SAT Southern African AIDS Trust | Supporting community responses to HIV and AIDS in southern Africa

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SAT SHARE Series

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HIV Prevention

Community Responses to Immediate Drivers of HIV

June 2009

About School Without Walls

School Without Walls (SWW) began in 1993, in response to the needs and demands of SAT's CBO and NGO partners in the southern Africa region. SWW is a pioneering initiative of south-to-south skills training, lesson-sharing, mentoring relationships, and study visits.

SWW follows a strategy of strengthening the programming skills and organisational capacities of organisations involved in HIV and AIDS related activities at community level. A defining characteristic of SWW is the emphasis placed on sharing the knowledge, skills and experience already available within the southern African region. This 'south-to-south' approach has proven to be not only effective but also technically and culturally appropriate.

Key tools and approaches that are used in SWW include:

- **Organisation-to-organisation mentoring** – experienced, well-established organisations provide advice, guidance, training and inspiration to less experienced organisations.
- **Organisational 'nesting'** – experienced organisations help emerging groups to become established.
- **Study visits** – carefully planned visits from one partner to another create opportunities for on-the-job training and the exploration of programming possibilities.
- **Workshops** – national and regional events create fora for skills training, facilitator training, lesson-sharing and critical thinking.
- **Network meetings** – partners benefit from structured opportunities for mutual support and experience-sharing.

The purpose of SWW is to facilitate communities to become 'HIV and AIDS competent', so that individuals, community organisations and institutions are able to initiate, design, review, own and manage local actions in response to HIV and AIDS.

Community HIV and AIDS competence is a quality that has to be generated from within, i.e. by community members themselves. It is not a technique that can be taught, or a service that can be delivered by outsiders. SAT believes, however, that every community has a certain amount of HIV and AIDS competence, which an outside organisation can help to identify and strengthen.

The SWW network has grown to include more than 150 organisations – mostly CBOs and NGOs – working mainly in the following southern African countries: Malawi, Mozambique, Tanzania, Zambia and Zimbabwe.

SAT and its partners in southern Africa are convinced that SWW offers a viable approach and methodology for helping communities to become HIV and AIDS competent. They also believe that the SWW approach has the potential to help spread good practice by and through many different types of organisations beyond the SWW network, including those working outside the field of HIV and AIDS.

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HIV Prevention

Community Responses to Immediate Drivers of HIV

SHARE
(Shaping HIV and AIDS Responses)

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SAT and the SHARE Series

The Southern African AIDS Trust (SAT)

SAT is a regional organisation that supports community responses to HIV and AIDS through in-depth partnerships with community groups in southern Africa. It also supports wider networking, skills exchange and lesson learning throughout the region and internationally. The organisation's overall goal is to build the competence of communities to develop and manage effective, appropriate and sustainable responses to HIV and AIDS.

SAT believes that most of the information and inspiration needed to increase the scale, speed and quality of the response to HIV and AIDS in southern Africa already exists within communities in the region. It is the role of SAT and other similar organisations to facilitate the process of learning, and sharing those resources.

The SAT SHARE series

This is a document of the SAT SHARE (**S**haping **H**IV and **A**IDS **R**esponses) series. The series aims to document practical experiences, identify lessons learned, and advocate effective strategies and policies. As part of SAT's Good Practice Strategy, the series seeks to inspire, inform and improve the evolving community response to HIV and AIDS in southern Africa.

Workshop participants

Key Terms and Acronyms

ADR	Age Disparate Relationships
AIDS	Acquired Immune Deficiency Syndrome
APM	Annual Partner Meeting
ART	Antiretroviral Therapy
CBO	Community Based Organisation
CSO	Civil Society Organisation
HEARD	Health Economics and HIV/AIDS Research Division, University of KwaZulu-Natal
HIV	Human Immuno Deficiency Virus
IEC	Information, Education and Communication
IGS	Intergenerational Sex
MC	Male Circumcision
MCP	Multiple Concurrent Partnerships
M&E	Monitoring and Evaluation
NGO	Non-Governmental Organisation
OVC	Orphans and Vulnerable Children
PEPFAR	The US President's Emergency Plan for AIDS Relief
PLWHAs	People Living with HIV and AIDS
RANNGO	Regional African HIV and AIDS NGOs (informal network)
SADC	Southern Africa Development Community
SANAC	South African National AIDS Council
SAT	Southern African AIDS Trust
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SWW	School Without Walls
TB	Tuberculosis
TOT	Training of Trainers
UNAIDS	United Nations Programme on HIV and AID
USAID	United States Agency for International Development
VCOs	Vulnerable children and orphans
VCT	Voluntary counselling and testing
WHO	World Health Organization

Contents

Executive Summary

Sub-Saharan Africa and southern Africa in particular remains the region highest in HIV prevalence in the world. Key drivers for the epidemic have been identified as multiple concurrent partnerships by both men and women with low consistent condom use and in the context of low levels of male circumcision. In order to integrate the key drivers of the epidemic into current HIV prevention programmes, the Southern African AIDS Trust (SAT) hosted two regional workshops in 2008 for their partner organisations. To review progress on prevention efforts and to share lessons and experiences, SAT invited representatives from its partner organisations to a further workshop in March 2009.

This report is based on the March 2009 workshop. This workshop focused on the three thematic HIV prevention areas of male circumcision, multiple concurrent partnerships and intergenerational sex. A participatory approach was used to achieve workshop objectives. These included a review of the information on the key drivers; presentations by workshop participants regarding the interventions integrated into their programmes and the challenges they confronted; guided discussions; and lessons sharing activities from across the eight southern African countries represented at the workshop. Formal structured interviews were conducted with selected participants to gain more detail and insight into particular programmatic activities currently underway. This was done in order to identify especially promising initiatives and to document aspects of programming that could be of use to partners wanting to initiate similar programmes.

Participants at the workshop described their current projects where attempts had been made to introduce activities to address the key drivers of male circumcision, multiple concurrent partnerships and intergenerational sex. As part of SAT's continued efforts to build knowledge and understanding amongst its partners, the workshop provided an opportunity for participants to share personal perspectives and experiences with both traditional and medical male circumcision (see APPENDIX A, page 39). Promising initiatives to address circumcision as well as the other key drivers were identified and discussed. Several of these are showcased in the Case Studies contained in this report. These included local campaigns to promote social sanctioning against involvement in intergenerational sexual relationships (IGS) through the negative branding of the 'sugar-daddy' image (e.g. Tanzania); the use of a range of media to get particular messages to the people; the mobilisation of youth and traditional leaders to set up IGS committees for exposing IGS (e.g. Malawi); and building momentum in terms of getting medical personnel and male circumcision services into rural communities through mobile clinics (e.g. Zambia). In that country in particular there appears to be a high and growing demand for male circumcision, and SAT partners from other countries have shown a great eagerness to acquire the skills that have allowed their Zambian counterparts to foster such a positive response to circumcision and to move forward with implementation of those services.

The search for sexual satisfaction in relationships was reported to be a common motivation for the multiple concurrent partnering of both men and women. There remains a great need for programmes that assist couples to talk not just about HIV but also about relationships, hormonal and physical changes throughout the life-cycle, sexual needs and desires, how to foster the development of intimacy in relationships, and how to sustain or enhance sexual desire and pleasure with mutual monogamy. Ideas that sexual pleasure is mainly the preserve of young people and mostly to be found outside of marriage, are amongst the pervasive myths that need to be debunked through culturally appropriate and sensitive HIV prevention programming. Women known as "Queen Mothers" (older retired commercial sex workers who continue to provide older men with younger women for sex), were familiar to participants from at least three of the countries represented. These women were identified as a largely overlooked group whose cooperation was believed to be essential to the discouragement of intergenerational partnerships in the communities. It is through workshops such as this current review workshop that previously overlooked and largely invisible groups such as "Queen Mothers", who play significant roles in supporting the high-risk behaviours that drive the HIV epidemic, can be identified and targeted for interventions.

While considerable efforts are being made by SAT's partner organisations to introduce and roll-out interventions on the HIV key drivers into their prevention programmes, there is room for further intensification of efforts. There remains a need for partners to give further consideration to their programmes taking account of the peer review and information gained at the review workshop. Ongoing constraints to the rolling out of interventions as well as facilitating factors and opportunities for achieving greater programme success were identified. These included the following

- cultural and ethnic challenges for male circumcision programming;
- the lack of progress in terms of policy development in many of the countries;
- limited resources, especially human resources, in the form of medical personnel;
- limitations in simple, clear IEC materials in local languages which would assist with the sharing of information and the reinforcement of messages provided through other media;
- gender imbalances which continue to undermine engagement of women in discussions involving sexuality; and
- information and training still not translating into behaviour change (even amongst partner organisation members themselves).

The workshop provided an opportunity for partners to take stock, to reflect on their experiences to date, to share ideas, learn from one another, and to acquire inspiration and motivation for intensifying their efforts towards better and more effective HIV prevention programming for the people they serve.

This report is a synopsis of the deliberations that took place and the results that were obtained from the review workshop. It represents an attempt to provide a type of situation analysis of how some southern African organisations, with the ongoing and strong support provided by SAT, are currently engaged in taking forward the evidence to grapple with the key drivers of HIV in the region.

Introduction

In support of the Year for Accelerating Access to HIV prevention, and spurred on by the continued increase in the epidemic, an expert think tank meeting on HIV prevention in high-prevalence countries in southern Africa was held in Maseru, Lesotho in May 2006. A number of drivers of the epidemic in the region were identified. These included key drivers, contributing drivers and social and structural drivers. The key drivers identified were multiple concurrent partnerships by both genders with low consistent condom use and in the context of low levels of male circumcision (SADC Think Tank Report, 2006, p, 3).

At the same meeting, it was recommended that UNAIDS, along with other stakeholders, take forward a process of continuing to review the research and evidence regarding behaviour change, social norms, and male circumcision with a broader audience. In response to this, a two-day workshop in Livingstone, Zambia, was held with a range of civil society organisations (CSOs) working at different levels across the region. The workshop directed attention to the drivers of HIV (including male circumcision, intergenerational sex and multiple concurrent partnerships) and provided a forum for communities to discuss strategies for contextualising and taking the information forward and enhancing communities' participation in HIV prevention. At the conclusion of the meeting there was a commitment from those present to find ways to integrate the information into existing programmes and later to share the information on lessons learnt on implementation with other organisations.

The Southern African AIDS Trust (SAT) was one of the regional NGOs present that committed to presenting the research findings to its partner network and provide technical support to all the partner organisations to adapt their programmes to address the key drivers. In delivering on this commitment, SAT used its existing School Without Walls (SWW) mechanism for partners' learning and development to replicate the Livingstone Conference and share with the partners the vital research findings on drivers of the epidemic. An initial replication in the SAT network was held in January 2008 in Johannesburg where a team of partners from each country was presented with the research findings and allowed participatory sessions to think tank ways to work this information into the community responses. These country teams were then assisted by SAT to replicate the regional meeting at a national level workshop in all the SAT networks in Malawi, Mozambique, Tanzania, Zambia and Zimbabwe. Later in 2008 a similar initiative focusing on young people was initiated.

