

**2007 HIV/AIDS Implementers' Meeting: Gender:
Gender-Based Violence
PEPFAR, The Global Fund to Fight AIDS, Tuberculosis
and Malaria, UNAIDS, UNICEF, The World Bank, WHO, GNP+
June 17, 2007**

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DR. AGNES BINAGWAHO: This issue should have more and more attention. What is good? But we have to be careful and we have to take the opportunity of this momentum to do a good job. Because we totally need to approach this issue taking into account the culture and the environment where the women are living if not, we can have a negative impact.

That is the reason why we really need to listen to those specialists who are here in the panel with me because they have good things to share with us, concrete experience under ground. First we have Dr. Faustin Malele Bazola, who is a Doctor, who has a master in infectious disease. This is correct? Yes? And actually works now for CDC for the Global AIDS program in Atlanta but is based in Kinshasa.

He has worked in the area of HIV and AIDS for more than 20 years. Twelve years with six workers that means that he has a strong experience of violence based on gender. He has also worked in the first program providing HIV treatment in Kinshasa. So that means he is going to share with us the experience of [inaudible], prevention, care, and treatment for vulnerable woman and access to care.

Near him we have Katie [misspelled?]. Katie Schank. Katie Schank works for Population Council and Horizon program. She conducted research on the subject in many countries in

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Africa, South Africa, Zambia, Kenya, Tanzania, and Uganda. She conducted also research on children affected by HIV and AIDS. And she is an author of "Ethical Consideration for Working among Young People Affected by HIV and AIDS". So that means she has a lot of things to share with us for use. And we know that young girls who are in trouble may often shift to prostitution. But she is presenting on behalf of Julie Pulerwitz.

Julie is working for PATH Horizon program. She is a gender and HIV specialist, and she did also a lot of research in other of areas; Brazil, India and Vietnam and Julie was not able to join us for personal reasons.

Here we have Madeleine. Madeleine is my fellow compatriot. She is working for PROFEMMES/TWESE HAMWE as a monitoring and evaluation officer. But before that, and what is really important also, she was a community leader during five years. She was a mayor of district and on day to day basis she was dealing with reporting of such a fact or dealing with community problems.

On my left here we have Julie Hanson Swanson who is working for USAID at the office of Women in Development. She is an education specialist and she has been working on issues related with school gender violence based since 2002. She is also the one in charge of the review of the global [inaudible]

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on the subject of USAID. And she has designed a school program based on behavior communication for behavior change on school-related gender violence. So with all those experience I am sure that you are going to leave this room with a lot of things to bring home.

So I am going to give the floor now to, you are starting? okay. If you are ready Faustin, Dr. Faustin the floor is yours.

FAUSTIN MALELE, M.D.: It is okay, ladies and gentlemen good afternoon. My talk this afternoon is about HIV infection among female residing in this displaced and river population, along the Congo River, study we have done in 2005. First of all, I want to thank all the volunteers who participated in this study, they are listed on the screen.

Since 1998 to 2004 the [inaudible] faced [inaudible] the countries civil conflict which led to approximately to 3.9 deaths and 2.2 million [inaudible] displaced person. And HIV prevalence in the general population is 4.2 but prevalence is known in displaced person and in the communities living along the Congo River that interacts with the group that sells goods and with river's [inaudible].

The objective of this study was first to determine HIV and syphilis prevalence among these women. And second to assist the [inaudible] between HIV infection and selected risk

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factors. Also, we wanted to have some base line data for productive health needs in these populations. For that, we selected two river communities near Kinshasa, the capital, and one IDP camp. We conducted a two stage sample for women aged 15 to 49 years. And then we obtained informed consent from the women, interviewers conducted to assist demographics, risk factors and reproductive health factors.

And also we ask the consent from for blood collection for HIV and syphilis testing. We set up some of visiting centers in the health [inaudible] cities near those populations and, also, a referral voucher was given to them for free counseling and testing. Onsite we perform HIV/syphilis, sorry, we perform syphilis tests using the [inaudible] rapid test and those person who was selected was given treatment.

After that, in the reference lab, we perform RPR and TPPA testing. Also on site, we perform HIV testing using Determine and Uni-gold in parallel. In the case of [inaudible] we used OraQuick as tie breaker. And the collection culture was performed at the national lab.

As we did the study in conjunction with the branch of CDC in Atlanta, we used the software they way they were experiencing in [inaudible] for data entry. [Inaudible] and these are performed to assist a [inaudible] between a selected variance and an HIV infection. And by normal distribution

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provides 90 percent confidence intervals. Standard error was adjusted by finite population correction. We can see that the participant rate was high. More than 80 percent of the women who was asked to participate in this study accepted and I can say that the total of them accepted to perform testing. For demographics what we can say is that more than 80 percent was less than 35 years-old.

