

Serra Sippel

Female condoms... Saving lives now!

In 2007, women represented half of the HIV infections worldwide, and sixty-one percent of HIV infections in sub-Saharan Africa. Eighty percent of all HIV infections are sexually transmitted. In spite of this reality, two and a half decades into the HIV and AIDS pandemic, the disease continues to outpace the global response. For every person who goes on antiretroviral therapy for treatment, six people are newly infected with HIV. As international donors and country governments move forward with plans to make male circumcision more accessible and invest millions of dollars into developing microbicides and vaccines, they cannot afford to overlook an important and effective HIV prevention intervention that is designed to allow women to initiate protection and negotiate safer sex – female condoms.

Female condoms must be part of a comprehensive, rights-based approach to HIV prevention and family planning that includes behaviour change

communication, as well as a range of technologies, information and skills that allow individuals to choose the methods that will be most effective in protecting against infection and obtaining fertility desires throughout the life cycle.

Female Condoms: An essential tool for women

In light of women's vulnerability to HIV infection, and existing social factors that obstruct their sexual agency, women urgently need access to a prevention tool that they can initiate. Unlike microbicides or vaccines, female condoms are available now.

The most widely available female condom is the Female Health Company's FC1 Female Condom, a durable polyurethane sheath that is open at one end and closed at the other. Two flexible rings at either end – one facilitates insertion, the other rests outside the vagina – hold the condom in place. The FC1 is

In this issue • 1 Female condoms... Saving lives now! • 2 Editorial • 10 Why are we so accepting? Female Condoms... a human rights issue? • 14 The Female Condom... A 'novelty' • 19 Where are the femidoms? • 22 Values and beliefs make people vulnerable... Realities and challenges of condom use • 26 Prescribed by institutions... Religion and condom use for married couples • 30 The future is mine to create... The tales of a young NGO director • 36 Regional View • 42 Provincial View • 48 Now More Than Ever... Human rights are to be at the centre of the response to HIV and AIDS

Editorial...

...if more women and girls have the right to abstain; to ensure their partners' faithfulness; to negotiate condom use; to live their lives free from violence; to access basic education; to earn incomes adequate to feed their families – their ability to protect themselves from HIV would be real... [UNAIDS]

It is within the context of acknowledging persistent women's rights abuses, which greatly impact on women's HIV risk, and recognising the 'power' of HIV prevention methods, which can be initiated and controlled by women, that this edition of the *ALQ* focuses on female condoms, exploring various realities and challenges of female condom accessibility, availability, acceptance and use. Female condom availability and acceptance, and the role of donor agencies; the access to female condoms as a human rights issue; the lack of a conducive environment for women to access available female condoms; condom realities of 'people at higher risk'; condom use in married couples and the role of religion; and the 'novelty' of female condoms are some of the issues examined in this edition.

This issue also introduces a 'regional view' on condom realities and challenges from a Nigerian perspective; makes a 'comment' on consultative processes in the context of developing Provincial Strategic Plans; and includes a 'personal view' revealing the tales of a young NGO director. Advocating for human rights to be at the centre of the response to HIV and AIDS, this edition also highlights the *Now More Than Ever: Human Rights and HIV/AIDS* global human rights declaration, and the identified 10 reasons as to why human rights are to be at the centre of the AIDS response.

In this edition, **Serra Sippel** explores female condom realities and challenges. Examining the acceptability, effectiveness, and use of female condoms, as well as the role of donor agencies in female condom procurement, distribution and programming, she argues that, for female condoms to realise their full prevention potential, they cannot remain an afterthought in the response to HIV and AIDS.

Premised on the understanding that the access to female condoms is a human rights issue, **Fiona Nicholson** raises the question as to whether or not the continuous lack of access to female condoms would thus constitute a human rights violation. Discussing issues of acceptance, as well as costs of female condoms, she argues that commonly used 'excuses' – that lack any real evidence – and the failure to afford accessible female condoms constitute gender-based discrimination and thus, violation of women's human rights.

Recognising that female condoms are more of a 'novelty', than a 'real' HIV prevention tool, **Johanna Arendse** examines female condom availability and use. She explores women's realities and societal barriers impacting on female condom use and argues that, in order for female condoms to become a 'real' option for women, it is essential to 'change' the societal context in which women make decisions about condom use.

Highlighting the constitutional imperative to equality, autonomy and non-discrimination, **Gahsiena van der Schaff** raises the question – where are the femidoms? Discussing various elements of women's realities, including the extent to which societal norms and values impact on women's control over sexual choices and decisions, she argues that as long as the environment remains non-conducive for women's sexual choices, the question of *where are the female condoms* will remain unanswered.

Erica Kessie explores specific female condom realities and challenges for various 'groups at higher risk'. Referring to the description of 'people at higher risk', as outlined in the NSP, she introduces realities and challenges of female condom use of young people, sex workers, and lesbian women, and argues that the challenges of accessibility and availability of female condoms are not 'specific' to a particular group of people at 'higher risk', but instead 'specific' to the societal context in which available female condoms are accessed.

Acknowledging both the risk of HIV infection and the resistance to condom use in married couples, **Jameyah Amien** explores the role of religion in condom use in married couples. Examining the Islamic and Catholic perspectives on condom use, as

the only female condom approved by both the World Health Organization and the U.S. Food and Drug Administration (US FDA).

...for every person who goes on antiretroviral therapy for treatment, six people are newly infected with HIV...

The Female Health Company's second generation product, FC2, retains the basic features of the FC1, except it is made of a latex derivative called nitrile, which reduces the cost of production. The WHO approved the FC2 for use in 2006. Though not yet approved by the U.S. Food and Drug Administration, the FC2 is available for distribution and used in developing countries. The non-governmental organisation, PATH, is in the process of producing a women's condom, and MedTech Inc. is producing the Reddy Female Condom, but neither of these two products have been approved by the WHO or US FDA.

The female condom has high rates of acceptability

The World Health Organization has found high rates of user acceptability for the female condom, ranging from thirty-seven to ninety-six percent.¹ There is no denying that female condoms require partner negotiation. While this may be problematic in some relationships, especially where there is violence or coercion, many women discover a sense of empowerment in negotiating the use of protection with their partners, and feel more confident in the method's efficacy. In addition, in situations where men have refused to use the male condom, either because

of discomfort or stigma associated with the product, women have been able to present the female condom as an alternative.

Studies suggest that male partners often respond positively to the female condom, attracted to its novelty and finding it less restrictive and more conducive to body heat and texture than male condoms. Some men even find the inner ring of the condom produces extra stimulation, and women have discovered the same about the outer ring. The fact that female condoms can be inserted prior to arousal means that protection does not have to interrupt sex – an added benefit. It also means that women anticipating self or partner inebriation during sex can insert the condom hours prior to sexual intercourse and still ensure protection.

...male partners often respond positively to the female condom... finding it less restrictive and more conducive to body heat and texture than male condoms...

The female condom is effective

The female condom is highly effective at preventing both unwanted pregnancy and sexually transmitted infections (STIs). With average use, female condoms prevent seventy-nine out of one hundred unwanted pregnancies (compared to eighty-five out of one hundred for the male condom).² With correct and consistent use their efficacy has been found to be as high as ninety-eight percent.³ Female condoms are estimated to be eighty to ninety-five percent effective at preventing HIV transmission (this is the same

well as the impact on condom availability, she argues that condom use in married couples is more prescribed by religious institutions, than based on informed decisions as to whether or not to use a condom.

Busari Olusegun introduces complexities, barriers and realities of condom use in Nigeria. Discussing barriers, such as inconsistent policy development, psychological inaccessibility, lack of perceived individual HIV risk, as well as the role of religious institutions and cultural complexities, he argues that the barriers to condom use have to be addressed in their entirety to carry the potential of increasing condom use, and thus reducing the risk of HIV infection, in Nigeria.

A *'personal view'* on experiences and challenges of a young NGO director is provided by **Gaetane le Grange**. Raising issues of young people in leadership positions and the challenges of daily NGO management, she tells the personal tales and journeys of a young female NGO director and concludes that even though it might be challenging at best of times, it is worthwhile to continue, as *'the future is not mine to take, but mine to create'*.

Theodore Powers is *'making a point'* about the importance of, and risks associated with, consultative processes for national and provincial strategic plans guiding the response to HIV and AIDS. Examining the Western Cape Provincial Strategic Plan consultative process and comparing this experience with various national consultative processes, he argues that local realities not only need to be acknowledged, but also inform the final form of the provincial strategic plan, so as to ensure that the NSP becomes a reality.

While it may appear that there are many varying facets describing female condom realities and challenges, there also seems to be common barriers and underlying factors determining the inadequate and limited access to female condoms. And at the core of these *'limitations'* and women's apparent *'inability'* to access available female condoms, to negotiate condom use, and thus, have *'control'* over the risk of HIV infection, lies the gendered context of society, which is fundamentally unequal, *'powered'* and patriarchal. Subsequently, female condom accessibility, availability, acceptance and use are not defined by women's realities and needs, but instead by a societal context which renders

women largely *'incapable'* of making informed choices as to whether or not to use female condoms, as well as *'powerless'* and in no *'control'* over their bodies and HIV risks.

Since HIV prevention, including the promotion of, and access to, female condoms, are based in the paradigm of patriarchy and unequal power, women's right to access female condoms will continue to be violated, and most will continue to be most at risk of HIV infection. It is the same *'paradigm'* that seems to define the extent to which women are in *'control'* over their bodies and have the *'power'* to make decisions about how, when and with whom to engage in sex. And finally, it is the *'paradigm'* that also seems to *'justify'* the prioritisation of male over female condoms; the limited *'right'* of women to make informed sexual choices; and the *'powerlessness'* of women to reduce HIV risks and vulnerabilities – despite the constitutional framework guaranteeing everyone the right to security in, and control over their bodies, and the numerous national, regional and global calls to make female condoms available.

The continuous gap between women's rights, realities and needs and female condom accessibility clearly highlights that female condom programmes advocating for increased access, without addressing societal *'barriers'*, such as power and social norms *'defining'* women's HIV risks, will continue to be ineffective – and thus, further perpetuate both women's heightened risk of HIV and the violation of fundamental rights and freedoms.

As long as the core of female condom barriers – gendered power – is not challenged and transformed, the increased *'availability'* of female condoms is unlikely to increase the *'access'* to condoms; female condom acceptance will remain limited, as women are not *'supposed to control'* and/or have *'power'* to make sexual decisions; and the use of female condoms will continue to be the exception, rather than the norm, to HIV prevention *'controlled'*, and *'initiated'*, by women. Without addressing the *'real'* problem of inadequate access to female condoms, the status quo, that most women have no power to control individual HIV risks and vulnerabilities, will prevail – and the female condom will remain but a *'novelty'*...

Johanna Kehler

efficacy as the male condom), and are thought to confer extra protection against other STIs, because the external portion partially covers the outside of the vagina and base of the penis.⁴

...women urgently need access to a prevention tool that they can initiate...

Female condoms provide an additional protection option for anal intercourse, the sexual behaviour with the highest probability of HIV transmission. After removing the inner ring, female condoms can be used during anal sex, thereby, expanding choices available to heterosexuals, men who have sex with men, and people who are bisexual and transgender seeking to engage in safer sex.

Despite concerns that the female condom will be used to replace male condoms, studies from the U.S., Brazil and Zambia indicate that overall rates of protected sex acts increase, when female condoms are made available alongside male condoms, meaning that rather than replacing male condoms, female condoms supplement them.⁵

Preparation for future interventions

Lessons learned about successful strategies for building political will and consumer interest in the female condom should inform donors, activists and programme managers, as they make plans to invest in the promise of future women-initiated prevention methods. The female condom is marketed as a tool for women's empowerment, similar to the way in which microbicides are being promoted, and both products

require a basic familiarity with women's reproductive anatomy, and demand programmes that address social norms around women's sexuality and agency. Moreover, as the case of male circumcision has shown, when partially effective HIV prevention methods, such as vaccines and microbicides, become available, the female condom will be a necessary tool for additional protection.

Despite being a highly effective dual-protection method and the only method designed for woman's initiation, only twenty-six million female condoms were distributed in 2007 – compared to some twelve billion male condoms.

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Overcoming Challenges to Acceptability and Use

Certainly, female condoms are not the perfect method for everyone, and they bring unique challenges.

In many of the countries where female condoms could have the greatest impact as an HIV prevention tool, men retain power over sexual and reproductive decision-making. Though there is no easy solution for overcoming social and cultural constructs that oppose women's agency and condone sexual and physical violence against women, experiences from the field demonstrate that men can become partners in female condom programming and promotion, and that female condom programmes that incorporate men, increase the method's use.

In addition, female condoms are costly compared to male condoms, and users can find them noisy, physically unappealing, or difficult to use. However, female condoms are a cost-effective mechanism for HIV prevention, when measured against the costs of potential HIV infections or other HIV prevention mechanisms. Also, as more and more female condoms are produced and purchased, their cost will drop. Well thought out and implemented programmes can overcome challenges, such as noise and physical appearance, and can result in successful uptake and usage.

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However, if current low investment levels in female condoms persist, these obstacles will remain significant. Female condoms are not readily accessible in most countries. In the countries where they are accessible, there is a growing demand for them. But because the vast majority of potential consumers are unaware that female condoms exist, there are no meaningful estimates of global demand. It is clear, however, that insufficient numbers of female condoms are available to people who need them globally for HIV prevention.

