: Sam Samarasinghe, Tulane and Vasu Gounden, ACCORD*

- Durban Declaration: A Statement on Consensus
- Closing Remarks

**SMALL GROUPS:**

*Central Africa Group: Congo-Kinshasa, Congo-Brazaville, Rwanda, Burundi*
*Facilitator: Manuel Carballo, ICMH*
*(This group will use* French *as its primary language. If you need to be in an English-speaking group instead, please join Group 2.)*

*Eastern Africa Group: Kenya, Ethiopia, Uganda, Tanzania*
*Facilitator: Pravina Makan-Lakha, ACCORD*

*Southern Africa Group: Namibia, South Africa, Mozambique, Zimbabwe, Zambia*
*Facilitator: Colleen McGinn, Tulane*

# Appendix D: Summary of Symposium Proceedings

**Day One focused primarily on an introduction and overview of the topic, issues, and participants.** In addition to opening sessions, there were presentations (personal experiences of coping with HIV/AIDS and war), a participant panel on case studies of HIV and vulnerable populations, and a small group activity on women's struggles against HIV/AIDS and violence.

The primary **consensus and lessons learned** on Day One were:

- While there has rightly been much focus on women, **the roles and needs of men must also be recognized and dealt with**. There was a strong call for developing complementary programs that respect and draw upon the different but interrelated needs and roles of men and women.
- **Women's empowerment is essential** – but this is also a complex and challenging process.
- The impact of trauma, and the **overwhelming need for psychosocial services**, is imperative when addressing HIV/AIDS and other needs in a post-conflict context.
- It is imperative to **address the needs of militaries, ex-combatants, and their families and communities** – psychological, physical, and economic - and to reintegrate them into communities in a positive way. This was seen as a particularly under-served and poorly understood aspect of post-conflict reconstruction. There are many lessons to be learned from the Namibian military HIV/AIDS programs. By contrast, The Ethiopian demobilization program funded by the World Bank was cited as a negative example. The ex-combatants had no counseling and were highly likely to be infected and to spread HIV/AIDS.
- Meeting the **needs of internally displaced persons and orphans** is absolutely essential, and while the need is recognized and there are successful examples from which to learn, strategies, resources, and commitment to truly confront these crises is lacking.
- There is a strong **need for better networking and communication among Africans working at the grassroots** on the issues of conflict, HIV/AIDS, and women's empowerment.
- **Removing the stigma attached to HIV/AIDS** is a pre-condition to successful programs. The Ugandan government, for example, made it more legitimate by declaring the fight against HIV/AIDS official policy and the disease a national disaster. In Senegal, also, the willingness of the government to accept the presence of the disease and to pro-actively develop a policy to cope with it has helped that country's relatively successful fight against the disease
- **The most successful HIV/AIDS programs are holistic and interdisciplinary.**
- Having to shoulder a disproportionate **burden of the disease has galvanized women into action to cope with and fight against HIV/AIDS**, especially through creation of new women's civil society organizations. However, these are mainly found in urban areas. Both conflict and HIV/AIDS affects rural women even more than urban women, but their ability to organize in civil society is more limited.
- **Successful HIV-AIDS programs appear to depend on strong community involvement**. Qualities such as compassion and dedication are as vital as if not more than technical correctness and financial resources. Rwanda's on going grassroots workshops to teach families to care for AIDS patients is one example of success.

- Uganda is an example that illustrates the challenges that all of Sub-Saharan Africa faces - that **"good" polices are not always accompanied by good practices**. The good policies in HIV/AIDS, education etc. are largely donor-driven and do not have strong local political commitment and ownership. The implementing agencies in government have little capacity or commitment, and the grassroots Community-Based Organizations (CBOs) have almost no voice in the process.
- A **complete overhaul is needed in the way that refugee/IDP camps are set up and run** in order to address HIV/AIDS issues.
- Poverty reduction is one of the key contributing factors to vulnerability to HIV/AIDS. So **poverty reduction must be a concurrent goal in HIV/AIDS interventions.**

Day Two also included participant panels, focused on health care in post-conflict environments and health as a bridge to peace. However, the **focus of Day Two was on consensus-building and priority-setting** within small groups.

