



STRATEGIC ADVOCACY, SKILLS SHARING & CAPACITY-BUILDING EVENT ON SEXUAL & REPRODUCTIVE HEALTH RIGHTS IN SOUTHERN AFRICA

22 – 25 NOVEMBER 2011

CAPE TOWN – SOUTH AFRICA

INTRODUCTION

CHRISTELLE CRONJÉ, EXECUTIVE DIRECTOR, MOSAIC
& KATHY MULVILLE, EXECUTIVE DIRECTOR, WGNRR

This partnership event was hosted by Mosaic and co convened by the Women's Global Network for Reproductive Rights (WGNRR), Centre for Health Policy and Innovation, the Triangle Project and supported by NACOSA. The event aimed to create a space for SRH Advocacy Capacity-building and to provide a platform for regional advocates to engage on global SRH developments in preparation for the ICPD +20 and MDG +20. Advocates from more than 7 countries participated in deliberations at the Mosaic Training Venue in Wynberg, in Cape Town over a period of 4 days.

This important opportunity sought to build and strengthen Southern African Regional capacity in Sexual and Reproductive Health advocacy at national and regional levels through definition of major issues, exploration of opportunities and challenges, and sharing of skills knowledge and experiences. The event comprised of three components (1) development of a new agenda for SRHR, (2) advocacy skills building and (3) preparation and capacity building for CPD and ICPD review processes.

We are confident that the four days spent together with inspiring activists from around the region recharged, focused and positioned our energies in a space conducive to stronger partnerships and mobilization efforts that provide a foundation for future advocacy initiatives.

Christelle & Kathy

I am the issue you seek out to address,

But somewhere **you lost me**, this
much you must confess

You used to **desire**, to bring about the
change

But you'll discover that things remain the
same

I draw in the terminology, **jargon** and
verbosity and I am overshadowed by the
acronyms and policy

What happened to **simplicity** which
eloquently spoke articulate in action?

The berries you **broke**

What happened to the **action** in victims'
strategy?

It bonded with philosophy and soon become
a theory

Workshops, our languages skills improve

But we are movement and we should **be**
on the move

I am the issue, there are many just like me

And as you deliberate, **I wait** patiently

Slowly but surely **the door closes**
on me

But the frame work, pulsation, plus
passion is the key

SAMMANATHA NDLOVU – SEXUAL RIGHTS
CENTRE, HARARE, ZIMBABWE

HOST: MOSAIC TRAINING, SERVICE AND HEALING CENTRE FOR WOMEN

mosaic.org.za



Mosaic was established in 1993 and is an organisation with a strong understanding of and expertise in the field of violence against women, domestic violence, sexual violence and sexual reproductive health. Mosaic serves communities across the Western Cape and works in partnership with organisations in other provinces in South Africa. It is a , non-governmental organisation (NGO) with a specific focus on gender-based violence, preventing and reducing abuse and domestic violence, particularly for women and youth living in disadvantaged communities and providing a fully comprehensive Sexual Reproductive Service to women and girls. Important outreach work with men and boys forms part of the core functions of Mosaic. Mosaic’s main objectives are increased availability and accessibility to high quality, integrated services for survivors of domestic and sexual violence. All services are offered in English, Afrikaans and Xhosa and to a limited extent, French.

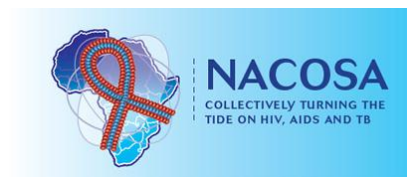
CONVENED BY:

WOMENS GLOBAL NETWORK FOR REPRODUCTIVE RIGHTS - wgnrr.org



WGNRR is a southern-based global network that builds and strengthens movements for sexual and reproductive health, rights (SRHR) and justice. Our work is grounded in the realities of those who most lack economic, social and political power. WGNRR works to realise the full sexual and reproductive health and rights of all people, with a particular focus on the most marginalised. We believe that achieving this goal requires transformative social change. WGNRR strives to achieve full SRHR for all people via advocacy, campaigns, networking and capacity building of members. WGNRR places a particular focus on access to safe and legal abortion, access to contraceptives, sexual rights and the special unmet demands of young people. Towards achieving this goal WGNRR will work to advance the implementation of SRHR targets within the ICPD PoA and the MDGs alongside commitments made under the Beijing Platform for Action.

NACOSA – nacosa.org.za



NACOSA is a network organisation with over 1,500 member organisations in South Africa and works in partnership with many regional and international organisations within the SRHR and HIV/AIDS field. NACOSA was a donor to the regional conference and their focus during the conference was health financing as it relates to SRHR and Violence against Women

TRIANGLE PROJECT - triangle.org.za



Triangle’s Vision is the development of a non-discriminatory society, where organisations such as Triangle Project are a choice and not a necessity, our mission is to contribute towards eradicating discrimination against and within the lesbian, gay, bisexual and transgender (LGBT) community, and to provide defined services to the LGBT community until they are no longer required. Our aims are educating, lobbying and advocating against harmful stereotypes, attitudes and behaviors towards Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) people; Providing relevant, defined services in a responsive and flexible manner; Building the confidence and visibility of the LGBTI community; Striving to achieve a better understanding of this community for ourselves and others; Establishing and utilising both functional and developmental partnerships.

PROGRAMME

Objective	Activity	Resource Person
Day One		
Welcome from Mosaic		Christelle CRONJÉ
Introduction to Programme		Kathy Mulville
Introduction of Participants		Kathy Mulville
Icebreaker		Kathy Mulville
Ground Rules	Participants define guidelines and principles for workshop and how they interact with each other	Jeanette Sloombeek
Advocacy Frameworks	Participants create their own definition	Rishita Nandagiri
	Facilitator confirms & adds information & confirms and/or identifies frameworks from suggestions	Jeanette Sloombeek
Advocacy Campaigning	Create Definitions for campaigning, advocacy, movement building, networking, policy influencing	Rishita Nandagiri Jeanette Sloombeek
	Link to advocacy process. Are these activities part of the advocacy process? Where do they fit in the model? Identify needs/challenges for youth advocacy	
Advocacy Skill	Accountability Literacy and Data for Advocacy	Phillipa Tucker AIDS Accountability International
Advocacy Process Framework National/Local Advocacy	Provide participants with framework for movement building and link to Advocacy Process	Rishita Nandagiri Jeanette Sloombeek
	Participants identify and discuss national advocacy issues	Rishita Nandagiri Jeanette Sloombeek
Interactive Evaluation		
Day Two		
Recap	To identify previous day's learning, to discuss current days objectives and to report on activities	Kathy Mulville
Advocacy Initiatives	To link current advocacy efforts with practical sessions below -Current National Initiatives	Karen Trueman: IPAS South Africa
Government Delegation ICPD	To provide a Government overview	Department of Social Development: Chief Directorate Population Development
The Opposition	Identify who the opposition is and how they organise Increased ability to counter opposition in formal and informal spaces Identify ways to monitor their activities and counter their arguments	Rishita Nandagiri
Future Advocacy Mechanisms	Repoliticising sexual and reproductive rights, An overview of the Langkawi Meeting . Why we need to look beyond 2014 at new development architecture and frameworks	Amanitare: Dr Lesley Ann Vorster
Current Advocacy Mechanisms	Identify differences with national advocacy Explore linkages and networks with broad alliances Apply learning to real issue within regional context Develop an outline regional advocacy strategy for same issue	Dr Marijke Alblas Jeanette Sloombeek Rishita Nandagiri