High quality female condom programming is critical to increasing female condom demand and uptake. Providers should ensure access to the product in a comfortable environment to promote acceptability and continued use of female condoms. Programmers

also need to approach their distribution creatively, using engaging and appropriate marketing for different populations. To increase accurate and consistent use, training for providers and consumers is essential. Another consideration for programmers is that female condoms should be provided to groups who are most in need of alternative options to male condoms, without stigmatising condom use. Civil society groups can be extremely valuable in developing effective programming, because of their access to populations vulnerable to HIV infection, and their experience working with these groups.

Donor Impact on Female Condom Procurement, Distribution and Programming: The Case of U.S. Foreign Assistance and Policies

The U.S. has an important role in female condom procurement, distribution, and programming and is one of the largest procurers of female condoms for international distribution. Compared to other donors, the U.S. excels at female condom procurement and logistics. Recipients of U.S. female condoms experience fewer stock-outs and supply chain challenges than the recipients of non-U.S. procured female condoms.

...female condoms are a cost-effective mechanism for HIV prevention, when measured against the costs of potential HIV infections...

However, bureaucratic obstacles, funding restrictions, and a lack of high level commitment to female condoms have significantly hindered the

expansion of U.S.-funded female condom distribution efforts. The U.S. government has no policy guidance encouraging missions or contractors to promote female condoms, which has meant that female condom procurement is dependent on a few field-level champions who are committed to the method. The cost differential between male and female condoms also discourages the latter's procurement, as providers who do not understand the benefits of female condoms see little reason to choose a higher priced method.

...perhaps the most significant deterrent...is the congressionally mandated requirement that 33% of prevention funds under the President's Emergency Plan for AIDS Relief (PEPFAR) must be spent on 'abstinence-until-marriage' programmes...

Perhaps the most significant deterrent for both male and female condom distribution within U.S. policy, however, is the congressionally mandated requirement that 33% of prevention funds under the President's Emergency Plan for AIDS Relief (PEPFAR) must be spent on 'abstinence-until-marriage' programmes. This requirement, as interpreted by the U.S. Office of Global AIDS Coordinator (OGAC), confines condom promotion efforts to certain 'high risk' groups, stigmatising condom use and leaving married women and youth at particular risk of HIV infection. Reports by the Government Accountability Office (GAO) and Institute of Medicine, National Academy of Science

(IOM) both found that the 'abstinence-until-marriage' requirement is an obstacle to effective HIV prevention efforts and should be removed.

The Center for Health and Gender Equity has issued a report on U.S. foreign assistance and female condoms, entitled *Saving Lives Now*. The report is based on interviews with key experts and an extensive review of current literature on female condoms. Based on the report's findings, recommendations for the U.S. include:

- USAID (U.S. Agency for International Development) and OGAC should issue policy guidance encouraging female condom procurement and programming within U.S.-funded development programmes, including PEPFAR.
- The U.S. should strengthen HIV prevention efforts by expanding the scope of female and male condom promotion to the general population. Programming of female condoms will depend on each area's epidemiological profile, and should be free of messages and attitudes that stigmatise condom use.
- The U.S. should invest more funds in female condom promotion and programming. The U.S. should subsidise female condoms for PEPFAR-funded programmes.
- At the country level, the U.S. should include civil society, especially women's health and rights groups, in stakeholder meetings and encourage financing mechanisms that increase government-civil society collaboration in female condom programming.

- The U.S. Congress should remove all earmarks and funding directives for ‘*abstinence-only*’, ‘*abstinence-until-marriage*’, and ‘*fidelity*’ prevention programmes and fund comprehensive, integrated, and evidence-based HIV prevention programmes that include female condoms and that promote and protect women’s health.

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Conclusion: Where do we go from here?

Civil society can play a significant role in educating governments about the importance of female condoms by focusing on individuals responsible for procurement and developing relationships with members of parliament, government officials and prominent members of society, who are willing to use their positions of power to promote female condoms at the policy level. In order to ensure that female condoms are not haphazardly procured and delivered, governments must establish national strategies for procuring, marketing and programming female condoms, and international donors must provide logistical and financial support for these plans. Though national media and marketing campaigns can generate significant interest in female condoms, national plans must ensure that funding, supplies and programmes are in place at sustainable levels in order to meet the demand generated.

Although female condoms hold promise for women’s sexual empowerment and reducing the spread of the AIDS epidemic, they cannot remain an afterthought in national and global AIDS strategies, if they are to realise their full prevention potential. An effective response to the AIDS epidemic requires increased investments in female condom programming, distribution and procurement, but this response must be coordinated from the level of the international donor to the local distributor, with particular emphasis on addressing the needs and concerns of women and men.

Significant efforts that advocates can link to, in order to increase access to female condoms, include UNFPA’s Global Female Condom Initiative, the Dutch Universal Access to Female Condoms project, and the Center for Health and Gender Equity’s *Prevention Now!* Campaign.

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Join the Prevention Now! Campaign

Prevention Now! is a global campaign working to prevent the spread of HIV, reduce unintended pregnancy, and advance the sexual and reproductive health and rights of all people worldwide. Through education and advocacy, the *Prevention Now!* Campaign seeks to ensure that governments and donor agencies provide the funds needed to dramatically

increase access to female condoms and other existing HIV prevention options for women and men now. The campaign seeks to build dynamic partnerships amongst national efforts, allowing civil society groups to share success stories and advocacy strategies while linking them to a vibrant international movement.⁶

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FOOTNOTES:

1. Hoffman, S. et.al. 2004. 'The Future of the Female Condom'. In: *International Family Planning Perspectives*. Vol.30, No 3, Sept. 2004.
2. 'Female Condoms.' *Family Planning: A Global Handbook for Providers*. World Health Organization. 2007.
3. 'How the Female Condom Affects Male Condom Use.' *FHI Research Briefs on the Female Condom – No. 5*. Family Health International. [<http://www.fhi.org/NR/shared/enFHI/Printerfriendly.asp>]
4. Ibid footnote 2.
5. Ibid footnote 3.
6. To join the campaign, visit www.preventionnow.net.

Real choices

require facts
and access to information

**Not social
expectations and norms**

Who have you
discriminated against lately?



The AIDS Legal Network is a human rights organisation committed to the promotion, protection and realisation of fundamental rights and freedoms of people living with - and affected by - HIV and AIDS
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www.aln.org.za

Human rights must be non-negotiable...

**No matter what...
age, sex, gender,
sexual orientation, and/or HIV status**

Who have you
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Fiona Nicholson

Why are we so accepting? Female Condoms... a human rights issue?¹

A lot has been said about female condoms, the impact of the lack of adequate supply of female condoms, and the need to increase the access to female condoms, so as to ensure that women do have the choice of choosing and using female condoms as an HIV prevention tool. However, very little has been said thus far about the access to female condoms as a human rights issue.

This input intends to raise some of the questions – from a rights-based perspective – about the lack of access to female condoms, also raising the question as to whether or not the failure to supply and facilitate adequate access to female condoms does constitute a human rights violation.

Legislative provisions and arguments

There are many constitutional, legislative and policy provisions, which guarantee everyone, including women, the right to make informed choices about their bodies; the right to autonomy.

Everyone has the right to bodily and psychological integrity.²

This constitutional guarantee includes the right to make an informed decision as to whether or not to use a female condom – thus, the right to have access to female condoms, as and when a woman decides to do so.

There are also a number of global women's rights declarations and documents, which are fundamentally based on, and advocate for, women's right to have control over their bodies. One of these documents is the Beijing Declaration and Platform of Action (1995), which declares in Section C that

The human rights of women include their right to have control over their bodies and decide freely and responsibly on matters related to their sexuality and reproductive health, free of coercion, discrimination and violence.

Recognising the global commitment, and national constitutional guarantee to autonomy, including and/or especially women's autonomy, an argument could be made that there is a legal obligation to provide adequate access to female condoms – as one of the 'tools' for women to realise the right of autonomy.

HIV and AIDS realities and responses

Since the advent of the HIV and AIDS pandemics over 20 years ago, the challenge has been that most women are not in the position to protect themselves; that most women are not in the position to negotiate condom use and/or insist on their partners wearing a condom. And this seems to remain the greatest challenge, despite the fact that there are numerous studies and findings indicating that women are more infected, especially in Sub-Saharan Africa. There are studies indicating that of all women infected with HIV, 75% are living in Sub-Saharan Africa. Yet, national, regional and global responses seem to fail to develop interventions that respond to these findings – thus providing adequate programmes and interventions that take this reality into

account. Subsequently, too many responses to HIV and AIDS remain largely inadequate, as they fail to respond to women's realities and needs – thus, failing to afford HIV prevention options, which are accessible to women, and which women have 'control over'.

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The National Strategic Plan for HIV & AIDS and STIs, 2007 – 2011 (NSP) – the policy guiding the national response to HIV and AIDS in South Africa, has been adopted, without dissent by civil society, in April 2007. The NSP sets out clear goals, objectives, and targets pertaining to the national response to HIV and AIDS. Amongst other goals and objectives, the NSP plans to annually purchase and distribute 425 million male condoms per year, but only 3 million female condoms – 'at selected sites only' – over the same time period.

While these unequal figures at a national level are rather disturbing, it is important to note that this 'distribution' follows an international trend, where it is estimated that donors and government are buying/spending an average of three condoms per male every year – but only one female condom for every 250 women.

Questions to be raised

The above seems to lead to various questions, asked to various groups of people and sectors of society. The questions raised here, however, are more 'introspective' questions – in that these are questions 'we', civil society;

'we', women's rights organisations; gender violence organisations; and human rights organisations should ask ourselves...

The 'obvious' questions, of course, would be

...why this discrimination is allowed to exist and why it seems to have become the 'accepted' form of discrimination in the response to HIV and AIDS...

...and why are 'we', as civil society, so accepting of this particular form of gender discrimination...

And even though there are many answers, 'we', civil society, have to find within our own strategic and programming decisions, including decisions as to which of the 'hot issues' are we 'prepared' to take up, there are some 'official' answers as to why women are continuously discriminated against in the national response to HIV and AIDS, and, more specifically, in the context of condom availability and access.

One of the most commonly 'heard' and 'used' reasons is that

...women don't like female condoms...³

...the NSP plans to annually purchase and distribute 425 million male condoms per year, but only 3 million female condoms...

Irrespective of whether or not this might be true, it is fair enough to ask as to 'how' we know that women do not 'like' femidoms; and 'where' is the evidence to prove this hypothesis? And if the argument of 'liking' condoms is a valid reason to justify production, distribution, access and availability – then the next question arises as to 'why' are there NSP goals/plans to distribute 425 million male condoms, even though there is more than enough 'evidence', scientific, anecdotal and otherwise, that male

condoms are not a *'tool'* likely to be considered during sexual intercourse. And even though specific reasons as to why male condoms are not *'liked'*, common explanations would include that *'they interfere with sexual pleasure'*, *'who want to eat a sweet in its wrapping'*, *'if you love/trust me then why is there a need for condom use'* – to name but a few of reasons.

*...women don't like female condoms...
'where' is the evidence to prove
this hypothesis?...*

What this highlights is that the argument of *'liking them'* seems to be *'acceptable'* in the context of increasing the access to female condoms, while the number of available and accessible male condoms does rise – irrespective of the fact that male condoms are not *'liked'*.

Besides the argument of *'liking them'*, there also seems to be the *'harsh'* reality of male condoms advertised, promoted, distributed and demonstrated *'everywhere'*, while female condoms are *'hard to find'*; female condom promotions are rather rare; and the *'ability'* of female condom demonstration is, more often than not, limited through the lack of demonstration *'tools'* and *'skills'*.

And then, of course, there is the issue of *'evidence'*, which in fact counters the argument that women do not like female condoms, as studies conducted by John Hopkins Medical Centre and UNAIDS about the *'liking'* of female condoms indicate not only that women *'like'* female condoms, but so do their men.

Analysis of studies from 40 countries show that the acceptability rates for female condoms range between 37% and 93% of potential user. In addition, a recent South African study found that 80% of men liked the female condom, as did the same percentage of women. Men surveyed on the acceptability of female condoms

further indicated that femidoms do not reduce sensation during sex as much as the male condom, and that female condoms were much less *'restricting'* – considering the fact that a female condom can be inserted hours before the actual sexual act, and thus, does not *'interfere'* with the *'passion of the moment'*. There are also anecdotal reports from women, that some men do *'not even notice'*, when a femidom is used during sex.⁴

The second most common argument against the increased production, distribution, availability and accessibility of female condoms is that:

They are too expensive...⁵

While this argument may *'work'* considering the costs associated with the production of female condoms, there are numerous questions which should be raised in response to this particular argument, including if the production of female condoms is/would be more expensive than:

...loosing the nation's mothers...

...caring for a nation of orphans...

...the costs associated with providing on-going ARV treatment for women...

...the societal problems created by ever-increasing numbers of 'child-headed' households...

Moreover, the question could be raised as to whether or not there is indeed a *'real'* lack of funds to provide for female condoms or whether or not there is a *'fund allocation'* problem. Considering the fact that billions of Rands are spent on *'arming'* the country in case of war – while the *'war'* against AIDS has been raging for more than two decades – the question seems to be more one of *'allocation'* and *'priority'*, than one of real costs associated with *'protection'*.

...considering the fact that billions of Rands are spent on 'arming' the country in case of war – the question seems to be more one of 'allocation' and 'priority', than one of real costs associated with 'protection'...