The primary **consensus and lessons learned** on Day Two were:

- **Reform of the security sector** is an underpinning of good governance
- **Development is impossible without security.**
- **In emergency environments, the health priorities are to save lives and then to preserve health.** It is at the second stage that it is critical to mainstream HIV/AIDS issues, psychosocial care, etc., and to support self-sufficiency.
- **Psychosocial care is extraordinarily important,** but resources and lessons for large-scale implementation are scarce. Churches are very effective partners and bases from which to build.
- **Loss of health infrastructure is** terribly destructive, but can also represent **an opportunity for rebuilding a health care system** that is more responsive to public health and needs at the grassroots, and that involves traditional healers.
- **Building the capacity of communities is critical**
- **The most effective HIV/AIDS programs sometimes only address HIV/AIDS indirectly.** For example, in Southern Africa, there is high awareness of HIV/AIDS, but little behavior change. By contrast, one highly successful program in Zimbabwe adopted the strategy of exploring and promoting healthy interpersonal relationships. This could be a model for other integrated efforts.
- **Health, including mental health, efforts represent exceptional entry points into developing more holistic, integrated efforts.** For example, health can serve as a "bridge to peace" by bringing together antagonists around a common purpose, and helping survivors rebuild their lives and their societies. Successful examples are: (1) Rwanda's Polyclinic of Hope, which started out as "crying" and evolved into a diverse center aimed at empowering women genocide survivors and peacebuilding; (2) a women and child abuse center in Namibia that, by working with and sensitizing police, transformed the police into "the people's police," and (3) HIV prevention program for Ethiopian sex workers that evolved into supporting their diverse needs. Unfortunately, funding that restricts an activity to one particular sector frequently constrains the development of such initiatives.
- **Networking,** including international solidarity, **can play a critical role for empowering African women.**

- **There is a difference between gaining power and getting power**, as is illustrated by Uganda. Having formal political power is only part of the struggle, and when the momentum comes from the top rather than the bottom, there is a huge gap between policy and practice.
- **Civil society organizations**, rather than government, often **play the most important role in gaining a political voice for women.**
- There is a **need to educate donors** – government and international – **of the importance of** moving beyond narrow sectoral programmes towards more **integrated, holistic, and effective efforts.**

**Day Three focused on working towards consensus on key issues for policymakers, practitioners, and donors.** Following plenary discussions focused on identifying lessons learned and issues for consideration by these groups, the participants developed and debated the "Durban Declaration" which was unanimously endorsed.

The primary **consensus and lessons learned** on Day Three were:

- **Networking is seen as extremely valuable by African practitioners,** especially when it focuses on very concrete matters, e.g. work that has or is being done on the ground. Donors tend not to support such an activity, despite its perceived value by practitioners.
- **There is often a huge gap between good policy and good practice,** as is illustrated by the case of Uganda. The pattern in Uganda is that the central government and international donors dialogue, with some consultation with a "second tier" of civil society and junior government officials. It is this second tier that receives money to implement projects, with a "third tier" – the grassroots – as the beneficiaries. However, the intended beneficiaries are largely excluded from the decision-making process, thus resulting in lack of ownership over the process and inappropriate initiatives. Instead, all stakeholders should be involved in the dialogue form the very beginning, with more emphasis on transparency and accountability.
- **Behavioural change is key.** The importance of leadership and role models is very imp. Lack of commitment by institution and leadership to behaviour change is a severe problem.
- **Health professionals must be trained about ethical and human rights issues.**
- **It is ineffective to address one particular issue/aspect of a problem such as HIV/AIDS without addressing the overall context and contributing factors.** Preaching about safe sex without addressing the context in which infection is spread is useless.
- **Examples and role models can play a pivotal role**. Encountering "ordinary" people who are infected with HIV/AIDS impresses upon people, particularly youths, that they too are at risk, and also helps to overcome stigmatization of people living with AIDS.
- **A rights-based constitutional and legal framework is critically important.** But it is after it has been achieved that the real work begins. It is imperative to move beyond formal structures and transform contexts and norms at the grassroots.
- **Behavior change does not just apply to individuals, but also to groups and institutions.** That includes donors: they need to be educated and encouraged to change how they operate, so that they can better support real needs.