Youth Advocacy Interactive Evaluation	as worked on previous day in same groups Interactive panel and group discussion	Youth representatives
Day Three		
Recap	HIV/AIDS Funding In the African regional context: <i>Where is the money</i>	Kathy Mulville
Advocacy Priorities	Implementing Maputo Plan, MDGs and HIV/AIDS	NACOSA, Marieta de Vos Department of Health
Advocacy Priorities	Implementing Maputo Plan, MDGs and HIV/AIDS	Eka Esu Williams: Program Officer: Sexuality and Reproductive Health and Rights Office for Southern Africa, Ford Foundation
Regional Advocacy	Current Regional Advocacy Activities and youth challenges- Group discuss and identify	Kathy Mulville
Advocacy Issues and opportunities Interactive Evaluation	Participants develop an advocacy roadmap – and identify advocacy issues, frameworks and challenges	PANEL:SWEAT, Triangle, Gender Dynamix
Day 4		
Recap		
Advocacy Opportunities	The Peoples Health Assembly 2012	Anneleen De Keukelare PHA3
Advocacy Strategy	Developing an advocacy strategy – A case study for SA Identify strategic outcomes to develop Advocacy mechanisms for 2012	NACOSA Marieta de Vos Kathy Mulville
	Develop Action Plan	
New Development Framework	What are the issues/ challenges for New Development Agenda	Rishita Nandagiri
Advocacy Opportunities and communication	Increase participants ability to articulate messages using a variety of mediums in a safe and secure way Identify different mediums : Radio, internet, SMS identify opportunities and challenges	WGNRR
Interactive Evaluation Closure		

**ALL PRESENTATIONS & RESOURCES ARE
AVAILABLE FOR DOWNLOAD AT
WWW.MOSAIC.ORG.ZA**

DAY ONE

The focus of day one was to facilitate overall introductions of activists and partners, regional involvement and delegates focus areas of work relating to advocacy and programming. An overview of current advocacy frameworks, required advocacy skills and campaign-building created an environment for sharing and learning was also presented.

ADVOCACY FRAMEWORKS, SKILLS AND CAMPAIGNING

The morning session commenced with group specific discussions about the individual and collective understanding of advocacy. The following inspiring definitions of advocacy were shared:

- Influencing decision makers
- Speaking for those who cannot speak for themselves
- Accountability to realise a better environment for all
- Raising awareness and making change
- Speaking truth to power
- Action for change adding voice and lobbying stakeholders buy in

Advocacy is persuading people to take action. It is about recommending, supporting, challenging and defending Ideas.

Delegates shared their personal definitions and experiences in a group setting. The five groups deliberated on their current understandings and provided feedback to the bigger group. The feedback is summarised as follows:

1. Advocacy is deliberate action based on evidence to create change through:
 - A Human Rights framework
 - Strategic partnerships
 - Lobbying stakeholders
2. Advocacy is the strategic use of information and evidence to effect policy change that will improve the quality of life of targeted group.
3. Advocacy is about changing a mind-set, clear focus and direction, transparency and evidence based on information.
4. Advocacy is a service of strategic and deliberate actions that are directed at specific change.

Advocacy methods were seen to include :

- Mobilising/ consultation
- Use of evidence/ research
- Involvement of Stakeholders (beneficiaries and decision makers)
- Awareness raising/ sharing information and capacity
- Lobbying and campaigning to influence/ confront and persuade

AN OVERALL DEFINITION OF ADVOCACY

Advocacy consists of different strategies aimed at influencing decision makers at the local , provincial, national and international levels specifically :

- Who decides- elections, appointments and selection of policy –makers, judges, ministries, board advisers, managing directors etc...
- What is decided- policies, laws, national priorities, services, programmes, institutions, budgets.
- How it is decided- accessibility of citizens to information and the process, extent of consolation, accountability, and respondents of decision-makers to citizen and other stakeholders.



**GROUP
COMMENTS**

- How can we influence our beneficiaries to take ownership of the advocated programme?
- As Africans, we should look at ways of equipping young people to be agents of change at a very early age, so that we grow and invest in young role models who know what to do and how to stand up for what you believe in.
- How do you adjust your advocacy strategy as your context changes?
- How do you monitor the opposition?

Groups were then asked to discuss the processes of developing their local advocacy campaigns and agreed that accurate statistics and data is key to successful advocacy. Data and economic analysis was also recognised as an area that some advocates are not comfortable with but need to engage in to maximise the impact of their advocacy. It was further noted that experiences in the field compliment accurate data. The importance of recognising and adapting your advocacy strategy for specific contents was highlighted as well as knowing your stakeholders and

opposition forces. Other issues raised were the recognition of a clear time frame for activities, relevant resource mobilisation, clear objectives and goals as well as a mechanism for collecting data/evidence to support the advocacy initiative and fulfil monitoring and evaluation requirements.

Through intense regional and country group discussions, delegates summarised country specific goals and objectives in the following matrix:

COUNTRY	UGANDA	SOUTH AFRICA	ZIMBABWE	KENYA
GOALS	Reduction of maternal and infant mortality	Prevention of secondary victimisation of rape survivors by the justice system	Provision of comprehensive and holistic SRHR education for young people	To reduce teenage pregnancy and related deaths
OBJECTIVES	<ol style="list-style-type: none"> 1. Advocate for comprehensive sexual reproductive health care services for everyone by 2020. 2. Advocate for the legalisation of termination of unwanted pregnancy by 2020 3. Advocate for the integration of issues in the reproductive health in other development activities for sustainability. 	<ol style="list-style-type: none"> 1. Empower and support rape survivors 2. Train police and investigation officers, 50% of DOH, SAPS, DSD, court Staff, will sensitised and provide appropriate service that will decrease secondary victimisation by 2016. 	<ol style="list-style-type: none"> 1. We see a Zimbabwe youth (18-24 years) empowered openly to make sexual and health decisions in their lives, without feeling threatened or scared of any one. 2. Lobbying government for change in educational policies, stakeholder's campaigns. 3. Total re-structuring of system and change in leadership by 2015. 	<ol style="list-style-type: none"> 1. Kenyan youth free of unwanted pregnancy. 2. Access to comprehensive, modern, contraceptive methods and sex education. 3. Access to legal and safe abortion

Phillipa Tucker from AIDS Accountability International then presented on Monitoring the Maputo Plan of Action as well as facilitated a delegate discussion on accountability.