The intention of this approach is two directional: Firstly, to allow community developed responses to evolve in a contextually sensitive and appropriate manner while SAT focuses on keeping the partners up to date on relevant key driver information and new findings; and secondly, to feed the valuable lessons to other national and regional players and key stakeholders. This means having regular regional and national review workshops that also serve as a forum for researcher-led lessons sharing that can be presented at multiple stakeholder levels. The lessons on community responses that are shared among the partners hold important monitoring and research value and as such, SAT aims to harness this potential by inviting the original key driver researchers to these events in order to allow the researchers to witness first hand what effect their original efforts are capable of having in our communities. These regional review workshops are also replicated at national level to allow deeper and broader lessons sharing across the region. This document provides insight into a first such review meeting and the lessons shared between individuals, organisations, countries and researchers alike.

1 Background and Context

Sub-Saharan Africa accounts for 67% of people living with HIV and 72% of deaths in the world (UNAIDS Report, 2008). According to the UNAIDS report, the epidemic cannot be reversed and gains in expanding treatment access cannot be sustained without greater progress in reducing the rate of infections. Thus the prevention of new HIV infections still remains the key to reversing the epidemic. Prevention programming in sub-Saharan Africa has also recently been identified by UNAIDS and the Global HIV Prevention Working Group as an area in need of renewed and urgent attention.

In 2003, the Heads of State from the SADC region met in Maseru to discuss HIV and to pledge their political commitment to the issue. The Ministries of Health in Africa declared 2006 as 'The Year of Accelerating HIV Prevention in Africa'. In line with that declaration a SADC Expert Think Tank meeting on HIV prevention in high-prevalence countries in southern Africa was held in Maseru, Lesotho in 2006 to identify the key drivers contributing to the epidemic in the region. These were found to be high levels of multiple concurrent partnerships by both genders together with low levels of consistent condom use and in the context of low levels of male circumcision (SADC 2006, p.3).

The meeting recommended that UNAIDS, along with other stakeholders, take forward a process of continuing to review the research and evidence regarding behaviour change, social norms and male circumcision with a broader audience. The Southern African AIDS Trust (SAT) was amongst the first organisations in the region to take up this 'call to action'. In response to this, SAT together with SAFAIDS and UNAIDS held a two-day workshop in Livingstone, Zambia, in October 2007 with a range of other civil society organisations (CSOs) working across the region. Attention was directed toward the drivers of HIV, including male circumcision, intergenerational sex and multiple concurrent partnerships.

At the conclusion of the workshop there was a commitment from those present to find ways to integrate the information into existing programmes and share the information with other organisations.

SAT has a comparative advantage which lies in its approach of strengthening community competence to HIV and AIDS and providing technical and financial support to many communities, placing it in a better position to support communities to improve their prevention efforts, ensuring that the programmes are strategically focused and also enhancing prevention programming that is evidence-informed. SAT also supports and encourages increased research that can lead to further evidence-based HIV prevention efforts, thus building upon the momentum that started in 2006 with the Maseru SADC Expert Think Tank meeting.

Honouring the 2007 commitment made in Livingstone, SAT hosted two follow-up prevention workshops in 2008. Under the auspices of its School Without Walls (SWW) programme, the first workshop in January 2008 focussed on the key drivers of HIV, and the second in August 2008 focused on youth-driven HIV prevention. These workshops provided fora in which partners could contextualise the information, discuss strategies to take the information forward and thereby enhance prevention programmes at community level. The workshop in August focused specifically on youth-driven prevention and the relevance of the key drivers to young people.

Both workshops of 2008 addressed the three thematic prevention areas:

- male circumcision
- intergenerational sex
- multiple concurrent partnerships

As a follow-up to these workshops, SAT considered there was still a need to further enhance the knowledge of its partners in order to increase and strengthen the scale-up of prevention programmes, their impact and sustainability through a review of programmes being implemented and the sharing of lessons and experiences.

A review workshop was thus organised to draw together participants who attended the two regional workshops held in 2008 and other organisations, including strategic partners outside the SAT network, which had shown success in HIV prevention programmes. This 2009 review workshop was intended to consolidate the gains made through previous workshops and to take the process one step further, built as it was on the commitments made by SAT's partners during the 2008 workshops. It was intended that the workshop would enable partners to provide feedback on what had been done and what they were currently doing, to discuss the challenges they had faced, and to make commitments for carrying forward the lessons learnt. Partners were also asked to include as part of their delegation to the review workshop someone with extensive experience so that the workshop could be rich in practical experiences and to enable the sharing of this information with those from other countries, communities and organisations.

The review workshop took place over three days from 24 to 26 March 2009 at The Birchwood Hotel and Conference Centre, Johannesburg, South Africa. The workshop was attended by a total of 35 participants from 8 southern African countries. The objectives for the workshop were provided as follows:

- To share lessons and exchange ideas between partners as well as providing SAT and facilitators with evidence to carry forward further lessons learning exercises, and to add locally contextualised knowledge that will inform and increase regional prevention goals.
- To provide an opportunity for research experts to present technical update on the key drivers of the epidemic with a focus on areas of young people, women and other groupings for HIV prevention to facilitate programming.
- To develop shared understanding of the key drivers of the epidemic necessary for comprehensive prevention responses that are based on evidence from participating organisations and research.
- To look at existing HIV prevention programmes, identify how SAT partners have applied the knowledge gained from the two previous workshops (what has worked and what has not worked) and to develop strategies for moving forward or for future directions.
- To strengthen participant's skills and teamwork on key areas of HIV prevention programming.

Participants were asked to share freely and to contribute and participate fully. It was hoped that successful strategies that would help build on current momentum of partner organisations in implementing their HIV prevention activities could be identified.

It was also anticipated that following the workshop participants would be in a better position to plan for future directions and to identify new opportunities that would lead to the delivery of more effective prevention initiatives that would ultimately result in improved programme performance.

This report presents a synopsis of the findings from that review workshop.

Participants in group discussions

2 Male Circumcision

What is Male Circumcision (MC)?

Male circumcision is the surgical removal of the entire foreskin of the penis.

Following a presentation on the evidence for male circumcision and HIV prevention, participants were asked to give an overview of activities currently taking place in their respective countries and communities regarding male circumcision.

Only Zambia was reported to have a clear policy on MC. Malawi, Zimbabwe and Botswana did not as yet have clear policies, and neither did South Africa. However, all of these countries had started to either integrate MC services into existing services or were advocating for MC at different levels of society. The case of Zambia was highlighted as being well ahead of other countries with MC services:

- In Zambia organisations collaborate with service providers of MC to promote access and quality services.
- There is also collaboration with an NGO that provides mobile MC services. Clients are referred for MC to those who offer such a service. Some countries like Zimbabwe had the services but not enough doctors in the health system.

Information on MC was commonly disseminated by partner organisations through workshops conducted to sensitise community leaders including traditional initiators to promote their understanding of MC and to promote access to safe MC services. Information, education and communication are achieved using different channels e.g. video, radio, TV etc. Theatre for Community action is used in Zambia. Some organisations link up with experts to ensure the accuracy and relevance of the drama content. In Zimbabwe the SAYWHAT magazine is used to disseminate information.

Factors identified as barriers to MC promotion included:

- Limited facilities, human resources and information;
- The lack of clear policies, either government or policy within organisations;
- Inadequate MC information in rural versus urban areas;
- Lack of MC educational materials in local languages;
- Lack of materials for the visually impaired;
- Unclear message sent/unclear packaging of information;
- Lack of good role-models in the communities; and
- Problems in parent-child communication on matters around MC.

Strategies used by partners to overcome barriers included:

- Collaboration with available experts;
- Talking plainly and simply about how MC is done e.g. anaesthetics for pain relief during the procedure;
- Referral to MC service providers;
- Advocacy, people coming out with personal testimonies;
- Using local drama clubs; and
- Host Talk shows.

MC experience in certain countries

Participants described what steps were being taken in their areas with MC, and the following general snap-shot from the different countries emerged:

Zimbabwe

- Conducted a survey on male circumcision to assess the knowledge levels;
- Conducted feedback presentations to students on findings on male circumcision;
- Produced newsletter on male circumcision;
- Conducted advocacy campaigns on the advantages of male circumcision;
- Dealt with mixed reactions and feelings to male circumcision (some asked “why should I cut off my foreskin?”).

Group discussion

South Africa

- Conducted research on male circumcision using existing Youth Organisations;
- Perceived that there might be resistance from the Zulu clan because they regard circumcision as a Xhosa tradition (although research has not shown this to be the case);
- Conducted dissemination of the research findings;
- Noted overall response from the youth was good;
- SANAC currently preparing a draft document for government consideration.

Malawi

- Conducted awareness among the youth and traditional leaders on male circumcision;
- Conducted sensitisation on the 3 key drivers;
- Addressed perception that MC is an ethnic issue for the Moslem community;
- Met with traditional leaders from the north who strongly oppose male circumcision;
- Conducted meetings with member NGOs, CBOs and other local leaders;
- Encouraged parents to open up for their children to access male circumcision;
- Male circumcision is currently being provided in private hospitals on request;
- No data on impact available at the moment.

Role players who could support circumcision

All participants were asked to identify whom they felt were, or could be, the most valuable champions for circumcision. The role players identified included the following:

- Local leaders (political, religious and traditional leaders)
- SAT partner organisations and members
- Traditional circumcisers and initiators
- Medical personnel
- Young men (those already circumcised in communities)
- The Ministry of Health – through traditional leaders/healers, community leaders
- Faith-based health services/organisations

When asked why these role players were important, it was widely agreed that most have the power to influence the communities, they are assumed to be credible, and they can be reached and supplied with appropriate information after training.

Participants were then divided into groups – those working in or with communities where MC was a cultural or religious practice, and those working in or with communities where MC was not prevalent as a cultural or religious practice.

Group 1: Low prevalence circumcision

Questions posed to this group included the following:

- *Have you been able to/not able to include safe MC into your interventions? How and why?*
- *Who did you target? What were the outcomes and responses?*
- *How has your community responded to your MC intervention? Was there acceptance or barriers? How did you overcome these successes/no successes?*
- *How have you addressed any stigma of MC in your community?*

Bringing the message of male circumcision into communities where it is not traditional practice was said to be best done through community and government involvement during awareness campaigns. Training of stakeholders on safe MC (traditional leaders, traditional circumcisers and initiators, medical personnel and young men) was considered essential. On the whole community acceptance has not proven to be a particular problem. Rather it was resources and questions of who should be doing it – in some places there were no hospitals or clinics, hence the importance of raising awareness/training of safe MC with all stakeholders. Appropriate and culturally sensitive messaging was of on-going concern. Formulating proper messages so as to avoid confusion and to stress the medical benefits to the individual and the community was seen as vital.

Participants from Zambia highlighted initiatives they have taken to introduce MC into their current HIV prevention programmes (see Case Study 1, page 13).

Steps taken and shared with other participants included the following:

Zambia

- Conducted focus group discussions;
- Conducted sensitisations in ART clinics on male circumcision throughout the 8 existing ART clinics in Mumbwa district;
- Made use of the 15 treatment support workers to scale up in the communities – these were trained by the district AIDS task force, and so far about 5 people (of sexually active group) have come for MC per day;
- Provided training on sexual reproductive health;
- Advocated for the key drivers of HIV with a specific focus on MC;
- Held talks with teachers on the advantages of MC;
- Conducted national workshop to unveil the findings on MC;
- Organised meetings with CBOs on MC;
- Conducted sensitisation among the youth and sex workers;
- MC is provided in hospitals and there is an overwhelming response (to the extent that there is a waiting list, and people are even paying money to jump the queue);
- Other NGOs are coming in to start providing MC starting with those of at least 7 years of age;
- MC has now been piloted in 3 districts.