Prevalence, HIV prevalence was, sorry; first when we conducted the analysis, we saw that there were no differences between the two river population sites. So we combined the results for the two river populations and HIV prevalence was 2.1 percent for river population and 7.6 percent for IDP.

Active syphilis means that both RPR and the TPPA test was reactive, was 0.5 percent for river population and four percent for IDP population.

When we try to assist a [inaudible] between HIV infection and risk factor for the river population there were no [inaudible]. But for IDP population [inaudible] would [inaudible] with HIV infection. [Inaudible] symptom in the past twelve months and a history of forced sex didn't conflict so, in conclusion, HIV prevalence among female IDP where over two times than in the female in the river population.

The river population prevalence was quite the same with the general population. Finding of this study, I would like to

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[inaudible] of displaced female population in the [inaudible]
and the need for [inaudible] coverage and targeted prevention,
care, treatment program for IDP population in the country.

Some lesson learned; mobile visitor services have been
successfully implemented in settings that provides service for
hard to reach population. And here I can say that the take
rate for visiting for IDP people was about 90 percent. HIV
prevention, current treatment program, need to target this
population during and after displacement and should be
including in national HIV strategy plans. Also, as I said,
this study is helping us to have some basic data for
reproductive health needs among this population. Thank you very
much.

[Applause]

DR. AGNES BINAGWAHO: Thank you Dr. Faustin. Yes, I'm
going to take care of this. Thank you Dr. Faustin, with this
very good study, will give the evidence of the risk for women
in displaced circumstance. I propose to you to hear all the
presentation and to ask question in the end, to go for a full
debate. Now I am going to ask you to give you back the
[inaudible] Julie.

JULIE HANSON SWANSON: Thank you. We have been asked
by the chair to shorten our presentation so there can be more
time for discussion, but hopefully most of you have a hand out

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of the outline, the presentation so when I skip some slides you should still be able to follow. Okay, next slide please.

This presentation will touch on the following questions. How can a Safe Schools program model be part of a comprehensive HIV/AIDS prevention strategy? And what processes in a Safe Schools program are critical to success? I think we can all agree there is growing evidence that getting and keeping young people in school dramatically lowers their vulnerability to HIV. However, we also know that an unsafe and hostile school environment reduces the protection that education can provide.

So to respond to the global challenge of gender-based violence in schools, the office of Women in Development has been supporting the Safe Schools program since late 2003. Simply put, this is the goal of the program. A critical process in the Safe Schools program was first defining what we mean by school-related gender-based violence.

The definition needed to be broad enough to capture all the forms of gender violence that have a negative impact on children's ability to go to school and on their health. And it also needed to capture all the dimensions so that we could create a shared understanding of this issue. So first of all, school-related gender-based violence includes any form of

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violence that results in sexual, physical or psychological harm to both girls and boys.

It includes any form of violence or abuse as based on gender stereotypes. And it ranges from things such as rape to verbal harassment. I think another important thing to consider is that unequal power relationships between adults and children, and males and females contribute to gender-violence. Next, okay.

I have to admit the term school-related gender-based violence is not very elegant. But it tries to make the point that it's not only in the school where children are at risk, but there are also hot spots going to and from school, in school dormitories and in school toilets as well.

It's also important to point out the range of perpetrators. Gender-based violence can be perpetrated by teachers, students or community members. And the program was designed at the very beginning to stress that both girls and boys can be perpetrators and victims of violence. And so we wanted to make sure that we took a gendered approach to look at how girls and boys experience gender violence differently.

Even though we are trying to have a precise definition, we realize that the types of violence do overlap. Sexual violence can be either verbal or physical. Something like bullying can also be verbal or physical. And finally, I think

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for those of us coming either from the education or health sectors, we realize that such violence can affect the well being of students, putting them at greater risk of educational failure, absenteeism and dropping out. From a health point of view, it also impacts their mental and physical health, resulting in physical injury, pregnancy, sexually transmitted infections including HIV and emotional or physiological ill health.

We've taken an evidence based approach to this program using the processes that are numerated on this slide. And I also, I have a CD that includes some of the instruments and the reports that are on this slide. And so after the session, please come up and I'll give you a copy.

Okay. Safe Schools is trying to take a comprehensive and integrated approach to addressing gender-based violence in schools. The goal of working with community members, parents, teachers and students is to create a safer environment for girls and boys. Just as David Wilson mentioned this morning that we have to go beyond individual behavior change and try to get a critical mass, so in fact, we have a safer environment for all children.