PRESENTATION: MONITORING THE MAPUTO PLAN OF ACTION : AN ASSESEMNT OF SEXUAL AND REPRODUCTIVE HEALTH RIGHTS. RESPONSES AND REPORTING IN AFRICA

PHILLIPA TUCKER, SENIOR RESEARCHER, AIDS ACCOUNTABILITY INTERNATIONAL

PHILLIPA@AIDSACCOUNTABILITY.ORG

PAPER DOLL CAMPAIGN



Female Condom Activist Tian Johnson presented the Universal Access to Female Condoms Paper Doll Campaign to the delegates. The campaign aims to combine awareness-raising in different countries and advocacy efforts at national and United Nations level. People from all over the world write down their message demanding female condoms on Zawadi paper dolls.

These dolls are then collected and made into a long chain, representing the worldwide demand for female condoms. The strings of dolls send the powerful message that there is a great demand for female condoms, from people all over the world. Female condoms can help to solve two of the greatest challenges the world faces today: HIV/Aids and unintended pregnancy. Worldwide, there is a great demand for female condoms. In order to bring this to the attention of activists, governments and stakeholders the Paper Dolls travel across the world to ensure the message is heard. More than 300 paper dolls visited the MOSAIC/WGNRR/TRIANGLE Advocacy Workshop and generated discussion and further dialogue on Female Condoms. Tian Johnson demonstrated the FC2 , Cupid and Womens Condom to the group.

Requests for an additional 1500 dolls were made at the meeting and these will be sent to organisations who will take the campaign to local communities and return the completed dolls to the Campaign. However due to current funding constraints the campaign cannot upscale this campaign, the situation is under review in the meantime. You can add Zawadi on Facebook , her name is Zawadi Smartlove to get up to date news and information from the campaign!

DAY TWO

Day two kicked off with a recap of the previous day and consisted of presentation by IPAS South Africa, National Department of Social Development – Population and Development Directorate, Amanitare Network and a Youth Advocacy Session from across the region.

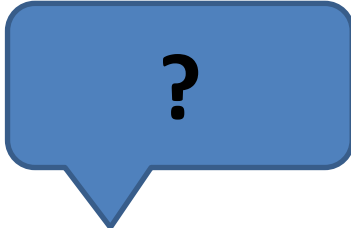
**PRESENTATION : MONITORING AND EVALUATION OF ADVOCACY INITIATIVES , KAREN TRUEMAN –
COUNTRY DIRECTOR, IPAS SOUTH AFRICA
TRUEMANK@IPAS.ORG**

Founded in 1973, Ipas is a global nongovernmental organization dedicated to ending preventable deaths and disabilities from unsafe abortion. Through local, national and global partnerships, Ipas works to ensure that women can obtain safe, respectful and comprehensive abortion care, including counseling and contraception to prevent future unintended pregnancies. Ipas believes that:

- Every woman has a right to safe reproductive health choices, including safe abortion care.
- No woman should have to risk her life, her health, her fertility, her well-being or the well-being of her family because she lacks reproductive health care.
- Women everywhere must have the opportunity to determine their futures, care for their families and manage their fertility.

“One reason I opted to render [abortion services] is because I saw women dying from back-street abortions. They came in with coat hangers hanging from their cervixes and lost their uteruses from sepsis. One case that will always be in my mind is a young girl who had shot herself in the abdomen to get rid of the unwanted pregnancy. I want to emphasize that we are saving lives.”

— Elizabeth Serobe, a registered midwife from Gauteng, South Africa



“What structure does IPAS have in place that educates young people on the consequences of having unsafe sex before terminating the pregnancy. Young people should be taught about sex at the early stage of their lives to be in control of their lives and made aware that the decision they make will have an effect in their lives at the end of the day. “

ANSWER: “IPAS does not motivate nor encourage young people to terminate the pregnancy, but they are there to give support to those who find themselves pregnant to have a safer abortion. This is better than accessing a back street abortion and creating complications at the end. We should also be aware of the positioning of abortion in the context of culture”

**PRESENTATION: TRACKING THE INTERNATIONAL, REGIONAL AND NATIONAL AGENDAS OF
SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS WITH SPECIFIC REFERENCE TO THE WORK
DONE BY THE CHIEF DIRECTORATE: POPULATION AND DEVELOPMENT
CHIEF DIRECTOR : NELOFOUR KHAN
NELOFOURK@DSD.GOV.ZA**

The National Population Unit researches and advises Government on population policy and planning and development issues; and builds capacity to integrate population issues into development strategies. The objective of the programme is to research, analyze and interpret population and development trends in order to inform policy-making and planning; monitor, evaluate and facilitate the implementation of the population policy through intergovernmental programmes and develop capacity to integrate population issues into development.

Q & A SESSION

- 1. Within the SRHR field, there are significant gaps in the initiatives by Government, civil society and women on the ground. What can be done to bridge this gap? Within SRHR issues, there is a disconnection in terms of capacity building and the integration of the work done. What can be done to help this?**

Yes, these challenges are acknowledged. As a first step, more co-ordinated and continual communication and collaboration between Government, civil society and people on the ground. Learning from each other through formal and informal means can also address some of the capacity building gaps. Learning and working together (preferably through some form of structured network) will also help in integrating work done in SRHR.

- 2. With reference to the youth SRHR dialogues, will there be more structure or continuity of these youth dialogues?**

Yes, whilst we have only begun with our youth dialogues, thus far it has been beneficial. Depending on resources and strategic focus in the near future and the outcome of the remainder of the scheduled dialogues, we hope to continue with these dialogues with youths more regularly.

- 3. Given that the world has reached 7 billion people and problems are tackled on a global (macro level) how can we ensure that we do not lose focus on the micro level (i.e. national)?**

Whilst taking the global scenario into account is important, maintaining a national perspective is crucial to SRHR. Whilst there can be many solutions to this, for me at this juncture is more co-ordinated, collaborative efforts especially between Government and the NGO sector that offer that 'national reality check. Whilst we remain committed to international PoAs and treaties, engaging with national progress together and not opponents can help in focusing

the matter domestically.

4. Update on SHARISA?

As at September 2011, SHARISA has been registered with CIPRO and an interim board has been established. Currently vacancies are being filled. We are awaiting further information, especially once staffing has been completed.

5. For the provincial consultations, to what extent are NGOs and CBOs involved? Is there financial support by DSD for NGOs and CBOs to attend?