And finally, it is a commonly recognised fact that production costs of products, including the female condom, are largely defined by both the 'demand' and the preparedness of national government, bilateral aid agencies and international donors to prioritise female condoms and 'buy in bulk'. While this approach of 'reducing prices' has been successfully applied to several reproductive and sexual health technologies, including the male condom, there seems to be great reluctance to 'drive down' the price of female condoms so as to make femidoms affordable, available and accessible. Why?

Female condoms are available now. Female condoms provide an alternative for women to initiate and control HIV risks during sex – and yet, there seems very little preparedness to support, promote, advocate and increase the availability of female condoms.

Concluding remarks

The excuses and 'justifications' for the failure to afford adequate access to female condoms, as described above, seem to leave some remaining questions as to why is this 'blatant' form of gender discrimination 'acceptable', and decisions about female condom production and distribution not raised/questioned as exactly that – a gender-based discrimination, which violate women's fundamental rights to equality, non-discrimination and autonomy.

Most importantly, we, as civil society, advocating for

women's and human rights have to ask ourselves: Why are 'we' accepting this form of blatant and life-threatening discrimination against women? What, if anything, are we doing to ensure that women have the equal right to access condoms, which are women-initiated and women-controlled?

FOOTNOTES:

1. An earlier version of this paper has been presented at NSP Roundtable Discussion in June 2008.
2. Section 12(2) of the Constitution of South Africa, Act No 108 of 1996.
3. This reason has been provided by the SA Government HIV/AIDS Directorate.
4. For more information on these findings contact the author.
5. Member of the South African National AIDS Council.

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Johanna Arendse

The Female Condom... A 'novelty'

The 'ABC' approach – **A**bstain, **B**e faithful, use **C**ondoms – is the most commonly used approach to HIV prevention. Irrespective of the efficiency of this particular HIV prevention message, there seems to be the need for more than one message, in order to provide HIV prevention options, especially for women, because women are often not in the position to '*control*' the 'ABC' of prevention. More women are infected with HIV, not only because of the lack of sufficient access to information, but also because women generally lack the power to make decisions about their bodies.

It is well recognised that

...If more women and girls have the right to abstain; to ensure their partners' faithfulness, to negotiate condom use; to live their lives free from violence; to access basic education; to earn incomes adequate to feed their families; - their ability to protect themselves from HIV would be real.¹

But this is not the case, since very few women are in the position to negotiate conditions of sex, and safer sex, due to various reasons, including misperceptions of '*safety*' within marriage and/or long-term relationships, as well as inadequate access to quality sexual and reproductive healthcare services. While

...it is a real challenge to get married couples to use condoms because of the way they [condoms] are perceived as a tool for single people² –

marriage is also often perceived as a prevention method in and of itself – despite the fact that married women are often more vulnerable to HIV and other sexual transmitted infections, which could later have an impact on women's sexual and reproductive health.

The inadequate access to sexual and reproductive healthcare services contributes, amongst other things, to unintended pregnancies, unsafe '*abortions*', inadequate antenatal care, as well as the lack of skilled attendance at birth. It is estimated that:

...for 3 million women per year, complications during pregnancy or delivery lead to short-term, as well as long-term disabilities.³

In the context of this article,

...sexual and reproductive health is defined as a state of physical, mental and social well-being in all matters relating to reproductive systems at all stages of life.⁴

This also requires empowering women to be in the

position to choose the number of children, and when they will have children. An important step towards empowering women is to ensure access to adequate information about family planning and its methods, which needs to be readily available and accessible to women.

...marriage is also often perceived as a prevention method in and of itself – despite the fact that married women are often more vulnerable to HIV...

Female condom availability

Women visiting healthcare facilities for family planning information are very seldom informed about the 'option' of the female condom as part of the family planning package. Instead, family planning information, introducing condom use, is often limited to, and centred on, male condom use. Hence, the female condom, as a preventative method, is deemed a 'novelty' – and not promoted or distributed the same as the male condom.

The female condom has been developed not only as an alternative to the male condom, but more importantly as a prevention tool, which affords women control, and protection from HIV and other diseases, as well as unintended pregnancies. However, it also has to be acknowledged that, despite the availability of the female condom,

...rates of HIV infection among married women

and those in committed partnership are increasing rapidly worldwide. Yet the vast majority of married women at risk are not using any barrier method during sex.⁵

Considering the available knowledge about HIV risks, especially for women who are married and/or in long-term relationships, the question arises as to why the female condom – a prevention tool, which has the potential to 'save lives' – is neither promoted nor available to women. The cost of producing this barrier method seems to be one of the recurring arguments explaining the limited availability of female condoms.

...the current cost of the female condom is prohibitive for the majority of women at risk of HIV infection, as well as health programme directors with tight budgets. Its unit price in developing country governments ranges from 57 cents to 70 cents, compared with between 3 cents and 5 cents for a male condom.⁶

...the question arises as to why the female condom – a prevention tool, which has the potential to 'save lives' – is neither promoted nor available to women...

While comparing these two prices for manufacturing, it seems 'obvious', which condom will be promoted by governments. However, the question remains at what cost, especially since

...the short-term costs of producing the female

condom have to be compared with the long-term cost to economies and societies of women contracting HIV.⁷

Illness, or the death of a woman, has devastating and 'costly' consequences; not only for the immediate family and household, but also for the community and country as a whole – as households, families and communities without 'healthy' women do not make a 'healthy' nation.

Reality of female condom use

However, it is important to recognise that even adequate availability of female condoms would not necessarily translate into adequate accessibility of female condoms, as

...a woman's vulnerability to the virus is attributable not only to biological differences, but also to deeply entrenched socio-economic inequality that further compound susceptibility. This includes economic vulnerability leading to transactional sex, forced or coerced sex and the inability to negotiate condom use.⁸

...it is difficult for women to negotiate conditions of sex, and the use of female condoms, since discussion about sex and sexual practices are commonly not part of communications...

Even if women make an informed choice to use a female condom, women will, in most cases, still need to be in the position to negotiate the use of the condom, which is especially difficult, considering that most relationships exist in an unequal and patriarchal paradigm. In addition,

...many women interviewed by the Amnesty International said that they were often unable to protect themselves against HIV infection because they felt at risk of violence when they suggested condom use.⁹

The potential risk of violence associated with women negotiating condom use is further exacerbated for women living in abusive relationships.

Even in relationships, where equality is assumed, existing values and norms of women's sexuality and sexual behaviour, will remain a barrier for many women to 'control' the use of the female condom – due to economic dependency and fear of violence, many women may feel 'forced' to submit to the sexual demands of their partners. Furthermore, it is difficult for women to negotiate conditions of sex, and the use of female condoms, since discussion about sex and sexual practices are commonly not part of communications within the family home.

There seems to also be the additional challenge that

...some men may believe that the use of the female condom gives women too much control over sex. [In response] ...the female condom is now usually referred to as 'female-initiated', rather than 'female-controlled', to reflect that its use is not fully in the hands of women.¹⁰

This is but one of the many indicators highlighting that women still need to have the 'power' to negotiate the use of female condoms. However, since women have limited 'power' to define conditions of sex, most women have, thus, also rather limited 'control' over both condom use and the risks associated with sex without a condom.

There is also the argument that

...prevention fatigue is certainly a factor when it comes to women's ability to use contraceptives correctly and consistently over the decades to prevent unintended pregnancy or men's willingness to use a condom 'every time' to reduce the risk of transmitting or contracting HIV.¹¹

...many people experience difficulties using contraceptives or condoms constantly over a long period of time – as 'prevention fatigue' sets in...

In reality, many women will visit healthcare facilities for advice on contraceptives, or to refill their prescriptions, for many years. At the first visit, healthcare providers will provide information on the use of the contraceptive of choice. After years of refilling prescriptions, there is limited encouragement, and/or extra information from the healthcare provider about other options. It is also a known fact that many people experience difficulties using contraceptives or condoms constantly over a long period of time

– as 'prevention fatigue' sets in, potentially exposing women to numerous risks.

...even though condoms are known and proven to be the most successful method of prevention, be it female or male – there remains ... the individual challenge/difficulty to consistent condom use...

It is commonly assumed that

...when faced with a life-threatening danger people can and will modify their behaviour, once they are given the right information in the right way.¹²

However, when applied to the 'danger' of sexual behaviour and practices, there seems to be the extreme reluctance to change. This resistance to change sexual behaviour and practices is also highlighted in the fact that even though condoms are known and proven to be the most successful method of prevention, be it female or male – there remains to be the individual challenge/difficulty to consistent condom use.

Despite the fact that condoms are the 'tried and tested' method of HIV prevention – and research findings are available to prove this – there are still conservative and moralistic voices, who would argue that promoting condom use leads to riskier sexual behaviour, as

...the access to contraceptives has an inherently disinhibiting effect on people, especially young

*people, causing more sex and increasing the risk of HIV and other STIs, as well as unintended pregnancy and abortions.*¹³

Sentiments like these also highlight a main challenge to the adequacy of HIV prevention efforts – in that HIV prevention messages are too often placed within a moral argument about ‘appropriate’ sexual behaviour, as compared to factual information on methods that have been proven to minimise the risk of HIV transmission.

...despite the fact that condoms are the ‘tried and tested’ method of HIV prevention ... there are still conservative and moralistic voices, who would argue that promoting condom use leads to riskier sexual behaviour...

Concluding remarks

To redress the situation that female condoms are seemingly more a ‘novelty’, than a ‘real’ HIV prevention option for women, there are many obstacles to overcome. In addition to increasing the availability and accessibility of female condoms, it is equally important to address common beliefs about female condoms, as well as the lack of acceptance of condom use per se.

Moreover, the unequal, gendered and powered societal context, in which condom use is negotiated,

has to be challenged and transformed, so as to ensure that women are in the position to make informed choices about their sexual lives, as well as to negotiate condom use without fear of violence.

Finally, for HIV prevention to become a ‘real’ and accessible ‘option’ for women, it is also crucial to

*...give women and girls equal access to prevention, treatment, care, and support services, including prevention methods they can initiate and control, such as the female condom, and once developed, effective microbicides – so they can stay strong and healthy.*¹⁴

FOOTNOTES:

1. ‘The Challenge’. Women and AIDS. [<http://womenandaids.unaids.org/tour/challenge.html>]
2. PlusNew, Feb 2008. [<http://www.plusnews.org/report.aspx?ReportId=76744>]
3. Women’s Health. [http://www.globalhealth.org/view_top.php3?id=225]
4. Ibid.
5. Worley, H. 2005. Obstacle remain to wide adoption of female condom. [<http://www.prb.org/Articles/2005/OstaclesRemaintoWideAdoptionofFemaleCondom>]
6. Ibid.
7. Ibid.
8. Women’s Health. [http://www.globalhealth.org/view_top.php3?id=225]
9. Rural Women the losers in HIV Response. [<http://allafrica.com/stories/200803180010.html>]
10. ‘The future of the Female Condom’. Volume 30, Number 3, September 2004. [<http://www.guttmacher.org/pubs/journals/3013904.html>]
11. The Guttmacher Report on Public Policy, May 2005, Volume 8, Number 2.
12. Ibid.
13. ‘The future of the Female Condom’. Volume 30, Number 3, September 2004. [<http://www.guttmacher.org/pubs/journals/3013904.html>]
14. The Challenge’. Women and AIDS. [<http://womenandaids.unaids.org/tour/challenge.html>]

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Gahsiena van der Schaff

Where are the femidoms?

There seems to be the continuous denial that women are full and equal bearers of all rights and freedoms, including the right not to be discriminated against on grounds of gender, sex, sexual orientation, age, pregnancy, marital status; the right to self-determination and to be free of all forms of violence; the right to have access to healthcare, including reproductive healthcare; and the right to make informed decisions on all matters concerning their bodies and lives.

Femidom reality

The continuous lack of femidoms – despite many calls for increased access to female condoms – is but one of the realities, which clearly highlights the failure to recognise women's rights, and thus, limiting women's right to access HIV prevention methods. Moreover, it fails to affirm women's individual responsibility to make decisions about and/or have '*control*' over their bodies and the risk of sexual transmitted infections, including HIV, and unintended pregnancies. The general lack of access to, and availability of, female condoms, arguably, also highlights and '*confirms*' women's gendered position of lesser power, especially in the context of decision making about conditions of sex, including when, how, and with whom to engage in sex.

It is estimated that women are up to four times more at risk of HIV infection. Yet, in 2005, 347 million male condoms were distributed nationally, as compared to 1.1 million female condoms.¹ Since it is well-recognised (and not contested) that women are at much greater risk of HIV infection, the question can be raised as to why the distribution in condoms does not reflect and/or respond to these estimates. It could therefore be argued that an '*adequate*' intervention to HIV and AIDS would indeed respond to the actual HIV risk of women and, thus, translate into higher distribution of female

condoms, as compared to male condoms – especially since the female condom is the only women '*controlled*' barrier method to HIV, other STIs, and unintended pregnancies. An argument could also be made that there should be a direct relation between estimated HIV risks for women and actual availability of HIV prevention tools. This would mean that female condoms are distributed in the same proportion as the risk is estimated – hence, if the estimate indicates that women are four times more at risk of HIV, then four times more female condoms should be made available.

However, while many arguments for the need to increase the access to female condoms could be made, there is also the reality in which women make decisions as to whether or not to access available condoms. This reality is gendered, unequal, powered, and non-conducive for women to have access to, and control over, the use of female condoms.