- **Consultation processes with governments and donors are often only window dressing,** and not genuine.
- **There is an urgent need for greater coordination among donors in their reporting requirements.** Tremendous amounts of time and energy are wasted writing reports, and often completely different materials need to be prepared for different donors on the same organization/project. If donors adopted identical or at least similar reporting (and grant) requirements, organizations could spend much more time on implementing projects rather than duplicative report- and grant-writing. As the executive director of one NGO asserted, "Liaising with donors takes 80% of my time and keeps me away from the work that I want to be doing."
- **There needs to be more effective partnerships forged between NGOs and donors.** NGO representatives expressed concerns that in trying to please donors they corrupt themselves, and that honest flow of information and perspectives is lacking. Similarly, donors should make more efforts to fund what the intended beneficiaries feel is most needed. Too often, funding reflects the priorities of the donors, not the people. There is an alarming lack of sincerity in communications between donors, governments, and NGOs.
- **Government decentralization creates opportunities for broader partnership and dialogue with grassroots NGOs**, who do not have access to top-level decision-makers. However, when capacity at the lower levels is weak, things may just fall apart.
- **NGOs need to be adequately resourced.** Specifically, funding for paid staff, especially administrative staff, is too often lacking.

# Appendix E: SELECTION OF PARTICIPANTS

A "call for participants" was drafted and broadcast via email and fax to organizations and individuals in SSA actively involved in HIV/AIDS prevention, peace-building, and gender issues. There was an enthusiastic response, and organizers received a large number of outstanding applications. The symposium was planned for a modest number of participants, and organizers considered geographic diversity, professional expertise, diversity in professions and backgrounds, and writing skills of the applicants. Twenty-five selected participants from twelve countries attended. The countries were Ethiopia, Rwanda, DRC, South Africa, Tanzania, Zambia, Uganda, Namibia, Burundi, Mozambique, Congo-Brazzaville, and Kenya (see list of participants in the appendix). In addition, background papers were commissioned from two resource persons, Dr. Manuel Carballo of the International Centre for Migration and Health (ICMH) and Dr. Millicent Malaza-Debose of Save Africa. International observers from USAID, the International Organization of Migration (IOM), and International Committee of the Red Cross (ICRC) were also present.

Too often, the voices of Africans working at the forefront of issues they are facing in their countries are not heard, and others do not learn lessons from the experience of Africans. Thus the Durban symposium agenda was designed to provide a forum for African practitioners to share and build upon their rich and complex personal and professional experiences working on HIV/AIDS issues amongst conflict-affected populations.

With the exception of two background papers presented by the two resource persons, all the speakers were drawn from the pool of African participants. In addition to formal presentations, substantial time was devoted to open discussions as well as small group work to prioritize strategies and issues on a regional basis. Throughout, there was an emphasis on identifying practical strategies and approaches. The organizers also encouraged the participants to meet in informal groups to discuss questions and themes of common interest; several such gatherings took place during evenings and meals.

Each of the participants was asked to submit a narrative prior to the symposium. These narratives were compiled and distributed at the symposium, and are also available online (http://www.certi.org/news_events/prev_coping_w_aids/papers_and_narrativesi.htm). These narratives represent a remarkable and diverse collection of the experiences of African practitioners, in their own voices, who are working at the grassroots to meet the challenges of HIV/AIDS, conflict, and the empowerment of women.

## Appendix F: List of Participants

**SYMPOSIUM ON "PREVENTING AND COPING WITH HIV/AIDS IN POST CONFLICT SOCIETIES: GENDER BASED LESSONS FROM SUB-SAHARAN AFRICA"**
**26 – 28 MARCH 2001**
**DURBAN, SOUTH AFRICA**

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