At national and provincial level, NGOs and CBOs etc are welcome to attend meetings aimed at engaging with the public, for e.g. World Population Day. Whilst the majority of our activities are aimed at Government officials, certain platforms do exist for engagement with a larger audience. In terms of financial assistance to NGOs and CBOs;, whilst attendance to meetings is by invitation; the cost of travelling to the venue and if necessary accommodation is for the cost of the participant. The same is applicable for any training offered to the public unless the department is in a position to fund individuals either through budgeted funds or donor funding.

6. How are projects funded? Donor funds or Government funds?

The majority of projects are funded by budgeted Government funds. Donor funding is accessed as well. However this is based on the condition of what the donor sees as a critical issue that deserves investment. For the National Population Unit, the United Nations Population Fund (UNFPA) has been a key donor in recent years.

7. Has there been any experience where as government officials you have feared the loss of your jobs due to a contentious advocacy issue? If so, how have you dealt with it?

Personally or in the case of my colleagues have not had any experience of this.

8. How much does DSD use the MPoA? What inputs do we make to the MPoA?

Much like with the ICPD PoA, we remained committed to the action plan to the MPoA. Any output relating to SRHR ensures that the MPoA is mentioned. Whilst we do not 'directly' fill in the country profile for the MPoA, the DSD and DoH (as well as other sister departments) work as far as possible through various platforms to ensure that work done by departments are reflected in some shape or form. So in DoH, completing the country profile, they are aware of the work done by DSD and will reflect on this accordingly as they make inputs to the country's progress towards meeting the commitment of the MPoA.

9. What is DSD communication strategy on SRHR matters?

As the National Population Unit, one of the recent initiatives is the local population seminars as a way to communicate population matters (HIV and AIDS, Gender and Youth) as well as adolescent SRHR. The aim here is to

communicate such matters in areas in which we have not done any dissemination work. So the key strategy here is discussing issues with communities and districts which we have not engaged with before thereby expanding our reach and allowing communal and voices of the youth to be heard.

10. Is there an NGO delegation that accompanies Government to UNCPD?

No, there is no delegation that accompanies Government to the UNCPD

The group expressed their gratitude for the comprehensive presentation and stated that it has been encouraging to see how much progress has been achieved by the National Department Social Development, Population in this regard. There was also a realisation that the persistent advocacy initiative from Civil Society has filtered through and is translated to action at National Government level. However, many challenges remains and Civil Society is called upon to harness the opportunities available to them to further engagement with Government

**PRESENTATION: ACCELERATING THE RIGHT TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES FOR WOMEN AND GIRLS. JUDI MERCKEL, DIRECTOR, AMANITARE SEXUAL RIGHTS NETWORK
JUDIM@TELKOMSA.NET**

Amanitare Sexual Rights Network's Judi Merckel presented a joint programme funded by the European Commission and Oxfam Novib. Amanitare is an African Regional Network with a membership base located across 22 countries: Botswana, Cameroon, Egypt, Ghana, Guinea, Kenya, Morocco, Mozambique, Namibia, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Sudan, Swaziland, The Gambia, Tanzania, Tunisia, Uganda, Zambia, and Zimbabwe. Amanitare started as a project of Rainbow, a UK based African organisation working to advance the sexual and reproductive health and rights of women on the African continent.

Amanitare began by addressing issues of female genital mutilation but soon developed programmes which addressed all aspects of women's sexual and reproductive health. It drew in many women's groups on the continent right from the beginning so as to build a strong advocacy body for taking the concerns of women forward within a women's rights framework. Amanitare works with individual and organizational members, who work specifically with women and young women and girls on different themes as a primary target group. The key target group of our partners is marginalized women; the marginalization includes age, socio-economic status, HIV status, geographical location, displacement, sexual orientation and survivors of violence. Amanitare uses generational differences as a tool of empowerment and has consciously sought to build bridges between older women, young women, adolescents and girls in its programming strategies.

Amanitare's main goals are to develop a critical mass of women in every African country who can hold their governments to account in respect of SRH ensuring that fewer African women die from maternal health issues including unsafe abortions and HIV/AIDS related illnesses We also work to build a partnership between existing groups within the African continent who are active in the field of sexual

and reproductive health, gender equity and women rights through focused advocacy on women's rights to access basic sexual and reproductive health services and through bolstering and building feminist leadership at a national, sub regional and regional level in respect of SRHR. We do this by raising awareness, by providing a critical and unified regional voice on the issue of sexual and reproductive health rights and by conceptually and programmatically drawing the linkages between 'rights' and 'health' in a range of countries with a variety of organizations working on the continent.

PRESENTATION: PHASES OF PLANNING COMMUNITY PARTICIPATION , JUDI MERCKEL, DIRECTOR, AMANITARE SEXUAL RIGHTS NETWORK , JUDIM@TELKOMSA.NET

INTERACTIVE SESSION : THE OPPOSITION IN ADVOCACY WORK

This session explored the question "Who is our opposition?". It also sought to establish what the group felt about boundaries in their work. Participants were asked to work in groups of 5 to discuss the structure of their individual advocacy and interaction with their opposition. The group work also focused on the skill sets needed to increase their ability to counter opposition in formal and informal spaces, identifying ways to monitor the issue and counter argue their points. The group also shared experiences around dealing with the opposition in advocacy that spoke about censorship, religious fundamentalism and working in the context of patriarchy. Fact sheets that focused on how to respond to confrontation with the opposition, event planning and community mobilisation were also shared with participants. (see resource section). A discussion was also held on who the participants identified as opposition: churches, state, traditionalists, media, donors were identified as groups/entities that participants would view as opposition in their working contexts.

As a result groups listed potential areas of advocacy that, in their view, presented an opportunity for more strategic work or a credible threat. These were :

- Human rights advocates: Cultural, regional groups, as well as militarization, and the recognition of men's movement is key.
- International and regional treaties – Government / states with conservative religious views.
- Gender Equality and Equity- groups opposed to gender equality: Fundamentalists and professional associations conservative health professional's association's and NGO's who are funded by donors with differences agendas or donors with conservative agendas.
- Patriarchal systems: Involving general society at large, religions, and cultural traditional groups.
- Bodily integrity:
- Universal access: Global Health Care Institutes are potentially key allies to strengthen our work Participants were then divided into two groups which chose to focus on one country each as opposed to a general discussion.

The country outcomes are listed below:

Zimbabwe highlighted specific country issues: Sex work, youths access to contraceptives, abortion and sexual freedom are condemned by :

- Religion and, Government;
- Criminalisation of abortion, same sex relationships and sex work is still rife
- Inadequate funding
- Women's groups who condone the violation of other women's rights.
- Political parties- female parliamentarians opposing rights issues.