These are the five major components of the program. First, there is a student life skills program for children in junior-secondary school ages 10 to 14. And this aims to create

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some efficacy and give children the ability to protect themselves from all forms of gender-based violence and abuse by highlighting their rights as children, promoting healthy and responsible behavior in HIV/AIDS prevention, and providing them the skills to empower them to shift gender dynamics so they can reduce the risk of violence and foster positive relationships among their peers.

Secondly, as you can imagine, teachers play an incredibly important role in reducing school violence. One teacher training program tries to reenergize the role of teachers as protectors rather than predators of children. And it works to provide teachers new skills and attitudes to address violence in schools, reduce corporal punishment and help them create safer learning environments inside the classroom.

Related to that of course, which supports it, is the teacher code of conduct. We've found that in many countries, the code doesn't exist or perhaps is not enforced. So, the Safe Schools program is working with local partners who then work with ministries of education to strengthen and update codes so that they include all the forms of gender-based violence and also strengthen reporting systems.

Finally, in our research and also the global literature indicates that when children are abused, or experience

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violence, there is very little support available to them in their local communities. So we have tried to fill that gap by having a community volunteer support program in which communities identify a caring responsible adult who then can serve to help children who have been abused, by providing active listening, or making referrals to services, and also trying to help them seek redress through either the school or legal systems.

And finally, to round it all out, there are community action plans in which community members often including the parent teachers association or school management committees, look at what they can do to reduce gender-based violence in their communities and things that communities have done so far include accompanying girls and boys to and from school or creating safe and secure private latrines.

Okay, oh great okay. Finally, oh, go back please. Yes. So these are the critical elements that I think should be repeated if you're trying to address school-related gender-based violence. The first one is taking a comprehensive approach and we've done this on several levels.

As I've already mentioned, we try to reach all the stakeholders so we can create a critical mass towards social changed. It's also important to look at all the forms of gender-based violence. In the past, the emphasis has been on

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sexual abuse, but it's important to look at the psychological and physical aspects of it because those too can drive children out of school and can have a negative impact on their health and well-being.

And finally when we talk about gender-based violence, it needs to be grounded in the context of human rights, gender dynamics and gender equality or inequality as may be the case. Finally, I did touch on the fact that this program works with boys and girls. We've heard many presentations so far that talk about the importance of engaging men and boys in this situation of trying to reduce gender-based violence and also, addressing the fact that boys too can be trapped in their own gender box.

A quick word on child rights and power dynamics, a caveat, it's important when introducing child rights, that you talk about both the rights and responsibilities of adults and children because there can be a backlash where adults feel at risk and feel that their authority is being questioned and taken away. So, it's important to work with adults and help them work through that idea of letting go a bit. And finally, it's important to include HIV/AIDS in a violence prevention program.

And in conclusion, the last slide please, I think my take-away message is simple but important. A school based

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HIV/AIDS prevention program should also work to reduce the violence and abuse that make children more susceptible to HIV infection. And so I urge all the implementers here, if you are designing HIV/AIDS programs for children, prevention programs for children, that you also include the aspects of gender-based violence. Thank you.

[Applause]

DR. AGNES BINAGWAHO: Thank you Julie to have shared with us the dimension and the range of gender violence and the victim and the perpetrators. And to highlight the fact that boys and girls can be victims, also, the consequences and the responsibilities of all parties. Now, Madeleine is going to share with us, an experience in Rwanda of the fight against gender-based violence has HIV and AIDS prevention strategy.

MADELEINE BYUKUSENGE: Good afternoon ladies and gentlemen. My name is [inaudible] Madeline. I work for PROFEMMES/TWESE HAMWE. And I'm going to share our experience in gender-based violence and how it relates to HIV and AIDS transmission. I'll be talking to introduction to PROFEMMES, background, approaches, outcomes, results in detail, challenges and recommendations.

PROFEMMES/TWESE HAMWE is a number of [inaudible] associations acting for women, peace, and development promotion throughout Rwanda. It intervenes in health and HIV/AIDS, of

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course, in gender and gender-based violence, [inaudible],
education, environment, poverty reduction, women and children's
rights, communication, [inaudible].

Background into gender-based violence in Rwanda,
HIV/AIDS affects more women in Rwanda than men. Sexual
violence against women and children contributes to the spread
of HIV/AIDS.

In 2005 and 2006, more than 4,000 cases of violence of
young girls were reported to the Rwandan police compared to
over 1,000 cases of women older than 18 years. That means that
gender-based violence or sexual violence of our young girls and
teenagers is a high rate.

The study shows that out of 2,000 women genocide
victims who are interviewed; four out of five were infected
with HIV/AIDS. In Rwanda, a woman generally has no right to
refuse sexual relations to her husband. And that is related to
our culture.