Women's reality

Despite constitutional guarantees to make informed choices about one's body and life, and besides argument that, considering the feminised HIV pandemic and HIV risks, female condoms need to be made available – the real question seem to be as to whether or not women are in '*control*' to access female condoms, given their availability.

...if the estimate indicates that women are four times more at risk of HIV, then four times more female condoms should be made available...

In a societal context in which women are largely ‘perceived’ to ‘respond’ to sexual decisions made by their male sex partners, women’s ‘control’ over sexual choices and decisions are, arguably, limited in accordance with the societal expectation of ‘appropriate’ female sexual behaviour. Moreover, women continue to be largely defined by their ‘reproductive’ and ‘care-taking’ roles and thus, women’s ‘ability’ to make informed decisions about sexual behaviour and practices are often ‘influenced’ by societal gendered expectations.

There are also strong value, norms and belief systems defining women’s roles, responsibilities and ‘appropriate’ behaviour different to that of men. Social norms are also very clear in prescribing how, when and with whom women are to engage sexually – in an ‘appropriate and responsible’ manner. Women’s non-conformity to the social norms and sexual ‘rules’ are often responded to with judgement, stigmatisation and discrimination, irrespective of whether or not women have made an informed choice.

Recognising that women’s sexual behaviour and choices seem to be largely prescribed by gendered social norms, including ‘norms’ of sexual engagement, a question could be raised as to the extent to which women are indeed in the position to make informed sexual choices – choices, which are truly based on accurate information, instead of values, norms, beliefs, and societal expectations.

Within this context it is also widely recognised that most women have limited ‘power’ to make sexual choices and no ‘control’ over their bodies, or over decisions concerning and affecting their bodies and lives. This also means that women have rather limited ‘power’ to choose a female condom as an HIV prevention method, irrespective of whether or not women are aware of the risk of HIV

transmission during unprotected sex. Thus, as is argued, women will continue to have no ‘control’ over their bodies as long as women have rather limited ‘power’ to make decisions as to when, how and with whom to engage in sex, as well as whether or not to use a female condom.

And while this reality is a clear violation of the fundamental human right to bodily autonomy, it also seems to raise the question as to the extent to which the increased access to femidoms does carry the potential to impact on women’s ‘informed’ sexual choices about condom use and minimising the risk of HIV infection.

...only and as and when the increased number of available female condoms is accompanied by creating a ‘conductive’ environment for women to make informed sexual choices, will female condoms be a prevention tool for women...

Femidom Challenges

While there is a clear need to provide adequate availability to female condoms so as to ‘empower’ women to access this form of HIV prevention as and when desired, there is also the obligation of the national response to HIV and AIDS to take into account – not only in analysis, but through ‘real’ actions – both the feminised nature of the pandemic, as well as inherent gendered HIV risks and vulnerabilities. Thus, any HIV intervention needs to be responsive to the actual HIV risks and vulnerabilities – which are feminised – and calls for, amongst other things, women-initiated and controlled HIV prevention methods.

However, the availability of female condoms per se

will not necessarily translate into women's 'ability' to access and use female condoms – as the availability of female condoms is not increasing women's 'power' to make decisions or 'control' their bodies. Hence, it is argued that only and as and when the increased number of available female condoms is accompanied by creating a 'conducive' environment for women to make informed sexual choices, will female condoms be a prevention tool for women.

So, the 'femidom challenges' seems to be based not only on one, but two fundamental questions: *Where are the female condoms*; and *where is the conducive environment* for women to choose to access and use femidoms?

FOOTNOTES:

1. Kehler, J. 2007. *A responsibility of All: NSP and HIV Prevention*. Cape Town: AIDS Legal Network.

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**HIV Testing
consent, confidentiality
and counselling
are basic rights for everyone**

**not a privilege
for the informed few**

**Who have you
discriminated against lately?**



The AIDS Legal Network is a human rights organisation committed to the promotion, protection and realisation of fundamental rights and freedoms of people living with - and affected by - HIV and AIDS
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**HIV prevention
demands respect
for rights and choices**

not 'ABC'

**Who have you
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Erica Kessie

Values and beliefs make people vulnerable...

Realities and challenges of condom use

Current estimates indicate that South Africa has the largest number of people living with HIV and AIDS in the world.

In 2005 about 5.54 million people in South Africa were living with HIV. 18.8% is of the adult population (15-49 yrs old). 55% of the population are women. 40% of the population are women between the ages of 25-29 who are the worst effected. 75% of people caring for people living with HIV and AIDS are women and children.¹

In response to the HIV and AIDS pandemics, parliament adopted a five-year National Strategic Plan, 2007 – 2011, (NSP). The two main goals of the National Strategic Plan, are to reduce the number of new HIV infections by 50%, and to ensure that at least eight out of ten people (80%) living with, and affected by, HIV have access to the treatment, care and support services.

Unprotected heterosexual sex is the primary form of HIV transmission in South Africa. An effective response to the HIV and AIDS pandemics in South Africa needs to involve everyone – including women, young people, sex workers, people in prisons, men who have sex with men, women who have sex with women, refugees, people with disabilities, mobile workers and intravenous drug users – in HIV prevention strategies and programmes, so as to reduce HIV risks and vulnerabilities of the NSP identified ‘groups at higher risk’.

This article is based on the premise that people need to feel free to access HIV prevention, testing, treatment and support services, without fear of being stigmatised and discriminated against, based on a person’s age, sex, gender and/or sexual orientation. Since it is beyond the scope of this contribution to explore condom realities and challenges for all the ‘groups at higher risk’, emphasis will be given to some of the challenges of young people, women, sex workers, as well as lesbian women.

Young people

One of the groups identified to be at higher risk of HIV infection are young people, 15 to 24 years old. However, while adults express difficulties in talking to young people about sex and HIV prevention, young people frequently complain that access to condoms is denied by healthcare providers in local clinics. Healthcare providers’ attitudes often prevent young people from accessing condoms and thus, using condoms as a preventative measure to sexual transmitted diseases, including HIV, and unintended pregnancies.

...nurses say; ‘what are they gonna do with the condom? They should be focussing on their studies’.²

Especially considering the impact service providers’ attitudes have on the accessibility of available service,

healthcare providers are not to impose their values and beliefs on anybody who comes to the clinic for, either information, and/or services. Service providers are expected to address the needs of their clients, and not be judgemental. Stigma and discrimination based on age, can prevent or limit access to sexual and reproductive healthcare services. As a result of prevailing age-related stigma and discrimination in healthcare facilities, young people may not visit the clinic for fear of being ‘*scolded at*’ – leading to young people engaging in unprotected sex, which increases the risk of HIV infection.

...creating safe and free environments for young people to access factual information about sex and HIV prevention has to be combined with the adequate provision of condoms, both female and male condoms...

Besides the fact that refusing young people access to condoms is not in accordance with the aims and objectives of the NSP, this denied access to condoms is a violation of human rights. Healthcare providers are to accept that all people are equal, and are, therefore, equally entitled to access available services, including condoms, irrespective of age. The right to access sexual and reproductive healthcare services, without the fear of judgement, should be heavily promoted and practiced in all healthcare facilities, so as to ensure that especially young people have access and, thus, realise sexual and reproductive health and rights. Furthermore, creating safe and free environments for young people to access factual information about sex

and HIV prevention has to be combined with the adequate provision of condoms, both female and male condoms.

Gender and patriarchal systems

Society needs to challenge and transform the social norms, values and beliefs, which continue to support and maintain gender imbalances. However, changing the status quo demands a commitment to addressing the fundamentals of gender, patriarchy and power. This also includes recognising both individual and societal responsibility for maintaining the status quo of gender inequalities, as well as perpetuating gender-based stigma and discrimination. In this context of recognising individual responsibility, a church leader stated that

...I used to use the bible to defend patriarchy. I now use it to challenge gender stereotypes.³

The prevailing patriarchal system denies women their basic human right to bodily autonomy and bodily integrity, despite constitutional guarantees to freedom and security over one’s body, which includes the right to be free from all forms of violence.⁴

Taking into account that women’s vulnerability to HIV is largely defined by gendered norms and values and grounded within the patriarchal paradigm – and not by constitutional provisions – women’s right to autonomy and bodily integrity are constantly threatened, which in turn, increases women’s risks and vulnerabilities. Since the majority of women are not in a position to negotiate safer sex, within or outside of marriage, for fear of being stigmatised, abused, and/or abandoned, women have in reality limited control over their bodies, and thus limited sexual autonomy. Furthermore, since many women are in a position of financial dependency, women’s ‘*ability*’ to negotiate

conditions of sex, including condom use, is often limited accordingly.

It can also be argued that the impact of gendered imbalances and patriarchal systems are further manifested in the access to, and availability of, HIV prevention tools, such as condoms. While male condoms are freely available, the limited availability of female condoms perpetuates women's vulnerability to HIV.

...sex workers are perceived to be of 'lower social status' due to 'immoral' sexual behaviour and are also often 'blamed' for spreading HIV...

Sex workers

Sex workers face discrimination and stigma and are thus, vulnerable to HIV infection and abuse. Sex workers are perceived to be of '*lower social status*' due to '*immoral*' sexual behaviour and are also often '*blamed*' for spreading HIV.

Negotiating condom use is often difficult for sex workers, as this may lead to violence and/or abuse from clients. Moreover, there is also the situation in which clients will pay less, if they are to agree to condom use, impacting in turn on sex workers' ability to earn a sufficient income. As a consequence, sex workers are '*forced*' to engage in unprotected sex and thus, to risk HIV infection. And, as one sex worker expressed,

...it is better to die in 15 years time of AIDS, than to die in 5 days from hunger.⁵

Because sex work is criminalised, sex workers have no protection from the law, no access to adequate healthcare services, including HIV prevention tools, such as female

condoms. As many sex workers experience stigma and discrimination from healthcare workers, especially when accessing sexual and reproductive healthcare services, sex workers are often discouraged from accessing healthcare facilities. This situation not only compromises sex workers' rights to access available healthcare service and HIV prevention, but also increases sex workers' risks to HIV and other sexually transmitted diseases.

While the decriminalisation of sex work is key to an adequate rights-based response to HIV and AIDS, as it would reduce sex workers' risks and vulnerabilities to HIV and abuse, it also has to be recognised that decriminalising sex work impacts greatly on the extent to which healthcare services and available HIV prevention tools, such as female condoms, are accessible.

...especially black lesbian women are at high risk of HIV transmission, due to increasing levels of sexual violence and rape committed against lesbian women...

Lesbian women

There is the common perception that women who have sex with women are at a very low risk of HIV infection. However, little research has been done to evidence this assumption; to assess lesbian women's actual risk of HIV infection, and/or to ascertain the extent to which lesbian women are accessing and using HIV prevention methods.

Discriminatory and homophobic beliefs and attitudes limit lesbian women's access to available resources, including available HIV risk and prevention information,

as well as to adequate sexual and reproductive healthcare services. Prevailing homophobic attitudes also deter lesbian women from accessing healthcare services.⁶

However, irrespective of adequate research findings evidencing HIV risks and vulnerabilities of women who have sex with women, it has to be recognised that especially black lesbian women are at high risk of HIV transmission, due to increasing levels of sexual violence and rape committed against lesbian women.

Conclusion

In summary, it is argued that realities and challenges of condom use are not ‘*specific*’ to a particular group of people identified to be at ‘*higher risk*’, but instead ‘*specific*’ to the societal context – gendered, patriarchal, powered, discriminatory, judgmental and homophobic – which seems to define HIV risks and vulnerabilities of people.

*...stigma mitigation
has to become an integral part
of HIV prevention strategies...*

Thus, correct and factual information need to be given to people, and a safe environment needs to be created, so as to ensure that people are in the position to freely make informed choices about HIV prevention and condom use. As stigma and discrimination not only compromises the access to healthcare services, and limits individual ‘*ability*’ to make informed choices, but also violates human rights, stigma mitigation has to become an integral part of HIV prevention strategies – so as to

de-stigmatise and thus, increase the access to, and use of both female and male condoms.

FOOTNOTES:

1. UNAIDS. 2006. AIDS Epidemic Update.
2. Parker, W. et.al. 2004. *Breaking the barriers: An analysis of condoms-related calls to the National Aids Helpline*. Johannesburg: CADRE. p9.
3. Church leader and participant in Engender Health’s Men as Partners Programme in South Africa. [www.aidsalliance.org]
4. Section 12 of the Constitution of South Africa, Act 108 of 1996.
5. Kaplan, L. 2006. *Violence against Sex Workers*. Cape Town: SWEAT, p7.
6. For more information on lesbian women’s risks and vulnerabilities see Judge, M. 2008. ‘Invisibility in Plain Sight’: Lesbian Women and HIV. In: *ALQ*, March 2008, pp10-14.

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Jameyah Amien

Prescribed by institutions...

Religion and condom use for married couples

Various factors contribute to the important role of condom use within the institution of marriage. The increase in new HIV transmissions has prioritised protective contraception methods, such as female and male condoms, in order to decrease the risk of HIV transmission within society.¹ Since the inception of the first male sheath², the lack of condom use has often been ascribed to religious restrictions on condom practises and male supremacy, and due to women's 'inability' to negotiate condom use. However, the lack of condom practises has ultimately lead to an increase in new HIV infections, which has subsequently lead to the mutation of the HIV1 to the HIV2 strain³.

Condom use by married or cohabiting couples, where HIV infections are high, have become a significant public health issue. Based on the HIV pandemic, massive efforts to promote condom use has been underway, but these efforts have primarily focused on premarital and extramarital sexual relationships – and hence, the needs of married and cohabiting couples have been largely neglected. This focus needs to change, as many HIV infections occur within

marital and cohabiting partnerships, due to either prior HIV infection or infidelity.