Suggestions to improve strategies for SRHR advocacy included:

- Advocacy for change of attitude- challenging harmful traditional beliefs
- Lobbying government
- Development of a strategic alliance

Mozambique reported that due to the long-standing and persistent advocacy efforts, sex workers are now respected and protected to a large extent. Sex Workers are actively engaged in HIV Prevention programmes, and in teaching programmes for community on how to have safe sex and to protect themselves

The issue of increased violence against lesbian women was raised and the lack of access to justice highlighted as remaining challenges requiring intensified advocacy efforts. The youth group highlighted their experience that young people are still systematically excluded from advocacy platforms..

Youth

Participants representing youth were brought together on day one of the workshop and asked to prepare presentations on Youth Issues. In addition to the presentation below on Medical Male Circumcision which generated a significant amount of debate , Busiswa Ndlankulu (Gold Peer Education), Sammy Ndlovu (Sexual Rights Centre), Moussa Kabamba (Think Twice) as well as a five member group from Triangle Project made presentations on Peer Education, Sex Worker Rights, Community Health and LGBTI Advocacy respectively. (Sammy Ndlovu's presentation took the form of a spoken word poem and is reproduced with kind permission on page 2.) The presentation (available for download below) on Medical Male Circumcision lead to a diversion in the programme which resulted in the Yoth Group raising concerns about their legitimacy in such spaces where they are expected to present and not participate. They also spoke about the problematic barriers of tradition and culture and the importance of ensuring that young people can claim their own spaced that are respected and supported in a meaningful way. In light of the programme deviation it was decided that a specific youth discussion group would be formed for the session the next day.

LGBTI COMMUNITIES AND SRHR - MARLOW VALENTINE, DEPUTY DIRECTOR, TRIANGLE PROJECT

It's a typical, ordinary Tuesday morning, just like any other busy mornings at the Kuruman Community Clinic. The demands of clients seeking health care are no different to any other morning. The sister notices a person approaching the desk:

- *The person looks like a man!*
- *The person walks like a man!*
- *The person sounds like a man!*
- *The person is dressed like a man!*

The sister is shocked when the request of the person standing in front of her - is for a pap-smear... Sounds familiar? Or is it a scenario that never crossed your mind?

One cannot make any assumptions regarding sexual health and reproductive rights for Lesbian women; Gay men; Bisexual, Transgender and Intersex persons. Particularly, our assumptions and insights cannot be positioned within hetero-normative gender identity and the understanding and stereotypes attached to heterosexist gender roles.

When you happen to be a women; black; poor; uneducated; a lesbian who presents as being masculine or "butch" – your daily reality and experiences are compromised, challenged and disadvantaged to an extent that makes you highly vulnerable and puts you at risk – especially if your reality is one of living in a rural community.

"Sexual health and reproductive rights for LGBTI persons does not end with who you are attracted to sexually – or who you ultimately choose to have sex with – or reduced to accessing VCT's for HIV & STI's. Sexual health and reproductive rights for LGBTI persons, just like any other heterosexual woman is about:

- The individual's control over their bodies and to make personal decisions about their sexuality and sexual activity.
- It encompass bodily integrity, autonomy, choice, empowerment and diversity with reference to the sphere of sexuality & identity.
- The protection from discrimination and coercions as well as from violence and other forms of interference with personal choices and decisions. This includes the claim for respect, protection and fulfillment of those rights.
- The right to participate in the public sphere to assert the above mentioned claims and to be equally vested with power regardless of sexuality or gender identity. Sexuality, inclusive of gender identity, is a characteristic of every individual and it transcends culture, religion,

nationalities and ethnicity.

- Sexual rights belong to everyone as an integral aspect of their human rights.”

Sex is not only for procreation as promoted through religion and culture – sex is for pleasure and enjoyment – and people ought to be free to explore this in a way that does not harm each other. Globally – and particularly on the African continent, there is an assumption that the above rights are an extension of the Constitution. The Equality Clause enshrined in the Constitution ensures equality before the law irrespective of race, gender, class, age and sexual orientation. The rights afforded to the citizens are enshrined in the Bill of Rights which recognises our fundamental differences – however it ensures equality and equity before the law despite those differences.

So let’s reflect on the person introduced to us at the beginning of my input – she is black; unemployed; lives in a rural community lacking basic health services; is a lesbian woman who identifies or presents as “butch” or masculine – these intersections challenges her right to access sexual health care and citizenship and her personhood is devoid of equity, respect and dignity.

The sister does not “hear” her request for a sexual health service in the form of a pap-smear – what she perceives is someone looking like a man and because of this gender presentation, it triggers typical prejudiced and discriminatory response. This form of prejudice and stigmatisation of LGBTI persons by health care practitioners working in rural and township communities, is the norm and reality for the majority of LGBTI persons seeking to access basic health care.

Gender violence against LGBTI persons are often ignored, dismissed or not acknowledged. Our bodies are viewed as unnatural, deviant; abnormal – and our bodies and our “behaviour” needs to be corrected or cured through punitive measures – or simply silenced or “invisible-lised”. Very often when it comes to LGBTI persons who don’t conform to hetero-normative or hetero-sexist gender stereotypes – the corrective measures or actions include bullying; sexual and physical assault; rape; crimes of hate and prevention from accessing basic health care services.

- Secondary discrimination is also perpetuated by authorities when forms or acts of gender violence are reported.
- LGBTI persons are made to feel guilty, shameful and responsible for being victims or survivors of these types of violence when seeking health, support and safety services.
- Proactive preventative and barrier methods are not available and very limited information exists that include LGBTI sexual health issues. Very often there is misinformation and the messaging is not consistent or updated.

LGBTI communities are not a homogenous group – we are a diverse group of individuals who ought to have the right to explore our bodies; assert our human rights and have equal access to the laws of this country, subjected to the global humanitarian rights and responsibilities. We acknowledge that many view sexuality as fluid and part of the sexual continuum – many of us refuse to be confined to the terms, references and definitions as to who and what we are as LGBTI sexual beings.

- LGBTI sexuality cannot be defined to the public stereotype of a typical gay, white, middle class male living and socialising in Cape Town’s de-Waterkant Village – or the township “drag queen” ramping on the stage of a pageant in the Sea Point civic centre or community hall in Bonteheuwel.
- LGBTI sexuality or SHRR cannot be reduced to the stereotype that men “want to be women” and ‘women want to be men’ – or a person ‘trapped in the wrong body’.
- Lesbians are women! Lesbian women do not stand on the periphery of women’s rights movements. We form an integral and integrated part of the movement.
- SHRR includes our fight for justice and restitution – access to land, nutrition, safety, security and gender equity.
- It includes the right to having children – whether your own biological child; adoption; surrogacy; foster care or supporting the development of a child as a LGBTI person or a same-sex couple.
- SHRR does not mean special rights for LGBTI persons – but advocating for the integration of LGBTI issues into the SHRR agenda and conversations, as well as advocating for the implementation of approved policies and legislation; ensuring the visibility of LGBTI persons leading these discussions; and being part of the plan of action with regards to promotion of these policies and laws on community level

DAY THREE



Day Three began with NACOSA’s Programme Director, Marieta de Vos presenting on HIV/AIDS Funding in the African Context.