What PROFEMMES is doing to fight gender-based violence?
We are raising public awareness on gender and HIV and AIDS. We
are also empowering young girls to make a decision on how and
when to engage in sexual relations. We are, as well,
advocating that gender-based violence be a priority of
governments and donors. We are also creating partnership with
the national Rwandan police community-based [inaudible] the

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best organizations and the media. We did the research on HIV and AIDS in relation to women.

We are also coordinating activities of campaigns against the gender-based violence. Render the community accountability, we are trying to [inaudible] the community so that members of the community are aware and are responsible to protect their fellow members in the community.

We do train [inaudible] and the police force on the gender and gender-based violence so that they can also contribute to the prevention of gender-based violence.

Outcomes; there has been a better awareness of the magnitude and consequences of gender-based violence. Also, there has been a better understanding of the relationship between HIV and AIDS as well as gender-based violence.

There has been a greater commitment [inaudible] in the fight against gender-based violence. There also has been a greater involvement of the media in the fight against gender-based violence. We've been providing financial, psychological, clinical, legal and nutrition assistance to many victims of violence.

Our results in detail, PROFEMMES/TWESE HAMWE, together with the other gender-based violence partners and activists we've been advocating for a gender [inaudible] within the

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Rwandan national police to provide a toll-free 24 hour help line for GBV cases.

This has been really has done a lot because cases of gender-based violence can now be reported with no problem. We've been [inaudible] and management of gender-based violence and reproductive health clubs and have done this in the eleven secondary schools. We've trained policemen, [inaudible] teachers, and community mobilizers on gender and prevention of gender-based violence.

We've been supporting financially different associations of women victims of gender-based violence. However, we've met challenges. One of them is that Rwandan law does not rule on all incidences of the gender-based violence. There has been a lack of national policy against GBV. Our culture also—there has been a culture of silence regarding sexuality and gender-based violence.

There is the slow evolution of mentalities on the gender concept. Some men who are considered [inaudible] commit also gender-based violence and that's a big challenge there. Also, some women victims, whom we accompany to claim their rights, sometimes they suddenly stop the process without an explanation.

Our recommendations; strengthen the role of media and fit the best organizations on the fight against gender-based

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violence as well as HIV and AIDS. There is a need to increase the [inaudible] of communities to prevent gender-based violence and support the gender-based violence victims.

We are also continuing to facilitate women and empower them economically so that they become self-reliant. We are strengthening involvement of the community-based structures in the fight against gender-based violence, HIV and AIDS.

In proper clinical care of sexual violence, victims particularly the post-exposure prophylaxis. There is also a need to speed up the process to elaborate a national gender-based violence policy and law. Thank you. [Applause]

DR. AGNES BINAGWAHO: [Inaudible] and also how [inaudible] approach with involvement of the community is needed to tackle the problem. You're presentation is linked with the presentation of Dr. Faustin. Because you remember us how the woman are very venerable during really exceptional situation like war or genocide. Now, we are going to listen to Katie [misspelled?]. Katie [misspelled?] is going to speak on behalf of Julie Pulerwitz, so Katie [misspelled?], the floor is yours.

KATIE SCHANK: Thank you very much, I'd like to give the apologies of Julie Pulerwitz who's unfortunately unable to attend today and I hope that I can represent her work adequately and be presenting here on behalf of Julie and her

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co-authors from a study that was conducted in India and promoting gender equity to reduce HIV, STI and violence risk among young men.

The intervention that this study is evaluating is based on findings from a similar study that was conducted in Brazil. Some of you may remember that this was presented at last year's PEPFAR conference, and what I'm presenting here will be showing an example of how that intervention that was found to be successful can now be built on that experience to be transferred to a new and very different and fairly difficult new environment.

Both Julie and I work for the Horizons program. Julie is employed by PATH and I'm employed by Population Council. Both organizations are partners in the global operations research program of Horizons.

Although there is increasing awareness of the role played by norms encouraging gender equity and fostering HIV risk behaviors, and partner violence, there are very few studies that attempt to influence these norms and measure changes in support of them among young men exposed to an intervention. So in response to this gap, the Horizons program, previous slide please, the Horizons program and the partners indicated on this slide, conducted operations research to examine the impact on

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young men of promoting gender equity as part of an HIV prevention program.

Specifically, the research addressed the following questions. How is masculinity understood and expressed by young men in India? And how can gender equitable norms and behaviors including those related to violence and HIV risk reduction be promoted among young men? Will this type of intervention be feasible and acceptable in the Indian context? What kind of impact will this intervention have on the attitudes towards gender norms? And how can these changes in attitudes towards gender norms be measured? Next please.