Research reflect that 10% of European and North American, and 42% of Japanese married or cohabiting couples use condoms as their dominant method of contraception. Maharaj and Cleland (2005) argue that within developing countries, contraception use among couples increased significantly in recent years (from 9% to 60%), and countries in East and Southern Africa, which are severely affected by HIV, also recorded increasing levels of contraception use.⁴ These findings, however, seem to be in contrast to statistics indicating that 75% of women infected with HIV are either married and/or live in long-term relationships.⁵

Accessibility, availability and acceptance of condom use to prevent HIV in married couples

Global research reflects the resistance to condom use in married and/or long-term relationships. This resistance has been associated with lack of trust and illicit sexual behaviour from partners. Maharaj and Cleland (2005) found that women in Zaire were unable to negotiate condom use, even though women suspected their husbands/partners of infidelity with multiple partners outside the relationship. This confirms the likelihood of increased risk of HIV transmissions, due to lack of condom use as a contraceptive method by married couples in African countries. The negative attitudes towards condom use, especially amongst men, have created a situation in which many women feel vulnerable to HIV infection from their partners.⁶

...75% of women infected with HIV are either married and/or live in long-term relationships...

In addition to the above study, research in five East and Southern African countries sponsored by the World Health Organisation (WHO), reflected that about 20% of married or cohabiting couples *'sometimes'* use condoms. This study further reflected that 34% of wives were in the position to influence condom use – increasing the direct benefit that can be derived from greater condom use within marriages, as it would reduce the risk of interspousal HIV transmissions.⁷

Religious perspectives on condom use in married couples

Countries dominated by certain religions have seen religious leaders publicly orating that any association with condoms are perceived as *'sinful'*, and/or promoting *'sexual promiscuity'*. Positions like these imply that people using condoms lack any kind of morality to abstain from sex until marriage.⁸ The past few decades have seen vigorous efforts to make condoms more accessible and acceptable to the population.⁹ However, this has not occurred, as some governments either fail to guarantee access to condoms or impose unnecessary restrictions on access to condoms and related HIV and AIDS information. Any restriction placed on HIV prevention, intervention or education obstructs the promotion of HIV transmission as a public health issue, and further compromises basic human rights.¹⁰

In some, there also seems to be overlapping values, norms and practices systems, influencing the access to, and acceptance of, condom use in married couples – in that cultural/traditional and religious values, norms and practises are overlapping. In the first instance, women are *'ruled'* by traditional and cultural

boundaries, and in the latter women are *'ruled'* by religious restrictions. Either *'rule'*, women have very limited control over their bodies and sexual choices, including condom use.

Islamic perspective of condom use

Islam's decree on condom use is fundamentally based on social responsibility within the context of Islam. Research reflects how Islam has transformed its decree on condom use within married relationships. In order to reduce the risk of HIV transmissions, Islam allows married couples to use condoms. Gray's (2003) research reflects how various factors in Islam decrease the risk of transmission of HIV through aspects, such as male circumcision, prohibiting consumption of alcohol, which decreases unprotected sexual behaviour, and ritual cleaning practises.¹¹ This research also raises the issue that not all Muslims are practising Muslims – thus increasing the risk of HIV transmissions, due to sexual relationships before marriage.

...negative attitudes towards condom use, especially amongst men, have created a situation in which many women feel vulnerable to HIV infection from their partners...

This research has been confirmed by reports from the Muslim Judicial Council (MJC) reporting that 80% of all marriages dissolved through the MJC are due to infidelity.¹² Men have been the primary partner to commit infidelity and have practised unprotected sexual relationships. This places Muslim women at risk of contracting HIV within marital relationships; and due to the prospect of spousal abuse, women are seldom in the position to negotiate condom use. These coercive factors

lead to risky sexual relations between ‘legally’ married partners and has been substantiated by reports that Muslim couples do not need to be in possession of condoms.¹³

...couples’ decisions around condom use is not just dictated by their individual beliefs, but are largely prescribed by institutions such as religion, tradition and power...

Ultimately, these realities are to raise questions, such as whose responsibility it is to advocate for the access to, and availability, as well as acceptance, of condoms to the population in general. This question seems to be further corroborated by reports confirming that many HIV infections occur within marital and cohabiting partnerships, due to prior infection by one partner or infidelity.¹⁴

Christianity’s perspective of condom use

Christianity’s doctrine on condom use is based on laws of morality and the right to human life. In Chapter 14 of the Encyclical Letter of Pope Paul VI¹⁵, he reiterates and forbids any means of contraception, which prevents conception. This rule would arguably only apply to married couples, as the church does not endorse cohabiting. Countries where Christianity, more specifically the denomination of Catholicism, are preached and practised are countries where institutions, like governments, are frequently pressured by religious leaders into censoring information relating to condom use, promoting condoms in school-based HIV and AIDS curricular or other HIV-information, as well as HIV prevention programmes.

Within certain countries, The Holy See, who represents the Vatican, can exert considerable power and influence over HIV and AIDS policies, or the effectiveness thereof.

PEPFAR (Presidents Emergency Plan for AIDS Relief), which was implemented during 2003, is one of the known methods to ensure that abstinence becomes a central part of HIV prevention strategies. The consequences of this plan are seen globally, in that some donor countries reduced condom availability, and the access to accurate HIV and AIDS information in accordance with PEPFAR requirements.¹⁶

Discussion

In both Islamic and Christian religious institutions, the prescribed text differs to the practiced reality around sexual relations, behaviours and practices. What this has shown is that couples’ decisions around condom use is not just dictated by their individual beliefs, but are largely prescribed by institutions such as religion, tradition and power. In addition to individual beliefs, restrictions around accessibility to condoms have become a major factor, as accessibility and availability to condoms have been limited and controlled by religious institutions.

...it is estimated that approximately three of every four HIV infections in developing countries are transmitted through heterosexual intercourse...

Women’s accessibility to condoms is further limited, due to existing gender roles, sexual norms, inequalities in access to resources and decision-making power; facilitating women’s greater risk to HIV infection. It is estimated that approximately three of every four HIV infections in developing countries are transmitted through heterosexual intercourse. In countries, such as India, married women in Southern India, who may or may not have been infected by their husbands, constitute a significant proportion of new HIV infections.¹⁷

The main question seems to be when and how will clergies acknowledge that HIV infections occur within marriages. When will clergies realise that marriage is not a safe sanctuary, and that denial or silence around current HIV prevalence rates, will encourage further ignorance and increase HIV infection rates. Silence can, thus, be seen as a method of augmenting HIV realities and challenges in many communities. It has been reported that during 2003, access to condoms has been restricted to fewer than half of all people at risk of HIV.¹⁸

...during 2005 only fourteen million female condoms were provided for countries with high HIV prevalence rates, as compared to six to nine billion male condoms, provided during the same period...

Female condoms

Excluding the female condom, the United Nations Population Fund (UNFPA) estimated that over seven billion additional condoms are required in developing countries to reduce HIV infection rates.¹⁹ This estimate does, however, not speak to the amount of female condoms required, or the stigma associated with the female condom. Despite growing demands for the female condom, its access has been restricted by means of price barriers, manufacturing shortage, and the inability to reach women. Comparatively, during 2005 only fourteen *million* female condoms were provided for countries with high HIV prevalence rates, as compared to six to nine *billion* male condoms, provided during the same period. The female condom has to be clearly seen as an effective tool in preventing HIV infections, as it offers an alternative to the male condom.²⁰

Conclusions

If religion has such strict perimeters around condom use for married partners, why then are they constantly choosing to ignore the benefits of promoting healthy sexual relations, through means of condom use? Research has confirmed that HIV prevalence within marriage is on the increase and a long-term solution should be looked at. Religious institutions should start accepting that availing condoms to promote protective sexual relations will ensure that accessibility are maximised, due to knowledge.

FOOTNOTES:

1. Cleland, J. 2005. 'Use of the male condom within marriage'. In: *IPPF Medical Bulletin*. 39(3).
2. *Ibid.*
3. *Ibid.*
4. Maharaj, P. & Cleland, J. 2005. 'Risk perception and condom use among married or cohabiting couples in KwaZulu-Natal, South Africa'. In: *International Family Planning Perspectives*, 31(1).
5. Kehler, J. 2006 'Gendered Realities'. In: *ALQ*, June 2006, pp1-6.
6. Maharaj, P. & Cleland, J. 2005. 'Risk perception and condom use among married or cohabiting couples in KwaZulu-Natal, South Africa'. In: *International Family Planning Perspectives*, 31(1).
7. Ali, M., Cleland, J & Shah, I. (2004). Condom use within marriage: a neglected HIV intervention. *Bulletin of the World Health Organisation*. 82(3).
8. See www.hrw.org/backgrounder/hiv/condoms1204/1.htm.
9. Ali, M., Cleland, J & Shah, I. (2004). Condom use within marriage: a neglected HIV intervention. *Bulletin of the World Health Organisation*. 82(3).
10. See www.hrw.org/backgrounder/hiv/condoms1204/1.htm.
11. Gray, B. 2003. 'HIV and Islam: Is HIV prevalence lower among Muslims?'. In: *Social Science & Medicine*.
12. See also www.vocfm.co.za/public/articles.php?Articleid=18172.
13. See www.vocfm.co.za/public/articles.php?Articleid=18172.
14. Ali, M., Cleland, J & Shah, I. (2004). Condom use within marriage: a neglected HIV intervention. *Bulletin of the World Health Organisation*. 82(3).
15. See www.vatican.va/holy_father/paul_vi/encyclicals/documents/hg_p-vi_enc_25071968_humnae-vitae.
16. See www.hrw.org/backgrounder/hiv/condoms1204/1.htm.
17. PATH & UNFPA. 2006. *Female Condom: A powerful tool for protection*. UNFPA.
18. See also <http://inweb18.worldbank.org/sar/sa.nsf>.
19. See www.hrw.org/backgrounder/hiv/condoms1204/1.htm.
20. *Ibid.*

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Gaetane le Grange

The future is mine to create...

The tales of a young NGO director

A cross between Chuck Norris and Mary Poppins

Africa is blessed with a tremendous number of passionate, creative, caring and determined individuals. Only the most *'insane'* of these go on to be NGO directors. Personally, I think it's a prerequisite. No *'sane'* individual would even contemplate it. You have to be *completely insane* to contemplate such a thing before the age of 40. I am such an individual.

The strangest thing I find about being a director is the intense *'love-hate relationship'* I have with my position. I feel such intense love for the staff members who have managed to achieve so much with so little. They don't realise how much they have changed the world. They expect no rewards, they trudge through rain and mud to deliver food parcels, they tenderly counsel people who have tested HIV positive, feel pain when they hear how others have suffered, gently try to encourage people to change age old behaviours and perceptions, and support each other in times of hardship. I sit and watch them sometimes, truly astonished that I have been so blessed to work with these amazing people.

And then there are the *other* days... The days when the windshield wiper has fallen off the Tazz and *nobody* knows when and how it happened. The same can be said for the dent in the 4x4, the antenna that got snapped off, the stapler that grew legs, the viruses that have infested the network, the haunted look staff members get when I ask if they've read the constitution (or, indeed, any of the policy

documents), the photos of Caprice that keep appearing in the network printer.

There are other joys, as well, to being a director. There is the ward councillor who shouts at your donor, because the *'wrong'* ward councillor (who swore he was the *'right'* councillor) gave us permission to work in the area; the baker who writes 'Happy Birthday Twice' on the cake for your children's birthday party (instead of writing *'Happy Birthday'* on two separate cakes, i.e. 'Happy Birthday' twice); the tracksuits that you get sponsored for a project where the sponsor writes *'opharns'*, instead of *'orphans'*...

There is also astonishing fun to be had writing proposals and reports to donors. Its especially fun when you complete a document, as per the required format, only to be told that a) you were given the wrong format, or b) the format has been changed since you were given the format. Then, there is the obligatory *'I know you submitted the annual report 3 months ago, but I haven't read it yet and I have to report on it now, so I'm phoning you so that you can spend the next three hours of your life answering my questions, questions that are answered in the report you submitted three months ago, the one I haven't read'*. Possibly, the highlight of my career so far was, when one of the donors, during a routine update of partner information as per a very serious set questionnaire, asked me if I was affiliated with any of the internationally recognised terrorist groups.

And yet, these are the people, who make so many sacrifices to ensure that I am able to purchase vehicles to get into deep rural communities, birthday cakes for

children who have never celebrated a birthday before, and equipment to offer HIV counselling.

...the highlight of my career so far was, when one of the donors, ... asked me if I was affiliated with any of the internationally recognised terrorist groups...

That is, perhaps, the greatest contradiction of being an NGO director. So often you are astonished by the absolute wonder of these human beings – staff, community members, donors and board; that they would be prepared to give of themselves so freely for other human beings, who they don't know and will never meet. But then the very next moment they can infuriate you to the point where you start wondering if a 'rights-based approach' is actually preferable to the 'beat-them-with-a-big-stick-with-a-nail-in-it-based approach'.

But it is a director's lot in life to function as the fulcrum in the huge international machinery that is the social development sector. It is the fulcrum that has to make everyone happy and maintain balance and harmony between the staff, community members, donors and board; make sure that the organisation's vision is upheld, a nurturing work environment is created; the projects are implemented with care and produce results; and that all of the pennies are pinched and accounted for.