Group 2: High prevalence circumcision

This group was asked the following questions:

- *How have you been able to address the HIV preventative aspects of MC in your community?*
- *Have you made it part of an existing prevention approach/a new project? How?*
- *How have you dealt with any conflict arising from the difference between traditional/cultural circumcision and medical circumcision?*

Participants in this group felt that because the practice has been in place in some areas for a long time as a rite of passage, it was not difficult or necessary in some cases to address it as preventative per se. Many community members already had an idea about the association between male circumcision and diseases like STIs. MC had already in some cases been promoted as an intervention to reduce STIs, such as through a campaign rolled out by the Government in Mozambique. In some places circumstances like intermarriages among different ethnic groups prompted the demand for circumcision. For example in the case of Mozambique where there are 3 groups in one region (one practising circumcision, the other two not), mixed marriages between individuals from the 3 groups sometimes resulted in men losing their wives when they realised the man was not circumcised. This was said to have an impact on changing, or 'forcing', MC uptake in the region. Correct message dissemination was seen as key: targeting the traditional initiators with hygiene messages; and the need to take on board new methods of approaching the practice, including the use of theatre.

It is important to target the traditional initiators with hygiene messages and take on board new methods of approaching MC.

Education regarding circumcision and its important preventative aspects was part of the pre-natal training in some places for pregnant women. In Tanzania, there is reportedly a government policy in place for time to be given at every meeting to address messages of HIV prevention. Participants stressed that HIV prevention and MC strategies need to be approached in different ways in areas where traditional circumcision is prevalent:

- For example, some children go for circumcision while they are still young, others are adolescents or young men who go through the initiation ceremony as a rite of passage into adulthood. The issues arising are therefore different according to age and the reason for MC. Including MC as an HIV prevention approach needs to take these aspects into consideration.
- In some countries the approach to safe MC has included not practising traditional circumcision during hot seasons because the healing process can be impeded. In some places cognisance has been given to school holidays to ensure that children who go through the process do not abscond from school.

Good Practice – Male Circumcision

Selected CBOs participated in structured interviews aimed at documenting how partners made use of new information on the evidence for male circumcision and HIV prevention. While eight partner organisations were selected for the interview process, all revealing dedicated efforts to take information on MC forward, three case examples are showcased below for purposes of this report.

Case Study 1

Kotakota AIDS Support Organisation, Malawi

Type of intervention

MC integrated into existing HIV and AIDS projects.

How did the project start?

After the SAT prevention workshop attended in January 2008, we made a proposal for a one-year project and included the 3 drivers. We are doing the prevention as part and parcel of a comprehensive programme in our organisation, but as far as the 3 key drivers are concerned they featured highly in our programme after attending the workshop.

What is the project's current status?

We address issues affecting the youth and sex workers, and we are specifically targeting fishermen on these 3 drivers. The project is due to end in June this year, so we will be evaluating the project at that time, including an external evaluation.

What factors presented obstacles and how did you address them?

Some have to do with the issues of acceptance, e.g. we do couple's health education – wife and husband, when discussing the issue of condoms, there is sometimes resistance because the wife feels you are introducing the condom as a means of giving permission/agreement to infidelity. On the issue of MC we have Christians and Muslims. When advocating for the community to know that MC is an HIV-preventive measure, the leaders of the Christian church felt we were trying to convert them to Islam. We overcame this by having focus group discussions where we targeted the church elders and local leaders as well as the youth. It is one of the ways we disseminated and enabled people to capture the right information. We also have community dialoguing bringing in people that have undergone what we are discussing to share personal experiences so people can make their own decisions. Some leaders are trained to be peer educators and they invite stakeholders to come and talk at the meetings.

What factors helped/facilitated your work?

The approach that we take is that we usually involve the community and we work hard to instil ownership in all our projects. The people take the activities as their own. When we are planning, it starts at the grassroots level so we have a network for exchanging ideas and information on the issues.

What are your next steps?

We conducted a baseline survey in November 2008 taking into account the 3 key drivers. Our next steps are to programme for the next 2-3 years utilising all the research as well as information from our own baseline survey. The baseline was facilitated by us but the questionnaire was developed in conjunction with other organisations. We are now analysing the data and have included in this year's budget the convening of a meeting for all stakeholders in the area to share progress and outcomes. We then need an external evaluation and we will negotiate with SAT for funds for this.

What advice can you give to other organisations?

To look for the resources to conduct your own baseline so you have a picture of exactly what is on the ground because it may differ country to country, area to area, as is the case with MC. Then come up with good programmes that respond to what is on the ground. It is also important to network with other organisations. We will evaluate our programme in June this year but we have already done a service delivery assessment and our project on women empowerment has been evaluated.

Case Study 2

Youth Cultural Promotion Project (implementing partner of Youth Network, Forum for Youth Organisations), Zambia

Type of intervention

The MC project fits in under our existing HIV prevention package.

How did the project start?

After the 2008 SAT workshop we received the report and circulated it to member organisations. The organisations took an interest. A proposal was submitted and we have been awarded money for three months to use the information and create awareness through theatre. The project is to run in Kabwe. Experts have been invited to help inform the messages of the drama, and drama in line with particular messages can then be commissioned.

What is the project's current status?

There are 16 Theatre for Community Action projects that are currently running. Each caters for between 500 and 1 000 people. After the drama, focus groups invite 15 people for in-depth discussions. In each of the 16 communities we work in we have what are called Community Action Groups. After sharing information, these Action Groups are then asked what they would like to take forward as a priority. Each Community Action Group is linked to the nearest health facility or clinics and IEC material was provided by our funder.

What factors presented obstacles and how did you address them?

We have limited IEC materials which would help to consolidate the new knowledge being acquired and to help supplement drama messages. Sustainability is also an issue. We did not have sufficient funding to train all volunteers and instead set up a support structure so that volunteers could go to the nearest health facility and access personnel who could then help them with information if required. It would have been good to train them all. There is no guarantee of continued funding. It was important to us that the dramas carry the message of a combination approach to prevention. We use the metaphor of a soccer team whose defence is not limited to the goal keeper. So we say with male circumcision, don't throw away the rest of your defence team like condoms. It can be a challenge to performers to get this message across in a short drama.

What factors helped/facilitated your work?

The analogy of a goalkeeper and the rest of the defence was our approach. The use of theatre and tailored dramas to reflect cultural aspects of the community and drama was performed in local language. We also used local performers from the community. The performers were professional actors but were familiar to the people (given that they were locals). The community could relate easily to them especially because they spoke the same language.

What are your next steps?

We need to form more Community Action Groups. We will be conducting follow up monitoring and an evaluation process after 3 months. We want to know if people are going to the health facilities. We have baseline data so can compare pre- and post-numbers. We are considering scaling up activities but through deeper concentration within the same areas. We want to emphasise the messages to the same people to ensure impact.

What advice can you give to others?

We need to consider language and culture in our interventions. We must take care not to stigmatise other groups/practices. We need to simplify our IEC materials. Drama captures so many people. It is a popular way of getting messages out there and should be considered by others.

Participants discuss male circumcision

Case Study 3

Thavalelo Association, Mozambique

Type of intervention

It is part of our other projects.

How did the project start?

We invited the traditional leaders from the different communities. We also involved some medical personnel to highlight the advantages and benefits of MC. We sat with the traditional and local leaders to try to find community strategies. We saw that there was fear and the misinterpretation of information. So we sat together to find ways to make the messages clear and correct.

What is the current status of the project?

We are currently organising men's groups working with communities and addressing male circumcision. Results are starting to come through. Before MC was only practised in the traditional way. Now attitudes are starting to change.

What factors presented obstacles and how did you address them?

The big challenge was the messaging and getting it appropriate. In our community the issue is not about promoting male circumcision but about promoting safe male circumcision.

What factors helped/facilitated your work?

Inviting the leaders helped. Having the medical personnel on site also helped as they could explain the advantages from the health perspective and give the necessary evidence.

What are your next steps?

We want to get people to the medical centres themselves. This is a problem because some communities are far from the health centres and this is a costly exercise. The plan is then to try to get the medical personnel to the communities. Medical personnel can stay in an area for a few weeks and provide the necessary procedures during that time. The government is involved and paying for this to happen. We are also working with other partners to get medical personnel out to the communities – partners such as World Vision and Save the Children. We also want to organise some campaigns in those communities.

What advice can you give to others?

Get health personnel into the areas. Organisations cannot work isolated. We all need to link up with other organisations interested in this issue. We need to lobby political leaders so that they are engaged (traditional leaders). It is a big challenge because some people are reluctant. Culture can be a barrier. We need to work very hard. It's just a matter of time. We can't change the way people think instantaneously. We need to work consistently. Maybe this is a generational thing. We need to be careful with the messaging we get through given the risk that people misinterpret the information and think MC makes them 100% safe. Then they abandon other prevention strategies. We need to highlight that MC is not 100% safe.

3 Multiple Concurrent Partners

What are Multiple Concurrent Partners (MCPs)?

Multiple concurrent partnerships can broadly be described as relationships where an individual has two or more sexual relationships that overlap in time. Experts use different time frames to describe MCP including concurrent relationships that last one month or longer and relationships that have been active in the previous three months.

Following a video by Soul City entitled *'Untold Stories – Secrets and Lies,'* and complemented by a presentation on the topic, groups were divided into 4 "stakeholder-programming groups". These groups represented 4 different target populations for MCP programming, namely:

- programming targeting young people
- programming for older men
- programming for older women
- programming for leaders – religious, political and traditional

Groups were asked to share lessons learnt from taking knowledge about MCP forward with these various stakeholder-programming groups.

Young people and MCP

Since HIV prevention amongst the youth remains a major focus of many SAT partner organisations, participants were asked to share their experiences with MCP programming amongst the youth. The following general snap-shot of regional initiatives currently taking place in the region by SAT partners emerged.