FINANCIAL TRANSACTION TAX

Ms De Vos introduced the session by showing *The Banker*, an educational short film on the proceeds that could be generated by a Financial Transaction Tax (FTT). The film was produced by the

Robin Hood Campaign who lobbies for a global FTT to fight poverty in the UK and overseas. The concept of a global FTT was explained against the background of unregulated financing and excessive profit taking in the world leading to an economic crisis in the US and Europe, donor fatigue, negativity about the use of grant funds, Global Fund Replenishment challenges, PEPFAR’s flat lining and competing development priorities.

FTT refers to the taxing of financial institutions on financial transactions involving derivatives, bonds, currency transactions, real estate, insurance and credit transactions. It could generate USD 400 billion annually, even at low (0.005% - 0.05%) tax levels. The amount that can be generated depend on the number of countries effectively involved, the tax rate, which financial products are taxed and the impact

the tax would have on the market itself. The FTT also does not have to be global to work. An important message was that FTT does not involve the middle or lower classes, only financial companies and the very wealthy doing large-scale transactions would be affected.

Ms De Vos emphasized the importance of getting involved in this campaign which has blossomed across the world to lobby for development. While the discussion of how the proceeds should be divided is not central yet, much more funding will be available for health issues, including SRHR and violence against women. In Africa the African Union, Ethiopia, South Africa, Morocco, Cameroon and Mozambique have voiced their support for a FTT, while South Africa already has a form of FTT in place.

The presentation ended with a list of actions that participants could do to support the campaign in their countries as well as a number of regional events that could serve as opportunities for further advocacy during 2012. Participants were given a CD ROM with a comprehensive set of materials; video's and resource components that would enable them to advocate at National and Community level for the beginning of a discussion around the tax and what impact it could have on country level poverty in general but SRHR Advocacy and Programming in particular. The participants expressed interest in the campaign but also requested that clear messaging and specific country support be provided in terms of setting the context for advocacy work around the campaign. Participants agreed that there would be several upcoming opportunities to strengthen discussion around the campaign as well as to introduce it to communities/sectors that might not have heard of it. Some of these opportunities were identified as the 16th ICASA Conference, AIDS 2012 in Washington as well as at National Planning forums in country.

PRESENTATION: WHERE IS THE MONEY? THE CASE FOR A FINANCIAL TRANSACTION TAX
NACOSA, PROGRAM DIRECTOR : MARIETA DE VOS
MDEVOS@NACOSA.ORG.ZA

IMPLEMENTING THE MAPUTO PLAN OF ACTION , MDG'S & HIV/AIDS.

This session was facilitated by Patsy De Lora of Cape Town based, Partners in Sexual Health.

The African Union adopted the Maputo Plan of Action in 2006 to achieve the Millennium Development Goals and move sexual and reproductive health higher on Africa's political agenda. Over the past three years African nations have taken major steps forward in developing country-level plans for achieving the targets of the Maputo Plan. The challenge remains implementation.

PRESENTATION: SRHR ADVOCACY WITHIN THE HUMAN RIGHTS FRAMEWORK
PATSY DE LORA, PROGRAMME DIRECTOR
PATSY@PSH.ORG.ZA

MASIMANYANE WOMENS SUPPORT CENTRE

Masimanyane Women's Support Centre is a non-profit international women's organisation based in East London, South Africa. With a specific focus on violence against women, sexual and reproductive health and rights and the gendered nature of HIV and Aids, we aim to build the capacity of women and human

rights advocates to claim and realise women's human rights. This is done through the development of new knowledge and the utilisation of a rights-based approach.

PRESENTATION: REPOLITICISING SEXUAL AND REPRODUCTIVE AND HEALTH RIGHTS
DR LESLEY ANN FOSTER, DIRECTOR , MASIMANYANE WOMENS SUPPORT CENTRE
NWSC@IAFRICA.COM

PRIORITISING THE ADVOCACY AGENDA – GROUP WORK

Participants were divided into groups and asked to list the five most important advocacy issues for them in their context. The most prominent issues as well as action items are listed below. This session resulted in the group focusing on key issues and the sharing of advocacy strategies and challenges in their contexts. The groups were asked to share objectives, activities and target groups relating to their chosen area but also encouraged to feedback in a format most comfortable to them.

GROUP ONE: YOUTH

Participants stated that they would like to see more work being done in schools and tertiary institutions to lobby for various issues, to develop youth skills in advocacy and embrace diversity. The rarity of youth focused advocacy project and movements was also an issue flagged.

Representatives from the National Department of Social Development asked what the barriers were to Government's interaction with youth groups and the response of the youth to Government initiatives. The group responded that concerns around the capacity of Government officials remain. Government needs to understand the needs of the youth and not approach issues in a preaching manner.

The youth representatives from Kenya pointed out the lack of young role models that distance youth from Government initiatives. In South Africa the perception amongst youth is that they are only good to be used for internships but not sustainable "serious" employment. Funding concerns for youth programmes was also flagged as a concern.

GROUP TWO :SAFE MOTHERHOOD

Objective

- create awareness on potential of misoprostol for South Africa
- speak out about the women's health issues that face South African women.
- ensure availability of HIV and Safe Abortion drugs

Activities

- mobilisation of discussion groups
- training of community activists
- form relationship with medical service providers to ensure advocacy on sustainable supply of drugs
- conduct mother to mother peer health education campaigns
- look at the possibility of opening community based pharmacies to ensure sustainable drug supplies

Targets groups

- Communities
- Government

GROUP THREE : RURAL HEALTH

- Domestic Violence
- Rape
- Sexual Violence
- Violence against woman

All of the above were raised as common concerns in rural areas that directly impact access to and uptake of health services in rural areas.