So based on formative research and drawing on experiences addressing gender equity in other cultural contexts, a behavior change intervention targeted to young men was developed and piloted. It was named Yari-dosti in Hindi, which means friendship or bonding between men. And the program attempts to stimulate critical thinking about the gender norms that promote risky behavior and to create support for those that promote care and communication. So a six month pilot was conducted with 126 men finding that intervention participants decreased their support for inequitable gender norms. And they reported less sexual harassment with trends towards less risk behaviors compared to base line.

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So based on these experiences generated during the pilot phase of the intervention, there was a larger evaluation of the group education intervention set up in two sites, urban Mumbai and rural Uttar Pradesh. In both sites, there were over 1,000 young men, but I'm just going to be presenting the results from one site. Next please.

So the attitudes towards gender norms were measured what's called the Gender Equitable Men scale, GEM scale, which was developed originally in Brazil. The scale consists of a list of statements about men's and women's roles related to domestic work and child care, sexuality, sexual relationships, reproductive health, disease prevention and intimate partner violence as well as attitudes towards homosexuality and close relationships with other men. And as part of the formative research, these scale items were pre-tested and discussed with a sample of young men in Mumbai to confirm that those items were relevant and clear in the Indian context.

This formative research found that these questions and their approaches to measuring them were all still relevant and considered to be important in this new context. So the team adapted and pre-tested some group exercises based on participatory methods of learning with extensive use of role-plays and discussions and made a few adaptations including the format and the content and the names involved in the exercises.

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And at base line, the scale was found to be highly internal consistent and suitable for use in this context.

I present here some examples of gender equitable beliefs demonstrated by some of the participants, sorry gender inequitable, I apologize, beliefs demonstrated by the participants at base line. And this sets the context for the type of attitudes that the intervention was addressing. Next please.

In some sites, the group education activities were combined with a community-based, and gender focused, life style social marketing campaign to reinforce the gender equitable and HIV prevention messages from the group education sessions. The campaign promotes a gender sensitive and a violence-free life style for young men in the community. Young men actively participated in the development and implementation of the campaign, which consists of street plays, posters, pamphlets, banners and a service and information booth. Next please.

So here are some notes on the evaluation designs in the Mumbai setting. The study was designed with three arms. The first arm there was a group education intervention plus a community-based campaign. And the second, there was a group education intervention alone. And the third was a comparison group. Next please.

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Here you can see the basic socio demographics at the Mumbai site. I think the most important thing to note here is that approximately 15 percent of married at base line. This went down slightly at follow up because the men, the young men who were participating and those who are married kind of self selected them out thinking that this intervention wasn't entirely relevant for them. Next please.

As you can see from this data here, there are some significant attitudes over time in the two intervention groups. Now I'm presenting here four elements of the Gender Equitable Men scale and you can see that in the two intervention groups that those agreeing with those statements, disagreeing with those statements indicated by the numbers, and the asterisk indicate where the finding was statistically significant. So you can see that in the two intervention groups, that is the group education and the community based campaign, and the group education campaign, there were significant changes in favor of increasing gender equitable beliefs. Next please.

And although this slide, I appreciate this may be difficult to read, but perhaps I can try and describe what this slide shows, that there has been a change in overall gender equity scores that measured by the GEM scale. These slides are grouped into thirds according to whether the young men showed low equity in their gender attitudes, which is shown in blue,

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moderate which is shown in green, and highly gender equitable which is shown in yellow. So as you can see, again, in the two intervention groups, the change is towards becoming increasingly gender equitable in their beliefs where as in the comparison group, the change is in the opposite direction. Next.

And these reported attitudinal expressions are consistent with what they report as being their behaviors. There's a change from the pre-test which is shown here in a sort of reddish-maroon color, to the post-test which is shown in yellow, again, you can see changes in the same direction. Positive changes in select behaviors are indicated in two intervention groups. The changes here are shown in condom use with all partners during the last sex, and in communication with your partner about use of the condom during the last three months. Next.

And similarly again, in reported partner violence, experienced, perpetrated during the last three months, there were dramatic decreases, at least as far as these reported behaviors were concerned, while there was an increase in the comparison group. Next.

So the predominant view of masculinity and men's roles in sexual and romantic relationships that was espoused by these young men as we saw is one of entitlement and dominance. The

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gender focused intervention tended to promote positive norms such as responsibility, caring and respect for one's partner and women in general. The intervention appeared to be implemented successfully and almost all of the young men recruited for the project consistently participated in the activities.

Both the peer leaders and the participants indicated that the young men themselves were very interested in the topic areas. And it was often their first opportunity to engage in discussion about these issues openly. Participants decreased their support for inequitable gender norms. And there were trends towards less risky behaviors. Next.