Botswana

- Awareness of MCP and its impact through radio programmes such as *'Silent Shout'* is currently underway
- Training of youth and community leaders as counsellors to address MCP
- Advocacy on inclusive policy – youth were being left out, now they will be considered

Lesotho

- Collaborated with the National AIDS Commission to distribute posters on MCP targeting the youth during last year's (2008) World AIDS Day

Tanzania

- SAT partners have been encouraged to mainstream issues of MCP in all their interventions
- Young people formed youth groups to engage in peer education from school to school
- National campaign called LIVE supported by FHI, focusing on MCP
- Zooming-in campaign to the coastal areas where tradition was seen to perpetuate the practice – targeting traditional leaders
- FATAKI campaign, targeting young women

Multiple and concurrent partnerships under discussion

Mozambique

- Youth-to-youth intervention
- Theatre, speeches and debates targeting youth in and out of school
- Use of commemorative days to advocate for government to get involved and address MCP

South Africa

- Soul City – *One Love* Campaign educational materials distributed and discussed
- Research on young people, adolescents and sexual reproductive health
- Targeting of youth welfare organisations with MCP messages
- Conducting needs assessment targeting the youth in KwaZulu-Natal, Limpopo and Mpumalanga – used findings to cascade youth issues and concerns with MCP
- System support – use of research to help people plan according to specific challenges that exist in their communities
- Training on using research findings about MCP for leaders of youth welfare agencies

Zambia

- MCP is an ongoing concern for Zambia and has been identified as a priority – diverse programmes
- School programmes and out of school programmes currently taking place
- Use of drama and one-to-one debates
- A consortium formed to target school girls and those out of school
- 360 girls trained in various skills, 86 fully trained and 50 currently employed
- Micro finance programme in place – 30 girls given start-up loans with 86% repayment rate

Namibia

- The two key youth network players were infected when they were young, one is a former celebrity (middleweight boxing champion of southern Africa) and they have been encouraged to act as role models, focusing on young people and sharing personal experiences with MCP
- Radio programmes to sensitise people is currently underway
- Partner peer educators targeting places of entertainment
- Involvement of State President to address issues of HIV and MCP (President is Patron of the organisation)
- Training of youth in counselling through Lifeline
- Targeting youth living with HIV
- Addressing issues of alcohol, MCP, HIV and AIDS and treatment

Malawi

- Partners have mainstreamed MCP messages into all interventions
- Targeted religious leaders to address MCP with congregations
- Ran national workshops on MCP for all SAT partners
- Part and parcel of the One Love Campaign implementers, programme is currently being rolled out

Zimbabwe

- Justice for Children staff orientation on MCP
- Currently putting into place a workplace policy on HIV including MCP
- Orientation of other organisations on MCP so they can mainstream MCP in their programmes
- Awareness raising on legal challenges of issues of child inheritance (raising awareness of the consequences of MCP, such as illegitimate children and their rights)

Older men and MCP

Participants from partner organisations that have attempted to work with older men to address MCP identified the following activities as ingredients for successful programming:

- Do community sensitisation first through talk shows, workshops, drama, meetings, video shows
- Some CBOs have conducted situational analyses for better understanding of the dynamics of MCP, before attempting to address the issue
- Need to do advocacy against cultural practices that promote MCP
- Older men respond better with counselling and education
- Collaborate and network with other CBOs on addressing key drivers including MCP
- Train and involve men as peer educators in MCP (including other key drivers)
- Train fishermen boat owners to disseminate HIV and AIDS information to other fishermen (Malawi)

- Use model families *(Mabanja aChitsanzo)* for awareness raising on positive behaviours (e.g. 'zero-grazing' or drawing from Malawi experience where communities select these model families on the basis of their own specified criteria)

Older women and MCP

Participants concurred that MCP amongst older women was not uncommon. In some place there are culturally acceptable forms of extra-marital partnering which the family would know about and condone. One example cited was the practice of *'Nyumba Ndongos'* from Tanzania. It was also said to be not uncommon for young men to get involved with older women to receive help e.g. for transportation, accommodation, etc. Women who have lost their partners, have escaped abusive marriages, or have never married were reported to get men to fulfil their sexual desires and provide material support. Wives of truck drivers who were away a lot, or wives of fishermen who worked at night were also reported to engage in multiple partnering.

Participants from partner organisations that have attempted to work with older women to address MCP identified the following activities as ingredients for successful programming:

- Train couples on the use condoms when they suspect promiscuity and teach faithfulness.
- The wives of police officers can be trained on how they can talk to their husbands about HIV and AIDS, VCT and MCP (Tanzania).
- Educate and discourage people from ritual cleansing (widow cleansing in Zambia).
- Encourage marriage soon after graduation to try to prevent MCP.
- Produce ongoing radio programmes which discourage people from engaging in extra-marital affairs (Zambia).
- All public gatherings usually include some mention of HIV and related topics, and now they include MCP (Tanzania).

Leaders and MCP

Participants from partner organisations that have worked with leaders (either traditional, political or religious) to address MCP identified the following as ingredients for successful programming:

Traditional leaders

- They must first be sensitised on MCP in the communities.
- Traditional leaders can be, and have been, trained on MCP and its dangers.
- Committees can be, and have been, established in some communities to 'whistle blow' on MCP issues.
- Partners in Zambia have sought and gained the 'buy-in' of particular chiefs as role models.
- Inter-developmental approach – use structures already in existence and take advantage of groups/community activities on the ground and the atmosphere and openness in the community so that raising the issues of MCP is accepted by the people

- Target communities, especially traditional leaders, in their own territory because they know what is and is not acceptable in their own context. Allow them the opportunity to prepare a set of standards for their community.

Political leaders

- Lobby political leaders to come up with a specific position on MCP because of its socio-economic implications.
- Conduct sensitisation campaigns on MCP with political leaders (e.g. Malawi), including mentoring new/changed Ministers following frequent Cabinet reshuffles which result in the same people rotating and no new ideas/knowledge being introduced. Most ministers are not qualified - group discussed need for ministers to have achieved a certain academic level that would reduce continuance of stale/old ideas which created difficulties in gaining acceptance of political leaders to new information and need for action.
- Networking together and creating consortiums to address the issues, lobbying together as a consortium rather than standing alone as one organisation.

Religious leaders

- All participants agreed that the voice of religious leaders needs to be much louder on this issue. These leaders have moral authority and need to be encouraged to use it to speak out against MCP.
- Must start with sensitisation meetings.
- Training of marriage counsellors: in churches people go to counsellors before marriage – key opportunity that some partners are trying to use.
- Targeting church leaders to address and discourage sexual bias against women and unfair responses and perceptions (e.g. if both or either man/woman having an affair neither is more right/wrong, they are both wrong. Some Zambia churches are using this strategy.

Sound bites from discussions on MCP

"Training alone is not enough. We need to encourage the young to become role models."

"The most vulnerable is the one who thinks he is not vulnerable."

"Development workers like us are very vulnerable to MCP. We are away at workshops. We have the privacy of our own rooms. We are away with colleagues from other places. Even in our own countries MCP happens at workshops."

"Take advantage of community gatherings. Talk in the peoples' own territory, about their own problems."

"We tend to look at a man with a woman; we forget the sugar mammy is very real."

"How can leaders advise on MCP when they are doing it themselves?"

"The approach is important – rather not say it is wrong but that we have a problem."

"Show the results and consequences, and work back to the risks."

"When working with chiefs, don't overlook the chief's advisors (given they interpret things for the chief)."

"The community is like a clay pot, you cannot see what's inside. . . you must listen first."

Good Practice – Multiple Concurrent Partnerships

Case Study 1

Consol Homes, Malawi

Type of intervention

Our focus is OVCs, although we also have other HIV and AIDS programmes incorporated into it, community home-based care, support groups, prevention programmes etc. Whilst our programmes target the age group 0-18, actually they work with almost everyone.
In terms of MCP we have been doing several awareness campaigns and sensitisation processes with the local traditional authorities and chiefs, religious leaders, and members of parliament. We have discussions with these groups.

How did the project start?

We were already doing prevention. After the SAT workshop, I went back and mobilised staff at office level even the director by sharing with them information about the key drivers. The director welcomed the ideas. He helped me to mobilise the other members of the community, families and youths. Staff at the office also welcomed the ideas including that of MCP. Some women groups were also talking about this issue of MCP because they have been suffering as a result of this for some time. Men mostly practise this and typically women just comply with, or submit to, what the men say they must do. Some of the programmes are gender specific. There are for example women's clubs, and girls clubs, and boys clubs. But there are also occasions when the groups meet together to share views with one another.

What is the current status of the project?

In response to our discussions with them, community leaders have set up an MCO committee. One of the volunteers in a child care committee had a relationship with a female volunteer but he was married. The chiefs acted on this and basically told him that he and perhaps even the female should step down from the committee if they continued this relationship. They are therefore putting pressure on people not to practise MCP. The youth also have their own committees and they look into the issues of the youth and how they should act against HIV. They run campaigns for youth.

What factors presented obstacles and how did you address them?

The community leaders responded very well. But there are some leaders practising MCP. There are polygamous families where men have wives and still engage in sexual relationships with younger women. This is a big challenge. However the leaders have responded well in other parts and this includes the traditional leaders who are trying to help break this. For us as an organisation we have focused first on the traditional chiefs as the custodians of the people. But some of them are actually lower chiefs. Our interventions can be difficult if the village headman is involved in MCP because they begin to feel discriminated against by the others. It does however seem to put some pressure on them to abandon these MCPs so that they are not ostracised by the other leaders. If a chief says something is unacceptable, this generally carries influence.

What factors helped/facilitated your work?

There was buy-in and support from the organisational staff including the director. This has made this work. Also people are starting to support of young people that are part of MCP and IGS but do not want to be. A young girl disclosed something like this to children at the centre. The youth are in a position to go to the leaders and reports such incidents. The chiefs intervened in this case and helped the girl to get out of the situation.

What are your next steps?

This year we are planning more training for guardians and leaders including traditional chiefs. Local leaders include religious, political and traditional leaders. This training will be on prevention and will include the issue of MCP. There will also be training of youth. Some youth groups try to select leaders in these groups so they can train others. This is the same model that has been used with other topics such as HIV and AIDS, as well as psycho-social support.

What advice can you give to others?

For successful implementation we need to focus on the influential people such as traditional chiefs and leaders. Children also discuss issues with parents and this ultimately gets to leaders. If they are not well equipped, they might refuse to play a constructive role. If enabled they can help to roll-out. SAT could perhaps help us by considering inviting some influential leaders to attend these workshops where they can hear this information firsthand. This is sensitive information and sometimes it can be like we are children going to them and telling them this information. If they attend such sessions, they could be very influential people in helping to roll out programmes. Perhaps a few influential leaders from different regions could be selected.

Case Study 2

Rumphi HIV/AIDS Education Awareness Programme, Malawi

Type of intervention

IGS is mainstreamed into our 4 existing programmes:

- youth programme
- PLWHAs/home-based care
- women empowerment
- orphan care

This describes the women empowerment programme.

How did the project start?

Two Canadian missionaries came to the Seminary with their wives. One was a nurse and she discovered that women aged 15-29 had STIs. She thought this was a dangerous situation and decided to start the youth programme to capture these ages to address and prevent HIV infection. I was one of the members requested to join after 2000 when the project was funded by SAT. I did the women's empowerment programme.

What is the project's current status?

After doing an assessment we discovered that poverty was the most difficult issue among women which drove them into multiple partners. We found out that most of the women were widows, and this ran them into poverty because of the loss of the breadwinner. So we asked them what interventions they could implement; there were many including pig rearing. All the women who were given pigs have benefited and are selling some of the pigs.

What factors presented obstacles and how did you address them?

Usually we come up with interventions by doing a needs assessment. However, funds have been a big problem because we were not a registered organisation and so were unable to access funds from other donors. Now we are a registered NGO.

What factors helped/facilitated your work?

Working in collaboration with other stakeholders and organisations.

What are your next steps?

To extend our catchment area. We have registered some success in terms of reduction of HIV infection (stats from hospital) – in 2006 the rate was at 14% and in 2008 it was 12%. Have also been doing a lot of campaigning against IGS and MCP and will continue this (but not on MC because the government is silent).

What advice can you give to others?

As soon as you get new information act on it promptly before the situation worsens because the little you can give makes a difference. In most cases we have discovered that people go to workshops, then go home and sit on the information, but if you take action people appreciate it. Last year, it was before we had written a proposal, and I briefed everybody about IGS and MCP and sought information from the local leaders/chiefs and had a meeting with them. We invited Mr and Mrs Chiefs as counsellors (one of the topics was cervical cancers). We also trained a drama group on how to stage shows and gave them info on HIV and AIDS and domestic violence so that from the topics they could formulate dramas. All this was funded by SAT. So use the information and create interventions.