It's, like I said, you have to be insane...

The good, the bad and the proposals

There are very few people in high level, decision-making positions below the age of forty in the NGO

sector. This is true for many sectors in South Africa – young people in leadership positions, who are able to influence policy decisions, are relatively rare in our country. But our numbers are increasing.

I just recently turned 30 (there, I said it!) and my age has had a number of implications for me. Surprisingly, and perhaps naively, I never thought it would. I thought that if I worked hard and gave it my all, older people would take me seriously and respect my contributions. Very few do. This is the social development sector. Surely we are beyond discrimination and we recognise the contributions of all? Um, not really... In everyone else's defence, I think I am also facing multiple stereotypes though – young and female! Good grief!

...I thought that if I worked hard and gave it my all, older people would take me seriously and respect my contributions. Very few do...

To all the young leaders out there, you probably aren't alone in your experiences and frustrations. In your darkest hours remember my words and know that we suffer together... These are some of the things I've learned:

- **Don't worry your pretty little head about it**

Condescension takes many forms. It could be the blatant, 'You don't have as much experience as me, and so, what do you know?' In my experience, however, it is more likely to take the form of misguided 'protection'. Older people who are supposed to support you, start to have secret meetings and communications about how

'concerned' they are. They start strategising on how they're going to 'deal' with you. It is very seldom that you, as a young leader, will be openly confronted about issues. And the really funny thing was that when I found out about all these secret communications and openly addressed the issues and provided people with the correct information, it turned out that the 'concerns' were actually groundless. They stemmed from the secrecy. By trying to 'protect' me, they did more damage than they anticipated.

...strangely, I had never really experienced discrimination, until I became a director....

At the time I was so angry and I felt so betrayed. It took me a long time to overcome the bitterness. Traces still linger. Looking back, however, I think that these individuals really were trying to shelter me and were 'doing it for my own good', almost like they thought I might break under the strain, if they told me how they really felt and asked me direct questions, that I didn't have the experience to properly cope with a difficult situation. I related my story to other young leaders and found out that I was not the only one to have gone through this. When this happens to you, remember that, it is not a reflection of your competence or lack thereof, but rather an indication of their poor judgement and, probably, misguided 'good intentions'.

How to deal with it? I don't think I know the answer to that question. Strangely, I had never really experienced discrimination, until I became

a director. I'm a bit of a hothead when it comes to discrimination (of which condescension is a form) so I tend to go nuclear. I can tell you that this is not the right response – I've tried it; don't go there. I did realise that the only way to change their minds about my abilities, was to change their minds. This change takes time, constant communication and consistency. It is never easy to change someone else's preconceived notions about you, especially when those notions are determined by something beyond your control like your age, gender or race. It is so incredibly painful and their inability to acknowledge any excellence on your part, may cause you to doubt yourself.

- **If jealousy is the green-eyed monster, what colour eyes does self-doubt have?**

Ah, self-doubt... No human being can hurt us as much as we can hurt ourselves and self-doubt is the most effective 'weapon' we have with which to mutilate our souls. It can totally paralyse you, keep you awake at night fretting over every little decision you've made and cause you to undervalue and reduce the importance of every success you've ever had. Other people's negative words pound in your ears, drowning out all the kind words and compliments you've received. There was a period of many months where my self-doubt 'crippled' me. Every day, I had to drag myself through the miserable swamp of my existence. I felt very sorry for myself and needed several tissues for my issues.

What got me through? Firstly, I talked to people that I trusted about the way I was feeling

and found out how they dealt with their feelings of self-doubt. It helps to know that you aren't alone in this. The real turning point came when I suddenly realised that I had failed at something *and* that it was okay that I had. I was one of the 'failure is not an option' kind of people. It was my own fear of failing that fanned the flames of my all-consuming self-doubt. It was this fear that gave the harsh words of others more power, than they were due.

...no human being can hurt us

as much as we can hurt ourselves...

*I was one of the 'failure is not an option'
kind of people...*

Now, I'm the 'failure is an option, it is inevitable and the odd failure is probably preferable to no failure at all' kind of person. The painful slap on the forehead that is failure can be a positive opportunity for growth and learning! It knocks you right out of your comfort zone and forces you to face the unknown. You hear these things said, but I had never really believed it – after all, I never fail! Now I can say with 100% confidence that failure is a fabulous (albeit excruciating) thing, as long as you have first tried your hardest not to fail and then tried your hardest to learn from the failure.

And when I gave myself permission to fail, despite my best attempts to avoid it, I started to realise that if I can fail and make mistakes then so can others. And that if others are fallible, then I need to start taking the negative words I

receive from them with a pinch of salt, because they could be wrong. And I needed to start paying more attention to the compliments I received, because they could be right.

I also learned that a little bit of well-managed self-doubt is useful. A wise woman once said to me that 'A leader with no self-doubt is a scary thing indeed'.

- **You're such a know-it-all...**

The problem with some young people is that they think they know it all. The problem with some older people is that they *know* they know it all. I have come to the contentious conclusion that none of us know anything *really*. Sure, you know how to download ringtones or surf for porn or maybe you know how to upset your kids when you say that Eminem is the devil's mouth piece. But what do any of us *actually* know about resolving conflict, building good relationships, developing our spirituality, overcoming difficulties, the meaning of life? What we do have, are ideas and a collection of experiences that helped create those ideas.

*...now I can say with 100% confidence
that failure is a fabulous
(albeit excruciating) thing...*

At one point, I really valued other people's advice and would religiously implement what they advised me to do only to have it 'backfire' in some remarkably spectacular way. It was after several such experiments that I realised

that I can only take other people's advice *under advisement*. I have to collect advice, piece it all together, tap into my own body of knowledge and compare it to the situation I now face. Nobody in the whole history of humankind has faced the same situation I now face. Their solutions are not my solutions and I am the only one who can decide what the best solution is for me right now. My solution may fail, but then I will be in a better position to understand why it failed and learn from it.

...the best gift you can give yourself, as a young leader, is to surround yourself with people you trust to give honest advice...

The best gift you can give yourself, as a young leader, is to surround yourself with people you trust to give honest advice, people who will really listen to you and who have the skills and knowledge to support you. Try to get a group of strategic advisors with diverse ages, genders, races, sexualities, education level and so on. When faced with a tough decision, call on all your sources of information and advice, ponder their contributions thoroughly, sleep on it if you can. Rinse and repeat until you feel you have enough information and that your decision is the best possible decision you can make *at this time*.

A wise man once said to me that *'sometimes it's better to make a bad decision, than no decision at all'*. A leader held back by indecisiveness is a leader in name only.

- **Know your place...**

If you want to be a young leader, get used to the fact that many of the older, more *'experienced'* people that you work with will treat you with a fair amount of disrespect. Your calls won't be returned, you'll receive snotty emails and letters, people will say things to you that will make you want to instantaneously combust. You will know that your older counterparts don't get treated with the same disregard, which makes it even harder to deal with. It is all part of human nature and how the *'pecking order'* is established, *'helping you'* – the young person – understand that you are at the bottom of the pecking order.

...there are days when I wish I was younger still, so that it would be okay for me to throw a tantrum...

Best I can tell, from where I'm standing now, there is nothing for it. People will be people and sometimes people can be really foolish and insecure. That is what the *'pecking order'* is about – *'I don't feel secure in myself so I need someone to look down on (and make miserable) so that I can feel better and today that person is you'*. When I was describing how angry and frustrated I was feeling, another wise man said to me that *'it doesn't help to get angry and defensive. Rather, when you start to feel that way ask yourself what your objective is and what do you need to do to achieve it'*. The other thing that he said was that I should look at these

'irritations' as 'opportunities', as opportunities to grow, reflect and achieve success in the face of adversity.

Why being a young NGO director doesn't suck entirely

Yes... Being a young NGO director is full of challenges. Yes, it's very difficult to deal with the demands of the job *and* the stereotypical thinking of others. Yes, there are days when I wish I was younger still, so that it would be okay for me to throw a tantrum (you know the kind where you roll around on the floor, screaming, kicking your legs, flailing your arms a bit). I even wish I had the power to 'Jedi mind trick' people into being less annoying. Truly, there are days when it really, really, really, really isn't fun. But then, what in life, that is truly *worthwhile*, is also 100% fun. Even 'fun' is never 100% fun. Think about it.

...I reckon there's plenty of time to be old and cynical later. Right now we need passion, vision and hope to get us out of the mess we're in...

So, amidst all the angst and stress of my position, I constantly remind myself that the world needs 'youthfulness' just as much as it needs 'maturity', and that my contribution as a young person is important:

- Young people are far more inclined to speak openly and honestly and are far less skilled at 'diplomacy', than older people. What this means is that young people are far more likely to say exactly what they mean even if this gets them into trouble (I've been there). It also means that the real issues will be the

ones under discussion. None of this 'quiet diplomacy'; thanks. (I'm starting to suspect it doesn't work.)

- Young people have an incredible capacity for idealism and are able to clearly see, in their hearts, a better world. It is something we are criticised for. It's often called 'naivety'. Well, I reckon there's plenty of time to be old and cynical later. Right now we need passion, vision and hope to get us out of the mess we're in.

Despite everything I have experienced since I took on this position, or maybe because of it, my life is more profound than I ever dreamed possible. My life has meaning. It is *worthwhile*. I often wonder how many people can say that – too few, maybe.

So, yes... I get up everyday, and weekends too, and I sit down in front of my laptop to type reports and policy documents that no one reads; I put on a façade of ignorant cheerfulness in the face of being treated differently, because I'm young/female/both; I sit through the endless and distressingly boring meetings that seem so in fashion right now; I do a general office yell of 'Who keeps printing these damn pictures of Caprice!' all because, strangely, these are all the things I need to do to achieve my objective.

My objective, my dream is a future free of injustice, a place where all human souls are ablaze with potential and exhilaration. I know that, as a young African, that future is not mine to *take*. That future is mine to *create*.

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Condom use in Nigeria:

Complexities, barriers and realities

Introduction

More than 25 years after the definition of HIV as the primary cause of AIDS, HIV infection remains a major global health disaster, with increasing new infections particularly in sub-Saharan Africa.¹

Condom use is one of the 'ABC' triad of prevention of sexual transmission of HIV. This triad is perhaps the earliest preventive measure for HIV transmission. However, the inability of this measure to bring about sustained significant reduction in global new HIV infections has paved the way for research and development of new prevention technologies.

Unprotected sexual intercourse is the most important transmission route of HIV infection worldwide.² Although receptive anal sex is estimated to produce the highest risk of HIV infection, infection after a single vaginal insertive contact has also been described. The presence of other sexually transmitted diseases markedly increases the risk of becoming infected with HIV.²

The promotion of condom use is one of the major control measures for HIV in Nigeria; a country with the third largest number of people living with HIV in the world. Infection levels vary radically across this large country, from 1.3% in the south west to 4.9% in northern and central areas.

Condoms are an effective tool for the prevention of sexual transmission of HIV, when it is used consistently and correctly.³ However, there are complexities and challenges surrounding this '*powerful weapon*' in the response to HIV and AIDS. Condoms in Nigeria are synonymous with the male type.⁴ Female condoms exist only as a piece of information. It is rarely seen or used. The female condom situation is so pathetic that the majority of healthcare workers have never seen one. This is bad news, because if people, who work within the confines of the healthcare industry, display so much physical and mental ignorance about female condoms, then the generality of Nigerians are far from its reality.

Thus, the discussion is focused predominantly on male condom use in Nigeria. Nigeria, an African nation on the west coast of the Atlantic Ocean, is a complex country; the most populous black people on earth; multiethnic and multi-religious; and a rich, but poor people. Expectedly, the issue of condom use in Nigeria, like many other things, is also very complex. This article discusses this '*complexity*' of condom use in Nigeria, its implications, barriers and realities and the possible ways out of the doldrums.

Condom Use: A collective responsibility

Condom use in the context of prevention of transmission of HIV is a collective responsibility of all. The '*all*' here connotes everyone – the government

at all levels, policymakers, community leaders, condom manufacturers, development partners and donor agencies, parents, student unions, youth organisations, women societies and individuals.⁵ To ensure a sustained consistent and correct use of condoms in any community, all the aforementioned parties must work together in unison. The attainment of this unison is, however, difficult – hence, the negative realities that engulf condom use in most resource-poor settings.

The disconnect amongst the stakeholders is responsible for the failure of condoms as an effective HIV preventive tool in Nigeria. It is unlikely that the situation of condom use will improve until some critical changes occur in the belief system of people; the societal evaluation of women in relation to sex; female sexual and reproductive health and rights; and government's social responsibility to the citizenry.

Sexual Behaviour of Nigerians

In Nigeria, sexual behaviour is generally considered a secret and a personal matter. Open discussion about sex is forbidden and regarded a shameful issue. There is also a traditional belief that a man's sexuality cannot be confined to a single woman.⁶ Traditional and social institutions also encourage extra-marital relationships. Sexual behaviour is dynamic and not static and it changes as the society evolves. In the past, the incidence of pre-marital sex was very low. It was frowned upon by society, who expected girls to preserve their virginity until marriage. But nowadays, it is very common that some men refuse to seal marriage with their lovers until they become pregnant. Unprotected pre-marital sex is a common practice in Nigeria.⁷

Barriers to Condom Use in Nigeria

There are barriers to consistent and correct use of condoms in Nigeria.⁸ They vary from lack of political commitment and inconsistent policy development to unfriendly advocacy methods and a lack of individual responsibility. Some of these factors are briefly discussed below.