GROUP FOUR : HIV/AIDS

The following issues were flagged as barriers to making progress in the struggle against HIV:

- Understanding sexuality
- The existence and use of different kinds of barrier methods
- Sexual and reproductive health advocacy needs strengthening at grassroots level
- Reproductive rights training at community level
- Youth participation in HIV/AIDS and SRHR programmes
- Access to SRHR information and services for LGBTI groups
- MMC should be placed within a comprehensive HIV prevention package
- Violation against sex workers should be viewed as human rights violations
- Legalisation of SAFE abortion
- The funding of HIV /AIDS work should be sustained at all times
- Sexual education should be relevant to communities and contexts

- Family planning methods should be widely available for all of those who demand them

DAY FOUR

THE PEOPLES HEALTH ASSEMBLY 2012

"Primary Health Care was and still is the correct pathway for us all. Let's listen to these communities. How many times do we allow them to be part of their development? Genuine people-centred initiatives must be strengthened to increase pressure on decision-makers, governments and the private sector to ensure that the vision of Alma-Ata becomes a reality." - *Dr. Upunda, Chief Medical Officer Ministry of Health, Tanzania, April 2002, opening a People's Health Movement workshop in Tanzania*

"More than 50 per cent of the people in my country have virtually no access to health care. It's high time the public sector and the private sector focused on jointly providing health services to all sections of society." - *Dr Hugo Icu, Guatemala, January 2004*

"I believe in people. People's health is safest in people's hand. The objective is to empower individuals and communities with the knowledge and skills necessary to achieve health for themselves." - *Dr John Oommen, Orissa, India, May 2003*

"I am here to show solidarity with fellow activists. There is a need to create a critical mass of people for changing the deteriorating health, social and gender situation." - *Dr. Mira Shiva, All-India Drug Action Network, PHA, December 2000*

The **People's Health Movement (PHM)** has its roots deep in the grassroots people's movement and owes its genesis to many health networks and activists who have been concerned by the growing inequities in health over the last 25 years. The PHM calls for a revitalisation of the principles of the Alma-Ata Declaration which promised Health for All by the year 2000 and complete revision of international and domestic policy that has shown to impact negatively on health status and systems.

Anneleen De Keukelaere gave an overview of the Peoples Health Movement in general and then set the context for the upcoming people's health assembly as well as positioned it as a potential opportunity for activists to be heard. In less than one year, the Third People's Health Assembly (PHA3) will be taking place in South Africa so it is time to start preparations! Around the world PHM health activists have initiated dialogues and started mobilisation towards PHA3. Regular updates on the mobilisation and preparation will be published on the PHM website and PHA3 Facebook page.

During the first PHA in Bangladesh in 2000, the People's Health Movement (PHM) was born and the People's Charter for Health created, through input from health activists from all over the world. Over 1500 participants from more than 70 countries came together and sent the following vision into the world: Equity, ecologically-sustainable development and peace are at the heart of the PHM vision of a better world - a world in which a healthy life for all is a reality; a world that respects, appreciates and

celebrates all life and diversity; a world that enables the flowering of people's talents and abilities to enrich each other; a world in which people's voices guide the decisions that shape our lives.

**PRESENTATION: THE PEOPLES HEALTH MOVEMENT AND ADVOCACY OPPORTUNITIES
ANNELEEN DE KEUKELAERE , PEOPLES HEALTH MOVEMENT , SOUTH AFRICA
ANNELEEN@PHMOVEMENT.ORG**

At the end of day four the discussions turned to developing a specific strategy around building advocacy capacity, support and reach amongst the participants with a presentation by Marieta De Vos, Program Director of NACOSA.

**PRESENTATION: DEVELOPING THE ADVOCACY STRATEGY FOR SRHR MARIETA DE VOS, PROGRAM
DIRECTOR MDEVOS@NACOSA.ORG.ZA**

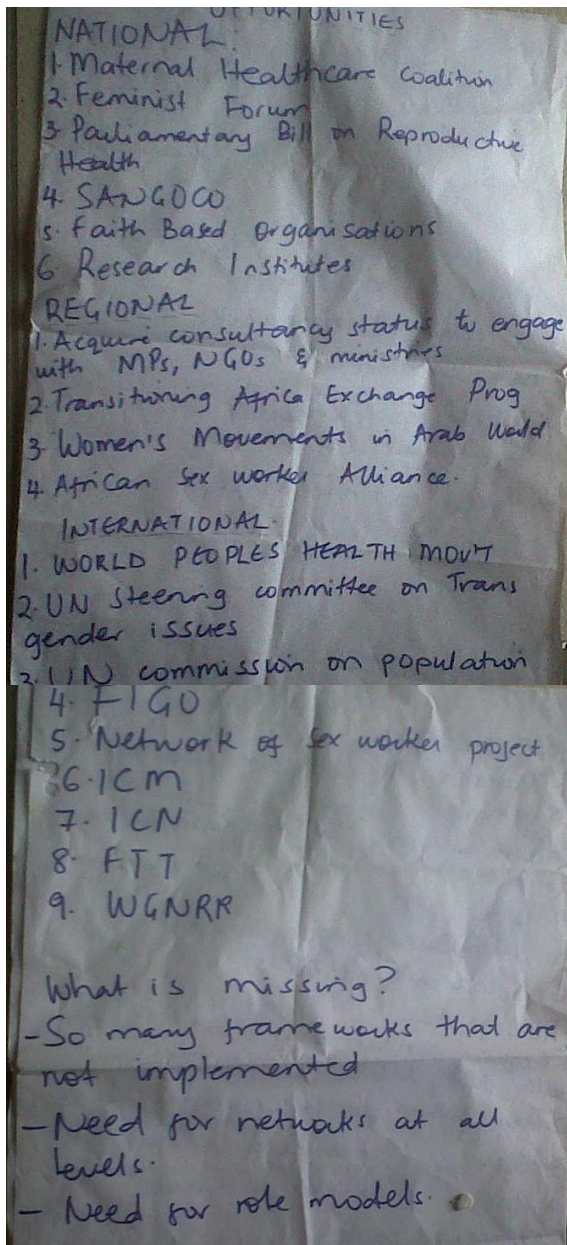
The presentation outlined the process around research and development of the priority issue at regional and national level as well as how to advocate for implementation of various interventions through monitoring and evaluation, evidence collection as well as GAP analysis of the current landscape.

Participants discussed opportunities to identify and advocate for the upscale in interventions that address/respond to the priority area. Statistics, interlinks and both qualitative and quantitative aspects of potential advocacy priority areas were also discussed and these opportunities were captured in the resolution table below. Policy advocacy as well as the essential integration of services including that of supply availability (as in the case of Female Condoms in South Africa) are all strategic areas that need to be looked at in the context of our advocacy work.

The area of leadership within the scope of the Priority Area was raised and began a discussion that explored the participation of women's groups and organizations at the conceptualization, development, peer review, implementation and M&E of the advocacy initiative. This was noted with the clearly identified need of capacity building and training at all levels of interaction within the Priority Area. Recommendations for collecting and tools for analyzing the information needed to upscale advocacy efforts was discussed and this is detailed in the presentation available for download.

There were many rich discussions and presentations around the ICPD, the MDGs, and the Maputo Protocol over the first three days; resulting in the creation of an advocacy roadmap with set goals and targets. (see resolution table) Linking with this was a discussion around the New Development Agenda [N.D.A] and its impact on SRHR advocacy in the region.

With uncertainty around the ICPD+20 process, the impact of Rio+20, and the looming shadow of the [then upcoming] COP17; the perceived challenges, issues, and potential roadblocks for SRHR in the New Development Agenda were discussed and debated.