> "In 2006, HIV infection rate was at 14%. It was down to 12% in 2008."

4 Intergenerational Sex

What is Intergenerational Sex (IGS)?

Intergenerational sex is a sexual partnership between a young woman or man and a partner that is at least 10 years older.

Following a presentation on the subject and review of key points from previous workshops and the action plans that emerged from participants at those previous workshops, participants spend some time reflecting on the circumstances that tended to breed IGS in their various communities and the challenge of addressing the issue. One participant stated: "IGS is found in the case of cultural practices such as wife inheritance. It is also widespread amongst students as a result of economic challenges, as is the case currently in Zimbabwe and elsewhere. It can also be perpetuated in cases when families are struggling to make ends meet." The issue of sexual satisfaction as a driver of IGS was a common theme. "Often people turn to sex with younger people because there is more sexual satisfaction with a younger man or a younger woman. The young are more physically active". Others stressed the need to debunk or demystify such cultural beliefs and myths "No, satisfaction is not just about age. You can still enjoy sex with your own age group." Clearly there is a need for education on sexuality through the life cycle.

The phenomenon of "Queen Mothers" was described and was familiar to participants from at least three countries represented at the workshop. The Queen Mother refers to an older retired commercial sex worker who sources young women for sex with older men. The Queen Mother earns a fee for this transaction. In such cases women are in fact enabling IGS rather than protecting young girls from this potentially risky situation. In Malawi it was said that IGS was common amongst fishermen who tended to have relationships with younger women when away from their wives. At the lake these relationships are referred to as *"Fish for Sex; Sex for Fish"*.

Participants were then divided into the same 4 "stakeholder programming" groups as with multiple and concurrent partnerships. These groups included:

- programming among older men
- programming among older women
- programming among young people
- programming among leaders – religious, political and traditional

Groups were asked to share lessons learnt from taking knowledge about IGS forward with the various stakeholders or programming groups.

Young people and IGS

Participants from partner organisations that have attempted to work with young people to address IGS identified the following activities as ingredients for successful programming:

- We gave the youth voice – a key intervention that has been sidelined, we need to know what youth themselves think are the appropriate interventions.

- Start with sensitisation programmes.
- Awareness for young people that includes the community – not just young people separately, but with the communities in which they live:
  - radio programmes/TV programmes
  - lifeskills programmes
  - peer education (M&E to avoid it being abused)
- Economic empowerment for the young people and the community.
- Youth mobilisation through sports.
- Establish youth resource centres and youth groups.
- Review legal system/legal reforms with young people.
- Development of youth-friendly IEC (information, education and communication) materials.
- Media – newspapers, theatre.
- Involvement of the youth, parents and the community in education.
- Advocacy for governments' involvement and political commitment.
- Develop linkage between schools and community programmes (direct link).
- Integrate HIV issues in schools' syllabus (from primary to tertiary levels).
- Produce regular update documentation of best practices.
- Go beyond age-brackets, not a blanket approach – we talk about 15-24 but each age has different challenges, e.g. 16-year-olds different from 23-year-olds, some are in universities – there is a different culture of independence.

Participants discuss intergenerational sex

Sound bites from discussions on MCP

"Youth participation is an intervention in itself."

"A young girl of 13-15 years living in a patriarchal society has no say over her life. How do you deal with these marginalised girls?"

"Parents and youth are not communicating – need joint interventions."

"Legislation is in place but not enforced."

"We tend not to understand our children. We tend to think that what works for us works for the youth."

"In Tanzania we had a youth group – they chose their own leaders, created peer groups and encouraged young people to go for testing, it worked very well. But they were too dependant on the donors. We tried to instil some knowledge to give them ideas/encourage their own income generation."

"Many girls from well-to-do families are practising commercial sex. What interventions do you propose?"

" Some youths lie about their age so they can engage in relationships with older persons."

Older men and IGS

Targeting older men to conscientise them about the association between IGS and HIV was said to be key to discouraging intergenerational relationships. Participants from partner organisations that have attempted to work with older men to address IGS identified the following activities as ingredients for successful programming:

- Men's sponsorship and men's championing. Men have to take the lead in awareness-raising for example in workplaces, at funerals and in advocacy.
- Use men as peer educators to influence behaviour change.
- Awareness-raising should target cultural practices that put men into superior positions (in decision making and issues of human rights of young people).
- Reinforce cultural values and responsibilities of the older men over younger people so they don't abuse their roles as caretakers.
- Fathers must provide for their daughters/their own children to be responsible.
- Older men should/must protect younger women's rights. (A story from Zimbabwe was told of an old man involved in a relationship with a girl. When she fell pregnant, he abandoned her without any support and also failed to provide for the child). The emphasis should be on men's need to protect women and not to abuse their positions.
- Assist older men to take up their responsibilities as parents.
- Assist men to transfer the new messages on IGS that they got during their initiation.
- Establish structures that encourage dialogue on the issue.
- Use group committees with people of the same age (an example of this came from Mozambique), i.e. older people together and younger people in separate committees. The committees then discuss sexuality, IGS and HIV and AIDS issues.

- Do awareness on dangers of IGS in the form of STIs and cancer of cervix. The provision of counselling and training on STIs, HIV and cervical cancer.
- Provide lifeskills training for young women on how to get out of poverty and dependency.
- Discuss with older men how to increase sexual satisfaction with their wives. Older men can be encouraged to communicate more with their spouses on what makes them sexually satisfied.
- Situate sexuality within developmental life cycle – create an opportunity for the older men to understand their sexuality and their cultural aspects. They should have regard for and see the value of the messages that come from younger men.
- Provide information about growing old – menopause and andropause (the male equivalent). The issue of understanding each other at different life stages is important. We equip men with knowledge on how to deal with these situations (counselling and skills to deal with issues of aging).
- Programmes such as *'Men as Partners'* in South Africa and 'Padare' in Mozambique are effectively addressing IGS as part of their men's group work.
- Advocate for national policies that would support these interventions.
- Discourage and campaign against MCP by older men through community mobilisation and imposition of negative sanctions for IGS.
- Mobilise communities to stigmatise and shame IGS. Example Fataki Campaign in Tanzania (see poster below). Fataki is a fictional sugar-daddy used as part of a campaign to oppose IGS. Such old men are also referred to as "explosives" in the quest to stigmatise and warn of the dangers of this behaviour. Such men are those who violate their positions in some way, police, hotel personnel etc and also tend to incentivise the sexual transactions often being called ATMs by the young girls.

Poster to discourage sugar-daddies in Tanzania

Taken from www.pepfar.gov/press/119789.htm

Sound bites from discussions on MCP

"By sleeping with young girls, men in higher positions are breaking their positions of trust."

"There is reluctance to target older men with IGS messages. Men are culturally expected to 'know it all'."

"Older men are at the epicentre of both IGS and MCP. They have to be engaged."

"In Malawi, IGS occurs through the cultural practice of cleansing. Now some of these reformed cleansers are being trained as IGS practitioners."

" In our cultures we are socialised to believe that relationships should be between younger women and older men. If the man is 21 years old and the woman is 21 years old, then we say the woman is actually older."

Older women and IGS

Participants from partner organisations that have worked with older women to address IGS identified the following activities as ingredients for successful programming:

- Target couples with the knowledge that this sort of activity does occur and therefore the use of condoms is of critical importance. (Nkhotakota AIDS Support Organisation, Malawi).
- Intervene with the wives to teach them the skills on how to speak with their husbands.
- Create an atmosphere of openness in talking about sexuality and other issues of concern involving sexuality through open discussions with older women (Tikondane Home Based Foundation, Zambia). Discussions help to challenge cultural beliefs that women are supposed to be submissive to men and the issue of men being the head of the family.
- Facilitate focus group discussions targeting community members on sexual issues.
- Work with men because they can be obstructive when there is an attempt to engage women in conversations about sex.
- Organise community events including sketches and songs where community members of different age groups select suitable topics for open discussion. Target specific topics which have a bearing on IGS and MCP for that community like polygamous marriages. Community events also help to demystify cultural practices like accepting IGS as normal.
- Organise a Grandmothers Club where older women share their experiences (Kimara Peer Educators, Tanzania).
- Also organise fun sessions for grandchildren within the Grandmothers' Programme mentioned above help to discourage age disparity in marriage. These help to debunk the strong belief that young women cannot marry younger men.
- Organise talks about breaking cultural beliefs that the age difference between partners equals sexual satisfaction (MUMBWA NZP+, Zambia). Debunk the myth of sexual satisfaction being age dependent and promotion of sexual satisfaction in committed relationships. Stress that sexual satisfaction is made up in the mind.
- Queen Mothers (in MUMBWA NZP+, Zambia) are involved in income-generating activities such as tailoring, pottery and poultry farming to provide them with an alternate form of income to that of pimping young girls or commercial sex work.

- Training of the Queen Mothers (KWENUHA Women's Association, Zambia) as community volunteers for which they are given an allowance, or training as community counsellors to reach out to young girls (as in WAMATA, Tanzania). Messages from retired sex workers were viewed as coming from "one who knows" and therefore a credible source of information for other women.

> "The Queen Mothers we work with are all rehabilitated sex workers. We have 9 clubs. Some of these clubs are headed by Queen Mothers, others by community volunteers and peer educators. All are given an allowance." (MUMBWA NZP+, Zambia)

Sound bites from discussions on MCP

"There is an issue of control with IGS – one wants to feel in charge/control of others. The age difference sometimes means that the older woman can demand certain things from the younger man that is exciting. In same age relationships the man is more likely to be the one in control."

"Power dynamics are a factor. Boys tend to say that if girls want to have the power to initiate relationships and sexual behaviour, then they should also carry equal responsibility like paying for the man when they go out for lunch."

"In our organisation we often say growing up and growing old are two different things. Growing up is optional. Growing old is mandatory."

"We talk of sex workers as if they have nothing. In Tanzania 30% are legally employed and 20% are university students. So it's not something restricted to the poor."

Leaders and IGS

Participants from partner organisations that have worked with the various levels and types of local leadership to address IGS identified the following activities as ingredients for successful programming:

Traditional leaders

- Use them to spearhead discussion forums: In Zambia there are discussion forums for traditional leaders and some traditional leaders are promoting condom use. Now they are talking IGS.
- Conducted counselling for traditional leaders/sensitisation workshops.
- Have deliberate, targeted campaigns for traditional leaders: not just bringing in traditional leaders to open a function, they must be part of the campaign at planning stage so they own the process, are involved and can institute 'sanctions'.
- Scale up SRH interventions to traditional leaders: many leaders hold sexual reproductive health as taboo, but we have involve them by identifying core leaders and equipping them with information and knowledge so they can then target other leaders (as in Zimbabwe – Ntengwe).