So some lessons learned from this study are [inaudible] in both the operations of the intervention as I described to you, but also some approaches towards measuring it and the successful adaptation of a scale developed in a totally different cultural context that was found to be acceptable here in Mumbai.

[Applause]

DR. AGNES BINAGWAHO: Thank you Katie. So here we have heard about positive change in attitude according different intervention and the power of free education to avoid gender-based violence against young men, and how to reduce the violence against their own partners. Thank you.

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So now that we have heard those good presentations, I acknowledge in this room very powerful Rwandan woman. We have the head of the National Women Counsel. We have also partners from PROFEMMES, the head. And we have Rwandan Woman Network. We have also what we call in Rwanda, not Rwandan Woman, but Woman from Rwanda, like the head of PSI [misspelled?] who's running very good program with us with sex workers, trying to pull them out of their work, but also try to reduce the spread of HIV and AIDS among that group.

And I see here UNICEF, et cetera, so what I expect from this room is a very strong debate. We are really here to talk the truth. To say the truth, to point out what we can improve in our program to [inaudible] this problem of gender-based violence, and to start a debate, I would like to throw some questions. How can we push the person who is concerned by gender-based violence to speak out? And to give to that person the feeling that she has not, she's not guilty. And she has to come out also to save other people from this type of violence.

Second question, how can we convince the community to speak out because the community surrounding most of the case, know the problem. And how we can convince the local leaders that they will be guilty if they don't do so? The third question is how to prevent gender-based violence in certain circumstances like displaced women or what we experience here

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dramatically in Rwanda, violence base on gender as a weapon of war.

So, I think we have here a good panel, but there are many knowledgeable people in that room to answer questions. The debate is yours. Yes please. So you come near the micro, there are two micro. You present yourself. You can go, you are ready.

NADIA KIST: Thank you. My name is Nadia Kist, I'm from Kenya working with the [inaudible] hospital. In all the presentations—well, first thank you for them, they were very informative. There was no mention of the presence or relationship with violence with alcohol abuse or substance abuse, and I'm wondering if that was there and how prevalent was it and what kind of interventions could then work in the context of such issue?

DR. AGNES BINAGWAHO: Let's take a couple of questions before to answer.

BILL PHILBRICK: Hi, my name is Bill Philbrick and I'm with CARE USA. Again, thank you for all excellent presentations, and I'm really, we're really particularly grateful to have particularly somebody from PROFEMME, who works directly within this field in the community. I have a two part question particularly for the presenter from Rwanda and it's connected to Dr. Agnes's questions.

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In order to answer your questions, I think there are two other big issues that come up when you're dealing with gender-based violence. And the first question is, if you're working in that area, you're basically trying to change not only behavior, but underlying behavior, underlying attitudes, and deeply rooted norms. And that we have found, at least in CARE, it often puts us, our members, our staff in the field, and people like you, like PROFEMME and the community workers who are working on the field at risk because we encounter some, a lot of hostility from the men, and even though we're trying to include men in our programs. I would like to ask you if you've had any experience in that area of encountering hostility in the communities and how you deal with that.

The second part of that question would be—my second question I would have too, is you had mentioned as one of your recommendations about women's empowerment. From our experience, and this happens only on occasion, and would like to ask if you've had this experience and how you deal with it?

A lot of times when you're talking about women's empowerment we have women's only micro finance groups. And that sometimes again, when the women are very successful in these groups, it causes resentment among men and which sometimes leads to taking it out physically, physical

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manifestations, and I wondered if you have had that experience and how you deal with those types of experiences. Thank you.

DR. AGNES BINAGWAHO: Yes, sir.

BRIAN MOORHEAD: Hi, my name is Brian Moorhead [misspelled?] from Peace Corps, Mozambique. I have two questions for Julie. First, do you have any examples, can you cite any cases, where civil society has been brought in as to provide redress for victims of school violence, in particular I'm thinkin of school counsels, when the rare cases in which it happens in Mozambique, this is how it happens is through a school counsel.

Second, can donors provide a certain degree of—can apply a certain degree of motivation to educational systems to implement reforms. Does your work reflect, or is it going to reflect any programmatic changes, any indicators, requirements placed on educational funding from AID in developing countries? Thank you.

DR. AGNES BINAGWAHO: A last question, and after that, the panelists will [inaudible].

FEMALE SPEAKER 1: It's more a reaction to the question made earlier and also to the panel, the question on what was for the Rwandan case, that exactly what is the reason of the gender-based violence? Why can't women react to it? When you said about empowerment, what are the elements in empowerment?