Lack of Political Will

There is lack of political will on the side of government to ensure that good-quality condoms, both male and female, are affordable and available for use by the sexually active population. The lack of political will, as it affects condom use, can be seen as a result of the belief system of the leaders, their cultural affiliations, and level of reproductive health education. For instance, if the majority of political leaders of a country does not believe in condom use, it may be difficult to support policies that promote condom use.

Corruption is another major problem that weakens the political will, and diverts funds meant for social and developmental issues to private pockets. Because of weak political will, government is not doing much in providing funds and logistic support for strategic programmes that will bring condoms to the doorsteps, bags, purses or hands of vulnerable and high risk populations.

Inconsistent Policy Development

The phrase '*inconsistent policy development*' is an understatement. I doubt if there is any serious policy direction on consistent and correct use of condoms as an effective control tool for HIV transmission in the country. However, this is not to say that there are no

sporadic *'knee-jerk efforts'* here and there on condom procurement and distribution, but they are, at best, incoherent and thus ineffective.

There are no updated guidelines and policies on effective logistic systems that ensure effective distribution of condoms to the consumers at the grassroots. There is no policy that focuses on the delivery of free condoms to settings inhabited by high risk populations, including sex workers, long-distant drivers, itinerant female traders at motor parks and public garages, uniformed service personnel and tertiary school students.⁹ As of now, there is no existing policy on female condoms – which is part of gender inequality and violation of the rights of women to protect themselves from the risk of HIV transmission.

Unfriendly Advocacy Methods

Although government cannot do everything, it is, however, sad that it has abdicated its advocacy role on condoms to non-governmental organisations (NGOs). But, NGOs are not much better than the government. Their weaknesses range from unfriendly advocacy methods and harsh campaign strategies to maladministration and corruption. NGO activities on promotion of condoms in Nigeria are shallow and discordant. It is the responsibility of the government to provide the enabling environment, logistic support and policy direction for NGOs to carry out their functions effectively.

Religious Institutions versus Condoms

There is a perception that people who use condoms are *'those'* with multiple partners and *'those'* who visit sex workers.¹⁰ Condoms are also associated

with treatment of sexually transmitted infections and HIV. There is a *'functional ban'* imposed by religious institutions on condoms, describing it as a satanic instrument and an agent of sin. This, no doubt, affects people's psyche and brings about feelings of guilt and shame. Since religious leaders are supposed to preach about living a sinless life, promoting condom use for prevention of sexual transmission of HIV may be equal to encouraging immorality or causing distrust among married couples. But, what about the fact that the majority of new infections in women are from their long-term male partners.¹¹

Cultural Complexities around Condom Use

The typical traditional African culture is a complex phenomenon. It disempowers women in all ramifications; encourages masculine excesses over women; and supports age-long traditions and myths that perpetuate the denigration of the sexual and reproductive health of women. It is not too much to say that the typical African culture promotes sexual irresponsibility on the part of men. This has a negative impact on the use of male and female condoms. It is also a taboo for an African woman to insist on her male sexual partner to use condoms, even in casual relationships.

Since a woman is seen as part of the man's property and she can be used at his whims, even sexually, condoms are infrequently used in stable monogamous or polygamous relationships in Nigeria.¹² Cultural complexities have put women at great disadvantage in sexual and reproductive health; and constitute a critical barrier to consistent and correct use of condoms in African societies. For some, there is an association of condoms with casual

sex and not with intimacy and trust. Many women are unable to negotiate condom use, because men control whether or not condoms are used.

In Nigeria, people are afraid to handle or talk about condoms in public places for the fear of being stigmatised or called bad names. In fact, when people come to shops to buy condoms, they use different names to refer to it. Psychosocial inaccessibility brings about functional inaccessibility.

The Psychosocial Inaccessibility of Condoms

There is need to redefine accessibility of a product for use. A product may be available and even physically accessible, but because of fear and stigma it is psychosocially inaccessible. This phenomenon is very critical to condom use in settings where there is palpable stigma around it. Psychosocial inaccessibility of condoms is a major challenge to condom use in Nigeria. It brings about functional inaccessibility. For example, all the shops in a town may be packed with boxes of free good-quality condoms and people are aware, and even know that condoms are protective, but people are not using condoms for fear of being stigmatised.

Failure of Product Regulatory Agencies and Burden of Substandard and Fake Condoms

There are uncertainties about the quality of condoms that are available in the markets. The issue of fake, substandard or expired condoms is a big problem. Studies have shown that incidences of slipping and/or bursting of condoms during sex constitute a major barrier to its use. In a setting where product regulatory agencies have failed woefully to ensure circulation of good quality condoms, and

where profit making is exalted above the value of life, it seems more reasonable to avoid using condoms, than to have a false sense of protection.

Lack of Individual Perceived Risk of HIV

The lack of perceived risk of acquiring HIV appears to be one of the most important barriers to the use of condoms. The response to HIV and AIDS is everyone's responsibility. However, there is still a general passivity about condom use and HIV in general. People do not want to take responsibility for their lives and health. There is a general saying that, *'everyone will die one way or the other, and that HIV is just one of the many causes of human deaths'*.

In as much as I agree that sexual responsibility or otherwise is a product of a myriad of factors – such as one's religious persuasion, cultural background, socio-economic status, parental upbringing, gender and general life philosophy – some people have all the favourable factors, but still engage in high risk sexual behaviour. The World Health Organization defines health as a state of complete physical, social and mental well-being. Psychosocial wellness includes taking responsibility for one's health life. Condoms can only be correctly and consistently used, when people start to take responsibility to protect themselves and others from HIV.

Condom's Physicochemical Barriers

Condoms are a product for human use and, thus, there may be various complaints attributable to its nature, content or use – constituting barriers to correct and consistent condom use. Condoms cause loss of direct contact between the penile shaft and the vagina and may reduce sexual satisfaction. Studies have also

reported loss of sexual satisfaction as a major barrier to the use of condoms by sexually active people. The thin layer of fluid on the condom may also cause excess lubrication, resulting into loss of friction and sexual satisfaction. Some condoms are so thin and fragile that they easily burst or leak, causing disappointments, fears and depression. Condoms made of latex can result in penile or vulvo-vaginal skin reactions, particularly in people with personal and/or family history of allergy to this chemical. Itching of the sexual organs after condom use can serve as a negative reinforcement for future use.

Personal and Community Illiteracy

The larger part of the Nigerian population of about 140 million is illiterate. Illiteracy in this context is defined as lack of formal education. Education empowers individuals to make informed decisions and to be in control of their sexual and reproductive health. It also enhances life skills that favour pro-health sexual behaviours.

Most of the scanty efforts of condom use campaigns are concentrated in the urban cities and towns. The rural settings are mostly cut off from these resources, thereby, deepening the level of community illiteracy on HIV and condoms, as well as health issues generally. Unfortunately, about two-thirds of the population in Nigeria live in rural areas.

The Issue of Fertility in African Societies

Fertility is another factor militating against the use of condoms in Nigeria.¹³ Fertility is a passionate issue in black African societies. Naturally, women who want to become pregnant may care less about their exposure to HIV risk, and steer clear of condom use.

Recommendations

The following are some of the measures to address the above challenges so as to ensure total access to quality condoms, and sustained correct and consistent use.

- Development of comprehensive, research-based national interventional policies on condom use. These policies should be based on country-wide research that clearly highlights the challenges and realities surrounding condom use. However, a policy remains only a paper work, until it is backed-up with substantial political commitment, adequate funding resources and an enabling environment.
- Support for local production of condoms in the country and enhancement of capacity of product regulatory agencies, so as to ensure high standard and good quality condoms for use. Condoms should be freely available everywhere and delivered to points and places that are accessible to the sexually active people.
- Culture-sensitive and religion-friendly educational campaigns should be adopted to improve public knowledge of the efficacy of condoms and to dispel misconceptions, myths and ignorance surrounding its use. Grassroots 'penetration' of advocacy messages can not be overemphasised. Campaigns that encourage personal risk assessment should be complemented with marketing campaigns that emphasise positive attributes of condoms.

- There is a need for continuous well-structured stakeholder meetings to strengthen the advantages of condoms and fine-tune strategies to ensure its consistent and correct use.
 - There is a need for the provision of sexual and reproductive health services for populations at high risk of HIV.
 - Men-folks should be encouraged to attend family planning and antenatal services with their partners – as these are, currently, the avenues where condom counselling services are provided.
 - General policies of government should be given a feminine face.
 - Government must develop and/or change legislation to promote the reproductive and sexual rights of women. This should include the rights of women to protect themselves from the risk of HIV transmission.
 - Alternatives to condoms need to be developed. Microbicides and other female controlled methods of protection could potentially fill the current gap.
- infection in these relationships, and can be used whenever condoms are not being used. However, even when an effective microbicide is identified, condoms will still have an important role in HIV prevention.

FOOTNOTES:

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Conclusion

The article highlights the challenges and realities of condom use in Nigeria. Although further investment in condom supply, distribution and use is needed, many people will still not use condoms, especially with their stable partners.

Microbicides could potentially fill an important gap in providing protection against HIV and STI

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Consultation...

Consultative process for the Western Cape Provincial Strategic Plan

Introduction

The National Strategic Plan for HIV & AIDS and STIs (2007-2011) was adopted by the South African cabinet in May 2007; to the approval of AIDS activists in South Africa and around the world. The ambitious targets and new monitoring and research components of the policy signalled to many an end to the era of *'denialism'*, and political intransigence, by the South African government on HIV and AIDS. However, a national implementation plan was not created for the new AIDS plan as provinces were given the responsibility to create their own implementation plans.

This article analyses some of the challenges of the Western Cape provincial consultation process for the National Strategic Plan for HIV& AIDS and STIs, a process that, as will be argued, has not adequately enabled local activists and caregivers to give their input on this policy.¹ Using the analysis of the provincial consultation process, this article also draws comparison to the NSP and other policy consultation processes.

Background

The National Strategic Plan for HIV & AIDS and STIs (NSP) was drafted in the aftermath of international condemnation of the South African HIV & AIDS policy, following the 2006 World AIDS Conference held in Toronto, Canada. At this conference AIDS activists from around the world challenged the South African governments' inaction on HIV and AIDS, and for its display of garlic and beetroot as treatment options.²

The absence of the Minister of Health, due to illness in February 2007, combined with the negative publicity generated by the World AIDS

Conference, created the political space needed to change the trajectory of South Africa's public sector HIV and AIDS response. The National Strategic Plan (NSP) was the outcome of this process.

Led by Deputy President Phumzile Mlambo-Ngcuka, then Deputy Minister of Health Nozizwe Madlala-Routledge, the Head of the National HIV/AIDS Unit Nomonde Xundu, and TAC activist Mark Heywood, the NSP was drafted through extensive consultation with key civil society groups through the re-structured South African National AIDS Council (SANAC). The NSP went through over ten drafts and set the ambitious targets of reducing the HIV infection rate by 50%, and placing 80% of people needing treatment on antiretroviral therapy by 2011.³

The establishment of a monitoring and evaluation component and aggressive treatment targets were significant accomplishments for civil society, as the strategic plan for the 2000-2005 period was characterised by slow implementation and a lack of accountable oversight. According to several individuals involved, the policy process was dominated by civil society representatives, particularly those associated with the Treatment Action Campaign.

However, the NSP is a set of national guidelines, not an implementation strategy – as provinces were given the responsibility to create their own implementation plans. Due to this shift in responsibility, the policy process may be entering its most crucial stage in 2008, as provincial implementation strategies are drafted and negotiated.

This analysis focuses on the provincial policy

process in the Western Cape. The process began in 2006, when the Western Cape Department of Health drafted a new provincial prevention strategy. Rather than serve solely as a provincial draft document, this prevention strategy fed back into the NSP drafting process at the national level. After the national plan was finalised and adopted by cabinet in May 2007, a Provincial Strategic Plan (PSP) was drafted for the Western Cape by the Provincial Inter-Departmental AIDS Committee (PIDAC) and released to representatives on the Western Cape Provincial Aids Council (PAC) in October 2007. The provincial draft plan builds off of existing initiatives in the Western Cape that were analysed and linked to targets set in line with the four priority areas of the NSP – Prevention, Treatment, Care & Support, Monitoring and Evaluation, Legal and Human Rights. However, as a draft policy document, the PSP was not released for public discussion.

Consultation

Although many organisations had not yet had the opportunity to review the details of the draft plan, consultation with civil society and community-based organisations (CBOs) began in February 2008. The Networking AIDS Community of South Africa (Nacosa) was directed by the Western Cape PAC to lead the civil society consultation process, utilising its quarterly district meetings to meet with stakeholder organisations in the community and channel their feedback into a revised provincial policy.

On Friday, 29 February 2008, the first consultative meeting was held in the city of George for the Southern Cape health district. Members of civil society and a handful of government representatives came together for a one-day, four-hour conference to discuss the provincial draft plan. Presentations by Nacosa and the Western Cape Department of Health gave an overview of the HIV and AIDS epidemic in South

Africa, and some of the specific challenges faced in the Western Cape. Although a final presentation from the AIDS Legal Network allowed for significant audience participation in addressing the issue of stigma, other presentations generally focused upon the statistical trends of the epidemic, while emphasising the core themes of the policy: prevention with a focus on youth, increasing the age of sexual debut, reducing the number of concurrent partners, reducing the risk and vulnerability of younger women who partner older men, and increasing the use of condoms.