- In Mozambique, traditional leaders trained as peer educators has helped to get buy-in for interventions from their peers – a way of empowering traditional leaders to empower themselves.
- Training of trainers (TOT) for traditional leaders for them to roll out to others: creates role models among the chiefs, e.g. the chief who went on TV and promoted condom use.
- Use of theatre for development in local languages (dramas): this is happening in Zambia, e.g. forum for African women using theatre to reach out to the chiefs. However, drama can be destructive – do not use primary school children as they may say something inappropriate in front of the chief. Include young people in age range that makes sense to the chief.
- Need to first translate the interventions into local languages: and language traditional leaders can understand and find easy to use.
- Develop safety nets for traditional leaders: so they can refer cases they feel they cannot handle/ referral points to get reinforcement/further information.
- In Mozambique traditional leaders address HIV issues during initiation ceremonies

Religious leaders

- Start by conducting sensitisation campaigns for religious leaders to open up: they have the moral voice; they are marrying IGS couples so they need to understand about risk.
- Encourage and assist them to mainstream HIV and AIDS into their sermons.
- Do training workshops specifically for religious leaders: correct focus of content – if labelled HIV prevention, they send a deacon or someone else but don't come themselves.
- Use theatre for development to communicate to very difficult religious leaders.
- Continue with advocacy for inclusion of IGS, condom use, prevention in their curriculum: factor in cross-cutting issues and integrate with what already exists. At one pastors' conference condoms were in the toilets, these were being taken and utilised. So no problem using them, the problem is giving the message to use them.
- Develop faith-appropriate IEC materials (written in 'faith-style' language). For example some are perceived to be pornographic and therefore the religious leaders find them unacceptable.

Political leaders

- Work on Influencing political leaders to make policies and laws (lobby) that prevent IGS: enhance relationships with them.
- Encourage political leaders to take a leading role in influencing positive change.
- Strengthen advocacy on IGS: present petitions to parliament – need to be heard, work together as a team not single organisations.
- Devise interventions that will work through the Speaker of the National Assembly: don't rely on members of Parliament, go straight to Speaker.

Organisational leaders (NGOs)

Participants felt that the leadership of local organisations that were advocating for behaviour change (especially against IGS) should be aware that they are also local leaders and role models. Participants described efforts that they had made to nurture the leadership of their specific organisations. These included:

- Educate and build capacity of leaders on the effects of IGS (e.g. transactional sex).

- Create a broad awareness on IGS among NGO staff.
- Conduct in-house sessions in NGOs on effects of IGS.
- Stiffen and enforce codes of conduct for NGOs on cases of IGS (role models).
- Develop a strategic communication system to other stakeholders on IGS – disseminate info.

Sound bites from discussions on IGC

"We need to work to empower leaders to empower themselves."

"What about our presidents in southern Africa because most of them indulge in IGS?"

"Chiefs act as entry points into communities, why not use them to advantage?"

"Political players have been left out of interventions."

"Chiefs have many wives – need for right communication strategy/approach."

"It is difficult to penetrate the Church, more effort needed here."

"Religious leaders say IGS is dangerous, next day they bless an IGS marriage."

"Might have left too much responsibility with interfaith networks, rather go to individual churches."

"Religious leaders can influence other religious leaders. Motivation begets motivation."

Good Practice – Intergenerational Sex

Case Study 1

Pfiriael Kiwia, Kimara Peer Educators, Tanzania

Type of intervention

The Grandmothers Project consists mainly of single women and widows who care for OVCs. As such it is not targeted solely on IGS. We do not have a lot of child-headed households. We do however have a lot of women older than 55 years of age taking care of young children.

How did the project start?

We started in the 2007/2008 period, after attending the SAT previous prevention workshop, with 32 women. We intended to offer training in 2008. We shared with the organisation the plan to focus on the older women with the assumption that they are not sexually active so how are they going to talk about sexual issues. We wanted to help them have these conversations. Self-help projects already existed. By the end of this year (2009), we anticipate having 52 women in the group.

What is the current status of the project?

They now meet at least twice a month and during feedback sessions on projects we got to meet the children in these families. We then decided to have two sessions – one for the younger people and one for the grandmothers. These are fun sessions, not just about projects, HIV and other problems. Initially when we started with the project the emphasis was on caring for non-biological children. It has broadened now to include coping skills including IGS and MCP as a way to meet financial needs.

What factors presented obstacles and how did you address them?

It was difficult for the women to speak openly. We had to build close relationships with them individually first to develop trust. Women tend to go with younger men as a result of their capacity to provide financial support. Typically these men are between 32 and in their 40s. The topic is a sensitive one and a way we got around it was to ask people to write personal experiences on paper. Only later did they start to share experiences openly in the larger group. Eventually they became comfortable in these sessions.

What factors helped/facilitated your work?

The staff in the organisation played a key role. We all sat down and discussed the key drivers and the problems of IGS and MCP and not practising MC. It is easy for skilled counsellors to speak to women. It is not easy for older women to speak easily with younger women. Our programme approach uses peer learning. We are a peer educator support organisation so have lots of skills in working this way.

What are your next steps?

We have already motivated a younger team of educators. We need to help the older women to join the other programmes and encourage them to go for VCT. We need to scale up to a wider group. This was not a core activity but we are expanding the Grandmothers Programme so this will continue. The grandmothers themselves want to be trained as facilitators/educators. We would like to roll this out in the community. We need to look for funding to cover travel expenses to other communities.

What advice can you give to others?

There is quite a bit of demand from the members of a number of NGO forums for these issues to be integrated into their programmes. We need facilitators' guides and manuals to encourage members to do this. We advise integration, but are empty handed.

Case Study 2

Tikondane Home Based Foundation, Zambia

Type of intervention

We have two projects running: the Behaviour Change Project; and the Prevention and Care Project.

How did the project start?

We engaged the community leaders and chiefs. We shared the rich information that we had gained at previous workshops and we had a good response from them. MC is not widely practised in our communities. We have thus far had meetings with the communities to discuss the issue.

What is the project's current status?

MCP and IGS are both quite strong. Most of those involved in commercial farming and small industries have multiple partners. Generally there have not been major challenges. The issues exist and we have been able to say we are being driven as a community by these issues. We are trying to address them and people want to understand the benefit of MC. We are involved in a consortium project with three organisations and with commercial sex workers. One of these organisation focuses on media, awareness and IEC materials. They have therefore helped to spread the message. Radio programmes have been conducted every Wednesday and Friday to discuss MC and how this could affect our community.

What factors presented obstacles and how did you address them?

The kinds of questions people pose about MC include: Will I be safe? Will I never contract HIV if circumcised? So getting the proper information out there is important. There is also a lot of focus on age and when people can be circumcised. Couples tend to still want separate meetings when discussing such issues. Some of these things are considered to be issues men want to talk to other men about. Things like "is it painful?" or "how is it done?" are questions that men feel more comfortable talking about when with other men. We stress the fact the medical procedure is different from the cultural process, and that it is safe and clean.

What factors helped/facilitated your work?

The radio programme includes a phone-in section so the community can ask questions. Questions are also directed to the organisations. Even schools have called in to speak about the key drivers. Drama and focus groups are also good mediums to encourage youth participation. They open up space for the sharing of information. Home based care services also provide an opportunity to meet the community and talk about prevention methods. It is easy for us to introduce information in this way. Meeting groups in a clinic setting has also proven to be a good strategy for encouraging couples to open up.

What are your next steps?

The radio programme was just a trial run. But the evidence is there that we can get a good response, so we intend to have more of these programmes running. We also want to take up an awareness campaign on male circumcision. We also want to produce our local magazine which is currently in English, in our local language.

What advice can you give to others?

MC and its health benefits can be used very strategically. We need to educate others and it is critical that people understand that MC does not make one "bullet-proof". Men tend to misunderstand the message. With MCP and IGS, cultural barriers need to be breached. We need to communicate that these are not serving us. IGS in particular makes girls very vulnerable and there is much work to do in terms of sensitisation at schools. We need to work together and speak with one voice.

> "It is critical that people understand that MC does not make one "bullet-proof".
>
> (Tikondane Home Based Foundation, Zambia)

5 Creative Messaging Exercise

In an effort to encourage partners to develop locally sensitive and culturally relevant messaging around the topics of male circumcision, multiple concurrent partnerships and intergenerational sex, participants were given an opportunity to design posters and suggest slogans that would be appropriate and likely to resonate with community members.. The following are some suggestions that arose from the groups.

Participants engaged in group discussions

Radio, TV and other media such as posters

Appropriate messages to discourage IGS would be:

- "Having sex with young girls is wrong, stop it!"
- "It could be your daughter, stop it!"
- "A man does not undress before a young girl – think before you act."
- "Love potions will kill you old man. Stop having sex with young girls!"

Condom promotion

An appropriate visual would be:

- "Pictures of an STI infected organ, for instance a penis infected and dripping with pus, displayed in drinking places with the message: *'Real men always use condoms when they have sex.'* "

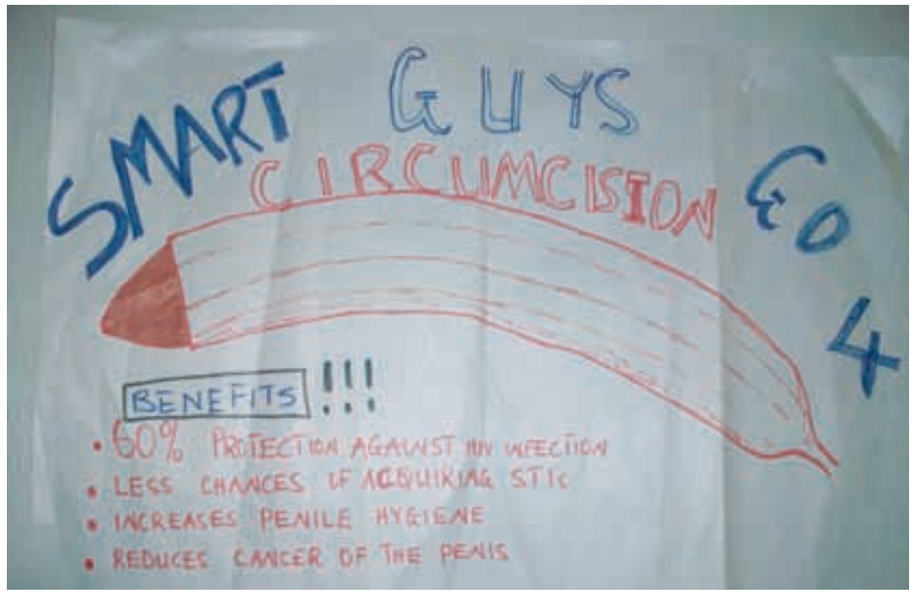
Posters advocating MC

Appropriate messages would be:

- "Parents promote your son's right to health – take him for IT".
- "Real men prevent their partners from cervical cancer through circumcision – go 4 IT".
- "60-65% impact" could be developed into a drama for TV or radio channels, and used at community gatherings that bring people together – punctuated with dance to create an 'accepting' environment.