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Is it mostly economic empowerment? And when you said that they are given micro-credit, but it is not always enough to just to give them micro-credit, or just to give them some skills. But marketing of the skills is most important. And whether that kind of empowerment, whether your program is focusing on that kind of empowerment, and is that a critical issue that once women are empowered, and this is a question to all of them, because of the experience that we've had in South Asia, that to change men, and to wait for men to change the fate of women is a long process. Whether a woman needs to change, and women need to be empowered to actually be a pressure group to change men. So this is my question then, how do you actually address this whole gambit and I understand that the behavior formation phase in the schools, that one must address the gender-based violence and the gender norms, and the conditioning of young people, men and girls and boys. But at an older age when already they've passed, how much do we focus on women's empowerment to change their fate?

DR. AGNES BINAGWAHO: Okay, thank you. So there is question for all of you. We are going to start with you Julie.

JULIE HANSON SWANSON: Oh. Okay, thank you those were two good questions. At this point, in the Safe Schools program, we're still in the piloting phase with the different training programs and we are working with, let's see, Malawian

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Civil Society origination WILSA, Women in Law for Southern Africa, and they're working on the code of conduct with both the Ministry of Education and the local communities.

So at this point, we're still working on laying the foundation and trying to figure out what are the reporting requirements? What are the ways that this violence can be redressed? I know in other countries they have used, like in Zambia, they have used the chiefs as a system to redress violence against school children. Regarding the second question, if I understood it correctly, it's will there be any reforms that will put requirements on education funding that USAID gives to countries visa vie gender-based violence?

That I think is a bigger issue than our project so at this point, I would say no, but it's a very interesting question. What we are doing for sustainability is working with both Ghana and Malawi to institute the code of conduct so there can be a change at the national level. And we're also working to institute the teacher program as part of their in-service and pre-service training. So we do hope to institutionalize some of these components at the country level.

DR. AGNES BINAGWAHO: Thank you. Madeleine, there was a couple of questions for you.

MADELEINE BYUKUSENGE: Thank you. There is a question on behavior on hostility in the communities and how we really

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try to go about it. I would say that maybe it's because of the approach used. Because sometimes these communities, they think if you go there to help them put in place some projects, sometimes they think those projects are their own projects.

So the approach which we've now put up is to let them say what they want. Sometimes they give their own contributions on what kind of project they want, and the way that they want to be implemented. When you include them in the decision making of that particular project, I am sure, that kind of hostility doesn't occur.

And another question on the women empowerment, micro-project activities here what we—the way we empower these women, there is a couple of ways in how they complete each other. Because okay, we help them to get some micro-projects or income generating activities. But before that, we have to prepare them on how they are going to make those projects.

And even before that, because we had a very difficult in Rwanda after the genocide, we have first to help them come together. We teach them the culture of peace, sharing ideas. We have different, as I may say, different groups of women. We have women genocide survivors. We have women who have they're husbands in prisons. We have women whose husbands have died. So all those categories of women, we have to put them together fast. And we try to teach them how they should reconcile.

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How they should live with each other. How they should move forward and go for developmental activities other than looking at those different areas where they come from the problems which they [inaudible]. So that's the first stage. And there after, we have to help them with this income generating activities. How to formulate them, how to manage them, how to go for bank services and of course how to take their [inaudible] because in most cases here in Rwanda, many women are heading their families and therefore, it's a couple of approaches which we use in empowering women. It's not just a simple activity. It's not a single activity.

It's a couple of activities which you have to combine, to combine so that these women come to get the resources [inaudible] income activities or project, their micro-projects event thought they are not sex related because they have the terrible background.

And then there is a question on the reason for gender-based violence. Here I may say that there are many reasons. [Inaudible] to say that in 1994 genocide, sexual-based violence was used as a weapon on women. And maybe because it's just an incident which happened in the eyes of many people even afterwards, we faced many cases of—let me just talk of sexual violence.

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And the other reason is that in our culture, our historical background in our culture, a woman has no right in the family, is not supposed to make a decision. But now, we have a gender policy, things are changing. But in the previous years, a woman was to be there and the husband could make all decisions in the home, at work, everywhere. But now I think things are going on well because government has put up a policy, a gender policy which is now trying to solve those questions, those problems.

And there's also alcohol. Alcohol is one of the reasons for gender-based violence. I think you would agree with me when people are drunk, in this case let me say when men are drunk, not all of them but some of them of course, they do violate their wives at home and as well the younger children. But you will allow me to say that not only men violate women, there are also some cases of women who violate men. Okay then.