The group identified some core concerns around the current global discussions relating to the N.D.A; reflecting on some of those shared on Day 2 in the presentation on the Langkawi Document [Repoliticising SRHR, Lesley Ann Vorster]. Participants highlighted the worrying trends in increased 'population control' rhetoric following the birth of the world's 7 billionth person, and the inevitable detrimental impact on SRHR- and specifically those on women and girls. Concerns around the 'Climate Change Agenda' making headway at the expense of SRHR and women also linked in to the previous discussion. As with several other discussions over the course of the meeting, the current state of funding for SRHR dominated the discussion. The current systems were deemed insufficient, and fears of greater cuts for SRHR and women's rights programmes & initiatives were vocalised.

After identifying some of the pressing concerns, the group divided themselves into small groups to discuss strategies and "non-negotiables" for the N.D.A discussions. The issue of participation in these processes was also raised- capacity, funding, access to information & knowledge, navigating spaces within loose coalitions, as well as concerns around transitioning from national to international/regional to international advocacy & vice versa. A small discussion around the UN system and the problematic structures therein was also observed by the facilitator.

Communications for Advocacy - WGNRR

As this session was held towards the end of the workshop, participant numbers decreased significantly in part due to travel arrangements. Due to this, a minimal discussion was held around Online Communications and the use of Facebook, Twitter, Blogs, & etc. The issue around safety of activists as a result of their online work was raised and flagged as a concern. Participants shared their experience of resources such as Ushahidi to map violations, Frontline Defenders and Tactical Tech. The lack of access to technology was also raised as a concern in this session. This led into a discussion around using alternative methods for advocacy such as the rubber stamping of currency notes to generate awareness of an issue/campaign, Flyers, Flash Mobs, Rallies/Demos, Music, Art and Films as advocacy tools. Some participants evaluated this session before its completion therefore the evaluation results may not be an accurate reflection of this process.

RESOLUTIONS

AIDS ACCOUNTABILITY committed to support the facilitation and development of a joint SRHR Advocacy Proposal with the participation and input of delegates. An agreement was made that a regional team should be set up to drive the development process on a regional level. This process will involve country specific consultations and subsequent input from the broader group. The team that will work on the development of the proposal is Phillipa Tucker – AIDS Accountability International, Judi Merckel – Amanitare Sexual Rights Network, Anneleen De Keukelaere – Peoples Health Movement. The process will be supported by Mosaic through the establishment and coordination of an e platform.

Throughout the workshop, delegates identified opportunities, platforms and partners strategically positioned and conducive to further our advocacy efforts.. These are listed in the table below according to National , Regional and International focus.

NATIONAL	REGIONAL	INTERNATIONAL	CHALLENGES
Advocate for Abortion Rights Day	AU Inter Ministerial Meeting - 2012	World Sexual Forum 2012	No youth-related frameworks/principles
Discrimination of Sex work in Zimbabwe - December 2012	PSH Youth Conference 28 September 2012	United Nations Agencies	Lack of regional networks with clear definition and function
Establish Maternal Health Coalitions in countries	Advocate for the Robin Hood Tax	Commission on Population Development	Limited access to resources
Advocate for a Parliamentary Bill on Reproductive Health	Support the work of the African Sex Workers Alliance	International Convention of Midwives	Limited access to advocacy tools
Work with a Feminist Forum Research Institute	Increase knowledge of the Transitioning Exchange Programme	WGNRR	Unequal collaboration with donors
Increase engagement with Faith Based Organisations	Recognise and support Women's month in the Arab world	Commission on the Status of Women, 27 Feb - 9 March 2012	Political lines have fragmented SRHR movements and therefore alliance building surrounding
Building stronger networks and coalitions	Peoples Health Movements and Peoples Health Assembly - July 2012 (Further development of Regional Advocacy Proposal as per task team above)		Existing frameworks aren't implemented
	World Economic Forum – Ethiopia 9th – 11th May 2012		Networks need to cut across all levels
	Inter Parliamentary Union – Uganda 31st March – 5th April 2012		There is a lack of positive role models especially for the youth

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28 November 2011

Dear wonderful SRH participants,

**SOUTHERN AFRICAN REGIONAL SEXUAL REPRODUCTIVE HEALTH AND RIGHTS WORKSHOP:
22-25 NOVEMBER 2011 CAPE TOWN**

I trust you are all well and have arrived safe at your various destinations following our four day SRH workshop. MOSAIC would like to extend our sincerest gratitude to you for your attendance, very insightful participation and great partnership during the SRH workshop.

It was an absolute pleasure experiencing local, national and international stakeholders deliberating on these prominent issues. A special note of thanks to WGNRR for guiding and facilitating the discussions so expertly and ultimately ensured that we develop a footprint to ensure closer regional cooperation and networking. We are also very grateful for Nacosa and Triangle for their expert guidance and contributions and for Tian Johnson who ensured these valuable contributions are skilfully captured.

Thank you to everyone for engaging in such enriching dialogue and making this event such a success. This has been a very valuable learning and strategic important opportunity. As mentioned at the closing of the SRH workshop, we aim to distribute an electronic finalised Workshop Report as soon as possible. We look forward in anticipation of our further engagements.

Warm regards



Christelle CRONJÉ
Executive Director

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RESOURCES

The following resources are available for download from the Resource Section of www.mosaic.org.za.

Resources

1. Monitoring the Maputo Plan of Action – Phillipa Tucker , AIDS Accountability
2. Monitoring and Evaluation of Advocacy Initiatives – Karen Trueman IPAS
3. Tracking the International, Regional, and National Agendas of SRHR with specific reference to the work done by the Government of South Africa – Nelofour Khan, Department of Social Development
4. Accelerating the rights to SRH Services for Women & Girls – Judi Merckel, Amanitare
5. Phases of planning Community Participation - Judi Merckel, Amanitare
6. Moving forward medical male circumcision - Leader Ngooyi , Sonke Gender Justice Network
7. Where is the money? The case for a financial transaction tax - Marieta de Vos , NACOSA
8. SRHR advocacy within the human rights framework - Patsy de Lora, Partners in Sexual Health
9. Repoliticising SRHR - Dr Lesley Ann Foster, Masimanyane Womens Support Centre
10. The Peoples Health Movement & Advocacy Opportunities - Anneleen de Keukelaere , Peoples Health Movement
11. SRHR – Marion Stevens, WISH Associates

Additional Reading

1. Exposed – Ten Myths of Religious Fundamentalism (AWID)
2. The South African National Strategic Plan on HIV, STI's & TB 2012 – 2016
3. ABC's of Movement Building
4. Catholics for Choice – Brief on the Opposition
5. Digital Security and Privacy for Human Rights
6. Maputo Plan of Action
7. Beijing Declaration
8. Maputo Plan of Action and the MDG's
9. Mosaic Advocacy Alert Pack

EVALUATIONS