TV advert on male circumcision

Adverts should emphasise the benefits of MC (see figure below). In the background some nicely written letters saying 'CIRCUMCISION', (Use a picture of a banana so as not to cause offence). Then flash the following messages across the screen:



Suggested advert/poster for MC

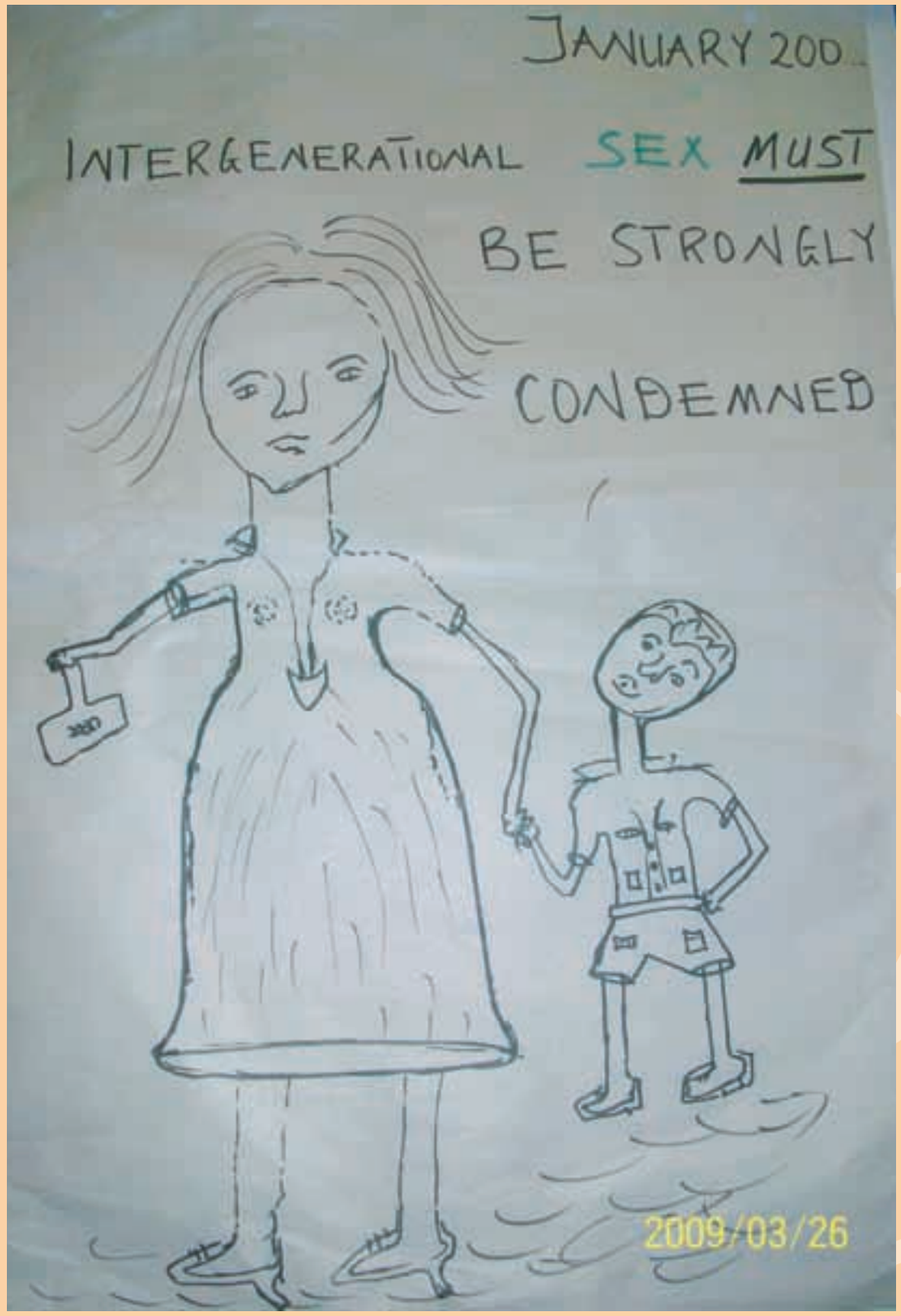
Drama – theatre for community action

Use drama with key messages about:

- Relationship between IGS and spread of HIV.
- SRH based approach, with IGS as component.
- Effects and risks on the bodies of young men and especially (incompletely formed bodies) of young girls – complications if pregnant, can die giving birth. Using basic language to increase understanding that the message is not just about saying it is wrong. Highlight the importance of the chiefs and traditional leaders and the role they can play in rolling the messages out so they gain a level of ownership.
- The drama could end at a point of discussion without any specific decisions and pertinent questions will be asked as a forum of discussion based on what has been seen in the drama and in the community.

Develop and distribute a calendar

These would be with a different picture carrying a different message every month targeting the key drivers (see figure below). For example, the January message could be – "IGS must be strongly condemned". Each month carry a new and reinforcing message.



Suggested calendar addressing key drivers

6 Conclusion

Following on from SAT's work of the past few years to inform their regional partners of the evidence for the key drivers of HIV in southern Africa and to encourage and support their efforts to address those drivers, partner organisations have made considerable and variable efforts to introduce and roll-out new prevention activities. While most have made initial starts with projects, they are aware that there is much room for improvement, growth, and further intensification of efforts. Ongoing constraints to the effective implementation of programmes, as well as facilitating factors and opportunities for achieving greater programmatic success, have been identified, and plans have been made by partners to work towards more effective programming.

Among these plans are commitments to make greater efforts to address the cultural and ethnic challenges of male circumcision; working more closely with traditional and religious leaders; addressing the lack of progress in terms of policy development and enforcement of progressive legislation in many of the countries; advocating for more resources especially human resources in the form of medical personnel; designing simple and clear IEC materials in local languages with which to assist in the dissemination of information and the reinforcement of messages provided through other media; addressing gender imbalances which undermine the engagement of women in discussions involving sexuality; and sharing of information and doing more training in order to promote behaviour change, especially amongst partner organisation members themselves.

Due to SAT's rapid response following the 2006 Maseru Think Tank Meeting, vital new evidence on the region's major HIV drivers has been disseminated among several key regional organisations and cascaded through those partners' local networks and communities. As a result, several good practice initiatives are currently underway to address the key drivers. Some of these activities are being assessed and monitored while others are not. There remains a need to ensure that partner organisations document, monitor and evaluate their myriad activities and their outcomes, as well as continue to have opportunities to share their successes and failures with other organisations. Capturing the finer details of the impact of initiatives being taken to address the key drivers of HIV will require more research. Such research will help to ensure that the lessons being learned along the way are not lost, and any new directions taken by partner organisations are the correct and essential directions for enhanced HIV prevention programming.

The HIV key drivers that partner organisations are currently attempting to mainstream into their HIV prevention efforts will likely continue to be major focal areas for prevention programming in the region for some time to come. SAT and its partner organisations are well placed to be playing leading roles in the production of knowledge that will inform an intensified HIV prevention effort for southern Africa. The work of SAT and its partners is a model initiative for HIV prevention in the region and should be encouraged to continue and expand.

Appendices

Appendix A

Personal Views on Male Circumcision (Fish Bowl)

In an effort to sensitive participants on the differential challenges involved in programming male circumcision in areas where circumcision is part of cultural initiation processes and where circumcision is not part of such processes, a fish bowl activity was held.

Participants formed two circles. An inner circle was formed by participants from areas where MC was cultural practice, and an outer circle comprised of those where MC was not part of cultural practice. After the first round of questions the membership of the circles was reversed. Any participant not comfortable with the fish bowl could opt out and there was no requirement to answer all the questions. Some of the ensuing dialogue is detailed below.

First fish bowl – MC part of culture

Question 1 – What is your personal position on cultural MC?

- I grew up with it in my culture. When I was 6 years old I was circumcised. In our culture it is called by a different name and you have to go in groups.
- Personally I have no problems with traditional MC; it is fine, because it is part of the culture which forms part of the traditional norms which govern us.
- We may call it traditional because it has been accepted. I was circumcised at the age of 16 but before the process I was not feeling very happy when I heard other boys, but after circumcision I felt very proud, I felt free. It was something to be proud of because if you do not undergo circumcision then you won't be accepted in your group and also are not involved in many social activities like others are.
- No problem to me. I got my circumcision when I was 8 years. When I asked my grandfather why he waited until 8 years he said he was waiting for my penis to be in a good shape for circumcision.
- My personal opinion is that we should not rush to condemn the society that is practising traditional circumcision. We should promote it in another way because in my society it is like the mingling of the Christians and Muslims and this is a good practice.
- For me circumcision is faced in a natural way because it represents the values of my community where I was born. Thanks to the circumcision it helped me to be a respected boy in the community because the girls and boys could play with me. My grandfather always told me interesting aspects about health and he also told me that if I didn't have the circumcision done I was not going to be able to play with other people, could not have a bath with other people. For these reasons the social aspects are important.

- I will talk about my late husband. When we got married he didn't do the circumcision so it was a problem for us to have sexual intercourse. It was hard work to pull the skin upwards but it was almost the same because we felt something, but when he went to the military service and was amongst groups of friends, he decided to go by himself to be circumcised. When he came back things were different; sexual intercourse was more pleasurable than before.

Question 2: People have voiced their concerns that MC is painful to go through. What can you tell men in response to this?

- Any practice that involves getting a cut can be painful, but as in such kinds of intermediary you have to go through pain. The pain is not indefinite and we have heard enough about the benefits of going through this pain. So it is a pain worthwhile going through.
- I personally feel that circumcision hurts, that is the truth. It is also the truth that our forefathers set values. It is the same way we have to do military service. In my opinion despite the pain, when a male goes through circumcision he goes through the status of becoming a real male. So I would say imagine the young soldier who goes into the army and returns to the community afterwards, imagine a young man that becomes circumcised and joins society, he feels free and he feels that he has values.
- Traditionally they were doing it at age 14 because when you went to surgery you were not getting erect. So when it is done as an adult get away from the women because the penis gets erect and it is very, very painful when you have stitches. There is no anaesthetic and after the process for one week you will feel pain, especially in the morning when you want to wee.

Question 3: As a man who has been circumcised can you share with us whether you experienced any differences in the way society treated you afterwards?

- One thing for my community, some people are practising circumcision because of religion. My father was a priest and so for him it was about becoming a Muslim. When you go to the river for a bath you have to wait for those that have been circumcised to finish bathing. I was in a boarding school and I had to save my pocket money and then go to the hospital to get circumcised secretly. In boarding school you wait until midnight to have a bath; otherwise the boys will laugh at you, not willing to share if you are not circumcised. So you get respect if you can prove that you are now circumcised.
- I was lucky because I did my circumcision very early but I saw boys of my age in my village that really suffered a lot for not having it done. Boys and girls knew that John and Manuel weren't circumcised and therefore John and Manuel were excluded from the group. In the river they couldn't bath with the group, at school couldn't sit with the group, and even worse couldn't play with the group; there was a big noise.
- In my society it goes along with change of names as well, so if you were called MacDonald you will be called Mr MacDonald, separation of boys from men, an obvious difference. Now even your mother will call you brother instead of calling you by your first name and you will be called the name you have inherited from your uncle or grandfather.
- In my case I was a little bit older when I did my circumcision. I did not feel rejection or discrimination although there were some sorts of issues because as boys we liked to show off and show our private organs. Myself, I used to feel a bit out of place because I was not circumcised maybe also others were in the same circumstances; hence I always had the worry of wanting to be circumcised. My family was neither for or against

Particapants discuss their views on male circumcision

circumcision they simply did not have anything that made them want me to be circumcised, it wasn't an enforced situation but I always wished I could be circumcised. I did it when I was 21 years old.

- It was like a gift to me because before that time I had difficulty to mix with the boys of my age. I was alone most of the time. I wasn't circumcised until I was 16, so it was like a gift. I was accepted into my group, I felt I was like others; I could share and also in the area where I come from there are traditional places where the youth used to go in the evenings. I also used to go in the evenings feeling like somebody who is accepted. Before that time I did not feel accepted but they did not tell me because I was hiding and could not go to the places where boys were taking a bath. I don't know how they would know I wasn't circumcised because I was trying not to be near to them but sometimes at school we were changing clothes because of sport.