KATIE SCHANK: I'd simply like to respond very briefly to the question about alcohol and substance use. I'd like to refer you to the comments of my colleague Julie Pulerwitz, who is the author of the Indian study who could share with you, perhaps, some of the instruments and intervention details that were used in India and Brazil which, I believe, did address alcohol and substance abuse, although that wasn't the focus of the results that were presented here today.

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And, I'd also like to draw your attention to some other work conducted by the Population Counsel in Kenya which is available on our web site where we're exploring the attitudes towards alcohol among VCT [misspelled?] clients and links to violence and HIV.

DR. AGNES BINAGWAHO: Thank you.

MALE SPEAKER 1: I think that I have a general comment. Fighting against gender-based violence is, I can say, the behavior change that we need to make in our society. And the behavior change needs time. If you want to succeed, I think we need to work on both sides. I saw that during the project in India, I think, employing or using men to reduce violence was a successful project.

And here in Rwanda, I saw that employing women was also. So I think, if you want to succeed, we need to work on both sides at the same time, I can say. Now gender is a matter which is spoken many times. So we need to take advantage of this time to employ women [inaudible] also we need to say, I can say to get men. Thank you.

DR. AGNES BINAGWAHO: Thank you to all of you, I see that time is running and I propose to take a couple of questions again, if you want, because we didn't finish the talk, even though we have got some good input from the audience. Please, sir.

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MALE SPEAKER 2: Mine is much more of a comment. I was very [inaudible] when I had about the successes of—sorry, I'm Pac Matin [misspelled?], I'm the coordinator of [inaudible] HIV in Nigeria. I was [inaudible] had about the effect of legislation and such in—

DR. AGNES BINAGWAHO: [Interposing] —we're going to try to be very brief in—

PAC MATIN: [Interposing] —yes.

DR. AGNES BINAGWAHO: —the question and in the answer so to give opportunity to all.

PAC MATIN: Yes, the effects of legislation in Rwanda, but in Nigeria, the men what ever has been enacted, the buck stop with the man in the home. Whatever happens, if the woman comes into the home and tells a man what's not acceptable to him, he either sends her home or he becomes violent.

We just heard that when a woman is empowered, and the woman is succeeding, it generates violence in the home. So, I think, the man has an ego that needs to be addressed. So men need to be made to shift position a little and understand that women should be taken care of. Thank you very much.

SHELAGH O'ROURKE: My name is Shelagh O'Rourke from USAID East Africa, and I would like to announce a practicum that will be held in Addis Ababa starting August 5th through the 8th. And it is sponsored by a group of communications

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specialist called Africom Net. On the table there are announcements. There express purpose of this practicum is to bring people together who are practicing state of the art interventions in HIV, alcohol and gender-based violence. So please, if you are interested-

DR. AGNES BINAGWAHO: [Interposing] Thank you, thank you.

SHELAGH O'ROURKE: -pick these up.

DR. AGNES BINAGWAHO: Yes, sir.

DUMI SANYA: Thank you, my name is Dumi Sanya, I'm from South Africa. Julie, I didn't get to get a sense of the impact of the project and how do you work with young boys? Because often we just say life skills, but what of life skills? And Katie I also do similar work and often we are challenged to say the GEM scale only talks to the intent of young boys and men wanting to do something or shifting their attitude.

What do you do beyond that in terms of behavioral change? And the Rwandan experience, if you could clarify for me, because when you presented, you said that there's a greater commitment from leadership, but as you went along as a challenge also, you said that there's no law that talks to these issues.

So, there'll some clarity there and if I can have one second Madame Chair? In South Africa, we have a beautiful

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constitution but in terms of implementing that [inaudible] is a challenge so I'm just wondering if you don't even have a policy in place, how much more could we talk about a beautiful commitment from leadership?

GASIN ZIGOIDA: Yes, Madame. Thank you very much, maybe if you allow me Madame Chairperson, if I can start with the question asked by the last here. I'd like to point out-

DR. AGNES BINAGWAHO: [Interposing] Please present yourself.

GASIN ZIGOIDA: I'm sorry. My name is Gasin Zigoida [misspelled?]. I am the president of the National Women Council in Rwanda. Maybe shortly, the National Women Counsel is a forum for all women in Rwanda. Private sector, civil society, women public leaders, women parliamentarians, in short, all women Rwanda combined themselves and they feel having something in common when they have a forum which I can easily, maybe inform you that it is in our constitution. That's why I wanted to, maybe to answer directly to the question raised, what we have done so far? What the government has done so far in trying to fight against GBV.

On the question he asked, I would like to inform that the law now is in the parliament. And this was the initiative of women parliamentarians where by we have about 48.8 percent.

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So that is the [inaudible] we are starting to get our women
parliamentarians. And-

[END RECORDING]