Although the presentations emphasised that the provincial draft plan was a work in progress that could be shaped by the input of those attending the meeting, the way in which the information was presented did not necessarily cater for audience participation. The presentations moved quickly through dense slides containing statistical information on topics, such as prevalence and mortality, which were presented in the language of public health and HIV and AIDS specialists.

After the presentations, participants were asked to discuss in small groups – organised by sub-districts – various questions⁴, and to present their feedback. The report-backs consisted of requests, such as access to, and education on, female condoms, training for educators, legal rights training and project management. These needs were interspersed with stories of public sector nurses stigmatising HIV infected patients, non-functional sub-district Multi-Sectoral Action Teams (MSATs), and unlawful restriction on access to condoms in schools. Although little time was allocated and no written policy documents were provided to conference participants, coherent and organised presentations were given that painted a challenging picture of the South African HIV and AIDS epidemic.

Other consultative meetings were held in

Metropole (07 March 2008), Caledon (14 March 2008), Beaufort West (28 March 2008), Piketberg (17 April 2008), and Worcester (18 April 2008).

While most of the meetings were very similar in their format and content of discussion, the Metropole meeting differed significantly from the other meetings, as the attendees openly expressed their frustration with the consultation process. Several participants asked that the consultation period be extended, while others stated that the provincial plan should be compiled based on a needs-based sub-district analysis of the Western Cape. One participant demanded that civil society have authorship of the policy, instead of being consulted on a plan that has already been drafted. The meeting was politically divisive, with some working groups internally divided over whether to support the consultative process, and one abstaining from doing so. The Metropole meeting was adjourned without a clear way forward for responding to the HIV and AIDS epidemic in the Western Cape Metropole.

Comparing consultation on the NSP and PSP

While the national-level consultation process for the NSP has been hailed by all parties involved as an exhaustive process, it is important to contextualise this in light of earlier HIV/AIDS policy processes. Consultation over the National AIDS Plan (1994) began with a conference in 1992 that was attended by nearly 450 participants from different sectors of South African society.⁵ There was also significant consultation on the National Strategic Plan 2000-2005 and the Operational Plan for Comprehensive Care, Management and Treatment for South Africa (2003). This has led some to characterise the current NSP as the latest in a long line of policies that have been developed through a consultation process with civil society. That consultation occurred for these policies

is not up for debate, but of what character was this consultation and who was involved?

One of the key differences in the NSP 2007-2011 is that the opinions and input of public health experts and academic specialists were outweighed by the political imperative to create a new and better HIV and AIDS policy in the aftermath of the Toronto conference. Civil society defined treatment targets as necessary to prevent further government inaction. The NSP is thus, an important departure from earlier HIV and AIDS policies, in that the government can be held accountable to its treatment goals. However, an important dimension of this consultative process was that the majority of participants were research specialists or members of national leadership in civil society organisations.

Although substantive consultation did occur for the NSP, it was not community activists who gave their input. I spoke with one person who had attended the consultative meeting held in George who had this to say about the consultation process:

The NSP and the PSP that we are having in our province haven't been discussed in our district. We were not invited. The policies were drafted without consulting us as the organizations locally. So we find out that they will be giving us only the policy that has been drafted already without consulting us about what we are facing, what are the issues we are having, and what we need in order to implement all of the things we are lacking for.

The NSP was a national-level initiative that was driven by top civil society leadership in organisations that did not involve internal consultation with their district-level branches. While a series of 'NSP Imbizos' did occur over the course of 2007 to consult with communities about the content of the national policy, it is unclear whether this process occurred within organisations themselves. However, the NSP process was driven by the political imperative to create a

new national policy framework for managing HIV and AIDS, not to determine the capacity or audit of needs of civil society organisations on a national scale. An undertaking such as this is not necessary for the production of treatment guidelines, but it is essential for the creation of an implementation plan for a joint civil society-government initiative. Due to this fact, the provincial process becomes very important in ensuring that community-based organisations get an opportunity to interact with government and other civil society groups around the policy. Unfortunately, this is not how the process has occurred in the Western Cape.

The consultations that have occurred for the Western Cape PSP largely excluded the input of *'ordinary people'*, who are doing extraordinary things to halt the spread of HIV and AIDS in South Africa. The Western Cape PSP was drafted by the Provincial Inter-Departmental Aids Committee, a collection of government policy experts, based upon an analysis of existing initiatives in the province and how best to *'ramp up'* these projects to meet the goals of the NSP. Similarly, policy presentations are couched in *'elite'* or technocratic terminology, making the policy largely inaccessible to the majority of civil society participants.

While public health experts are capable of explaining the Western Cape PSP in plain and accessible language, it would have, however, demanded more meeting time to adequately discuss key aspects of the policy, how they relate to the particular activities in a district or sub-district, and the way in which organisations should plan to alter their programmes to coordinate a joint civil society-government response. The bottom line is that adequate consultation over the allocation of public resources cannot be effectively negotiated, if participants do not sufficiently understand the policy.

This is perhaps the key difference between the

national and provincial level consultation processes: in the provincial process it is not highly trained specialists or national leaders who are involved, but local people working in community-based civil society organisations. However, the consultative meetings in the Western Cape have generally not been organised in a way that takes into account this key difference. The presentations have been pitched at policy *'experts'*, not local practitioners. Can community health workers be expected to contribute to HIV and AIDS policies that are explained in abstract scientific terminology? There is no doubt that specialists are needed to guide the PSP planning process, particularly with reference to issues of costing, as well as the coordination of existing initiatives. But where should the balance lie between the *'voices on the ground'* and the *'policy experts'*? People working at a community level know where problems occur within each respective district or sub-district and should thus, inform policy responses. How best can this *'local'* knowledge be leveraged to inform the expertise of public health and HIV and AIDS specialists, and direct the final draft of the Western Cape PSP?

The Western Cape PSP and policy consultation in the post-apartheid period

The NSP and PSP consultation processes are not unique in the post-apartheid period. While it is beyond the scope of this article to examine a representative sample of the social policies that have been adopted since the negotiated transition out of apartheid, an analysis of the consultative process around the Growth, Employment and Redistribution (GEAR) macroeconomic strategy and the social responses that this policy generated may offer insight into the possible outcomes of the Western Cape consultation process.

The GEAR macroeconomic strategy was the

product of a series of meetings with a small group of economic specialists from the private sector, government and academia. Starting in October 1995, work began on the policy to deal with economic instability, due to debt inherited from the apartheid era, and to create a foundation from which to build sustained economic growth. Restrictions on social spending, deemed to be necessary in order to stabilise the economy, led to decline in spending on health in real terms in 1997 and 1998 with subsequent spending increases far below that of the medical inflation rate, thus constituting a decrease in real terms⁶. The financial constraints created by GEAR necessitated the government to seek 'cost recovery' in the delivery of some social services, most notably in terms of the provision of water and electricity.⁷ This led, amongst other things, to the formation of social movements, such as the Anti-Privatisation Forum and the Soweto Electricity Crisis Committee, which organised communities to protest against privatisation and inadequate service delivery.⁸ The end result of the GEAR policy process has been social unrest over the distribution of services, and the destruction of the devices used to limit access to public resources.

GEAR and the NSP are nearly polar opposites when it comes to their content, aims, and the processes through which they were drafted. Perhaps most importantly, GEAR proposed to limit social spending, while the NSP proposed a massive increase in spending on HIV and AIDS, estimated to be between R39.8 – R44.9 billion for the 2007-2011 period.⁹ However, the political history surrounding GEAR should be considered by stakeholders driving the PSP consultation process – while the policies may be quite different, their destiny is intertwined. A medical doctor who used to work in a primary care clinic in Khayelitsha shared this disturbing experience:

I haven't experienced this in Khayelitsha, but in one specific day hospital, where I did locum work in Delft, patients really became violent. They started swearing at the staff, at the doctors, and they demanded being seen immediately because some of them were waiting from the previous day already. It's understandable that people will become frustrated if you've been waiting for more than 12 or 18 hours to be seen by a doctor. So I think most patients do understand the situation but it just takes a small number of patients to initiate a problematic situation and it is something that may happen. In a couple of day hospitals doctors have been assaulted by patients. So you are bearing the brunt of a system that is not capable of supplying people with what they actually need.

Violence in public health clinics is the most visible form of continuity with the social response to GEAR, but it is, thus far, spontaneous, without any organisational form, and grows out of frustration with inadequate public health services, not the NSP. But GEAR and the success of the NSP are inextricably linked due to the fact that the spending limits imposed by GEAR have created a lack of capacity in the public health system, which is collapsing under the weight of HIV and AIDS related illnesses. Provincial implementation strategies for the NSP must take into account that the public health sector is in crisis and tailor its responses to the uneven level of care provided at different service points.

The NSP, and by relation the Western Cape PSP, are proposing to reach ambitious goals, while the public health system is failing. The National Department of Health has not fast-tracked the accreditation process for health clinics to distribute antiretroviral drugs and this is causing huge backlogs at day hospitals. There has also been inaction on a central pillar of the NSP: task-shifting some duties of

doctors to nurses with respect to HIV and AIDS. This initiative is crucial for the public health system, as it can better deal with the increasing burden of HIV and AIDS, if nurses are allowed to monitor antiretroviral therapy, but has not been prioritised by the National Department of Health or SANAC. Currently the ARV clinics initiated by MSF in Khayelitsha are operating well over their capacities, and adherence is declining, due to the fact that patients must wait in long lines to get their medication.¹⁰ The public health system must be the foundation on which a coordinated response to HIV and AIDS is based, but this foundation is crumbling.

Conclusion: Dealing with Local Realities

In order to capacitate civil society to meet the challenge of reducing the infection rate by 50% and to increase the proportion of patients in need of care accessing ART to 80% by 2011, provincial plans must take into account the capacities of these organisations in the context of district and sub-district HIV and AIDS prevalence rates, and most importantly, empower activists to meet these goals by giving them a voice in how these plans are conceptualised and implemented. While technical expertise is necessary to draft *and* implement the finalised provincial plan, it must be nuanced by the local knowledge of non-governmental organisations and political realities on the ground.

Existing problems at the district and sub-district level include non-functioning coordinating mechanisms and divisive political dynamics amongst organisations that work side by side. These are the dynamics that will determine whether or not the targets of the NSP are met, not the high political drama that surrounds interactions between national institutions and 'elite' organisations.

While there is not single tried and true method to deal with these issues, if local realities are not

acknowledged and do not inform the final form of the different provincial plans, it is most likely that the NSP will become another South African HIV and AIDS policy that falls far short of expectations, when it comes to implementation.

FOOTNOTES:

1. The Western Cape provincial consultation process for the NSP took place between February and May 2008.
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Now More Than Ever...

Human rights are to be at the centre of the response to HIV and AIDS

...With the expanded resources now available for HIV/AIDS, it is finally possible to imagine HIV treatment programmes joining HIV prevention efforts in an integrated, rights-respecting continuum of services. Unfortunately, moralistic approaches to HIV prevention, which place new obstacles in the way of reaching populations that most need information and services, hinder such a comprehensive approach. [Joseph Amon, 2006]

At the end of 2007, more than 30 leading human rights and AIDS organisations issued a joint declaration calling for a major shift in the global response to HIV and AIDS. The global human rights declaration, **Now More Than Ever: Human Rights and HIV/AIDS**, highlights the need to place human rights and the protection of human rights at the centre of any efforts responding to HIV and AIDS.

Jonathan Cohen of the Open Society Institute (OSI), the organisation sponsoring the declaration, said at its release on 30 November 2007:

...It's plain and simple: without a greater focus on law and human rights, the global response to AIDS will stagger and fail ... This is widely recognized, yet few governments have ensured human rights protections for people living with, or vulnerable to, HIV.

The Human Rights Declaration comes at a time when effective HIV prevention, treatment, and care programmes are increasingly under threat – especially considering the WHO and UNAIDS released guidelines recommending that, in certain situations, people should be tested for HIV, unless they explicitly decline the test. Many human rights advocates worry that making HIV testing more routine, without scaling up human rights protections, could result in coercive, mass HIV testing programmes. Such programmes would further stigmatise people living with HIV, and deter people from accessing healthcare services.

In this context, Kevin Moody of the Global Network of People Living with HIV/AIDS, which endorsed the declaration, stated that:

...Universal access to HIV testing is critical, but there is no evidence suggesting that human rights need to be relaxed in order to achieve this goal ... public health and human rights can and should go hand in hand.

The Declaration introduces 10 reasons as to why human rights are to be at the centre of the global response to HIV and AIDS, including that

- Universal access will never be achieved without human rights
- Gender inequality makes women more vulnerable to HIV
- The rights and needs of children and young people are largely ignored in the response to HIV, even though HIV is significantly an epidemic of young people
- The worst affected receive the least attention in national responses to HIV
- Effective HIV prevention, treatment and care programmes are under threat
- AIDS activists risk their safety by demanding that governments provide greater access to HIV and AIDS services
- The protection of human rights is the way to protect the public's health
- AIDS poses unique challenges and requires an exceptional response
- Rights-based responses to HIV are practical, and they work
- Despite much rhetoric, real action on HIV/AIDS and human rights remains lacking

Since its launch, an international endorsement campaign has been under way to collect a minimum of 500 endorsements – culminating with a global march for human rights at the 2008 International AIDS Conference in Mexico City.

For more information and/or to endorse the Declaration please go to www.aln.org.za or to www.soros.org/initiatives/health/focus/law/articles_publications/publications/human_20071017.



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