Question 4: As a woman in your community can you share any experiences that show how men in your community have been affected by going through cultural male circumcision?

- Personally I have not had any adverse situations where men have been affected. I did, however, witness when boys found out their colleague was not circumcised they attempted to do it on their own. Fortunately we managed to deal with this but it shows how the situation can get worse when the passage of rite is broken. The other thing I witnessed among the boys, when you get to a certain age and are not circumcised you are considered a cowered because the pain can bring you from a boy to a man. But the boys are not prepared and for those not ready, it is difficult. So I realise it is a procedure that if it is not done on you, you have a lot of set backs in that community. The other point for women is that when their boys go for it under 18, 16, 14 years, the mother has the time to cook for you special diets and it is the time to talk to your mother, the only time when you talk to your sons, so this is something we would miss in our community.
- In the area where I live, some families break this traditional circumcision and they leave

the decision to that youth. Also they do not use any sterilised instruments and after 2 or 3 weeks where a boy was cut it became septic and lots of sores. All around the penis was very swollen and inflamed and they did not know what else to do. Later he was helped by a nurse who lives in the area. They took the youth to the hospital and he was cured. It is something that we can capture from our community to serve as an example and share with the general population that to do circumcision that way can be very dangerous. In answer to the question about before and after circumcision I can say that sex after circumcision is much easier and it is not so easy for the circumcised man to transmit illnesses/infection.

Question 5: Some of you have mentioned that you were circumcised early, some later in life. When you approached the time what were you feeling about it, emotionally, psychologically? And what were you expecting of the procedure?

- At first I was optimistic because I heard from my community that I would have the opportunity to be married and be accepted in my community. I thought I could marry any girl in my community.
- For me it was a mixed bag. I went through a process of a mixture of Christian and traditional because it is still done in the bush but done by a doctor. I could see my friends screaming when I approached the place. I was scared but I knew my friends, some of them don't know how to board the aeroplane and only know how to scream. When it came to my turn I confirmed my fears but this is what I was expecting and it was the rite of passage in my community and I had to go through it.
- It was done very early in my life. I was taken very early in the morning by my eldest brother. He told me you are not going to school today you are coming with me. He took me to the bush, there were 4 adult men, they held me as if I was a bird and they put me on the ground. Each man had his own role. After that I felt extreme pain. After that they released me and the traditional person that did my circumcision tried to console me saying it is past, you are a man now. I have to confess I was extremely hurt towards him. That hate I had for him lasted for about 2-3 years, I didn't want to face him. He used to ride a bicycle and every time this gentleman passed by I used to run away.
- Before I was circumcised I had 2 different groups of friends. I had a group circumcised from my school and another group not circumcised. At school my friends always asked why are you not circumcised, why are you not going to be circumcised? After I was circumcised I had problems with my peers from my other circle because they were now teasing me. I always wanted to be circumcised because there was a lot of talk about infection and diseases and I was afraid of getting those diseases. I saw my mother go through 2 operations and she had to have courage in me so I wanted to have this operation. You see my mother used to tell me when I gave birth to you I didn't feel any pain, so I am sure to cut a bit of skin you are not going to feel any pain.

Question 6: As a parent, what did/do you want for your boy child with all the information that is available to you today?

- I have a grandchild whom I wish could be circumcised in the first six months so that he could not feel pain.
- For me I have 3 sons. I took them to the surgery when they were 14. I enjoyed doing the cooking and listening to their stories when they woke up in the morning.
- I have 3 sons and I made sure they were done before they were 6 months old because sometimes they look different when they go through the rural areas.
- I have a son. When he was 8 years old I took him to hospital so he could be circumcised.

Second fish bowl – MC not part of culture

Question 1: Think of your communities, do you think there would be resistance to clinical MC?

- I don't think there will be any resistance. After the workshop there were lots of inquiries about where they could go for circumcision.
- Not much resistance if parents take their children. We just need to ensure it is in the best interests of children and that this is emphasised.
- Resistance is not an issue in our community. We have seen a good response. People who can make decisions on their own are ready to do it.
- There should not be resistance. I am from a town in Zambia with highest HIV prevalence rate. There is so much suffering so people are working together to bring this down.
- I am from a rural part of Malawi where there is no history of male circumcision. When we introduced information to the chiefs and sensitised them, they were comfortable with other key drivers but said "a big no" to male circumcision. This is a thick wall to break through. We work with them on other issues but they said if we wish to continue working with them we must not speak about this. They ask why no cure for the virus has been found.
- There is no problem in the peri-urban settings. In the rural settings we have a culture of initiation. They are resistant to change and wary of people trying to convert them.
- Youth will go for it. Those who are 60 years and above are not highly sexually active so they won't go for it.
- We will never have 100% acceptance and this issue needs time to be accepted. We have faced resistance but there has also been acceptance.

Question 2: What are your personal concerns about having male circumcision performed on you?

- My major concern is the misplaced emphasis on sexual satisfaction. People tend to stress that rather than health reasons. People then get defensive and say that they have no problem with their sexual prowess or sexual satisfaction. This is not acceptable to me. It is also not acceptable when people try to say that not being circumcised means one is not man enough.
- My concern is I am married with two children. I have no problems with my sex life so far. The pain worries me though. We are talking about a very tender place. I have no problem with good hygiene. I think there should be free will around this issue.
- Firstly I fear the pain, and secondly if I become the unfortunate one and the wound does not heal, I fear losing such an important part of the body.
- The concern for me comes from my immediate family. I am happy to be circumcised but I worry about my wife and my girls, the last one is 18 years. If I said I wished to do this they would say "You are 58 years old? What for? What do you want to achieve?" Personally I have no problem. I have even taken grandchildren for circumcision.
- I am accepted the natural way I am. Foreskin removal and pain thereof has put me off. My parents told me to do this but I would rather leave the situation as it is.
- I have no problem with what I am. I am productive, I can perform, I have good hygiene. There are other ways of protecting ourselves from HIV and AIDS like condoms. But as teacher I encourage people by way of providing them with good information so they can make their own choices.

- No man should take away what has been given by God. I would feel strange if I had this done. I believe in giving people the information and letting them make their own choice. I can't make this decision for my son; he will make his own choice. Other HIV prevention methods do exist.

Question 3: As a parent what are your concerns for your children especially the boy child? What do you want for him?

- I have spoken to my teenage son about circumcision and I would be pleased if he decided to do it.
- My major concern is that I give my son all the necessary information so that he can make an informed choice. When he was young, I was told to let him be older than 5 years when it is done. But then when our children get older they say no. I see my responsibility as giving him the information so he can make his own decision.
- I believe in ensuring he has the ability to choose. There is nothing fantastic about circumcision when growing up. There is no serious stigmatisation. I would want him not to make judgements about others but rather be comfortable with those who are circumcised and those who are not.
- He must be given the choice to make own decision. I will give him the right information.
- If I have a son I will make sure he does not make choice from cultural or peer pressure.

Question 4: Does the gender of the practitioner make a difference?

- I would be more comfortable with a man. A big decision would have been made. I had a bad experience with a medical checkup by a female doctor. She used a pen to check my penis and I felt very humiliated. So I would feel more comfortable with a man.
- The most important thing is that the practitioner is qualified.
- I may not be comfortable with women. I react differently to different touches. I don't want to have an experience that is not attended to there and then.

A feedback session at the workshop

Appendix B
Workshop Programme

Day	Time	Session Title	Methodology	Facilitator
Tuesday 24 March 2009	08:00	Registration		SAT
	08:30	Opening Remarks		Lindiwe Dladla
	09:00	Introductions and Objectives	Spider Web	Gareth Coats
	09:30	Review our action plans	Presentation 30 mins and programme review	Gareth Coats
	10:30	Tea		
	11:00	Intergenerational Sexual Relationships	Presentation: recapping 2008 IGS discussions Q and A	Suzanne Leclerc-Madlala
	11:30	IGS Group Work	TBC: Contextualising how IGS info from 2008 has informed CBO work	Suzanne Leclerc-Madlala and SAT Team
	13:00	Lunch		
	14:00	IGS group presentations	Groups present findings	Suzanne Leclerc-Madlala/Gareth Coats
	15:00	Tea	Elect CBOs for interviews	
	15:30	Structured interviews for elected CBOs (in-depth for clarification etc) Non elected CBOs: Group Messaging Activity – Creative Messaging on IGS and Project Plan	CBOs that facilitators want to interview are nominated through the day	Suzanne Leclerc-Madlala, HEARD, SAT Team. 1 Facilitator for the campaign group
	16:30	All partners complete evaluation		
	16:45	Facilitators Debrief.		

> "Intergenerational sex must be strongly condemned!"

Day	Time	Session Title	Methodology	Facilitator
Wednesday 25 March 2009	09:00	Gallery Walk of Day 1 outcomes	Walk through flipcharts, post-it key questions and/or network requests	All
	09:20	Male Circumcision	Presentation: recapping 2008 MC discussions	Anita Sandstrom
	10:00	Tea		
	10:30	MC and our Programming	Group Discussions – Cafeteria model	Suzanne Leclerc-Madlala/Anita Sandstrom
	12:00	Group Presentations		Suzanne Leclerc-Madlala/Anita Sandstrom
	13:00	Lunch		
	14:00	Male circumcision and inclusion of MC in partners programming and community acceptance	Fish Bowl and present discussion points	Suzanne Leclerc-Madlala/Lindiwe Dladla
	15:15	Tea		
	15:30	Structured interviews for elected CBOs (in-depth for clarification etc) Non elected CBOs: Creative messaging to better target and promote MC (considering Fish Bowl discussions)	CBOs that facilitators want to interview are nominated through the day	Suzanne Leclerc-Madlala, HEARD, SAT Team. 1 Facilitator for campaign group
	16:30	All partners complete evaluation		
	16:45	Facilitators Debrief.		

Day	Time	Session Title	Methodology	Facilitator
Thursday 26 March 2009	09:00	Gallery Walk of Day 2	Walk through flipcharts, post-it key questions and/or network requests	Participants
	09:20	Multiple Concurrent Partners Video	Soul City Television Show	Gareth Coats
	10:00	Tea		
	10:30	MCP Review of 2008 discussions	Presentation	Suzanne Leclerc-Madlala and Rayhana Rassool
	11:00	How have we addressed MCP in our programmes? Discuss your own experiences and what has changed.	Group Discussions	
	12:00	Present discussion points		
	12:30	Lunch		
	13.30	Interview elected partners for clarity on MCP issues. Non elected participants: Creative Messaging to address MCP in your community		Suzanne Leclerc/ Rayhana Rassool
	14:30	Tea	Elect partners for interviews	
	15:00	Continue interviews if necessary Carrying Forward our lessons shared	Commitments? Plans? Challenges?	Gareth Coats
	16:00	All Partners complete evaluations End		

> The most vulnerable person is the one who thinks he is not vulnerable.
>
> (MCP discussions)

Appendix C
Workshop Participants and Contact Details

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> “Start at the grassroots level so that there is a network for exchanging ideas.”
>
> (Kotakota AIDS Support Organisation, Malawi)

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Appendix D – References

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Supporting documentation made available to participants

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